

**HEALTH SEEKING BEHAVIOUR IN ASIKUMA-ODOBEN-  
BRAKWA DISTRICT: A PLURALISTIC HEALTH  
PERSPECTIVE**

Prince Michael Amegbor



Master thesis in Human Geography  
Department of Sociology and Human Geography  
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## **ABSTRACT**

The phenomenon of health seeking behavior in the developing world has always been of interest to both researchers and policy makers. Over the years many academic and policy research have been done on this subject, however, these works have often failed to capture the health seeking behavior from a pluralistic health system perspective. Most works have concentrated on one health system at the neglect of the other when examining the health seeking behavior in the developing world. In the ones that have examined this phenomenon from both modern biomedicine and indigenous traditional medicine, the concept of spirituality and health has been totally ignored or given little attention.

In light of this, the study sought to examine health seeking behavior in the Asikuma-Odoben-Brakwa district of Ghana from health pluralistic perspective giving attention to the issue of spirituality and health. The chosen study area is a predominantly rural district with few biomedical facilities thus helping to view the phenomenon from the angle of the rural, poor and vulnerable – a group that have been identified as most affected in the health care system of the developing world. A conceptual model of factors that determine health seeking behavior for both biomedicine and traditional medicine was developed based on a modified models of Aday and Andersen (1974) and Buor (2004) behavioral models of health care utilization. To appreciate the breadth and depth of this phenomenon, the study employed both quantitative and qualitative methods of research in soliciting for primary data from the field.

The findings of this study revealed that despite various policies made to make biomedicine accessible to Ghanaians such as introduction of the National Health Insurance Scheme and Community Health Posts, majority of people in the study district still use self-treatment as their first choice in addressing their health needs. Although a vast majority would prefer using biomedicine to meet their health care needs, barriers such as finance and time prevent them from doing so. The preference for biomedicine was high compared to traditional medicine or self-treatment among respondents irrespective of their geographic location, gender, educational and economic background. Financial barrier was also seen as a challenge to access to traditional medicine, especially with the monetization and formal institutionalization of the practice. The study also revealed that the media plays an important role in the decisions and drugs people use for self-treatment; also family and social relations play a key role in determining the choice of treatment for terminal and sever ailments.

The study also revealed a strong attachment among respondents and informant for spirituality and health irrespective of their socio-demographic background. Determining whether an ailment is spiritually caused comes through a complex process of social identification either by the patient or by a recognized healer. Patient often associated ailment with spiritual causation after failure of other remedies in healing and In the situation where the ailment comes after social dispute. Often, the choice of which type of healer used in addressing such ailment depends on

factors such as one's religious orientation. The practice of buying substances from drug peddlers believed to have special powers to solve and heal spiritual infirmity is also another health seeking behavior exhibited by informants and respondents in meeting their spiritual health needs.

## **DEDICATION**

To My God and King – Jehovah Nissi, I could not have done this without you.

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## **ABBREVIATIONS**

CAM	Complementary and Alternative Medicine
CHPs	Community Health Posts
EU	European Union
TMPs	Traditional Medicinal Practitioners
USAID	United States Agency for International Development
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

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# CHAPTER 1 INTRODUCTION AND BACKGROUND OF STUDY

## 1.1 Background of Study

The health of a population is an important element in its ability to progress and develop. To improve the health of the population in the developing world, health services must be capable of delivering effective health care and the members of the population must use these services. Several studies conducted by researchers (Leslie 1976, 1977 and 1980, Nichter 1978, Press 1978, Kleinman 1980, and Young 1983) have shown that the medical system in many places, especially in the developing world, is pluralistic – that is, people use both Western biomedicine and non-Western form of health care in meeting their health needs. For most inhabitants in the developing world, access to biomedicine remains a challenge; hence patients use folk or traditional medicine more frequently because it is more easily accessible. Aside its easy accessibility, traditional medicine is also embedded in the cultural and the belief system of the indigenes, thus making it acceptable to them (Anyiman 1987 and Twumasi 1988).

Yet, over the years from colonial to post-colonial eras, the aim of many governments in the developing world has been to promote modern biomedicine and to increase its accessibility. These attempts have ignored the fact that people in this part of the world have their own set of local beliefs and practices regarding illness and diseases. Kroeger and Franken (1981 cited by Subedi 1989) reported that the preference for folk or traditional medicine over modern health care is due partly to the “social distance” between the latter and the people in the developing world. Gesler (1984 cited by Subedi 1989) further states that healing or treatment has two function from the perspectives of patients in this part of the world – control of sickness and providing meaning for a person’s experience of sickness; however modern biomedicine only performs the first function. This is not to say modern biomedicine does not provide meaningful explanation of sickness, but the explanations it gives are not from the social and cultural perspectives of patients in the developing world. Thus, traditional medicine offers a satisfying and culturally meaningful interpretation of the illness, hence despite the effectiveness and curative power of modern biomedicine, it is widely not used by the populace here (Subedi 1989).

Patients in the developing world exhibit a health seeking behavior termed by Kroeger (1983) as healer shopping. This phenomenon is defined by Kroeger (1983 cited by de-Graft Aikin 2005) as “the use of a second healer without referral from the first for a single episode of illness”. According to de-Graft Aikin (2005), studies have shown that this phenomenon exists mainly as a response for chronically ill people in Africa. Its existence in the African health care system is due to the existence of spiritual cause etiology for chronic illness and the need for cure for these kinds of illness. The idea of spirit caused illness finds its root in the indigenous African traditional religion and other indigenous religions in the developing world (Twumasi 1975 and de-Graft Aikin 2005). This idea thus endorses the traditional healer as the only person with the knowledge and expertise in treating and healing such illness. The divorce of from the supernatural by modern science means that illness with a perceived supernatural cause can only be treated by the traditional healer and with traditional medicine. de-Graft Aikin (2005), however, corrects the pre-existing notion that the phenomenon of healer shopping depends entirely on cultural and other theories of illness causation, she affirms that the economic constrain of modern health care system in Africa and the existing of few resources for treating and caring for chronic illness makes traditional or ethno-medicine the primary health care choice for most African population. This phenomenon is presented in a study conducted on malaria in rural Burkina Faso; in the study, local concept of illness associated with malaria were identified and patterns of treatments used by patients examined (Beiersmann et al. 2007). Beiersmann et al. (2007) observed that respondents use traditional medicine for certain diseases such as *dusukun yelema and kono* (respiratory distress syndrome and cerebral malaria respectively) whereas respondents in the study used a mixture traditional and modern medicine for diseases such *sumaya* (uncomplicated malaria), *djoliban* (severe anaemia) was treated with modern medicine. This study and many others as well as personal life experiences helped in shaping the research problem for this study.

## **1.2 Research Problem**

Over the years, scholars in the academia have conducted research on the health seeking behavior of patients in the developing world. These studies have led a number of quantitative models and frameworks on the access and utilization of health care; however their application in the

developing world is somewhat not reliable as a result of their focus on modern medicine only. In solving this problem, researchers (Andersen and Newman 1973, Aday and Andersen 1974, and Dutton 1986) have developed explanatory models of utilization of health services. These models failed in incorporating health belief systems into their analysis of health needs in the predominantly traditional societies in the developing world (Buor 2004); these models have failed to explore the want of people in the developing world to use traditional medicine, especially for spiritual purposes which may be important for their health.

Although various improvements have been made to the various models and new ones such as Buor (2004) have been introduced, all these models in their quest to provide an expression of the health care system in the developing world and the factors that account for the health seeking behavior of patients in the developing world have failed to capture the real picture of the health care system in the developing world. The models and studies conducted so far have tended to view the health need of patients in the developing world and even some parts of the developed world from a single perspective – the physical needs of patients. However, patients in the developing world exhibit a holistic view of health which does not only involve the physical need of healing afflictions, but also a spiritual need of removing the perceived root cause of their afflictions and restore harmony between the patient on one hand and the spirits and social environment on the other. There is little understanding of this phenomenon in existing literature. At first sight, spiritual needs of patients might be interpreted as referring to religious beliefs, but many people would say that spiritual needs are more than this. It may be an individual's sense of well-being, happiness or peace of mind. The models developed by researchers fail to take into account the relevance of this psycho-social aspect of health care for patients in the developing world and as such view health seeking behavior shown by patients in this part of the world from a monistic view.

In light of these shortcomings, this study will be examining the factors that account for health seeking behavior of patients in the Asikuma-Odoben-Brakwa district of Ghana in light of the pluralism that exists in the health care system and health needs of patients in Ghana and the developing world. An understanding of the dynamism of the health care system and needs of patients is vital for health care policy making and planning; as well as address the issue of how to meet the holistic health needs of patients in this part of the world.

### **1.3 Research Questions**

Health seeking behavior exhibited by people in the developing world is complex given the plurality of the health care system in this part of the world. However, these studies on health seeking behavior in the developing world have often ignored the phenomenon of health pluralism and examined patients' behavior from the perspective of a single health system. In addition to this, often the concept of spirituality and health is often given little attention in these studies. These studies have failed to capture the pluralism of health care in this part of the world and have sought to portray these two health systems as if they are separate entities which are mutually exclusive to each other in the view of the patient here. It is against this background that this study seeks to fill this gap in knowledge and examine the rationale behind patients' choice of a health system and the factors or rationale that motivate their choice.

This study seeks to answer the following questions:

- What is the existing health seeking behavior?
- What is the role of media and social relations in health seeking behavior?
- What is the link between spirituality and choice of health care?

### **1.4 Research Propositions and Hypotheses**

The propositions for the qualitative aspect of this study are

- The choice of healing system is more dependent on the perceived cause of illness rather than an individual's socio-economic background.
- The belief of spirit caused illness is a wide social phenomenon independent of an individual's religious orientation, level of education, economic status, place of residence and/or gender.
- The choice of physical treatment or seeking of spiritual remedy for an illness is a collective social decision involving the patient and close acquaintances.
- Perceived etiology of patients concerning an illness is dependent on the level of information available to them concerning the illness.

The formulated hypothesis for the quantitative aspect and statistical testing are

- There are no significant relationships between demographic variables such as place of residence, gender, education on one hand and health insurance status of respondents on the other.
- There are no significant relationships between demographic variables such as place of residence, gender, education on one hand and respondents' first choice of treatment on the other.
- There are no significant relationships between demographic variables such as place of residence, gender, education on one hand and respondents' view on which health system is more costly.
- There are no significant relationships between independent variables such as economic status, occupation and health insurance status on one hand and respondents' preferred health system.
- There are no significant relationships between independent variables such as economic status, occupation and health insurance status on one hand and respondents' view on which health system is more costly.

### **1.5 Relevance of Research**

The dream of having a universal health care coverage for all through the integration of modern and traditional medicines be best achieved by understanding and careful examination of the health seeking behavior of the patient or health user. A patient's health seeking behavior is informed by a lot of factors: social, economic, cultural, spatial and political dimensions as well as the type of illness; and these factors explain the rationale behind the choice and usage of a particular health care system or their combination in treating disease and illness. Patients in the developing world choose different health care be it modern or traditional medicine for different illness and this choice is informed by both socio-economic factors and the perceived etiology of the ailment. The interplay of modern and traditional medicines in addressing the health needs of people in the developing world is evident at the patient usage level. Patients use modern medicine or traditional medicine for different illness; they may even employ both for the treatment of the

same illness, thus to look at these two health systems (modern and traditional medicines) in complete isolation of each other remove the reality of their existence in the health care system of the developing world. It is in this view that this study will examine the health seeking behavior of the populace in Asikuma-Odoben-Brakwa district in the context of the pluralistic nature of the health care system in the developing world.

The study seeks to understand the rationales that influence the choice of a particular health system for an ailment or the combined usage of modern and traditional medicines for an ailment. The study area chosen is a predominately rural district in Ghana with only one modern health care facility, but several traditional healers and practitioners; it also epitomizes the typical rural setting in Ghana and the challenges the rural people face in their use of modern health care. The use of this study is to provide insight into rural health care usage and the dynamism of rural health care needs in the developing world. The study will use both quantitative and qualitative research methods in carrying out the study objectives. The adoption of this research approach is to help find a general pattern of health seeking behavior in the study area as well as have in-depth understanding of why the current health seeking behavior exist. Findings from this study would be useful in planning ways of integrating modern and traditional medicines in order to ensure equity of access and use of health services for all especially the rural poor and vulnerable.

## **CHAPTER 2 LITERATURE REVIEW AND CONCEPTUAL FRMAEWORK**

### **2.1 Introduction: Review of Literature**

For millions of people in the developing world, access to basic biomedical (Western medicine) health care remains a distant and evasive prospect. Like the rest of the developing world, in Africa dealing with health problems occupies a large part of most people's life. The adequacy of access to basic biomedical health care is more acute here in Africa than in any part of the developing world (Good 1987). Over the years, there have been substantial increments in governments and international bodies' expenditure on health services and related infrastructure such as water supplies and sanitary works; however, this has not yielded the desired results these stakeholders anticipated.

In contrast to the phenomenon of inadequacies in access and usage of biomedicine in the developing world and especially in Africa, the influence and presences of traditional medical practitioners (TMPs) is extensive in almost every country and community in the this part of the world (Good 1987). The influence and vital role of TMPs in the health care sector in developing countries is not only limited to the rural areas where due to the phenomenon of urban bias there is scarcity of biomedical facilities, but also prominent in urban areas. According to Good (1987), in recent times the activities of TMPs coexist and complement biomedical services in both rural and urban areas in the developing world. However, until recently the activities of these TMPs were not recognized or of little recognition in local and international health promotion agenda in most countries in the developing world. The World Health Organization (WHO) in 1978 recognized traditional medicine as a vital and essential resource in achieving universal health coverage for people in the developing world during its Alma Ata declaration on Primary Health Care (WHO-AFRO 2010). This recognition was in line with the recognized "handicap" nature of modern biomedicine in terms of its accessibility and usage for people in the developing world.

Concepts of illness and practices of cure are capable of significant input to social control, economic leveling, stress or anxiety release and other important personality or group regulating process (Press 1978). According to Hallowell in non-industrial or non-Western societies, illness

and its cure serve a variety of nonsomatic functions, and health concepts and practice play important roles in "... The maintenance and persistence of socio-cultural systems..." (1963:263 cited in Press 1978). Press (1978) notes that "... folk medicine is everywhere used, yet nowhere adequately defined" (page 72). He further asserts that the discussion of the results of various definitions will require a separate and lengthy treatment; he, however, notes three most common meanings assign to it. First a folk medical (traditional medical) system is seen as any health system at variance with Western, scientific medicine; second, it is viewed as any health system at variance with a codified, formal and literate medical tradition (Western, Ayurvedic, classical Chinese); and lastly, as any system of health practice at variance with the the official health practice of the community or nation (Press 1978). The third meaning of traditional medicine as stated by Press (1978) raises question, the statement "...the the official health practice of the community or nation..." (page 72) is ambiguous and a fallacy. The word official was not defined hence the acceptability of folk medicine by large number of people in the developing world and its relevance in societies here make it official; in light of this the third meaning contradicts the definition or meaning Press sought to give folk medicine itself as in this case it is the official health practice of the community hence cannot be "folk medicine". This shows the illogic in the third meaning or definition of folk medicine as presented by Press (1978)

For long, traditional medicine and TMPs have been recognized by their communities and other by other people in the urban setting, as individuals competent in providing one or more remedies or therapies through the use of methods such as divination, psychotherapy and plants, mineral and herbal substances (Good 1987). Bannerman et al. defines African Traditional medicine as "... the total body of knowledge, techniques for the preparation and use of substances, measures and practices in use, whether explicable or not, that are based on ... personal experience and observations handed down from generation to generation, either verbally or in writing and are used for the diagnosis, prevention or elimination of imbalances in physical, mental or social well-being." (1983 page 25). Good (1987) points out that, traditional medicine ideally is an all-embracing system of healing that is deeply rooted in the indigenous religion and socio-cultural institutions; thus, often reflecting the values and practices, both local and foreign, which have been incorporated and adapted over the years. This assertion is also supported by Twumasi

(1988) when he stated that traditional medicine is a holistic method that uses magico-religious acts and concepts encapsulated in the culture of the people.

However, these notwithstanding, it is worth noting that like all social institutions and structures, contemporary traditional medicine in the developing world has undergone changes due to the cultural interaction between the societies in the developing world and those in the developed world through colonialism and globalization. Thus the religious tenant of traditional medicine in the developing world, especially Africa is now not only based on traditional African religion or indigenous religion but on others such as Islam and Christianity as well. This integration of religions with their values and belief systems as well as the cultural content with the African society has resulted in what Ali Mazzuri terms the “Triple Heritage of Africa”. One can therefore find traditional medical practices with Islamic or Christian components in Africa and some part of the developing world today, hence traditional medical practices in Africa and the developing world are not only restricted to the values and belief systems of the indigenes but also to foreign cultural and belief systems.

The existence of modern biomedicine and traditional medicine as well as other form of alternative medicine in the developing world present patients here wide varieties of health or therapeutic options to choose from in meeting their health needs. This phenomenon has resulted in a special health seeking behavior in this part of the world; patients switch between different medical systems is addressing their health needs. Patients in the developing world choose different medical systems for different illnesses within their pluralistic health environment. It is this special and characteristic phenomenon which has informed the conduct of this study. The review of existing literature on these phenomena has been categorized in three sections. The first section looks at the global patterns of medical pluralism, and examines approaches to medical pluralism and cooperation of medical systems in the developing world. The second section reviewed literature looks at competing paradigms and integration of biomedicine and traditional medicine as well as examine the traditional healing and the concept of illness in the socio-cultural perspective of patients in the developing world; delve into the traditional healing process and the role of faith in healing. The third section looks at health seeking behavior in the

developing world, the approaches in studying health seeking behavior, problems and prospects of health care in the developing world then the global paradox of health status.

### ***2.1.1 Medical Pluralism and Global Patterns of Medical Pluralism***

According to Kleinman (1976), medical pluralism is a phenomenon found in most contemporary societies where there are different, co-existing, complementary or competing medical system resulting from different traditions, practices and bodies of knowledge. The phenomenon is not only peculiar to non-western societies as some literature tend to make us believe, however, it is more predominant in non-western societies where western style of medicine (biomedicine) was introduced through early contact (colonialism) as an alien cultural entity. In the some other part of the world, it exists is as a result of the existence of heterogeneous societies which have their diverse cultural and ethnic as well as the historical origin as is the case of North America (Unschald 1980). Medical pluralism is a global phenomenon that virtually exists in every contemporary society. What differs about this phenomenon in different countries is the fact that in most western or European societies, there is an existence of biomedicine and other forms of alternative medicine such as chiroprathy, acupuncture and other form of oriental medicine instead of the traditional religious medicine, which involves supernatural beings as is the case in Africa and some other countries in the developing world especially in Latin America and southern Asia. Medical pluralism normally involves a system where there is a dominant player in the health system which mostly is biomedicine co-existing with “alternative medicine”, defined by the WHO (1993) as all forms of health care provisions which “usually lie outside the official health sector”. This implies that medical pluralism can be found in almost all societies with alternate form of medical system either recognized legitimately or illegitimately.

In the developing world, the local medical practice is referred to by various names such as “traditional” (Twumasi 1987), “indigenous” (Kleinman 1980), “folk” or “ethno-medicine” (Kleinman 1976, Press 1978 and Good 1987). The local medical system is defined by Stoner (1986) as practices that have evolved in particular cultural settings and have, until recently been the sole source of health care for most people in those cultural settings. To this end, Das (1996)

points out that traditional medicine is embedded in the culture and beliefs of the indigenous people in the developing world, hence the focus is predominantly on the every aspect of patient as a whole and not only on the biological aspect. By focusing on the patient as a whole human being, Twumasi (1988) explains that it takes into consideration the social, psychological and physical aspects of the illness in building a social causation paradigm. The human being in traditional system consists of body, soul and spirit thus all these aspects of the human being need to be taken into consideration during a medical therapy.

In modern science, however, there is no room for the supernatural or that which cannot be accounted for physically or mentally. In light of this, biomedicine has several shortcomings for the African and the majority of patients in the developing world who have this view of the supernatural and its influence on one's health. Harrison and Dunlop (1974) first noted that modern medical education and care as it is in the developing world were copied from western models and as such are often considered irrelevant, given the fact that western society have a different socio-cultural background from those in the developing world. However, one needs to view and assess this assertion with caution as biomedicine is not considered irrelevant in the developing world, at least not in all health cases. Biomedicine may be considered irrelevant here for health problems deemed to be of supernatural origin, but for ones of physical causation biomedicine remains a vital healing option. Brookbanks (1990) puts this in the right perspective by saying that the failure of the biomedical system to take into account the various sections of the human being as understood in developing world – body, soul and spirit makes it ill-suited to understand the meaning of illness from the patient's perspective and as such meet the patient's psychological needs in the developing world. Alternatively Freeman and Motsei (1992) assert that technological advances in biomedicine have created limited contact between patient and healers, resulting in the erosion of the human quality of care in health.

There has often been the tendency of limiting pluralistic medical configuration of medical systems to the technologically less-developed world (Good 1987). However, with all the technological brilliance and advances of biomedicine, studies have shown that the health seeking behavior of people in western societies suggests an increasing mutual understanding and cooperation among a variety of contemporary alternative therapy systems. Western societies are

increasingly becoming societies of medical pluralism. Besides the dominant biomedical health care practice, there exist other non-conventional health practices. According to Good (1987) in the United States orthodox biomedicine does not singularly fulfill either the demand or need for health care. There is considerable evidence that the boundaries of ‘legitimate’ medical practice in western societies are expanding to include systems such as chiropractic, psychological counseling and oriental medicine.

A study conducted in 2002 in the United States revealed that 62% of adults used alternative medicine in the previous year before the year of the research (Barnes et al. 2004). According to the European Information Centre for Complementary and Alternative Medicine (EICCAM 2008) report analysis of surveys done over the past ten years preceding 2008 indicate that 20% of European citizens have clear preference for complementary and alternative medicine (CAM), and another 20% are regular users of CAM. The report further states that more than 100 million citizens in the EU make use of CAM and the most commonly used CAM therapies are homeopathy, phytotherapy (herbal medicine), anthroposophic medicine, naturopathy, traditional Chinese herbal medicine, osteopathy and chiropractic. In the developing world, the co-existence of various traditional medical systems such as Ayurvedic, classical Chinese, Yoruba, Unani Tibbi and Akan with biomedicine is well-documented phenomenon (Good 1987). Together, these various modes of interpreting and responding to sickness from what Charles Leslie (in Janzen 1978 page 14) termed “more or less pluralistic, more or less integrated, and more or less syncretistic regional systems”. According to the WHO (2008), in some Asian and African countries 80% of the population depends on traditional medicine for primary health care.

### ***2.1.2 Approaches to Medical Pluralism and Cooperation in the Developing World Societies***

The form of interaction and integration of traditional or alternative health systems into the main health system in the developing world takes many forms. Stepan (1983 pages 292-308) identifies four basic broad approaches to medical pluralism namely: *exclusive, tolerant, inclusive* and *integrated*. These approaches identified by Stepan (1983) depend on the level of integration and official state legislation concerning traditional and alternative medicine. Countries in the developing world show one of these forms or approaches to medical pluralism as the predominant characteristic feature of their health system. Whereas some countries have and

exhibit strict legislation against traditional and alternative medicine others have loose and flexible policies concerning them. However, over the last decade a lot of countries in the developing world have come to value and appreciate the essence of traditional and alternative medicine in the health care needs of the people, hence have adopted more friendly health legislations towards the practice and use of traditional and alternative medicine. This subsection of the review will examine the level of cooperation between modern biomedical system and traditional medical system in the developing world and developed world.

Modern biomedical system as they exist in the developing world is rooted in the old colonial system and its western style of service delivery, making it inefficiently designed to meet the different expectations and demands placed upon it by people in Africa and the rest of the developing world (Stepan 1983). Dorozynski (1975 cited by Good 1987) stated that the biomedical health system in many ways is inappropriate and of limited relevance to the conditions of life of people in the developing world. Good (1987) further adds that its inefficiency in service delivery and care is not limited to only rural areas, but also in urban areas; nevertheless even in areas where services are physically present, prevailing social and cultural values as well as attendance patterns portray biomedicine as the non-preferred choice for many illnesses nor common events such as childbirth. These assertions by Stepan (1983) and Good (1987) must, however, be viewed with a retrospective 'lens' in contemporary Africa and the rest of the developing world; especially when the socio-economic and political conditions in the period these works were conducted necessitated the shift from biomedicine to traditional and alternative medicine due to governments cut for health expenditure and the introduction of the health user fees through the Structural Adjustment Program (SAP) (Waddington and Enyimayew 1989). According to Sowa (2002), there was evidence that after the introduction of the user fees, outpatient attendance in some rural areas dropped by nearly 50%; he further cites the Ghana Living Standard Survey (1987/88) which indicated an average 48% of Ghanaians did not consult any kind of health provider within the survey period. There is the need to recognize in contemporary times the modifications to the health care delivery system in face of the challenges patients in the developing world. In many countries, especially India and countries in South Asia, mobile health units have been set up to provide adequate access to areas which have little or no

access to modern health care due to lack of or poor social infrastructures such as roads. In Ghana, through the millennium development account community health posts (CHPs) have been established in remote rural areas with no access to modern health facilities. These and many more shows that biomedical health care delivery in the developing world is now being tailored to meet the health needs of people there. These new modifications and policies have if not eliminated the inefficiencies of the biomedical system, have limited or reduced them.

The lack of adequate of cooperation between modern biomedicine and traditional medicine is partly as a result of what Good (1987) termed “two widespread fallacies” about health beliefs and behavior about other societies outside the western world. The first fallacy is what Polgar (1962 cited by Good 1987) referred to as the “empty vessel fallacy”; this refers to the situation whereby a society (territory) and its people are assumed to lack systematic beliefs and a therapy system until the arrival of biomedicine from western societies. The second fallacy is “the fallacy of separate capsule” noted by Scrimshaw (1979 cited by Good 1987). On the contrary the second fallacy recognizes the pre-existence of indigenous medical resources and theories of disease, but maintains that these indigenous medical systems are inferior and not a viable option or alternative to Western medical practices. These fallacies give the tendency to health professionals and governments to view traditional medicine as archaic and not relevant to modern societies; yet the evidence remains that traditional medicine remains a major resource used by people in the developing world to cope with their health problems.

### ***2.1.3 Competing Paradigms of Modern Biomedical and Traditional Medical Systems***

The nature of the health care system in the developing world can be likened to the market, where there different varieties of option that shoppers and consumers choose from. The health systems in the developing world present the “health seeker” wide varieties of option to choose from when addressing his health needs. Each health system has a basic underlying concept or paradigm that is known and understood by “health seeker”; and this understanding helps the patient to choose a particular health system for a particular health problem. Over the years, there have been attempts to encourage formal cooperation between biomedicine and traditional medicine. These attempts have encountered basic fundamental problems due to the difference in the concepts of the two

health systems. There exist a confrontation between scientific, profession-centered biomedicine and the alternative paradigms of health and illness in pluralistic health societies.

In the biomedical system, disease and illness are essentially Newtonian, mechanical and organismic state of physical manifestation that can be diagnosed and treated separately from the person's psychological condition and social milieu (Kleinman 1978b). This is the basic underlying concept of biomedicine; hence most people in the developing world assign biomedicine to the limited role of treating and healing organic diseases or acute illness symptoms. Rappoport (1980) observes that the structure value of biomedicine tends to remove or minimize the contact between the therapist and the patient. He asserts that the individualist qualities of the physician, such as charisma, style and capacity of communication and the ability to hope, to the patient are crucial in the healing process. Thus, healing is not dependent on the drugs administered only, but also the form and level of interaction between the physicians and their patients. This is an aspect most often biomedical practice fall short of in the developing world, especially coupled with high doctor-patients ratios of 2.3 per 1,000 people in Africa and 5.4 per 1,000 people for South and East Asia (WHO 2011). Biomedicine treatment gives precedence to 'technique' over 'person' and adheres to the scientific method and procedure subjugated in objectivity thus limiting the length of time for routine diagnosis and patient consultation (Good 1987). This form of health system places little or no emphasis on understanding the patients' socio-cultural background as well as the economic and political ties between the patients and their social environment.

On the contrary, traditional healers place great importance to their patients' social network and identity as well as their role and status in this social network. In the traditional medical system, the patient is viewed as a social being whose actions and inaction occurs with a social setting, and the social environment wields an influence on the patient. The conceptual background of traditional medicine, which originated outside western influence placed great emphasis on the patient's social, psychological, spiritual and other biophysical phenomena and processes (Good 1987). At the base of traditional medicine is a psychosocial paradigm which conceives a person's body, mind and soul as an indivisible whole and their consideration is vital to the healing process (Swift and Asuni 1975, Twumasi 1975 cited by Good 1987). In the

traditional medical system disease and illness are known to have two origins: supernatural (susumu yadea) and natural (honamu yadea) (Twumasi 1988). The former is perceived to be caused by breakdown in social relations, witchcraft or sorcery (Twumasi 1988).

Another distinguishing difference between these two medical systems is noted by Press (1978). Press (1978), describes 'folk' health systems (traditional health systems) as open systems that accept "substantive input" from economic, familial, ritual, moral and other institutional sectors and in so doing thus capable of contributing to these sectors as well. Referring to Manning and Fabrega (1973), Press describes modern health systems on the other hand, as a closed system based largely on precise defined "knowledge, techniques and procedures, all of which are discontinuous from ordinary social process" (Press 1978). Modern health systems are also described as isolated from the social and cultural environment due to its governing paradigm; "its concepts and methods have become universal in its application and are not altered significantly by time and place of treatment" neither by the personality of the physician (Press 1978). This distinction makes 'folk' or traditional health systems popular with people of the developing world or non-Western societies.

Despite the popularity of traditional medicine in terms usage in the developing world, biomedicine still holds a respected and vital position in this part of the world too. This reality is due to the effectiveness of biomedicine in identifying and treating many clinical symptoms of disease and illness, particularly acute ailment. Leslie (1980 page 193) asserts that it is "the experience of illness, not the biological reality that causes people to consult others about their health." Good (1978) and Leslie (1980) made a crucial observation that even with easy accessibility and full staffed professionals and facilities of biomedicine in the developing world, traditional medicine will continue to be used by individuals who need alternatives to illness they perceive cannot be treated by biomedicine.

According to Good (1987), the cognitive linkage of people's belief in the cause of a disease and the choice of healing options is a crucial factor in health planning. The exist of parallel treatment for diseases exist in societies where people separate the symptoms of the disease from its underlying cause; meaning the treating and healing of symptoms does not necessarily meet the

full health needs of patients in such societies as they believe the cause of the symptoms still exist and must be dealt with. To make this point clear, Good (1987) cites two incidents, one involving a mother whose child experiences a sudden loss of weight and a man injured in industrial accident. All these two patients sought biomedical treatment for the symptoms of their ailment, but their desire and that of the family for a satisfactory explanation to why these incidents happened to the patients prompted the consultation of diviners or medico-religious specialists. There are cases where doctors cannot diagnose or treat disease or illness patients send to the biomedical facilities, hence patients of such circumstance seek alternative channels to address their health needs such as the use of traditional healers. Thus, until the spiritual concerns and beliefs of patients and people in the developing world are met in biomedical health care systems, the use of traditional medicine in the developing world will continue to exist.

#### ***2.1.4 African Traditional Healing and Concept of Illness***

An understanding of the traditional healing system in Africa requires an in-depth knowledge of the African worldview which determines the concepts of health and ill health in this part of the world (Karim et al. 1994). By African worldview, Karim et al. (1994) was referring to the belief system which encompasses the physical world and sociological environment. This worldview finds its expression in the continuity between the living and the dead, thus embracing the metaphysical forces of the universe (Good, Hunter and Katz 1979). In this worldview factors such as family, the community and influence of ancestral spirits are seen as determinants of an individual's wellbeing. The African worldview conceptualizes the human being as comprising of body-mind-spirit continuum which are inseparable and mutually interdependent; the state of one determines that of the others at any given moment in time (Karim et al. 1994)..

Fortunes of health are regarded as balance between the person and his/her relationship with the social environment and the supernatural forces within this environment. According to Gumedé (1990), good health and good fortunate are often conceived as reward for good behavior, constant sacrifice to the spirits, whereas, ill health is viewed as a punishment for sins or wrongs committed by the individual. However, it's worth pointing out that such considerations are made

about illness that is perceived to be of supernatural cause. The existence of taboos and other customary laws in the African society is to regulate behavior and ensure the continuance of the harmony between the living and the unseen. Thus in Gumede's (1990) words, taboos are "a system of avoidance, which regulate human conduct in order to ensure a healthy whole – "physically, spiritually and morally". These taboos are often verbal conventional laws of the society pass from generation to generation to teach the new members of the society the accepted code of conduct.

Straugard (1985) explain that in the traditional belief system, the well-being of an individual is not solely dependent on the individual himself or herself, but also on the relationship the individual has with others in the social environment he/she finds him/herself. With the understanding provided above on the African traditional worldview, it worth noting that the African concept of health, thus finds its expression in the WHO definition of health – "... as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Bannerman et al. 1983). A peaceful and good relationship between the individual, social relations and the social environment is essential to achieve and promote good health and well-being, whereas illness is seen as a material or physical sign of a disturbance in that harmonious relationship (WHO 1978 and Karim at al. 1994).

To heal an infirmity, knowledge of the cause of that infirmity is relevant for building a therapeutic response for it. In modern science a strain of the microscopic disease causing agent is taken and analyzed, then a biochemical agent is developed to counter it or a biological neutralizing strain of the agent is developed. The therapeutic healing process in the traditional medical systems is somehow similar to this in principle. As far as the perception of illness is concerned, the African traditional healer distinguishes between natural and supernatural causations (Karim et al. 1994). Natural causation refers to an illness that has a specific, recognizable and predictable course, whereas the supernatural refers to those which are cultural-bound and perceived to be inexplicable by natural laws, that is, their etiology and diagnosis and treatment are all inextricably bound up with the African traditional worldview. Supernatural illness is deemed to have cultural or social causation.

It is normal for afflictions such as cough, cold, headache and fever to be considered as natural occurrence since these afflictions respond to the use of traditional herbal medicine and/or modern biomedicine in treatment. However, in situations where these afflictions become malignant and does not respond to drug therapy, then the perception about its natural causes change. It is regarded as a deviant case and thus explanations are sought for it. In this regards Karim et al. (1994) explains that while biomedicine asks for causation and how patients fall ill, the traditional medical system requires answers to the questions of “who” and “why”. These questions are explained through the role of ancestors and taboos in the lives of the society members; the role of ancestors is to sustain and look after their descendants hence when they withdraw their protection due to a person’s misconduct, that person becomes susceptible to misfortunes and diseases (Twumasi 1988 and Karim et al. 1994). Social issues such as dispute between family members, flouting of certain customs and norms are some of the main causes of ancestors withdrawing their protection. In this view, supernatural illness is seen as originating from displeased ancestral spirits and other angered spirits.

It is only by displeasing of the supernatural forces that makes an individual vulnerable to illness but also an individual’s state of impurity or uncleanness such as menarche, childbirth, miscarriage and death are also factors that bring about supernatural caused illness. Alternatively, witchcraft, sorcery and jealousy may cause others to place harm or illness on an individual; Karim et al. (1994) cite stroke as one of the illnesses perceived to be caused by witchcraft and sorcery. There is therefore a wide variation in the types of diseases and illnesses under the traditional medical system; the TMP deals with these wide range of sickness from both natural and supernatural origins. In his research Campbell (1998) points out that the conditions treated by traditional healers range from diabetes, stroke and asthma to personal emotional problems, as well as other economic and social problems such as employment issues and bad luck in relationship. Some practitioners deal with epileptic seizures, suicidal tendencies, nightmares, infertility and other economic misfortunes. As far as AIDS is concerned, many healers according to Campbell (1998) feel able to prolong and improve the quality of life of patients through diet, exercise and herbal treatment.

### ***2.1.5 The Traditional Healing Process and the Role of Faith in Healing***

Karim et al. (1994) provide an in-depth knowledge of the traditional healing process and the aim of the healing system. According to Karim et al. (1994), in the traditional medical system, the healers approach to illness depends on the perceived causation. The healing process follows different stages for different perceived causes. The first stage entails the identification of the cause of illness; according to Karim et al. (1994) this stage is vital to the entire healing process because the ‘who’ – or causation factor is ascertained and thus gives the healer an idea on what to use for the healing. The second stage involves the removal of hostile source, which maybe through rituals and sacrifices to appease offered spirits, neutralizing witchcraft and sorcery or by prescribing certain herbal medication. Whereas modern biomedical practice follows the same trend in regards to the first two stages, it deviates in the second stage. In biomedicine, the causation agent of the disease needs to be identified either through laboratory analysis or symptoms shown by patients; however when it comes to the removal of the causative factor it does so physically. Modern science does not have a place for supernatural and rituals or sacrifice in its medical therapeutic system. Thus, the inefficiency of biomedicine as seen by patients in Africa and other parts of the developing world is its inability to deal with these ‘perceived root cause’. Karim et al. (1994) notes that even in situations where traditional healers recommend, prescribe or dispense biomedical drugs to their patients, they often reinforce the supernatural elements through rituals or chanting to fend ‘off evil spirit or restore equilibrium to the elements’.

In the traditional healing system, healing takes place in the healer’s home where physically and mentally ill live together as part of the therapeutic community (Karim et al. 1994). However, there are some variations to this assertion by Karim et al. (1994) especially in among modern day traditional healers in the urban centers. Often, most TMPs in the urban setting have place of work which may be close to their homes or far from their homes; in these cases healing thus take place outside the healer’s home. According to Good et al. (1979), healing in the traditional medical system which often takes place in the homes of healers is group oriented and the concept of the family as the “extended” to the patient stands in contrast to the isolation of sick individual from his social environment often imposed by modern medical system. This assertion by Good et al. (1979) is not entirely true; there are medical cases in which traditional healers often isolate the patient not only from the family but the entire community.

Patients with diseases such as leprosy or whose illnesses are perceived to have been caused by breaking important taboos are often taken outside the community to the outskirts of the settlement. This is done to keep the community and society from being infested or contaminated with the curses or ailment the patient is suffering from. In some communities in Africa, people believed to be possessed by witchcraft or evil spirits which may cause the possessor to exhibit health problems like epilepsy seizures are taken out of the community and a special settlement is established for the outside the community. Thus, there are medical conditions in both modern biomedical system and traditional medical system that require the isolation of the patients.

The one aim of the healing process in traditional medical systems is to remove the anxiety of the individual, tension between family or community members and establish social order that is the settling of antagonistic feeling between people (Karim et al. 1994). Rituals used in the healing process seek to restore balance and harmonize the society in terms of cultural beliefs and values. Rituals thus have a calming effect on the patients and relieve their feeling of guilt. In this regards, many practices of the traditional medical system are designed not preserve cultural institutions but also to help the individual live at peace with family, clan, village, tribe and the inner self (Freeman and Motsei 1992). In its entirety, traditional healing process seeks to provide a meaningful explanation to illness from the patient's socio-cultural perspective; it is thus a social strategy therapy. As Gumede (1990) and Karim et al. (1994) pointed out the traditional healing process is a holistic process which seeks to promote well-being of the individual and to maintain the continuity of the way in which society functions. A deeper appreciation of this helps understand why treatment given without explanation in biomedical practice may confuse the patient and render the therapy less effective from the patient's perspective or even unacceptable. It might also explain why an African patient will go to a biomedical practitioner for the relief of symptoms and to the traditional healer to discover the cause of the illness.

The concept of faith in therapeutic process often associated folk medicine and religion. The idea of faith in healing of illness is held by many in the modern biomedical field as outlandish. The integration of foreign religious beliefs and the traditional African medical system has created a new therapeutic field in the traditional medical system which is faith oriented. The role of faith

healers in the contemporary medical system in Africa and the rest of the developing world and even in some part of the developed world has been recognized by many. Many of these faith healers are often church based; patients with infirmity go to these healers to seek healing. The role of these faith healers have often tend to viewed as unscientific and religious oriented, however, Levin (2009) through his work “ How Faith Heals: A theoretical model” provide various theoretical perspectives and the psychology supportive of the healing effect of faith. He does so by examining the works of Osler (1910), Paulsen (1926) and Dr. Jerome D. Frank a preeminent psychiatrist of John Hopkins.

To provide a profound explanation of the link between faith and healing Levin (2009) carefully examined the conceptual meaning of faith and healing. According to him, the conceptual meaning of the two is vital for the commencement of any theoretical bases for them. After carefully examining the meaning of faith in the various religions, Levin (2009) noticed that a commonality exists in all the divergent concept of faith. This commonality bordered on mental (cognitive/intellectual) component, an emotional or affective component and a premium placed on action. In light of this discovery, Levin defines faith as “a belief acted on, with instrumentalities of both affect and behavior” (2009 page 79). He further elaborated that “belief and trust, accompanied by an effort to put them into action, ideally create a sense of hope or optimism or expectation that, reinforced, ultimately leads to reliance upon the object of one’s faith.” (page 79). Concerning healing, he points out to the different and wide array of meaning given to it by different professionals in the health industry. He provided some conventional definition of healing from biomedical and clinical psychological perspective. Levin (2009) states that in biomedical convention, “the word healing, where it is used at all, refers almost exclusively to the adhesion and granulation of a focal lesion such as a dermal wound.” (page 79). Thus in William and Wilkins words healing “connotes the successful outcome, the endpoint, of a multifactorial process of recovery, restoration, and, ideally, curing.” (1982 cited by Levin 2009 page 80). From the clinical psychology perspective healing is seen as an outcome, recovery, remission and cure from any health problem. In general Levin however defined it as “as an outcome, whether focal or systemic or something in between” (2000 page 79), limiting his definition to the traditional biomedical concept.

Levin (2009) cites two ways through which faith heals from the works of Paulsen (1926) and Levin et al. (1998). According to Paulsen (1926 cited by Levin 2009) a possibility of how faith heals is by suggestion. By suggestion, Paulsen was referring to the notion that through “discussion, reading, recitation, mediation and concentration” the inhibitory influences in the mind or body of the patient are counteracted. The second explanation is given by Levin et al. (1998 cited by Levin 2009) is a hypnosis effect – defined as “an altered state of consciousness” induced by the faith or a faith healer that enables the patient to marshal a self-soothing psychophysiological mechanisms that enhance the patient’s coping and mitigate pain, symptoms and morbidity.

To further expatiate on the role of faith in the healing process or how faith heals, Levin (2009) examined various hypothesis that exist in the scientific community. These hypotheses concern how faith mitigates the deleterious effects of illness through cognition and the therapeutic significance of this curing or preventing of illness. The first hypothesis is that of Idler, who hypothesizes that there are two distinct “cognitive consequences” of religion for health. The first is the reduction of a sense of fatalism or helplessness in the face of the unexpected and unpredictable in one’s social environment; the second is the fostering of a sense of optimism in the face of the first, a perception that things will turn alright, whether or not one has control over them. Vaux (1976 cited by Levin 2009) provide an alternative hypothesis, he idealized that religious faith when internalized and active does promote health which can be attributed to some extent the sense of immortality. By immortality Vaux explains that it is “peace in existence” and “a life orientation derived from more basic confidence that alienation from God and self has been overcome, through the release from eternal death”. Vanderpool (1977 cited by Levin 2009) offer another hypothesis that faith in God or a high supernatural being and the ‘healing power associated with it’ is similar to present day effect of psychosomatic medicine, bio feedback and immunology.

These works examined by Levin (2009) gives a scientific credence to the concept of faith healing. The theories and hypotheses he cited in his work point to the scientific bases of the role of faith in healing although faith healers may have or hold different view of how faith healers. This work by Levin (2009) and other researchers he cited shows there are more similarities between modern biomedicine and traditional medicine than we tend to acknowledge. Although

the professionals in these two medical systems holds different views on how the therapeutic means of traditional medicine, the common bases for the therapy remains the same – to heal or alienate an infirmity suffered by a patient.

### ***2.1.6 Health Seeking Behavior: Approaches, Problem and Prospects in the Developing World***

The importance of human behavior and its impact on health is mainly as a result of two basic assumptions: that a large proportion of mortality and morbidity we suffer as humans is largely due to our socio-cultural behaviors and that these behaviors can be modified (Conner and Norman 1996). In relations to this, over the years attempts have been made by both local and international stakeholders in health to change the behavior of people in the developing world with regards to health. According to MacKian (2003) these attempts have focused on the idea that by providing knowledge and information about causes of ill health and the choices available (in the biomedical field), individuals will change their behavior towards a “more beneficial health seeking behavior.” The question, however, is what is beneficial? and from whose perspective? There is now a growing consciousness among government, international bodies and policy makers that, providing health education and knowledge is not sufficient enough to bring about the radical change in individuals’ health seeking behavior in the developing world as envisaged. Baum and Poslunzny (1999 cited by Conner 2002) point out that behavior exerts influence on health in three basic ways: by producing direct biological changes, by conveying health risks or protecting against them, or by leading to the early detection or treatment of disease.

Health researchers distinguish between health behavior and health seeking behavior; the latter is seen as part of the broader former – health behavior (Conner and Norman 1996 cited by MacKian 2003; Redding et al. 2000, and Conner 2002). Health behavior is seen as embracing all behaviors which are associated with establishing and retaining a healthy state, and those aspects that deal with any departure from that state (WHO 1995). Conner (2002) provides some alternative definitions for it from the works of Conner and Norman (1996) and Gochman (1997). Conner and Norman (1996 cited by Conner 2002) define health behavior as” any activity

undertaken for the purpose of preventing or detecting disease or for improving health and well-being.” Gochman (1997 cited by Conner 2002) in the *Handbook of Health Behavior Research alternatively* defines health behaviors as “behavior patterns, actions and habits that relate to health maintenance, to health restoration and to health improvement.” Health seeking behavior on the other hand refers to the process of illness response, that is, how an individual treat or seek treatment for an illness he or she is already having (MacKian 2003).

According to Kroeger (1983) there are two broad frameworks for examining health seeking behavior. The first framework is referred to as the “pathway model”, which describes the steps taken by a patient from the stage of recognition of clinical symptoms of disease or illness to the use of a particular health facility for its treatment. This approach or framework, takes into consideration how social and cultural factors affect and shape the sequence. The second framework is known as the “determinant model”, and as its name implies, it seeks out the determinants which are associated and influence the choice of different kinds of health services for a single episode of disease or different diseases. According to MacKian (2003) there are spatio-temporal factors that act as purposive and decisive agents in promoting health seeking behaviors. These factors have collective and interactive characteristics which emanate from the interaction between an individual and the social structures within the environment he or she lives in; thus, over the years focus have been on how these local dynamics within societies and communities shape the well-being of individuals within them and the extent of the influence these social structures bear on the individuals.

Furthermore MacKian (2003) notes that over the years there have been a plethora of studies on health seeking behavior of people in both developed and developing worlds. He, however, indicates that these studies have been organized on two main approaches, first recognized by Tipping and Segall (1995). According to MacKian (2003), first, there are studies which place emphasis on the ‘end point’ – that is the usage of formal system or health care seeking behavior; the second approach lay emphasis on the ‘process’ – that is illness response or health seeking behavior. This distinction is crucial as factors that influence the use of particular health system by an individual may be different from those that influence the choice of a health system as a response for certain illnesses. The health care seeking behavior approach refers to the

study of the use of formal health system within a defined context (MacKian 2003). These studies gather data on the use of the formally recognized health system and other health care seeking behavior such as self-care, traditional healers and unofficial channels (Ahmed et al. 2001 cited by MacKian 2003). However, in doing the purpose of data gathering on the use of unofficial and non-formal health systems are often to present findings that seek to limit or curtail the use of these unofficial channels as Ahmed et al. (2001) points out. Thus, the findings and purpose of these studies led to promote the idea of encouraging the use of the formally recognized system – biomedicine – first. Tipping and Segall (1995) indicate that, contrary to existing knowledge, recent studies have shown that the decision to use a particular health systems is influenced by a variety of factors such as gender, age, social status, type of illness, access to services and perceived quality of services as well as politics.

Table 1 Determinants of Health seeking behavior

Category	Determinant	Details	Sphere
Cultural	Status of women	Elements of patriarchy	'Cultural propriety'
Social	Age and sex		
Socioeconomic	Household resources	Education level Maternal occupation Marital status Economic status	
Economic	Costs of care	Treatment Travel Time	Physical
	Type and severity of illness		
Geographical	Distance and physical access		
Organisational	Perceived quality	Standard of drugs Standard of equipment Competence of staff Attitudes of staff Interpersonal process	Technical  Staffing  Interpersonal  <i>formal</i>

Source: MacKian (2003)

The health seeking behavior approach, on the other hand looks at the process of illness response by patients. These studies look at factors which enable or prevent people from making 'health choices', in either their lifestyle behavior or their use of medical care treatment (MacKian 2003). These studies are deeply rooted in psychology as they look at how behaviors and other factors that influence health seeking behavior from the individual's level. Whereas, the first approach – health care seeking behavior – is conceptualized as a 'sequence of remedial actions' taken to rectify "perceived ill-health" (Ahmed et al. 2001), the second approach examines health access and usage as the individual perceives it and how factors from the individual's perspective hinders or promote access and usage. There may be similarities within the factors that operate at both levels, but there are differences as well. A number of 'social

cognition' models have been developed from the second approach, which help to predict possible behavior patterns.

In the developing world, patients are noted for combining different health systems and remedies in tackling ailments. The type of health system used or their combination to address a health problem varies from person to person and disease to disease. Sermsri (2002) in a study on the "Changes in Health care Utilization in Thailand" portray the existence of this phenomenon among health care seekers in Thailand. Sermsri (2002) reported that in Thailand patients choose from a wide range of health care option: private health, public health, drugstores and traditional medicine. He however noted that the predominant health care practice was self-treatment and the use of drugstores, where both modern biomedical drugs and traditional medical drugs are available and one do not require a physician's prescription to purchase. When asked their preferred choice of treatment, most Thais state modern health care as their preferred choice of treatment. He stated that this choice was because they considered modern medicine as efficient and superior to traditional medicine; he further elaborates citing Riley and Sermsri (1974) that this notion is due to three components of modern health namely: personnel, medicine and techniques of treatments. The underutilization of modern health care in the developing world has been well documented by various scholars (Waddington and Enyimayew 1989, Biritwum 1993 and Asenso-Okyere 1995 cited by Asenso-Okyere et al 1998 and Ashford et al. 2006). These scholars attribute the reason for various factors, but the primal factor being economic or out-of-pocket expenditure owing to the introduction of the Structural Adjustment Program (SAP) in the 1980s by the Bretton Woods Institutions (IMF and World Bank).

Given these challenges with modern medicine and previous relegation of traditional medicine from the national health care policy of many countries in the developing world, patients in this part of the world were caught in a dilemma. However, with recent recognition and promotion of traditional medicine as well as efforts to integrate it into the national health care policy of many countries, there remains hope of universal access to health care for all in this part of the world. The acceptability of both modern and traditional medicine among patients in the developing evident through their combined usage makes the effort to integrate the two a hopeful phenomenon for patients here. There integration will ensure that patients are safe in their use of

both systems for treatment. Nonetheless, much need to be done in this integration effort. There is the need to be cautious not to over monetized traditional medicine is the course of its integration into the modern health care system, as it affordability and socio-economic accessibility is what makes it more popular with patients in the developing world.

## **2.2 Conceptual Framework - Model of Factors of Health Seeking Behavior/Utilization**

There have been a number of quantitative models and frameworks on the access and utilization of health care; however their application in the developing world is somewhat not reliable as a result of their focus on modern medicine only. In solving this problem, researchers (Andersen and Newman 1973, Aday and Andersen 1974, and Dutton 1986) have developed explanatory models of utilization of health services. These models failed in incorporating health belief systems into their analysis of health needs in the predominantly traditional societies in the developing world (Buor 2004); these models have failed to explore the want of people in the developing world to use traditional medicine, especially for spiritual purposes which may be important for their health.

Although various improvements have been made to the various models and new ones such as Buor (2004) have been introduced, all these models in their quest to provide an expression of the health care system in the developing world and the factors the account for accessibility and utilization in the developing world have failed to capture the real picture of the health system in the developing world. A holistic program of health care involves the need to meet the spiritual needs of patients, however, there is little understanding of what this means. At first sight, spiritual needs of patients might be interpreted as referring to religious beliefs, but many people would say that spiritual needs are more than this. It may be an individual's sense of well-being, happiness or peace of mind. The models developed by researchers fail to take into account the relevance of this psycho-social aspect of health care for patients in the developing world

The model below identifies five major factors as causal factors that influence people's behavior in health seeking and utilization. These factors are namely: patient's characteristics, the socio-cultural environment of the patient, the health policies, health resource, illness/sickness and the level of accessibility of health resource. A sixth factor – characteristics and perception about physician/healer is informed by factors emanating from the five major factors identified earlier; information about the physician/healer may be available through patient's own contact with him/her or through views and opinion of peers and family members. The characteristics of physician/healer are also to a large extent influenced by prevailing health policies. Health policies affect health resources available to the patient, which in turn affect the level of accessibility of these resources to the patient. The socio-cultural environment within which the patient can be found influence and affect the level of accessibility of health resources as well as the type and nature of the illness/sickness; this factor also do influence the perceived cause of illness and the choice of treatment to some extent.

The model is an improvement of Aday and Andersen (1974) and Buor (2004) behavioral models of health care utilization. The model views the patient as a social being whose actions and inactions are informed and influenced by the environment he/she lives in and the political policies about health. Thus, the decision or often the choice of treatment for an alignment is informed not be one factor but multiples of factors. It also recognizes the role of peers and family members in the choice of treatment. The model holds that different types of illness may call for different choices of treatment depending on a list of factors such as: the type and nature of illness, perceived cause of illness, patient's history with the illness and information about the illness available to the patients.

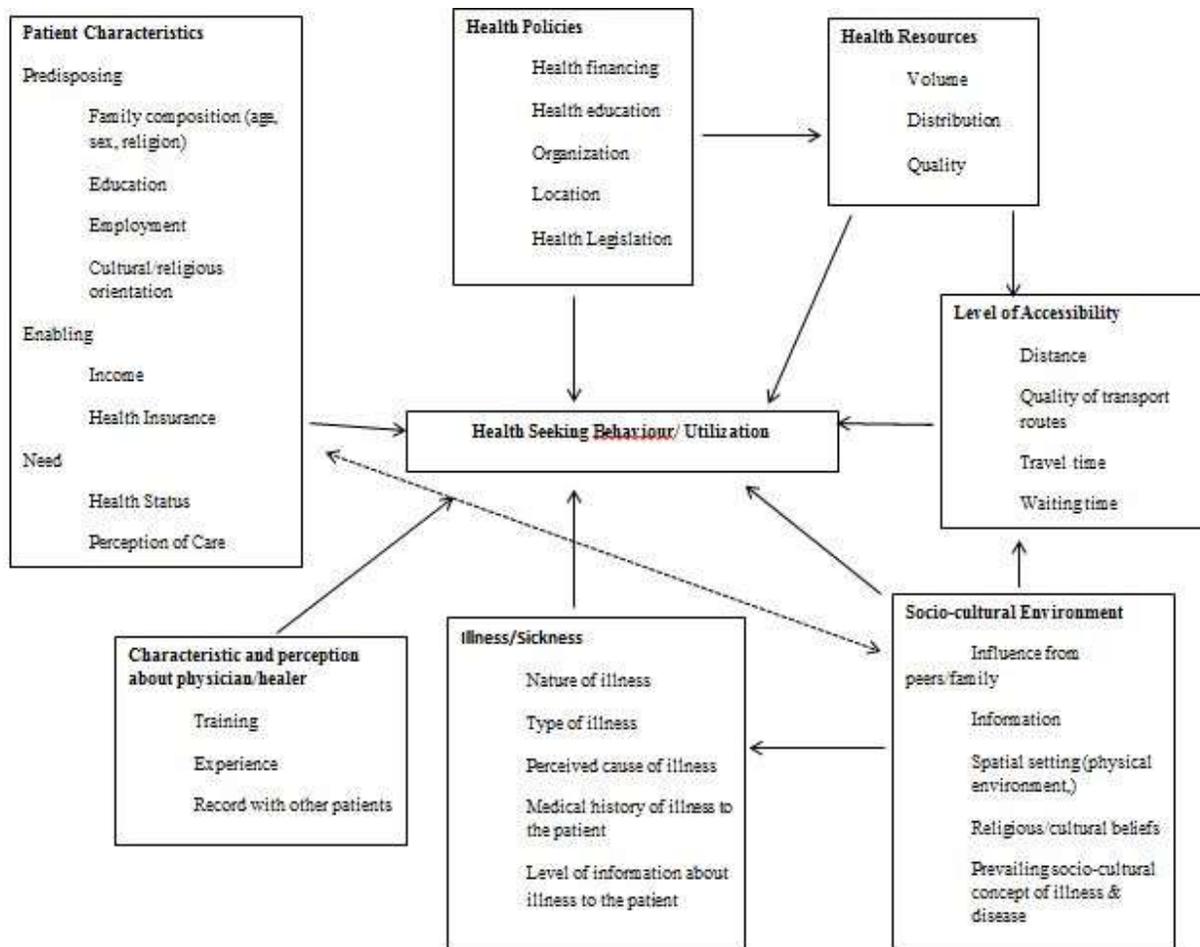


Fig. 1 Model of Determinant Factors of Health Seeking Behavior

Source: Author’s own construct based on Aday and Andersen (1974) and Buor (2004)

In the model above, there is a two-way interaction between individual (Patient) characteristics and his/her socio-cultural environment. Human beings are by nature and necessity, social animals as such we cannot survive in the absence of society. Society is indispensable for the human race. People are social beings from the very beginnings of life and their social relations shape every aspect of their being (Siegel 1999, Schore 2000 and Trevarthen and Aitken 2001 cited by Schlitz et al. 2010). We are born into social group and we are socialized with the values and norms of the social groups we are born into. These norms and values shape our worldview and influence our decision making process. However, humans form social groups hence their values, expectations and views become embedded in the shared social

norms and culture of the society they are part of. Thus, there is a two way interaction always between a person and his/her socio-cultural environment. This understanding is vital in order to perceive the complex interaction between individuals and their socio-cultural environments and how this interaction influence behavior and decision making process.

Some factors in this model are deemed more influential in the health seeking decision making than others. Factors such as patient's characteristics, socio-cultural environment, type and nature of illness; and health policy sway more influence on health seeking behavior than the rest. Although a lot of study conducted by researchers such as Buor (2004) emphasis the importance of distance or physical proximity of health resource in health seeking behavior, the concept of distance and time is relative. For instance, if a patient is sick and knows that he/she will get cured from a health service (be it modern or traditional health service) which is 100km from where he/she is, the distance does not become an impediment to the patients decision to seek care from such a place. However, other factors of economic and social bearing rather influence their decision making. Poverty or economic challenges prevent the patients but not the location of the service, as the level of need of the patients makes distance a relative phenomenon in health seeking behavior. Aside economic challenges, other factors of social origin, such as family or the social group can restrain the patient; being part of a social group means an individual's decision making is not solely by him/herself alone. Another factor such as a health legislation prohibiting the use of the service in question can also indeed deter the patient. The concept of distance or physical proximity and its influence on the health seeking behavior of patients in the developing world have been overly emphasized without researches paying attention to other factors such as the demand for the service in question. Different health services command different levels of demands; thus, different health needs/services have different range of distance to which a patient will travel to gain access depending on factors such as the patient's level of demand for such service, ability to afford such service as well as the expected outcome of using such service. Thus, in this study, minimal concentration is placed on distance and other spatial factors as important factors influencing health seeking behavior.

### **2.3 Summary**

In this chapter I look at the concept of medical pluralism and the global pattern of this phenomenon. From the literatures reviewed, medical pluralism is not only limited to the developing world, but also existing the developed world. It also looked at the approaches medical pluralism in terms of the degree of integration and acceptance of the non-formal health system as well as the level of corporation between biomedicine and traditional medicine in the developing world. The chapter also looks at the competing paradigms of biomedicine and traditional medicine and how this affects effort to integrate the two health care systems. It further examines the African healing process and the concept of illness from the African cosmological perspective where the physical and supernatural are integral part of a whole. It also delves into health seeking behavior in the developing world, Africa and Ghana in relation to the problems associated with the behavior exhibited and the prospects for improving and tackling these problems in this part of the world. The chapter also provides the conceptual and theoretical framework for the study.

## CHAPTER 3 STUDY AREA

### 3.1 Brief Profile and Demographics

Asikuma-Odoben-Brakwa District Assembly is one of the seventeen political and administrative districts established in 1989 by Legislative Instrument 1378 (LI, 1378). The district capital is Breman Asikuma. Asikuma-Odoben-Brakwa district is located in the north-central portion of the Central Region of Ghana. It covers an area of 884.84 square kilometers. It is bordered on the North by Birim South District in the Eastern Region, on the South by Ajumako-Enyan-Essiam District, on the West by Assin District and on the East by Agona District. Breman Asikuma, the administrative capital is also the traditional capital of the Breman Traditional Council and is one of the three traditional councils of the district. The others are Odoben and Brakwa traditional councils. The district has over 464 settlements scattered all over the district and the main settled towns are linear in character along the main trunk roads. The district is made up of three town councils and five area councils.

By the final summary result of the 2000 Population-Housing census, the population size of Asikuma-Odoben-Brakwa District was 89,395 representing 5.6% share of the regional population and 0.5% of the national Population figure. (GSS 2000). The figure for the recent population census was 112,706 representing 5.1 % of the region's population and 0.5% of the National Population figure. Out of this figure 54,293 are males and 58,413 are females; with 54,213 being urban residents and 58,493 being rural residents. The annual population growth rate from 2000 to 2010 was 2.6%, a little above the national figure of 2.5% and below the regional rate of 3.1%

The potential labor force of the district was derived from its adult population ranges between the ages of 20 years to 60 years. The district labor force, by 2000 PHC was 52.9% of the District population. Using the District male-female ratios, 48.4% constitute the male labor force while 51.6% for the female. The major occupation in the district is agriculture, which employs 65.0% per cent of the labor force. About 52.0% of those engaged in other occupation still take up agriculture as a minor occupation

Being a typical Akan speaking area and matrilineal, the household units in Asikuma-Odoben-Brakwa District is still traditional. That is the extended family living in the same housing units. The district household figure remains high; they are even higher as one gets into the rural communities. The average household size is 6.5 based on the 2000 Population and Housing Census; this figure decreased to 4.1 based on the 2010 Population and Housing Census with 26,997 households in the district (GSS 2012). However, the size of household varies with individual communities. The more rural the community is, the larger the household size. One other characteristic of the district household size is that, there are more females in each household than males.

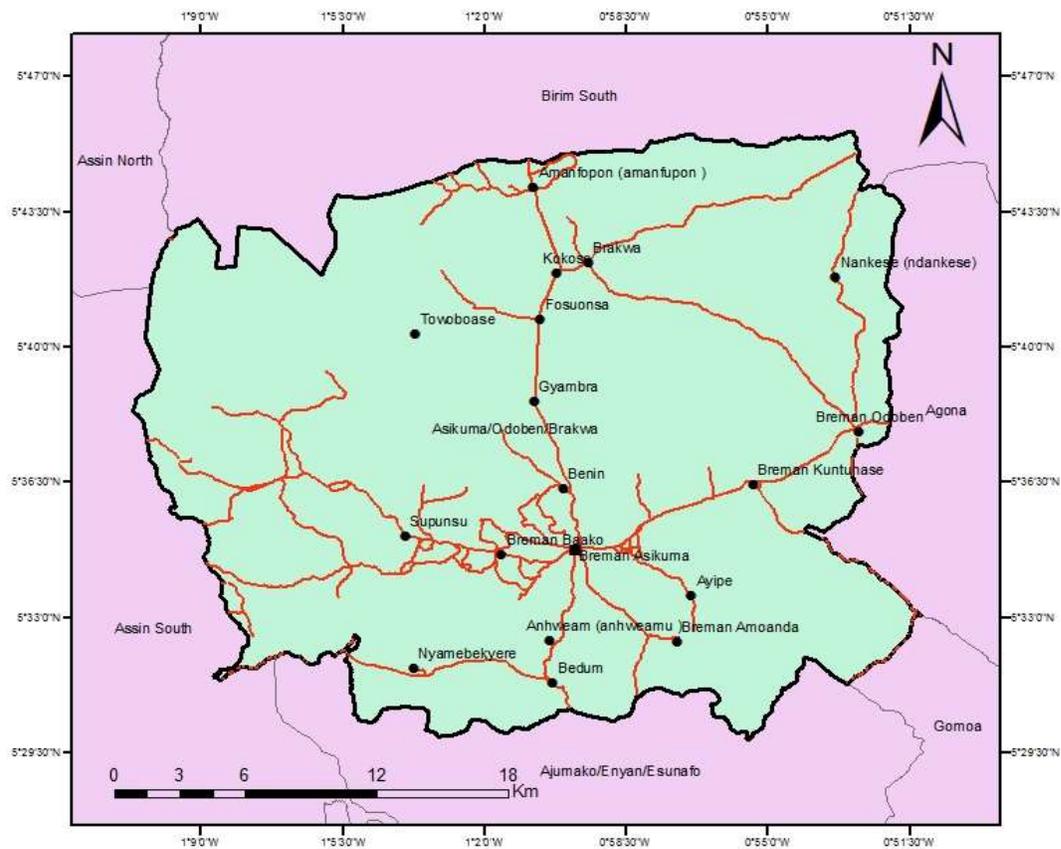


Fig. 2 Base Map of Study District

### **3.2 Level of Poverty in Asikuma-Odoben-Brakwa District**

Poverty is defined as a situation where an individual of a household is not able to generate sufficient resources to satisfy the basic needs of life such as food, shelter, clothing and medical care. The poor in the District are primarily subsistence farmers with small land holdings between one-quarter of an acre and two acres. About 55.0% of these farmers are aged according to recent studies by the district directorate of agriculture in conjunction with District Planning and Coordinating Unit (DPCU). The able-bodied people in the district are under the poverty line because they have no work to do.

### **3.3 Key Health Data**

The district has one main hospital, which serves its 112,706 population. This hospital is located at the district capital – Asikuma and it also serves as a referral for the point for the 10 community health post compounds and two clinics in the district. These health facilities are manned by 9 medical officers and 6 medical assistances; with the help of 23 midwives, 18 staffed nurses, 12 enrolled nurses and 8 public health nurses. These health statistics are not encouraging given the fact that the main district hospital is also a referral point for other surrounding districts hence the number of patients that use the facility daily far exceeds the number the staff can handle; furthermore these key health personnel are not even distributed across the district, majority of the personnel are stationed in the district capital. However, with 54 community health nurses dispersed among the 10 CHPS compounds in the district is an encouraging figure. With regards to specialist, the district survives the same fate as most rural district in Ghana; the vast concentration of health personnel in the urban areas, especially in the three big cities of Accra-Tema area, Kumasi and Sekondi-Takoradi has often led to poor staff in other areas especially the rural areas. The district has a specialist, a registered mental health nurse and 5 laboratory assistants handling special health cases in the entire district as well as those from the other surrounding districts.

These shortfalls in biomedical system are augmented by the activities of traditional healers, licensed chemical shops and drug peddlers in the district. There are currently about 35 licensed chemical shops in the district that serves the health care needs of patients. These shops

do not only provide biomedical drugs, but also sell traditional medicines mostly herbal medicines prepared by licensed traditional herbal practitioners in the country. The table below gives an overview of the distribution of these chemical shops in the district.

Table 2 Licensed Chemical Shops in Asikuma-Odoben-Brakwa district

<b>Town / Area Council</b>	<b>No. Drugstores</b>
Asikuma Town Council	15
Odoben Town Council	3
Brakwa Town Council	4
Breman North Area Council	3
Jamra Area Council	2
Bedum Area Council	2
Kuntenase Area Council	4
Baako –Anhwiam Area Council	2

Source: A.O.B DHMT, 2010

## CHAPTER 4    METHODOLOGY AND METHODS OF DATA COLLECTION

### 4.1 Philosophical basis for the study and the choice of methods and techniques

The philosophical basis of this study and the choice of methods of data collection is the realistic approach of social sciences. This approach – Realism – was popularized by Bhaskar (1978). Realists believe that there is a “real” world of physical things, which exists whether or not we perceive or recognize them. Phenomena in the real world are structured and possess causal powers and liabilities. The main argument is that there is a real world, but that some of its most significant components are not immediately observable. There are two types of non-observable structures: Capitalist or other structures and forces of power, and the second entails structures that are found in the form of experiences and conceptions “in people’s heads”, which cannot be observed or measured directly, but which are the basis for actions. Thus in line with this, the study acknowledges the existence of structures as well as non-observable structures and forces that influence health seeking behavior. These structures in social reality interact in shaping the individual’s choice of health care systems and beliefs; these structures are mutually interrelated. Observable structures such as health care resources – hospitals and professionals – influence choices of health care in the same manner non-observable experiences such as previous usage of a health care system and perceived quality shape future health seeking behavior. Thus to have an informed knowledge about people’s health seeking behavior and how their spirituality shape this behavior, there is the need to study both structures.

Realism sees a connection to both Giddens’s (1984) structuration theory and humanism approach in social sciences. It thus advocates for the focus on both structures and experiences in social science research. There are three distinct domains (worlds) of reality. The *real* – mechanisms (which are unobservable), the *actual* – events (which are observable phenomena), and the *empirical* – experiences of events. Realism emphasizes theoretical abstraction; one must examine both external structures and those based on experience.

## **4.2 Study design**

The study employed both quantitative and qualitative research methods; the two methods were used in a sequential manner. The study is a cross sectional involves the Asikuma-Odoben-Brakwa district in Ghana. The data for the research study and analysis were obtained through both primary and secondary sources. Primary data were obtained through the administering of questionnaires and in-depth field interviews as well as from direct field observations. Secondary data were sourced from the district assembly. Thus, three basic data sets were used in the study: questionnaires for a research survey, an in-depth interview and government demographic and statistical data.

### ***4.2.1 Study population and study sample***

The study population for the study comprised of all residents in the Asikuma Odoben Brakwa district. Within this study population a sample was drawn from all persons within the working age – from 18 years to 65 years – and people from the higher dependency age structure (65 years and over). The age for the working population was pegged from 18 to 65 years because the study area is predominantly a rural area; hence it is common to see young adults engaging in an employment mostly farming. This phenomenon is less common in urban areas where people as old as 19 years and over may be still dependent on their parents or guidance due to high unemployment rates in the formal sector and high cost of living in urban centers. Thus, young adults in the rural areas are more likely to be free of parental control at a very early stage of their lives than those in the urban areas. With this in mind, the study assumes these young adults exhibit health seeking behavior that is of little control by their parents than those in urban centers.

In all a total of 227 respondents were interviewed in the quantitative survey, out of which 5 were drawn for the qualitative in-depth interview. Table1.1 below shows the socio-demographic characteristics of the respondents for the quantitative survey from the three communities selected for the study in the study district. Informants for the qualitative interview were drawn based on gender, age and level of education; appendix 1 shows the characteristics of these informants interviewed during the qualitative data collection.

Table 3 Socio-demographic Characteristics of Respondents

<i>Socio-demographic Characteristics</i>	<i>Asikuma</i>	<i>Bedum</i>	<i>Fosuansa</i>	<i>Total</i>
Gender				
• <i>Male</i>	51	30	17	<b>98</b>
• <i>Female</i>	51	47	31	<b>129</b>
Age				
• <i>18-29</i>	23	9	6	<b>38</b>
• <i>30-50</i>	51	45	16	<b>112</b>
• <i>51-65</i>	18	16	8	<b>42</b>
• <i>66+</i>	10	7	18	<b>35</b>
Level of education				
• <i>Basic education</i>	35	49	29	<b>113</b>
• <i>Secondary education</i>	27	8	6	<b>41</b>
• <i>Tertiary education</i>	31	2	1	<b>34</b>
• <i>No education</i>	9	18	12	<b>39</b>
Ethnicity				
• <i>Akan</i>	78	75	48	<b>201</b>
• <i>Ga</i>	9	1	0	<b>10</b>
• <i>Ewe</i>	8	1	0	<b>9</b>
• <i>Mole-Dagbani</i>	6	0	0	<b>6</b>
• <i>Others</i>	1	0	0	<b>1</b>
Occupation				
• <i>Formal sector</i>	29	5	2	<b>36</b>
• <i>Informal sector</i>	53	69	42	<b>169</b>
• <i>Unemployed</i>	8	1	4	<b>13</b>
• <i>Student</i>	4	2	0	<b>6</b>
• <i>Clergy</i>	3	0	0	<b>3</b>
Religion				
• <i>Christianity</i>	85	69	47	<b>201</b>
• <i>Islam</i>	16	7	1	<b>24</b>
• <i>African Traditional Religion</i>	0	1	0	<b>1</b>
• <i>Others</i>	1	0	0	<b>1</b>
Marital status				
• <i>Single</i>	28	14	9	<b>51</b>
• <i>Married</i>	60	46	28	<b>134</b>
• <i>Widow</i>	7	8	6	<b>21</b>
• <i>Divorced</i>	6	9	5	<b>20</b>
• <i>Others</i>	1	0	0	<b>1</b>
<b>Total number of respondents</b>	<b>102</b>	<b>77</b>	<b>48</b>	<b>227</b>

Source: Fieldwork

#### ***4.2.2 Sampling and Sampling Techniques***

In the collection of the primary data, the district was divided into eight unit areas base on the administrative division that exists within the district – thus, an area sampling technique was employed here. These eight administrative divisions were further clustered into three basic spatial units, based on their degree of urbanity; the three clusters were urban areas, peri-urban areas and villages or hamlets. Area sampling is defined as a type of cluster sampling, where the primary sampling unit represents a cluster of units based on geographic area (Kothari 2004). The criteria for these divisions were based on the criteria used by Ghana Statistical Service which are population and the predominant type of occupation. Although this criteria have flaws as they may not reflect reality on the ground and sometimes there is no clear cut distinction between places. For instance an area may have the population required to be classified as an urban settlement, however it may lack social amenities and services necessary for its function as an urban area. With this flaw in mind, however, its adoption was informed by the availability of statistical and demographic data; data are categorized in this manner, hence its usage in this study was to ensure easy access to data. The use of areal and stratified sampling techniques was due to their practical feasibility and the objective of obtaining representativeness for the quantitative method. In so doing, the selected study units within the district were fairly represented all the eight administrative units in the district. From this areal cluster, a lottery sampling technique was used to draw one community from each cluster for the study thus representing all the clusters in the categorization stated earlier. Through the lottery sampling techniques, three settlements were chosen – Asikuma, Bedum and Fosuansa – representing urban, peri-urban and rural criteria respectively. Within each chosen study place, selection of participants for the research survey was done by choosing an 8<sup>th</sup> house along a street or a path randomly selected in the urban and peri-urban areas (Asikuma and Bedum); and 4<sup>th</sup> house along a street or a path randomly selected in the rural settlement (Fosuansa). The variations in the n<sup>th</sup> number used for the urban and peri-urban areas on one hand and rural areas on the other hand was due to the small size and number of houses in the latter. The choice of this selection technique was influenced by the unavailability the list of all units in the population.

Although a listing of all the population units in the selected clusters could be done, time limitation did not permit this. A total of 240 questionnaires were used in the survey, each settlement was assigned a number of questionnaires based on the population of the settlement.

Asikuma was assigned 110 questionnaires, Bedum was assigned 80 and Fosuansa assigned 50 questionnaires. In all a total of 227 respondents were interviewed in the research survey; 100 respondents were interviewed in Asikuma, 77 respondents in Bedum and 45 respondents in Fosuansa. Questionnaires from 13 respondents representing 5.42% of the total sample population could not be retrieved; these respondents were highly educated individuals who work in the study area as civil servants. They wanted to fill out the questionnaires themselves and instructed a later date for the questionnaires to be collected; however due to an ongoing District Chief Executive election and other reasons that the researcher cannot account for the respondents were indisposed during the remaining period of the fieldwork. This anomaly, however, does not affect the quality of information gathered and the findings of the fieldwork.

The informants for the qualitative in-depth interview were chosen through the quantitative research survey; during the survey potential informants were identified and their consent sought for further interviewing. The selection of these informants was based on demographic variables such as education, economic status (determined through employment and income as well as certain household characteristics), gender and age. This decision was not to seek representativeness, but to have varied and in-depth information from a variety of social actors from different social background.

#### ***4.2.3 Data collection techniques***

The study employed two main data gathering techniques in soliciting for primary data; these were questionnaires and in-depth interviews. A research survey using a questionnaire was used in gathering quantitative data on the socio-demographic characteristics and general health seeking behavior. This method was also employed to help elicit information on the choice of modern or traditional medicine for different types of illness and to establish a basis of reality of people's preference because there is no information about this phenomenon which was available to me. The survey questionnaires used on the field for data collection had closed-ended types of questions. The questionnaires were organized in four modules. The first module delved into the individuals and their demographic as well as socio-economic characteristics and conditions. The second module covered respondent's understanding of health, knowledge of the existence of health facilities and their health seeking behavior. The third examined the choice of treatment for

some categories of diseases and the perceived etiology for these diseases. The fourth module delved into the role of friends and family in an individual's health seeking behavior as well as the use and perceived role of the supernatural in a person's health.

Qualitative in-depth interview technique was used to get insight or in-depth information from respondents (willing to participate) knowledge about the rationale and factors that informs their choice of one particular health system or their combination; as well as delve into the factors which make one health system more favorable than the other. It was also used in soliciting information about the role of spiritual beliefs in health seeking behavior and the extent to which these beliefs are important in informing their choice of a health care system; this is informed by the fact that an understanding of people's experience and knowledge is a key in determining their health seeking behavior. The choice of a particular health care system or combine usage of the two health care systems by individuals is informed by these experiences and knowledge gained from the social world through their interaction with the health system and other socio-economic structures such as religion; spiritual beliefs emanating from religion and cultural form vital part of these experiences and knowledge.

#### ***4.2.4 Data analysis***

Quantitative data gained through the use of questionnaires was analyzed with the Statistical Package for Social Sciences (SPSS) version 16. The analysis was to mainly look for correlations between the causal factors in the model used employed earlier in this study as well as their regression. The analyses were therefore focused on frequencies, correlations, linear and multiple regressions in testing for the hypotheses postulated in the study.

Data from the in-depth interview was manually transcribed and coded to identify pertaining themes in them for further discussion. The discussion of the interview data was done consequently with the literature reviewed in this study to identify correlations and the difference between the field data and information from the literature. Further discussion was made on the reasons for the similarities and differences between the field data and the literature. Also the data were used to assess the model adopted in this study. The analysis also focused on the differences

in data gained from the quantitative research survey and the qualitative in-depth interview as well as highlight areas where there is corroboration.

#### ***4.2.5 Variables***

The study conceptualized seven main factors that influence the health seeking behavior of people: patient's characteristics, health policies, health resources, level of accessibility of the health resources, the socio-cultural environment of the patient, illness and the characteristics and perceptions about the healer. Within these factors, some variables such as education, employment, type and perception about the illness, influence of family and peers, and perception about the healer were key important variables that shape one's health seeking behavior. The other variables in the model are directly or indirectly influenced by these key variables. The table below (modeled after Kroeger 1983) distinguishes some of the key explanatory variables that shape the health seeking behavior of patients. The variables in the conceptualized framework are grouped under four broad categories ranging from individual characteristic, illness characteristics, health resource and service characteristics, and socio-cultural environment. This categorization acknowledges that the decision making in health usage does not rest on the individual alone but on other external factors. These external factors interact with the individual's characteristics in everyday life to shape one's health seeking behavior.

Table 4 The Choice of Health Care System in relation to various possible explanatory variables (after Kroeger, 1983)

	<i>Subject Characteristics</i>	<i>Illness Characteristics</i>	<i>Health resources and Service characteristics</i>	<i>Socio-Cultural Environment</i>
Explanatory Variables	Age Sex Marital Status and position in Household Formal Education Occupation Health insurance status Health status Perception of Care Resources	Nature of illness Type of illness Perceived cause of Illness Medical History of Illness to the patient Level of information about illness to patient	Distribution Quality Cost of treatment Acceptability Appeal (opinions and attitudes towards healer)	Spatial setting (rural and urban) Level of social interaction Transport and communication system Public Health Information
<b><i>Choice of Health Care System</i></b>				
Dependent Variables	Modern Medicine		Traditional Medicine	

***4.2.6 Administering of Research Survey Questionnaires and the use of Research Assistants***

Before the commencement of my studies at the University of Oslo, I had established contacts with people I was to use as gatekeepers and field research assistants when the period of my fieldwork commence. However, upon my arrival in Oslo, I lost contact with these people. This made my first week Ghana very difficult as I had to seek new gatekeeper and assistants for the fieldwork. After spending two weeks in the district with no success, the District Planning Officer together with the District Coordinator offer to help by making available their national service

personnel who were working throughout the district as revenue mobilization units. Using the lottery sampling technique to select my study communities within the district, six personnel were made available to me. These personnel who became my field research assistants were stationed in the communities selected for the study: Asikuma, Bedum and Fosuansa. These three communities represented the three degrees of urbanity used in the categorization of the district; Asikuma which is also the district capital was the urban community, Bedum was the peri-urban community and Fosuansa was the village.

The field research assistants in these communities were contacted then dates were established for the administering of the questionnaires. The research assistants were taken through the questionnaires and the purpose of the study explained to them. To ensure quality and efficient collection of data a 15-questionnaire per day limit was assigned to each assistant and also data collection made on different days, so the data collection process can be monitored and the administering of the survey questions supervised. Multiple starting points were used in the administering of the questionnaire. The entire data collection period for the questionnaires took six days; two days for each community.

#### ***4.2.7 Interviewing: Negotiating Entry and Recruiting Informants***

The act of interviewing is the common method used in information gathering from people. We collect information consciously or unconsciously in our everyday interaction with others. Hay (2010) however, points out that interviewing in academia is more than just having a “chat”; it entails careful planning and detailed preparation, aside these it requires diplomacy in contacting informants and negotiating ‘research deals’. Maccoby and Maccoby (1954:499 cited by Hay 2010) define an interview as “a face-to-face verbal interchange in which one person, the interviewer, attempts to elicit information or expressions of opinion or belief from another person or persons. The purpose of this technique according to Silverman (1993 cited by Cloke et al. 2004) is to ‘give an authentic insight into people’s experiences’. The scientific method in quantitative research attempts to mirror people’s social and geographic worlds, however, qualitative research interviews employ interactive approach to gain access to the meanings people attach to their everyday experience in these worlds (Cloke et al. 2004). In line with these,

the study employed semi-structured interview technique to elicit information on the rationale behind people's health seeking behavior and the role of spirituality in them.

The use of semi-structured interview technique was to make the interviewing process content-focused and deal with the issues and questions raised in the interview guide; as well as giving room for the informants to freely to express themselves. This interviewing technique is best adept for this study because whereas giving the researcher the role of a facilitator, it also opens the research to ideas and experiences he/she may have not thought of in the initial stages of the study. The informants express themselves freely, hence bring to light new ideas and information unknown to the researcher. This technique does not strictly limit the responses and information the informant gives as is the case with structured interviewing technique nor does it allow the informant from swaying off the topic of discussion as unstructured interviewing techniques have the tendency of doing. It opens up the researcher to new ideas and information at the same time keeping the interview in focus.

In spite of the numerous benefits of using qualitative interviewing as a research data gathering tool, Nunkoosing (2005) warns that it should not be taken for granted. He identified four basic challenges or problems associated with the use of interviews: power, consent, truth and authenticity of information given and the projection of the self (researcher's positionality). With regards to the issue of power, this phenomenon is inevitable in any social interaction as it has both macro and micro perspectives. Power is widely acknowledged in qualitative research; there is recognition of biases in the relationship between the researcher and the researched. It is outward expression, the researcher can minimize it but when it is concealed in thoughts and is at the individual level it is difficult to deal with this. Dowling (in ed Hay 2010) identifies two major ways in which power can enter into a research and three types of power relations. The first way in which power enters into the research is through the stories or interpretations created from information gathered. Power comes to play here through the input of information gained into policies and the impact of the results on the people as well as through the stories the researcher tells about his/her informants actions and words which have a way of changing how people are thought about. Secondly, power enters into the research process in the early stages of the research through the differences in the roles and intentions of the researcher and the informants. To minimize the effect of power relations and ensure that informants are not exploited, I

explained vividly the purpose of the research study and informants were made aware that the process was purely for academic purpose and knowledge gaining. They were also made aware of their right to exist the interviewing process at any time they feel so. This platform was also used to seek their informed consent before and after the interview. Informants consent was sought in recording the interview and after the interview they were asked whether they were okay with the process or they wanted the interview deleted.

In regards to the issue of truth and authenticity of information given, the advice of Charmaz (1995) was taken in this regard. According to Charmaz (1995), the important thing here is that the interview is not an end in itself, but can be used to generate hypothesis or theories for further studies. The stories or reality created by the interviewee and the interviewer are social construct based on information and means available to them, hence all stories in this context are authentic rather than true. The research interviewing process is not a neutral product of the academia. Like all social interaction and academic products, the interview serves a hegemonic purpose of the context in which it was created. This context consists of socio-cultural, economic and political elements; thus the text and interpretations derived from the interviewing process often have these elements imbued in them. In this regard, Seidman (1998) state that the question one ought to ask is not just the purpose the research, but also whose purpose is being served in the research. This phenomenon defines the position of the research in the research process and how this position may have or may not have influenced the research interviewing process. My positionality as an outsider in the community and a student made informant feel comfortable in talking about their personal experiences in their health seeking behavior. The informants were at ease knowing that whatever information they are giving was not be spread in the communities they live in and also their anonymity was protected. My ability to speak the local language – ‘Fantse’ – also created an atmosphere of comfort and trust as the informants viewed me as one of their own.

Seven informants were used in the in-depth interview for this study. The informants were gained through contacting participants of the research survey who were willing to be further interviewed to gain explanations to some questions. Six respondents from the quantitative survey were interviewed for the qualitative study and one person outside this group was interviewed in addition; making a total of seven informants for the qualitative in-depth interview. The person

interviewed outside the quantitative survey respondent group was a faith healer a renowned prayer camp at Bedum, this interview was unplanned as it occurred spontaneously during the negotiating for access to respondents in that section of Bedum. Access and entry were negotiated during the administering of the questionnaires; the purpose of the study was explained to them and they were informed that they can redraw from the study anytime they feel so. Modified version of the interview guide was read out to them for them to know the nature of the interview and also to put them at ease. The access to the informants from the prayer camp – Great Jesus Prayer Camp – was gained through negotiation with the leader of the camp. The purpose of the study was thoroughly explained to her and her consent sought before interview three individuals at the camp. Later the leader of the prayer camp was also interviewed to gain knowledge about how spirituality and faith comes into play with health; and to establish the nature of her work.

Some informant felt uncomfortable with the recording of the interview, in such situations one of the research assistant stationed in the community of these informants was asked to help in the transcribing of the interviews. The interviews were conducted in the workplace of all the informants gained through the research survey and at the prayer camp for the informants at there.

#### **4.3 Issues of Ethics and Power**

O'Connell-Davidson and Layder (1994) define research ethics as being about the conduct of researchers and their responsibilities and obligations to those involved in the research, including sponsors, the general public and most importantly the subjects of the study. Social scientific research is based on human interaction which involves the creation of relationships between people. Such relationships are the core of qualitative research; they often entail questions and inquiries into individual's personal life. This thick description of individual's life raises the inevitable question of ethics (Mason 1996); such ethical considerations, according to Hammersley and Atkinson (1995) border on informed consent, privacy, harm to the researcher and the researched, exploitation of research subject and sensitivity to the cultural difference and gender (Cloke et al. 2004).

The study protocol was to be reviewed and approved by the department of Sociology and Human Geography of University of Oslo as well as the Ethical Committee of the University for approval before the commencement of the study. However, due to time factor this could not be done, hence the ethical considerations were discussed with the supervisor of this study and improvements were made where it was deemed short. The purpose of the study and its objectives was explained to local authorities, gatekeepers and the informants used in the in-depth interview. The researcher had a thorough discussion about the research and the objectives with the District Coordinating Director and District Planning Officer of Asikuma-Odoben-Brakwa district. Participants in the study were verbally informed and the purpose of the study explained to them before gaining their consent to participate in the study. Written consent for the study to be carried on in the district was given to the district assembly, however, due the level of illiteracy and technological limits written consent for all participants and informants in the study could not be sought. The Institutional Review Boards (IRB) approves the use of oral consent prior to the start of the study. Anonymity of informants was ensured by using pseudo names in the analysis and discussion of data gained from the in-depth interviews; and the informants were not asked to provide their names during and after the interview. In cases where during the building of rapport informants gave their names, the pseudo name assigned during the analysis and interpretation of data to take care of that.

#### **4.4 Research Limitations**

In the pursuit of this research a number of factors inhibited the study or posed as a challenge. These challenges have been grouped into two broad categories for discussion. The limitations for this study border on methodological limitations that range from sample size to data availability; and limitation of the researcher, which concerns issues such as access. Like every study, this research has got its limitations which are addressed in the work, but for generalization purpose the limitations have been grouped for a general overview.

Methodological limitation in this study is concerned with the characteristics of the study design or methodology that influenced how the study was carried out as well as the application or interpretation of the results of the study. The first limitation acknowledges in this study is the

lack of current statistical data on demographic and health information in the study area. Although a recent population and housing census have been conducted in 2010, the result of this census is not available to the public. As at the time this study was being conducted, the district assembly did not have access to information from the 2010 population and housing census. In light of this, data and information from the 2000 population and housing census were used for this study. The researcher acknowledges the limitations and the challenges in the use of this data as socio-demographic characteristics of the study area may have changed significantly over the thirteen year period. Another methodological limitation acknowledged in this study is sample size used for the various communities selected for the research. Due to the choice of the entire district as the study area and limitation of time, smaller sample sizes were used for each community, especially the urban and peri-urban communities; hence it may be difficult to find significant relationships from the data collected, as statistical tests normally require a larger sample size to ensure a representative distribution of the population and to be considered representative of groups of people to whom results was generalized or transferred. This however, does not deny the research the general picture of health seeking behavior for the district. Another methodological limitation acknowledge is the use qualitative research technique – in-depth interviews – in the data collection process limit the data and information gained as the facts or knowledge obtained can rarely be independently verified. These self-reported data contain several potential sources of bias that have been duly noted as limitations such as selective memory (remembering or not remembering experiences or events that occurred at some point in the past) and exaggerations.

Some of the limitations emanating from the researcher’s position borders on the issue of time, access and language. The longitude effect of the time available to investigate the research problem and the size of the district was constrained by time available for the collection of data. However, these notwithstanding adequate and ample data were collected to ensure the credibility and reliability of the research. Access to district health data from the district health directorate was limited due to an ongoing problem by the directorate. The time period slated for the data to be available exceeds my staying time for the fieldwork. Another limitation duly acknowledged in this study is language; this limitation is not with language fluency as I am well knowledgeable in the local dialect – ‘Fantse’; but it was with translating certain words which either lacked “Fantse” vocabulary or its ‘Fantse’ vocabulary is not well known. A critical example was how to

translation of some of the diseases in the quantitative questionnaire into ‘Fantse’, as there are no ‘Fantse’ name for them or if such names exist, they were uncommon. In situation like that, phrases and sentences that best described the phenomenon were used in explaining them. Some of the field research assistants used in the gathering of qualitative data were not well abreast with some vocabularies in the ‘Fantse’ dialect; this was because the local dialect is not their mother tongue. Thus, although they can speak and understand ‘Fantse’, they lacked some technical vocabularies like the names of some common diseases in ‘Fantse’. This limitation was addressed by taking all the field research assistants through the questionnaires in both the English and ‘Fantse’.

#### **4.5 Summary**

In this chapter, I discussed the ontological and epistemological basis of this study. The choice of realism as the ontological and epistemological approach in this study is explained. The chapter delved into the study design of this research explaining the choice of sample population and the techniques and methods of sampling. It further looked at data collection techniques and data as well as data analysis processes in light of the variables of this study. Issues of ethics and power as well as the researcher’s positionality were also considered in this chapter together with some observations made during the period of field study.

## CHAPTER 5 DATA ANALYSIS AND INTERPRETATION

### 5.1 Characteristics of Study Population

The survey is an empirical cross-sectional covering the Asikuma-Odoben-Brakwa district in the Central Region of Ghana. A sample of 227 representing 0.2% of the district's 112,706 people according to the 2010 Population and Housing Census was drawn for the quantitative survey; of this study sample, 98 were males and 129 were females. The age range of the sample population was between 18 to 85 years. The age group with the highest frequency of 112 representing 49% of the total sample population was those with the ages of 30 – 50 years, the second highest was those within the ages of 51 – 65 years with a frequency of 42 representing 19% of the total sample population. With regards to the educational background of the sample population, majority of the sample population – 50% (113 out of the total sample of 227) had basic education as their lowest education status. Also, people from the Akan ethnic group formed the majority – 89% (201 out of 227 of the sample population) of the respondent in the quantitative survey; this is mainly due to the fact that the study area is located in the Akan belt of the country with 'Fantse' as the main Akan dialect.

Informal sector was the main source of employment avenue for the majority of respondents – 74%; this figure is a reflection of the national employment picture where private informal sector constitute 86% of economically active persons in the country (GSS 2012). This employment sector includes all forms of non-formal employment avenues such as farming, trading, artisanship and craftsmanship. There is, however, spatial variation in what forms the main form of non-formal sector employment for the three selected communities used in the study. In Asikuma, the capital of the district and the most urbanized settlement, trading is the main form of informal employment, whereas for the other two communities, farming is the main form giving their rural orientation. It is, however, worth noting that there were cases where respondents work in both formal and informal sectors. In such situations, the latter source of employment – informal – served as an additional source of income to help meet the financial needs of the home. Thus, some formal sector workers owned shops or traded in other goods and commodities either after work or hired attendants and helps to manage their informal sector businesses. Christianity was the predominant religion of the sample population - 89% (201 out of

227 of the sample population). This fact is not surprising considering the study district is in the southern part of the country where Christianity is the predominant religion, aside this religion also being the predominant religion in the country – 71% (GSS 2012). Majority of respondents were married with a frequency of 134 representing 59% of the sample population. Although there were no national statistics available for this study on marital status of people in the study district – Asikuma-Odoben-Brakwa, figures for the region (Central Region) within which the district is located show similarity between percentage of married people in the study and that of the region. According to the 2010 Population and Housing census, out of the 1,180,896 people between the ages of 18 years and above in the region, 589,376 representing 50 % are married and 83,517 representing 7% are in consensual union. These percentages together form 57% of people between the ages of 18 years and above in a form of marital union (GSS 2012).

From the information above on the characteristics of the sample population for the study, it can be said that the sample is a true representation of the study area. The similarities in the characteristics between percentage figures for the study sample and that from the national population census give credence to this assertion. The table below gives an overview of the socio-demographic characteristics of respondents in the quantitative survey with row total and percentage

Table 5 Socio-demographic Characteristics of Respondents in Asikuma-Odoben-Brakwa District

<i>Socio-demographic Characteristics</i>	<i>Asikuma</i>	<i>Bedum</i>	<i>Fosuansa</i>	<i>Total</i>	<i>Percentage(%)</i>
<b>Gender</b>					
• <i>Male</i>	51	30	17	<b>98</b>	<b>43.17</b>
• <i>Female</i>	51	47	31	<b>129</b>	<b>56.83</b>
<b>Age</b>					
• <i>18-29</i>	23	9	6	<b>38</b>	<b>16.74</b>
• <i>30-50</i>	51	45	16	<b>112</b>	<b>49.34</b>
• <i>51-65</i>	18	16	8	<b>42</b>	<b>18.50</b>
• <i>66+</i>	10	7	18	<b>35</b>	<b>15.42</b>
<b>Level of education</b>					
• <i>Basic education</i>	35	49	29	<b>113</b>	<b>49.78</b>
• <i>Secondary education</i>	27	8	6	<b>41</b>	<b>18.06</b>
• <i>Tertiary education</i>	31	2	1	<b>34</b>	<b>14.98</b>
• <i>No education</i>	9	18	12	<b>39</b>	<b>17.18</b>
<b>Ethnicity</b>					
• <i>Akan</i>	78	75	48	<b>201</b>	<b>88.55</b>
• <i>Ga</i>	9	1	0	<b>10</b>	<b>4.41</b>
• <i>Ewe</i>	8	1	0	<b>9</b>	<b>3.96</b>
• <i>Mole-Dagbani</i>	6	0	0	<b>6</b>	<b>2.64</b>
• <i>Others</i>	1	0	0	<b>1</b>	<b>0.44</b>
<b>Occupation</b>					
• <i>Formal sector</i>	29	5	2	<b>36</b>	<b>15.86</b>
• <i>Informal sector</i>	53	69	42	<b>169</b>	<b>74.45</b>
• <i>Unemployed</i>	8	1	4	<b>13</b>	<b>5.73</b>
• <i>Student</i>	4	2	0	<b>6</b>	<b>2.64</b>
• <i>Clergy</i>	3	0	0	<b>3</b>	<b>1.32</b>
<b>Religion</b>					
• <i>Christianity</i>	85	69	47	<b>201</b>	<b>88.55</b>
• <i>Islam</i>	16	7	1	<b>24</b>	<b>10.57</b>
• <i>African Traditional Religion</i>	0	1	0	<b>1</b>	<b>0.44</b>
• <i>Others</i>	1	0	0	<b>1</b>	<b>0.44</b>
<b>Marital status</b>					
• <i>Single</i>	28	14	9	<b>51</b>	<b>22.47</b>
• <i>Married</i>	60	46	28	<b>134</b>	<b>59.03</b>
• <i>Widow</i>	7	8	6	<b>21</b>	<b>9.25</b>
• <i>Divorced</i>	6	9	5	<b>20</b>	<b>8.81</b>
• <i>Others</i>	1	0	0	<b>1</b>	<b>0.44</b>
<b>Total number of respondents</b>	<b>102</b>	<b>77</b>	<b>48</b>	<b>227</b>	<b>100</b>

Source: Fieldwork

From the table above, there are some notable differences in certain socio-demographic characteristics based on the three selected communities used in the quantitative survey. With regards to education whereas in all the three communities the majority of respondents had

received only basic education, there are proportional differences between different levels of education among the communities. In Asikuma, the most urbanized of the 3 communities 34% of the respondents had basic education only and 26% had secondary education only with the the percentage difference of 8% whereas the other two communities Bedum and Fosuansa had percentages of 64% and 10%, 60% and 12% respectively; with the percentage differences of 53% and 48% for Bedum and Fosuansa respectively. This phenomenon indicates high level of education among urbanized respondents.

Another observable spatial phenomenon among three settlements is form of occupation. Like education, although the majority of respondents work in the informal sector in all the three communities the proportional difference between informal sector employment and formal sector employment. In Asikuma, 28% of the respondents are employed in the formal sector whereas 52% are employed in the informal sector with a percentage differential of 24. In Bedum the percentages were 6% and 90% for formal and informal sectors of employment respectively, with the percentage difference of 83.12 likewise in Fosuansa 4% are employed in the formal sector and 88% are employed in the informal sector with the percentage difference of 83. Below are tables and percentage graphs that give a picture of these geographic variations among the communities.

Table 6 Spatial differences in Respondents' Level of Education and Occupation

<b>Level of education</b>	Asikuma (Row %)	Bedum (Row %)	Fosuansa (Row %)
• <b>Basic education</b>	35 (34%)	49 (64%)	29 (60%)
• <b>Secondary education</b>	27 (26%)	8 (10%)	6 (13%)
• <b>Tertiary education</b>	31 (30%)	2 (3%)	1 (2%)
• <b>No education</b>	9 (9%)	18 (23%)	12 (25%)
<b>Occupation</b>			
• <b>Formal sector</b>	29 (28%)	5 (6%)	2 (4%)
• <b>Informal sector</b>	53 (52%)	69 (90%)	42 (88%)
• <b>Unemployed</b>	13 (13%)	1 (1%)	4 (8%)
• <b>Student</b>	4 (4%)	2 (3%)	0 ( )
• <b>Clergy</b>	3 (3%)	0 ( )	0 ( )

<b>Total</b>	102	77	48
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Source: Fieldwork

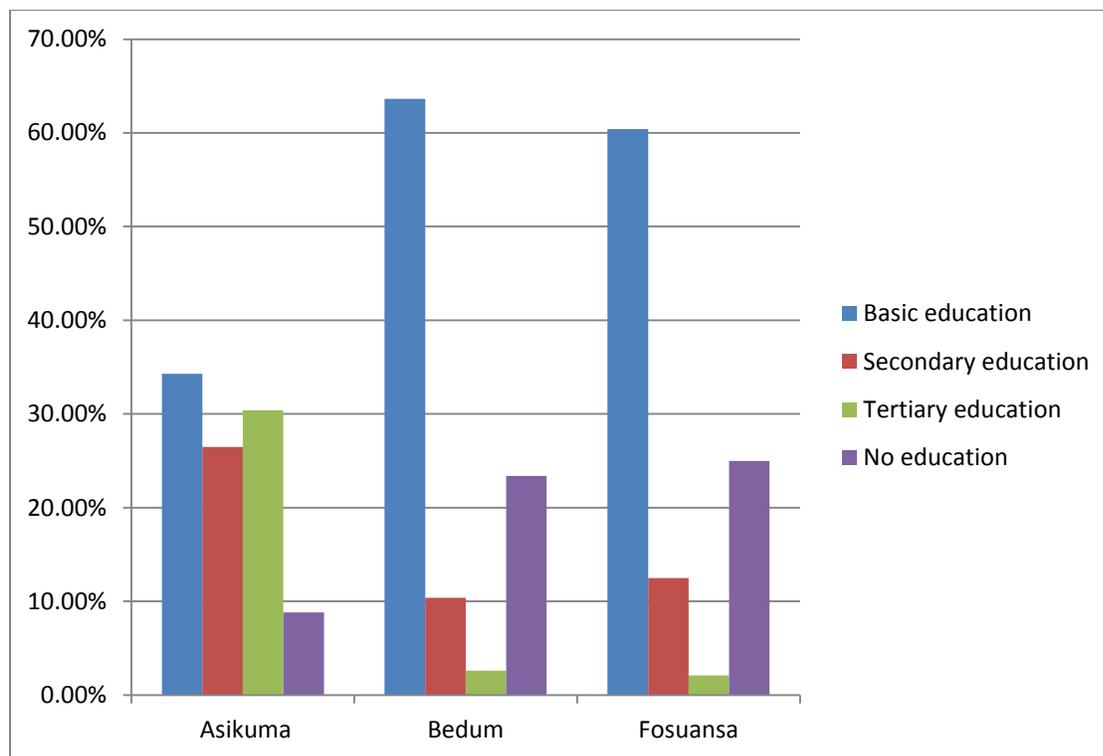


Fig. 3 Cluster bar graph showing Spatial differences in Respondents' Level of Education in %

Source: Fieldwork

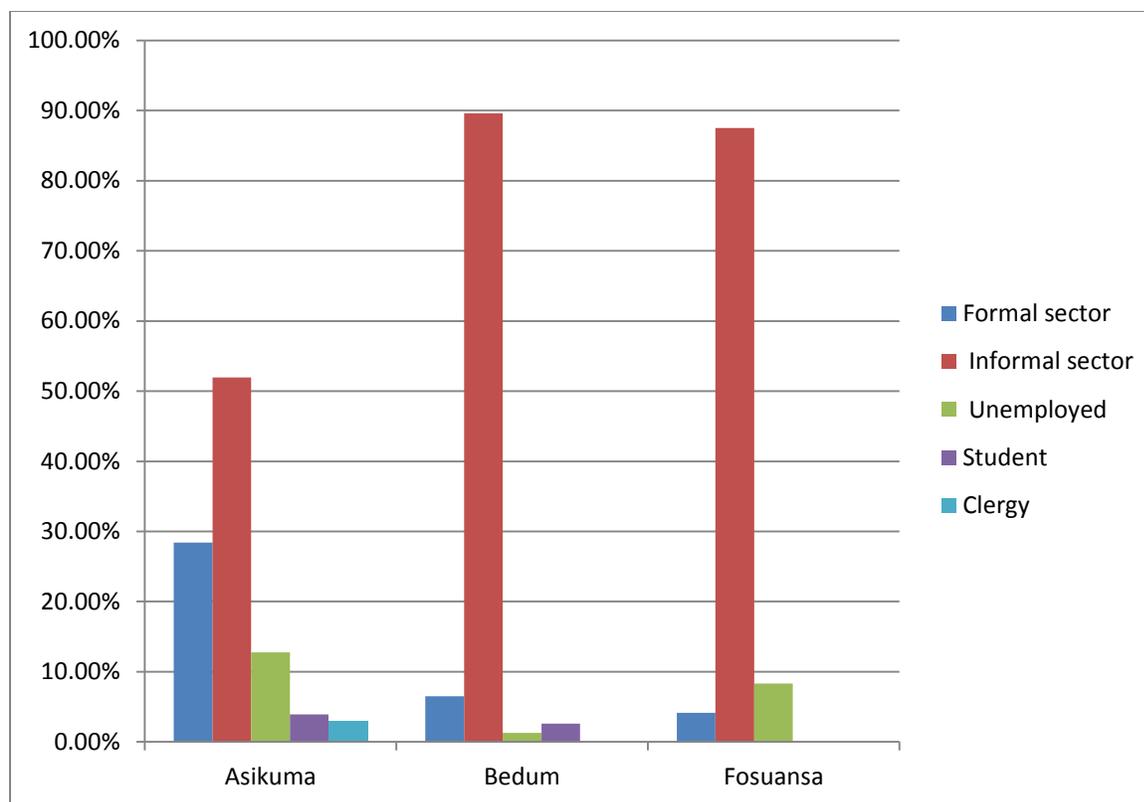


Fig. 4 Cluster bar graph showing Spatial differences in Respondents' Occupation in %

Source: Fieldwork

## 5.2 Measurement

A number of variables were selected in the quantitative study to represent the services and characteristics that exhibit respondents' health seeking behavior. These variables, however, do not represent an exhaustive list of all indicators of health seeking behavior, but rather key indicators of such behavior based on models of Andersen and Newman (1972) and Buor (2004). Although health care in pluralistic societies take many forms such as biomedicine, indigenous healing practices and recently oriental medicines such as Chinese medicine, this study restrict the use of the word to biomedicine and traditional (indigenous) medicine in Ghana. With regards to traditional medicine, the concept is used to embrace all forms of indigenous healing practices such as faith healing, bone setters, herbalist and diviners or traditional priest/priestess. However, later in the research process a third measure was derived from biomedicine and traditional

medicine – self-medication. This measure was used to refer to all forms of self-care by patients and respondents through the use of either biomedical drugs or traditional therapies without the use of any legally and/or socially recognized professional. Thus self-medication is a form of non-institutionalized health care that the individual employ meet his or her health needs.

### ***5.2.1 Dependent Variables***

The dependent variables for this deductive analytic study were biomedicine and traditional medicine. The choice or decision of a health seeker to use either biomedicine or traditional medicine or both is dependent on socio-cultural factors, health resources and policy, characteristics of illness and economic factors. Biomedicine as a dependent variable was identified by patient's use of hospital, clinic or community health posts similarly traditional medicine was identified patients' use of faith healers, herbalists, bone setters, traditional priest/priestess and diviners. Respondents were asked about their preferred choice of treatment and which health system they use most frequently. The response to these questions were categorized and coded as the following into SPSS: biomedicine (=1), traditional medicine (=2) and self-medication (=3). The inclusion of self-medication in the choices for respondent's preferred choice of treatment is to help distinguish institutionalized health care in both biomedicine and traditional medicine and that of self-care by respondents. This distinction is necessary because, in self-care patients use medicines available to them, be it biomedicine or traditional therapeutic remedies that don't require consulting a recognized professional in both medical systems. Thus a patient may purchase drugs from chemical/pharmacy shops or use herbal with his or her immediate environment for treating his or her afflictions without first consulting any health professional recognized by both the society and country either by legislation or conventional acknowledgement.

### ***5.2.2 Independent Variables***

The conceptual framework for medical pluralism used in the study and the hypotheses formulated provided the bases for the selection of the independent variables for use in determining patient's choice of a medical system or their combination in the healing process. The framework proposes that the use of biomedicine or traditional medicine or their combined

usage is influenced and dependent on a number of factors such as individual characteristics (gender, age, level of education, occupation, marital status and economic status), health resources and service characteristics (health insurance, distribution and quality of service, cost of treatment, acceptability and appeal), socio-cultural environment (spatial setting – urban or rural, level of social interaction, transport and communication system and public health information), and characteristics of illness (nature of illness, type of illness, perceived cause of illness, medical history of illness to patient and level of information available to patient about illness). Out-of-pocket expenditure or financial accessibility have been identified by many literatures on health care accessibility and utilization as a major determinant of usage. In light of this, patient's perception on which health care systems are most costly is likely to influence their choice of treatment. Health policy such as health insurance instituted by the government aim to reduce out-of-pocket expenditure of patients in their utilization of biomedical services, hence respondents with health insurance are more likely to view the usage of biomedicine as less expensive compared to traditional medicine. There are other latent secondary independent variables such as the characteristics and perception about the physician or healer and level of physical accessibility of health resources which find their expression in the other independent variables listed previous.

### **5.3 Data Analyses and Testing Hypotheses**

A number of descriptive analyses together with bivariate and multivariate analyses were undertaken to describe the variables in the study as well as to provide a preliminary test for test of association and relationships among variables based on the study's formulated hypotheses. Chi square analyses were computed for testing association between categorical nominal dependent variables and the independent variables. Pearson Product Moment correlation and Spear Rank correlation were also used to test for correlation between two sets of variables such as two independent variables, a dependent and an independent variable and two dependent variables. The test of correlation was to measure the strength and direction of the relationship between two sets of random variables. Pearson correlation was used for variables with interval or ratio measurement and these variables are assumed to have a significant linear relationship

between them. Spearman rank correlation, however, was used for variables with no interval or ratio scale of measurement and do not require that the relationship between them be linear.

Five hypotheses were formulated at the beginning of the study and these hypotheses are tentative statements about some relationships or conditions subject to verification with the purpose of determining whether a relationship exists.

The tests of hypotheses were that there are no significance relationship between selected demographic variables as independent variables of the study and selected health variables as dependent variables. The demographic variables under consideration in these hypotheses are place of residence, gender and education. These hypotheses were tested for by running chi square test of independence between each of independent demographic variables and health variables. This was done to assert whether there is any association between each independent variables and the dependent variable. After this, logistic regression analysis was done to assert or determine whether these independent variables together as a whole fit as a model in determining if there is a significant association between them and the dependent variables – health insurance, preferred choice of treatment, first choice of treatment and which treatment is more costly. Also test of relationship and association was run between some of the dependent variables such as health insurance status and preferred choice of treatment, and health insurance status and which treatment is more costly. The table below shows the chi square results of these tests and the regression model.

- *H<sub>0</sub>: There is no significance relationship between demographic variables and health insurance status of respondents.*  
*H<sub>A</sub>: There is significance relationship between demographic and health insurance status of respondents.*

Table 7 Chi Square Tests of Place of Residence, Gender and Education of Respondents against Their Health Insurance Status

Variables	Pearson Chi square	df	Asymp. Sig. (2-sided)
Place of residence * Health Insurance Status	6.025	2	.049
Gender * Health Insurance Status	0.053	1	.818
Education * Health Insurance Status	13.479	3	.004

Source: Fieldwork

From the table above there is a strong evidence of relationship between place of residence and health insurance status (Chi square = 6.025, df = 2,  $p < 0.05$ ) as well as between education and health insurance status (Chi square = 13.479, df = 3,  $p < 0.05$ ). We therefore reject the null hypothesis for the independent variables – place of residence and education, whereas we accept the alternative hypothesis that there is a significant relationship between place of residence and health insurance status; and significant relationship between education and health insurance status of respondents. However, we accept the null hypothesis for the independent variable – gender – and health insurance status of respondents (Chi square = 0.053, df = 1,  $p > 0.05$ ) that there is no significant relationship between gender and health insurance status of respondents.

Table 8 Logistic Regression Tests of Place of Residence, Gender and Education of Respondents against Their Health Insurance Status

Tests	Chi square	df	Sig
Omnibus Tests of Model Coefficients	16.536	6	.011
Hosmer and Lemeshow Test	12.621	8	.126
Model summary (Nagelkerke R Square)	.102		

Source: Fieldwork

From the logistic regression table above, the omnibus test of model coefficient had a p value of  $< 0.05$ , which means the predictor variables made a good prediction of the health insurance status of respondents. Likewise the Hosmer and Lemeshow Test with a p value of  $> 0.05$  indicates that the model is good model and as such significant. The Nagelkerke R Square indicates that about 10% of the variance in the outcome is being predicted by the predictor variables in the model; noting that only place of residence and education were statistically significant variables in the test of relationship – chi square test of independence.

- $H_0$ : There is no significance relationship between demographic variables and first choice of treatment by respondents.

$H_A$ : There is significance relationship between demographic variables and first choice of treatment by respondents.

Table 9 Chi Square Tests of Place of Residence, Gender and Education of Respondents against Their First Choice of Treatment

Variables	Pearson Chi square	df	Asymp. Sig. (2-sided)
Place of residence * First Choice of treatment	36.011	8	.000
Gender * First Choice of treatment	5.376	4	.251
Education * First Choice of treatment	19.063	12	.087

Source: Fieldwork

From the table above there is a strong evidence of relationship between place of residence and first choice of treatment (Chi square = 36.011, df = 8,  $p < 0.05$ ). We therefore reject the null hypothesis for the independent variables place of residence and accept the alternative hypothesis that there is significant relationship between place of residence and first of treatment by respondents. However, we accept the null hypothesis for the variables gender and education, that there is no significant relationship between gender and respondents' first choice of treatment given (Chi square = 5.376, df = 4,  $p > 0.05$ ) as well as that there is no significant relationship between education and respondents' first choice of treatment (Chi square = 19.063, df = 12,  $p < 0.05$ ).

Table 10 Multinomial Logistic Regression Tests of Place of Residence, Gender and Education of Respondents against Their First Choice of Treatment

Model	Model fitting criteria	Likelihood Ratio Tests			Pseudo R square
		Chi square	Df	sig.	Nagelkerke R Square
Model final	85.364	29.332	12	.004	.148

Source: Fieldwork

From the regression table above, the model fitting test had a p value of  $< 0.05$  at a  $df=12$ , which means the predictor or explanatory variables as a whole made a good prediction of respondents' first choice of treatment. The Nagelkerke R Square for this model test was .148, which indicates that about 14% of the variance in the outcome is being predicted by the predictor variables in the model; noting that only place of residence was the statistically significant variable in the test of relationship – chi square test of independence.

- $H_0$ : There is no significance relationship between demographic variables and which treatment is more costly.

$H_A$ : There is significance relationship between demographic variables and which treatment is more costly.

Table 11 Chi Square Tests of Place of Residence, Gender and Education of Respondents against Their Perception of Which Treatment is Costly

Variables	Pearson Chi square	df	Asymp. Sig. (2-sided)
Place of residence * Which Treatment is more Costly	8.413	2	.015
Gender * Which Treatment is more Costly	0.220	1	.039
Education * Which Treatment is more Costly	3.306	3	.347

Source: Fieldwork

From the table above there is a strong evidence of relationship between place of residence and which treatment is more costly (Chi square = 8.413, df = 2,  $p < 0.05$ ) as well as between gender and which treatment is more costly (Chi square = 0.220, df = 1,  $p < 0.05$ ). We therefore reject the null hypothesis that there is no significant relationship and accept the alternative hypothesis that there is significant relationship between place of residence and which treatment is more costly; and significant relationship between education and which treatment is more costly. However, we accept the null hypothesis in the case of education and which treatment is more costly (Chi square = 3.306, df = 3,  $p > 0.05$ ) that there is no significant relationship between education and which treatment is more costly.

Table 12 Logistic Regression Tests of Place of Residence, Gender and Education of Respondents against Their Health Insurance Status

Tests	Chi square	df	Sig
Omnibus Tests of Model Coefficients	11.112	6	.085
Hosmer and Lemeshow Test	8.055	8	.428
Model summary (Nagelkerke R Square)	.064		

Source: Fieldwork

From the logistic regression table above, the omnibus test of model coefficient had a p value of  $> 0.05$ , which means the predictor variables do not make a good prediction model of respondents' view of which treatment is more costly. However, the Hosmer and Lemeshow Test with a p value of  $> 0.05$  indicates that the model is good model and as such would have been significant if the omnibus test of model coefficient had a p value of  $< 0.05$ ; and about 6% of the variance in the outcome is being predicted by the predictor variables in the model, noting that only place of residence and gender were the statistically significant variables in the test of relationship – chi square test of independence.

- *H<sub>0</sub>: There is no significance relationship between economic status, occupation and health insurance on one hand and respondents preferred choice of treatment.*

*H<sub>A</sub>: There is significance relationship between economic status, occupation and health insurance on one hand and respondents preferred choice of treatment.*

Table 13 Chi Square Tests of Occupation, Economic Status and Health Insurance Status against Their Preferred Choice of Treatment

Variables	Pearson Chi square	df	Asymp. Sig. (2-sided)
Occupation * Preferred choice of treatment	7.925	8	.441
Economic Status * Preferred choice of treatment	12.751	6	.047
Health Insurance Status * Preferred choice of treatment	27.822	2	.000

Source: Fieldwork

From the table above there is a strong evidence of relationship between economic status of respondents and respondents' preferred choice of treatment (Chi square = 12.751, df = 6,  $p < 0.05$ ) as well as health insurance status of respondents and respondents' preferred choice of treatment (Chi square = 27.822, df = 2,  $p < 0.05$ ). We therefore reject the null hypothesis that there is no significant relationship and accept the alternative hypothesis that there is a significant relationship between economic status of respondents and respondents' preferred choice of treatment; likewise that there is a significant relationship between health insurance status of respondents and respondents' preferred choice of treatment. However, we accept the null hypothesis in the case of occupation and respondents' preferred choice of treatment (Chi square = 7.925, df = 8,  $p > 0.05$ ) that there is no significant relationship between occupation of respondents' and respondents' preferred choice of treatment.

Table 14 Multinomial Logistic Regression Tests of Place of Residence, Gender and Education of Respondents against Their First Choice of Treatment

Model	Model fitting criteria	Likelihood Ratio Tests			Pseudo R square
	-2 Log Likelihood	Chi square	Df	sig.	Nagelkerke R Square
Model final	65.352	43.279	16	.000	.213

Source: Fieldwork

From the regression table above, the model fitting test had a p value of  $< 0.05$  at a  $df=16$ , which means the predictor or explanatory variables as a whole made a good prediction of respondents’ preferred choice of treatment. The Nagelkerke R Square for this model test was .213, which indicates that about 21% of the variance in the outcome is being predicted by the predictor variables in the model; noting that only economic status and health insurance status of respondents’ were statistically significant variables in the test of relationship – chi square test of independence.

- *H<sub>0</sub>: There is no significance relationship between economic status, occupation and health insurance on one hand and which treatment is more costly.*  
*H<sub>A</sub>: There is significance relationship between economic status, occupation and health insurance on one hand and which treatment is more costly.*

Table 15 Chi Square Tests of Occupation, Economic Status and Health Insurance Status against Which Treatment is more Costly

Variables	Pearson Chi square	df	Asymp. Sig. (2-sided)
Occupation * Which Treatment is more Costly	10.907	4	.028
Economic Status * Which Treatment is more Costly	2.183	3	.535
Health Insurance Status * Which Treatment is more Costly	7.247	1	.007

Source: Fieldwork

From the table above there is a strong evidence of relationship between respondents' occupation and their perceived view of which treatment is more costly (Chi square = 10.907, df = 4,  $p < 0.05$ ) as well as health insurance status of respondents and their perceived view of which treatment is more costly (Chi square = 7.247, df = 1,  $p < 0.05$ ). We therefore reject the null hypothesis that there is no significant relationship and accept the alternative hypothesis that there is a significant relation between respondents' occupation and their perception on which treatment is more costly; likewise there is a significant relationship between health insurance status of respondents and their perception on which treatment is more costly. However, we accept the null hypothesis in the case of economic status and their perceived view of which treatment is more costly (Chi square = 2.183, df = 3,  $p > 0.05$ ) that there is no significant relationship between economic status of respondents and their perception on which treatment is more costly.

Table 16 Multinomial Logistic Regression Tests of Place of Residence, Gender and Education of Respondents against Their First Choice of Treatment

Model	Model fitting criteria	Likelihood Ratio Tests			Pseudo R square
	-2 Log Likelihood	Chi square	Df	sig.	Nagelkerke R Square
Model final	58.001	21.924	8	.005	.124

Source: Fieldwork

From the regression table above, the model fitting test had a p value of  $< 0.05$  at a  $df=8$ , which means the predictor or explanatory variables as a whole made a good prediction of respondents’ perception on which treatment is more costly. The Nagelkerke R Square for this model test was .124, which indicates that about 12% of the variance in the outcome is being predicted by the predictor or explanatory variables in the model; noting that only occupation and health insurance status of respondents’ were the statistically significant variables in the test of relationship – chi square test of independence.

**5.4 Correlation Analysis and Test of Model**

Aside the tests of the hypotheses, two tailed correlation tests were conducted to examine the strength of the relationship between the other study variables. Two tailed test of significance was used as the direction of the relationship between the variables was not stated. The Spearman's rank correlation analysis was employed here because most of the variables used in the study were in the ordinal scale and this correlation test only requires data that are at least ordinal. Unlike the Pearson product moment correlation coefficient, the Spearman rank correlation coefficient does not have any assumptions about the frequency distribution of the variables as well as does not assume that the relationship between the variables is linear. Also a multinomial regression test was used to test each component of the conceptual framework and to determine

the strength of association between each component and the dependent variable (use of biomedicine or traditional medicine).

First correlation tests were conducted among the dependent variables of the study such as the health insurance status of respondents, respondents' use of biomedical services, respondents' use of traditional medical services, respondents' preferred choice of treatment and respondents' perception of which type treatment is more costly. These tests were informed by the fact that these variables are categorical variables of the main dependent variables – biomedicine and traditional medicine; as such some of the variables may have association with others aside the main independent variables in the study. This helps determine which of these dependent variables have associations, the strength and direction of such associations. The table below gives an overview of the Spearman rank correlation tests for the dependent variables

Table 17 Spearman Rank Correlation Tests for the Dependent Variables

Variables	Spearman Correlation
Health Insurance*Use of Modern Health Service	<i>.314 (.000)</i>
Health Insurance*Use of Traditional Health Service	<i>-.298 (.000)</i>
Health Insurance*First Choice of Treatment	<i>-.035 (.605)</i>
Health Insurance*Which Health Treatment is Costly	<i>-.179 (.007)</i>
Use of Modern Health Service* Use of Traditional Health Service	<i>-.041 (.534)</i>
Use of Modern Health Service* First Choice of Treatment	<i>-.093 (.160)</i>
Use of Modern Health Service* Which Health Treatment is Costly	<i>-.072 (.280)</i>
Use of Traditional Health Service* First Choice of Treatment	<i>.098 (.142)</i>
Use of Traditional Health Service* Which Health Treatment is Costly	<i>-.043 (.515)</i>
First Choice of Treatment * Which Health Treatment is Costly	<i>-.035 (.599)</i>

Source: Fieldwork

From the table above the correlations that are statistical significant are respondents' Health Insurance status and their use of Biomedical services ( $r_s = .314$   $p < 0.05$ ), respondents' Health Insurance status and their use of Traditional medical services ( $r_s = -.298$   $p < 0.05$ ) and respondents' Health Insurance status and their perception of which Health System is Costly ( $r_s = .179$   $p < 0.05$ ). From their correlation values, respondents' Health Insurance status and their use of Biomedical services has a low positive correlation like that of respondents' Health Insurance status and their perception of which Health System is Costly has a weak positive correlation; meaning there are other factors that influence respondents' use of biomedical services and their perception of which health systems is more costly other than whether they have health insurance or not. On the other hand, respondents' Health Insurance status and their use of Traditional medical services has a low negative correlation, meaning there are other factors that account the inverse relationship between respondents and their use of traditional medicine than respondents' health insurance status.

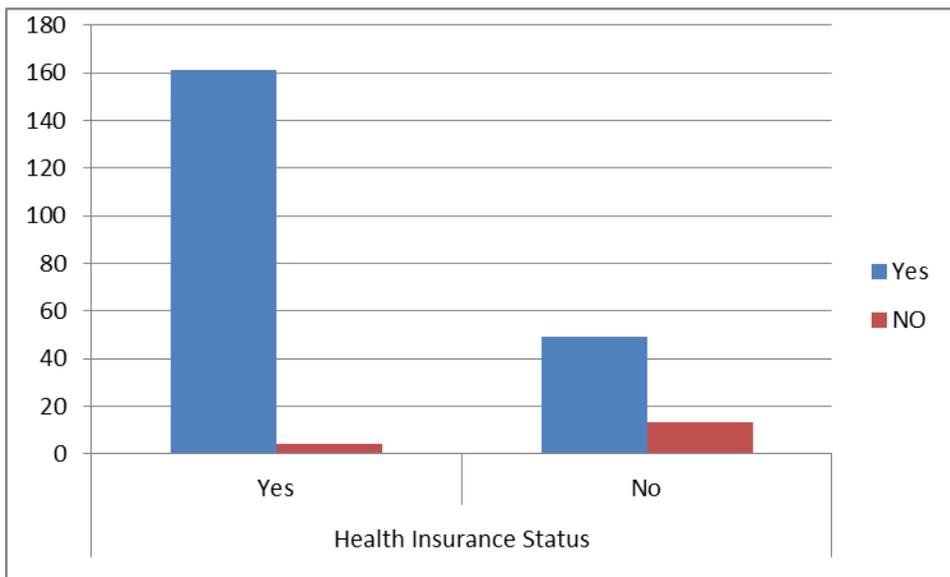


Fig. 5 Cluster Bar showing Respondent Health Status and their use of Biomedicine

Source: Fieldwork

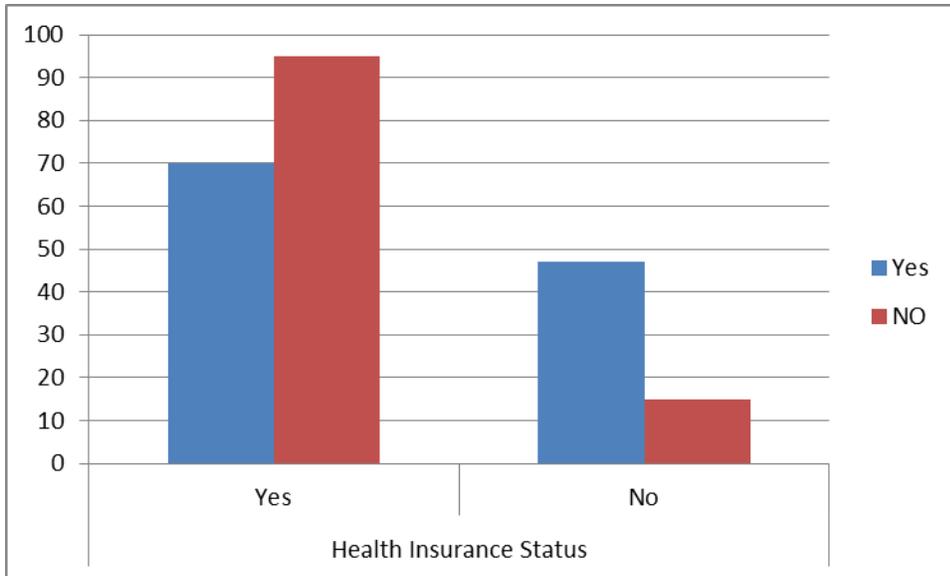


Fig. 6 Cluster Bar showing Respondent Health Status and their use of Traditional Medicine

Source: Fieldwork

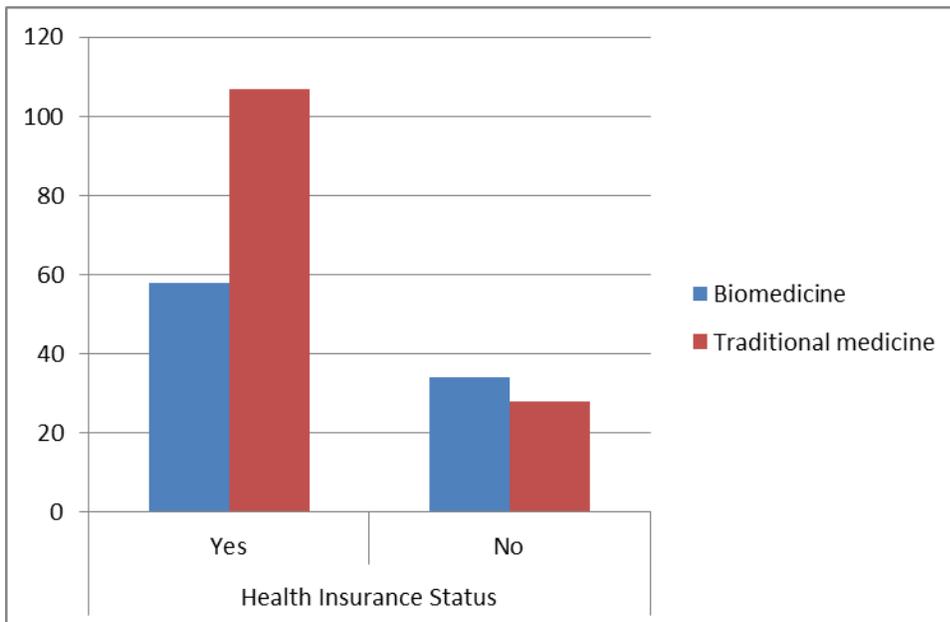


Fig. 7 Cluster Bar showing Respondent Health Status and their Perception on Which Health System is More Costly.

Source: Fieldwork

Multinomial logistics regression analysis was employed to test how some components fits as a whole in explaining patient’s preferred choice of treatment. The use of this analytical technique instead of binary logistic regression or multi regression is due to the fact that the dependent variable under consideration was categorical and the responses to it were more than two. First, all personal characteristics of patients were tested as independent variables against patient’s preferred choice of treatment; then health policy and resource variables such as health insurance, and the perceived cost of treatment (which treatment is more costly) together with level of the physical accessibility such as distance, travel time and waiting time were tested as independent variables against patient’s preferred choice of treatment. The lumping together of variables from health policy, health resources and level of physical accessibility as a whole in this test, was informed by the model. In the model there is a forward linkage from health policy to health resources then to the level of physical accessibility; these linkages show the direct causative effect of how health policy influence health resources in any given space and their distribution which in turn affect physical accessibility. The tables below give an overview of this and demonstrate how the models fit as a whole in explaining patient’s preferred choice of treatment.

Table 18 Multinomial Logistic Regression Tests of Place of Residence, Gender and Education of Respondents against Their First Choice of Treatment

Model	Model fitting criteria	Likelihood Ratio Tests			Pseudo R square
	-2 Log Likelihood	Chi square	df	sig.	Nagelkerke R Square
Personal Characteristics	270.770	90.069	56	.003	.401
Health Policy, Resources and Physical Accessibility	172.958	64.353	18	.000	.305

Source: Fieldwork

From the table above, both models are statistically significant in explaining the dependent variable under consideration – respondent’s preferred choice of treatment. The first model, personal characteristics had p value of < 0.05 at a df=56 and Nagelkerke R Square of .401 meaning about 40% of the variance in the dependent variable is explained by these predictor

variables. Likewise, the second model – Health Policy, Resources and Physical Accessibility – had p value of  $< 0.05$  at a  $df=18$  and Nagelkerke R Square of .305 meaning about 31% of the variance in the dependent variable is explained by these explanatory variables. Thus Personal Characteristics of respondents and Health Policy, Resources and Physical Accessibility as predictor variables account for about 40% and 31% of respondents' preferred choice of treatment.

## **5.5 Summary**

In this chapter, I provide details of socio-demography background of the sample population. The chapter also gives details of the measurement of the dependent and independent variables used in the study. Tests of hypotheses were done for the hypotheses formulated at the beginning of this study, as well as test of correlation between key independent and dependent variables. Overall these tests revealed that the selected variables in the study fit as a model in explaining certain health seeking behaviors such as health insurance status, preferred choice of treatment and first choice of treatment of the respondents in the quantitative study.

## CHAPTER 6 DISCUSSION OF RESEARCH FINDINGS

This chapter presents findings from the qualitative research interviews and quantitative survey based on the research objectives set at the beginning of this study. As stated in the methodology chapter, 7 informants were interviewed for the qualitative research interview. The interview guide was structured in accordance with the research objectives, however, the use of a semi-structured interview guide made room for flexibility during the interviews. This was to allow the rise of other themes relevant for the study that may have not been considered in the formulation stage of the research questions. Induction method of reasoning was used in analyzing the qualitative data. This method, also known as “bottom-up” approach allows for the situation where the premises of a research study supply strong evidence for the truth of the conclusion. This evidence is, however, not an absolute proof, but a probable truth based on the evidence given (Cohen and Flage 2007). As oppose to deductive method of reasoning that where the conclusion of the deductive argument is supposed to be certain, the inductive method based on the humanistic approach of social science which stress that reality is what people perceive to exist and as such knowledge is obtained subjectively in a world of meaning created by the individual (Bird 1993). In line with this, Bird (1993) states that the methodology of this approach is interpretative through the use of methods which make it possible for the researcher to investigate individual worlds; and the emphasis of this approach is on individuality and subjectivity rather than replicability. Although the inductive approach to reasoning is criticized for making uncertain conclusions based our relatively limited experiences as social actors, it value in social science research cannot be overlooked. The flexibility and ability to infer causes from results, outcomes and effects of inductive approach help compare and evaluate existing hypotheses within context specifics as is the case of this study. Social realities are not always objective, structured and patterned, however, they are subjective to social forces that influence and alter their nature and people’s experience with them. Moreover, forces and factors that create the structures and patterns we observe in the social environment may differ across geographic space and with time.

The combination of qualitative and quantitative findings in the discussion here is based on the ontological and epistemological bases of this study as earlier stated in the methodology

chapter. The use of the two findings is in line with the realism approach of inquiry in social science. This approach recognizes the existence of both a “real” world that is structured and possesses causal powers and liabilities as well as that aspect of this world which is not immediately observable and can only be constructed through people’s experience and interaction with their social environment (Bhaskar 1978). The realism approach places a connection between structuration theory and humanism, positivism and interpretivism, the objective and the subjective.

### **6.1 Existing Health Systems and the Rationale behind Their Usage**

With a population of 24.6 million, it is estimated that Ghana only has 1,439 biomedical health care facilities (IRIN 2008). Van den Boom et al. (2004) in their study noted that, these biomedical health facilities are not easily accessible; they attributed their inaccessibility to a number of factors such as: uneven distribution of facilities, rural-urban bias phenomenon where most rural areas – where a high percentage of the population are found – lack or have inadequate basic facilities such as hospitals and clinics as well as health professionals. Their study further acknowledges that on the average Ghanaians live about 16km from biomedical health facility where they can consult a doctor; however, half of the population live within a 5km radius. Although, studies like that of Van den Boom et al. (2004) in representing the picture of health inequalities in terms of distribution fail to acknowledge the high rate of urbanization and urban growth in Ghana and other countries in the developing world which increasingly call for provision of social amenities; nonetheless the deprivation of health care needs of the rural population and even the urban poor due to uneven distribution of health resources is an alarming phenomenon. In their strife for development, countries in the developing world need a healthy population to drive economic, social, political and infrastructural developments that are much needed here. On the other hand, the study asserts that the other half cannot consult a doctor within 5km, which corresponds to an hour walking distance, and one-quarter even live more than 15km from a facility where a doctor can be consulted.

This study and other literature on the subject of accessibility of biomedical health facilities have often attributed the slow and inequity improvement in the health status of

Ghanaians and people in the developing world to factors such as poverty, low literacy, especially among the female population, high population growth, poor nutrition, limited access to water and sanitation and poor performance of the biomedical health healthcare delivery system. According to Lund (2003) the 1999 health sector review of Ghana estimated that only one-third of the population were using formal health sector services, leaving the two-third majority to the informal health system which mainly consist of the traditional medical practitioners, herbalist and spiritualist. The report further estimates that, about 40% of the population did not have access to health services; while the remaining 60% who have physical accessibility are constrained by poverty and socio-cultural norms from having access to these services. Lund (2003) noted that financial barriers to access to biomedicine in terms of user fees are manifested in three ways: absolute lack of access, reduced access and delayed access to health care. In her study in Salamba in Northern Ghana, the possible choice of health providers available in the community, such as hospitals, drug store, herbalist and spiritualist, their usage and choice are all determined by the financial status of individuals.

In contrast to the reports above, a lot of changes have occurred in the Ghanaian biomedical health sector since 2005. Over the last decade, health policies and measures have been implemented to make access and use of biomedical facilities available to all including the rural and urban poor through policies such as the National Health Insurance Scheme (NHIS) and the Community Health Posts (CHPs) in line with Millennium Development Goals (MDGs) 4, 5 and 6: to reduce child mortality, to improve maternal health and to combat HIV/AIDS, malaria, and other disease. For example, according to the 2011 Ghana Health Service (GHS) report the population covered by CHPs increased from 16% in 2009 to 22% in 2011. These health policies have changed the nature of biomedical access and usage over the years hence there is to examine the recent health seeking behavior in light of these changes. This section will thus look at the health seeking behavior of respondents in the study district – Asikuma-Odoben-Brakwa – in light of the changes noted above and the rationale behind the current health seeking behavior.

From the quantitative data gathered during the field study, majority of respondents irrespective of their place of residence or geographic location stated they preferred biomedical treatment for their health needs. A total of 152 representing 67% of the sample population selected

biomedicine as their preferred health care system, whereas 47 respondents – 21% selected traditional medicine and 28 respondents – 12% selected self-medication. However, in terms of actually usage majority of respondents – 53% (120 respondents) were using self-medication as their first choice of treatment for their health needs, whereas 42% (96 respondents) and 5% (11 respondents) were using biomedicine and traditional medicine respectively for their health care needs. Comparatively, this finding is similar to that presented in many studies on health seeking behavior and accessibility and utilization of health care in the developing world save the low percentage of usage for traditional medicine. Many literatures on health seeking behavior in the developing world, including Ghana (Good 1987, Brookbanks 1990, Freeman and Motsei 1992, Das 1996 and WHO 2008) have shown the high level of usage and preference of traditional medicine in this part of the world. However, the picture here is different in this study because in assess respondents' and patients' preference and choice of health care, this study distinguished between institutionalized health care and non-institutionalized health care. In the case of institutionalized health care, an individual or a health patient consult a health professional be it bio-medically trained or traditionally trained; here there is a second party who does either a diagnosis or prognosis of the patient then recommend and/or administer therapies to that effect. Often the health professionals in this institutionalized health care work in a setup environment be it the hospital, shrine, prayer camp, home or a built structure for providing health care needs. In contrast, the non-institutionalized health care is where patient or health seeker makes their on diagnosis and prognosis then proceeds to purchase drugs for treatment or collect herbs and other medicinal items for treatment of the self-diagnosed ailment; here there is no second party involve.

This distinction between institutionalized and non-institutionalized health care is informed by the changing nature of both biomedicine and traditional medicine in Ghana and the rest of the developing world. With regards to traditional medicine, the monetization of all sectors of the economy in the developing world due to globalization, including rural industry has contributed to the modification of the way traditional healers operate. Whereas in some years back, the practice of traditional healers involved little or no money or user fees except for items sacrifices and divination, the current global economy has caused traditional healers to change and modify their practices. Now many healers have established their centers and make advertisement of their services and products through billboards, signposts and the electronic and

print media. These modifications in the modus operandi of traditional healers, means traditional medicine in this form may not be as cheap and financially accessible as early researchers and writers noted. In line with this respondents use traditional medicine in self-medication rather than the use of an established traditional healing institution.

In the self-medical care systems a wide array of drugs and therapies are available to health shopper from which they make their choice based on knowledge and information gained from experience and interaction with other members of society or through media advertisement of these drugs. Thus, in self-medical care system, there is a convergence of all forms of health care systems such as biomedicine, traditional medicine and recently in Ghana, Chinese medicine as well. The diagram below gives a pictorial view of the nature of the medical pluralism in developing countries.

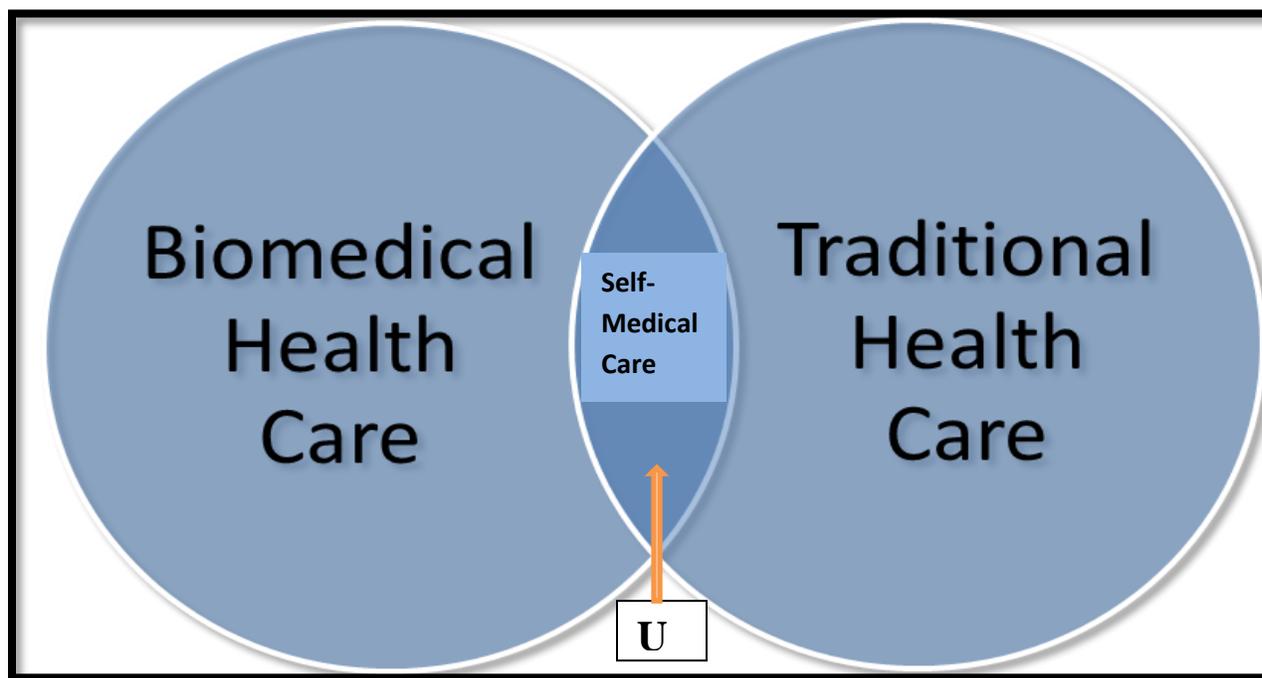


Fig. 8 Pluralistic health system in developing countries

Source: Author's own construct

The letter 'U' in the diagram above refers to other forms of alternative medicine that are foreign to the Ghanaian health system such as Chinese medicine and other oriental medicine from other parts of the world that have not fully integrated into the health system of the country yet. These

medicines can be found in the country, but their level of acceptability and usage is not widespread and popular like biomedicine and indigenous traditional medicine. The popularity of self-treatment or self-care as the dominant health care practice noted in this is similar to the finding of Sermsri (2002) on the predominant health care practice among Thais. In this study Sermsri (2002) noted that self-treatment and the use of drugstores is the predominant health care practice among Thais.

The preferred choice for biomedicine for health care needs instead of traditional medicine is contrary to what has been expressed in many literatures. A 52 year old female shop owner and A 49 year old female trader from the qualitative survey explained why there is a preference for biomedicine:

“My son, you see today all our foods are ‘fertilizer foods’. So, much of the sickness we are having is due to the chemicals in the foods. We never had sickness like cancer and hypertension during the time of our ancestor, but now we have them in our country. Because many of the sickness we suffer from come from the food we eat, which is made of chemicals from abroad, the only effective and prudent way to treat and heal ourselves is by using the hospitals and the drugs, they provide. This is not to say I don’t use herbs, I use herbs a lot but use them to prevent myself from the natural sickness that may affect me.” (Informant 1)

“I prefer to use of the hospitals for my illness because a lot of the sickness we experience today comes from the things we eat and drink. Now all our foods and drinks like Coca-Cola are made of chemicals. Because they are not natural sicknesses, the traditional herbs we have may not be potent enough for to cure and heal these sicknesses. I have a lot about these diseases anytime I turn on my radio while doing my trade all the speakers say a lot of these diseases are from the chemicals and foods and drinks we take. But how can we stop eating or drinking them? That is what we have in our markets today, so we have no option. Also, these sicknesses are strange and foreign to us so our local healers, especially those of the old generation and others who haven’t been to school don’t know what they are so can’t even diagnose and tell you ‘you are suffering from this or that if you go to them’ so it is wise to use hospitals these days.” (Informant 2)

These informants express views held by many people in the country about the origin and causes of the diseases that afflict many today. In light of this health belief, many believe the effective remedy to these sicknesses are the chemical drugs that biomedicine offer. The belief that western chemicals in the food and drinks they consume can only be cured effectively with chemical drugs from the western world, shape the view of patients and health seekers in selecting the use of biomedicine as their preferred choice of health care. This view however was not shared by all informants, as there were some informants who believed in the potency of the local medicines in treating most sicknesses that patients suffer from today. A 46 year old male galamsey miner gave a contrary view to that earlier expressed by other informants.

“Oh boss! Our local herbs are very potent to handle all the diseases that we suffer from. That is why I don’t go to the hospital unless it involves something that involves a caesarean operation. Whenever am sick, I use herbs and I happen to know a lot about herbs because my father was a herbalist; and in situations where I lack any inform of which herbs to use if the condition is severe, I consult my senior brother who took over my father’s trade. Even the time I had a caesarean due to my suffering from mild scrotal hernia, he later told me he could have given me herbs to melt the hernia away. Now even many of our herbalists receive training at Mampong as well, so they have a good idea of the diseases and how they work in the human body, so they also know the herbs to use.” (Informant 4)

The discussion above does confirm the first qualitative proposition formulate at the beginning of this study that the choice of healing system by patients is more dependent on the perceived cause of illness rather than an individual’s socio-economic background. The perception of the cause of illness comes from individual experiences or that of other close members of society as well as information available to the patient on the health problem he/she is experiencing. Consequently this perceived cause and patient’s knowledge or experience of which health system is effective in view of the perceived cause is what influences the ultimate usage of a particular health system to address the health problem at hand.

## **6.2 Reasons for Existing Health Seeking Behavior**

From the quantitative field research survey, there is a sharp contrast between respondents' preferred choice of treatment for health care needs and what respondents are actually using to meet their health care needs. Whereas most respondents preferred biomedicine for their health needs, majority of respondents were using self-medication in meeting their health care needs. This phenomenon is not different from that reported in other literatures on health care usage in the developing world. The sharp contrast between preference and actual usage comes from a number of determinants and factors that sharpens the health seeking behavior of people in the developing world, including Ghana and for that matter the study area – Asikuma-Odoben-Brakwa district. Factors emanating from physical access, health policies and resources, time and quality of service at biomedical facilities in the Asikuma-Odoben-Brakwa district, have made health seekers and patients to use unprescribed drugs and herbs in their health care needs. In addition, the commercialization of traditional healing in Ghana has made traditional medicine, especially those offered by healers of established institutions experience for the average rural dweller and urban poor.

### ***6.2.1 Financial Challenges***

Although the National Health Insurance Scheme was introduced as a risk pooling health insurance scheme to reduce out-of-pocket expenditure of health seekers and make biomedical health care accessible majority or as the policy framework states – “all”; many Ghanaians especially the rural dwellers and the urban poor cannot pay the premium of this insurance scheme as well as the annual renewal fees that comes with it. Despite revenue for the financing of the scheme coming from earmarked budgetary allocation through a system of ‘ring-fencing’, a national health insurance levy imposed at the rate of 2.5% on the supply and import of goods and services, social security contribution, Ministry of Finance resources for exempted persons, Parliament allocations, investment returns and voluntary contributions such as grants, donations, and gifts; enrollees are required to pay a premium ranging between GHc 7.20 and Ghc 48 based on their level of income (Durairaj et al. 2010). According to the NHIS 2011 annual report as the percentage of the scheme's membership as a percentage of the national population was 33% - 8.23 million active memberships. The reasons for this low membership have been attributed to

many practical barriers to entry remain that are of economic, geographic, political and cultural origin (Durairaj et al. 2010).

According Durairaj et al. (2010), for people living in remote, underserved areas membership of the NHIS may not be beneficial. they cite data from two Ghanaian districts to support this claim which found that renewal of the NHIS membership was affected by location – 88% of urban members said that they were willing to renew, compared with 57% of rural residents. Similarly, their study also found that the strict income norm for exempting the poor actually excluded the marginal poor, hence the inability of the marginal poor to pay the premium. As a result of this scenario there have been cases where an ILO program and some NGOs stepped in to pay the premium on behalf of these marginally poor people. Thus, low income households find it more economically challenging to meet the premiums required to enroll in the NHIS in order to benefit from the healthcare services it provides. This notwithstanding, the high level of out-of-pocket payments that still dominate healthcare financing in Ghana a decade after the launch of the NHIS; this has been noted to impoverish poor patients and limit access to life-saving care. Thus the introduction of the NHIS has not completely eradicated out-of pocket-payment as it ought to. Comparatively, the NHIS does not cover the use of traditional medicine from established traditional health care providers; hence there is a financial challenge in this system of health care as well. In line with these barriers of access to biomedical and traditional medical treatments, health seekers of low income households depend on cheap drugs from chemical shops and drug peddlers to meet their health care needs. From the quantitative data gathered from the field studies, 62 respondents –27% - described themselves as poor, together with 104 respondents – 46% who described themselves as being in the low middle income status. In essence, a total of 73% of respondents are within the poor and marginally poor income bracket.

Cost in both access and usage of institutionalized health care, be it biomedicine or traditional medicine thus remains a huge challenge to health seekers in the study district. Although from the quantitative data gathered from respondents, views of which health system is more expensive varies; what remains for certain among respondents is that the cost of treatment in both biomedicine and traditional medicine is dependent on the nature of the sickness and the nature of healing or treatment needed to cure it. The table below generated from the quantitative

data gained from the field gives a clear picture of respondents' health insurance status and their choice of treatment and their perception of which health system is more expensive to use in meeting everyday health needs.

Table 19 Respondents' Perceptions on the Cost of Treatment

	Which Health Systems is more Costly in Treatment		
	Biomedicine (Row%)	Traditional Medicine (Row%)	Total (Row%)
Health Insurance Status			
• Yes	58 (35%)	107 (65%)	165 (100%)
• No	34 (55%)	28 (45%)	62 (100%)
First Choice Treatment			
• Self-Medication	47 (39%)	73 (61%)	120 (100%)
• Biomedicine	36 (38%)	60 (63%)	96 (100%)
• Traditional Medicine	9 (82%)	2 (18%)	11 (100%)

Source: Fieldwork

From the table above it is clear that respondents' view of which health systems given biomedicine and traditional medicine, is dependent on their health insurance status and their actual usage of a particular health system. In the case of health insurance status, respondents with NHIS tend to expend less when using biomedical health facilities for their everyday health needs, hence their low perception (35%) of biomedicine being costly. On the other hand, respondents without NHIS spend more when using biomedical facilities for their health problems, thus, majority (55%) of them think biomedicine is more costly than traditional medicine. Likewise is the picture of respondents' first choice of treatment and their perception of which health care system is more costly. For respondents using self-medication and biomedicine in meeting their health needs, traditional medicine is more costly: there is the need, however, to bear in mind that the reference here is to institutionalize traditional medicine. On the contrary, 82% of respondents using institutionalized traditional medicine think biomedical health care is more expensive. A 52 year old female shop owner and a 37 year old male taxi driver through the qualitative interviews provided further explanation for this phenomenon.

“As for the money we spend in getting care in a hospital or from a herbalist or prayer camps, it depends on the sickness. We have a saying among us, the Akans that – ‘yariba bia na ne ho kaw’ – meaning every sickness and it’s cost. Sometimes when you are sick and you go to the hospital the doctors just prescribe common pills and tablets for you such as paracetamol, ibuprofen and malaria drugs which are not expensive. If you have health insurance, then you don’t pay anything and even if you do not have health insurance these drugs cost less than GHc2. The same way if the sickness is a trivial one and you go to the herbalists they even give you some herbs and treatment for free. Some will even tell you the type of herbs to use if it is common and tell you how to use it for your treatment. Some sickness, however, make you spend a lot of money whether you go to the hospital or a prayer camp or other traditional herbalists.” (Informant 1)

“You know there are so many drugs at the chemical shops we can buy, but the ones we normally buy without doctor’s prescription are not expensive. They cost less than GHc 1 at most. When you go to the hospital, and you don’t have health insurance like me, you first pay like GHc 3 at the OPD for your card then before you go and see the doctor. After seeing the doctors you will either go and do lab test which can cost like GHc 10 before going to buy your prescriptions which can also be around Ghc 7 - Ghc 10. So by the time you are done have spent almost GHc 20, meanwhile if you went to the chemical shop and bought Kinaparma APC you would not spend more than GHc 1. So for me I go to the hospital when the situation is urgent.” (Informant 5)

From these dialogues, it is clear that informants perceive the remedies they use in self-medication as less expensive than that acquired from institutional health care of both biomedicine and traditional medicine. Financial barrier as noted in the literature review chapter has been noted to bar people in the developing country from accessing biomedicine; however, the picture above indicates the same for institutionalized traditional medicine. In cases, where patients source for drugs and herbs to meet through health needs without using a formal institution of healing, the cost of treatment is cheaper relative to the opposite. Thus, despite the risk involve patients and health seekers in the Asikuma-Odoben-Brakwa district use self-medication to meet their health needs except in dire and urgent situations. This health care behavior is evident among health seekers in the developing world. The changes in the economy of countries in the developing world which has motivated changes in the administer and usage of

traditional medicine means traditional medicine is not as easily accessible to the health seeker here as it was once thought of – at least to those who have no knowledge in traditional medicine or knows a close relation with such knowledge. There is the need to address this cost factor if health care be it biomedicine or traditional medicine or both are to be accessible to all in this part of the world.

### ***6.2.2 Time Factor***

Time spent waiting for treatment and accessing health care in the biomedical field also account for the high number of respondents using self- medication. Time as a determinant of health seeking behavior comes into play in the form of travel time to health care facilities and waiting time at the health care facilities. In this new global era of capitalist venture and economy, time remains a crucial resource for all, especially the working class population, hence the time spent in accessing and utilizing a health care facility is of vital importance to the health seeker. The health seeker must balance this time together with other economic and social activities. As Buor (2004) rightly pointed out, in developing countries, time, as a barrier to utilization, is influenced by the season of the year, and the nature of patient's business activities. For example, he illustrated the case of the farmer who would not like to waste much time travelling long distances for health care during the peak of the farming season, and the urban busy entrepreneur who also may not sacrifice too much time for health care during peak seasons like Christmas. These professionals, he stressed, may prefer using intervening alternative to address their health needs. In this case the intervening alternative which is cheaper and time saving is self-medication.

The willingness of a health seeker to spend more time than what he or she can afford given his or her other economic and social responsibilities is dependent on the factors such as the nature of the illness the patient is suffering from and the sphere of influence of the medical facility that the patient needs to address this illness. Some illness and medical facilities command higher range of services than others; and this fact applies to both biomedical facilities and traditional healing facilities. However, the only difference between the two health care systems is waiting time at the medical facility. Whereas, patients tend to spend more time at biomedical facilities when using these facilities to address their health needs, the opposite is the case of traditional medical facilities. Also, the time spent in healer-patient consultation tends to be more

in traditional healing facilities than that spent in biomedical facilities. These temporal differences in waiting time and consultation time are mainly as a result of a higher number of patients using biomedical facilities and the inadequate number of these facilities to meet the high health seeking population as well as the high biomedical professionals-patients ratio compared to the low ratio that exist between traditional healers and patients in the developing world, including Ghana. For example, the ratio of medical doctors to population in Ghana is a mere 1: 20 000 whereas the ratio of traditional healers to population is 1: 200 (Tabi and Frimpong 2003 and Patterson 2006).

To address these shortfalls of time in biomedical health care, the government of Ghana together with international health partners such as WHO implemented the CHPs program which aims to provide biomedical health care within the range of all Ghanaians for easy access and usage, especially among the rural population where the problem of general shortage of personnel and geographical discrepancies in access to biomedical health facilities is more rampant. However, although this health program may have addressed the problem of traveling time in accessing biomedical health care, the problem of waiting time still remains and this is largely due to shortage of personnel in these remote coupled with high referral cases from these remote areas to the district hospitals where the personnel exist. In the case of the study district – Asikuma-Odoben-Brakwa – there is only one district hospital, which serves not only the district, but also surrounding districts such as Agona East, Agona West, Assin South, Assin North and Ajumako-Enyan-Essiam. The existence of optometry specialist clinic in the district hospital – Our Lady of Grace Hospital – which is the second type of optometry services in the region together with that of the Central Regional Teaching Hospital means there is an undue stress on this biomedical facility in terms of the number of people using it daily. The stress from this situation is expressed in the words of some informants. These are what a 28 year old male civil servant, a 52 year old female shop owner and a 55 year old male farmer had to say:

“HMMMMM, for me whenever I feel sick I just rush to the drug store and get some tablets and pills. I only go to the hospital when it is severe such that I can't do anything or feel very weak. You saw it yourself; I mean the hustle at the hospital when I went with you on Wednesday. Even with the help of a nurse I know there, it took us 4 hours to see the doctor and do the x-ray. I did not even finish oooo! I had to leave so I can attend to other matters at the office, so I have to go back tomorrow for the lab results. So just imagine if I had no help, we

would have spent the entire day there. Abi you saw the number of people there!”  
(Informant 3)

“For going to the hospital, I do that only when, after taking drugs from the chemical shop or using some herbs and the sickness still exist. You can see for yourself, am the only one running this provision shop. All my children are either out of town in their marital homes or at school. So even though the hospital is just behind my kiosk, I hardly go there. You spend a lot of time when you go there and the doctors only ask you what is wrong with you, then they prescribe the same drugs I would have bought in the chemical shop for you. So after spending like 6 hours there, depending on when you went there because you can spend like 8 hours if you went there in the afternoon; you only spend less than 5 minutes with the doctors. So why must I leave my business and waste the whole day when I have just a slight headache or fever? I will just buy drugs and continue with my business for the day.” (Informant 1)

“Well if am sick and I don’t have anything to do at the farm such as weeding around my cocoa trees then I go to the hospital. But if I have work to do then I just buy drugs or boil some leaves and drink. I have health insurance so I must go to the hospital whenever am sick, but I only do that when it does not interfere with my farm duties. There are times, I have some things to do at the farm, but because the sickness has made me too weak, I just go to the hospital at Asikuma and rather ask my nephews and nieces to attend to the farm duties ..... My son and daughter are in Accra schooling so they are not around to help.”  
(Informant 6)

In contrast, unprescribed drugs from the chemical shop or purchased from drug peddlers provide are less costly, time saving and easily accessible. The same applies to traditional medicine that patients and health seekers use without the need to consult a traditional healer in an establishment. The drugs used in the self-medication therapy, be it biomedical or traditional, may be recommended by friends or family members who may have had similar symptoms, thus here, there is no fee paid for consultancy to either the biomedical or traditional health professional. Similarly, information on these drugs and how to use them may be gained from radio or other electronic media advertisement or from the drug peddlers who ply on the roads selling their

products. Respondents and informants alike found this form of health care as an immediate response to their health care problem – more like “first aid”- irrespective of whether they have health insurance or are close to the medical facility. Time is thus a crucial and an important factor in determining health care usage especially in biomedicine. The concept of time and its influence on the usage of a particular health system does not only involve time spent in accessing health care facilities or time-spent waiting for treatment, but also time-spent with the healer. The more time a patient spends with a healer in consultation where there is a quality conversation between the healer and the patient, the more satisfied the patient feels with the treatment he or she gains from the healer.

### **6.3 Geographic Variations in Health Seeking Behavior**

In terms of geographical preference based on the three selected communities in the study, some form of variation was noted among the respondents of the three communities. There was a variation among respondents on the preferred choice of treatment and what they are using in meeting their health care needs. Respondents in Fosuansa the most rural of the three communities did not have a sharp difference in terms of their preferred choice of treatment. From the field data, 48% of the respondents in this community preferred biomedicine whereas 42% preferred traditional medicine; compared to that of Asikuma - 71% (biomedicine) and 11% (traditional medicine), and Bedum – 74% (biomedicine) and 21% (traditional medicine). Whereas in terms of actual usage, in Asikuma 43% of respondents use biomedicine for their health needs, 1% use traditional medicine (institutionalized healing) and 56% use self-medication; that of Bedum is 49% for biomedicine, 3% institutionalized traditional medicine and 48% use self-medication respectively to address their health care needs; and Fosuansa is 29% use for biomedicine, 17% use institutionalized traditional medicine and 54% use self-medication respectively to meet their health needs.

For the statistics above in terms of preference in the usage of biomedicine and traditional medicine, the spatial difference between the three communities may be attributed to the level of accessibility between the communities in terms of access to biomedicine and traditional medicine as well as the degree of social closeness between members in each of these three communities. In

Fosuansa, a rural community there is an easy access and knowledge of traditional herbs and medicinal plants in treating ailments as due to the nature of the predominant occupation in this community - farming. Farmers tend to have knowledgeable information about plants and herbs which have medicinal value and also the location of their farms deep in the forest grants them easy access to these plants and herbs. Also due to the small nature of the settlement in terms of population, which there is a high degree of social interaction between members of the society. This degree of social interaction grants members of the community some form of social capital, where mutual reciprocity in terms of giving and receiving help exist between. Thus, because the level of social proximity weans with the degree of urbanity, of a settlement, people in urban settlements like Asikuma may not have any form of social relation with the traditional healers that exist with their community, However, people in rural and small villages tend to have some form of close social relations with these healing which in tend makes receiving traditional healing virtually free. This coupled with the existence of a CHPs compound (clinic) within the community accounts for the closeness in percentage of preference for biomedicine and traditional medicine. Traditional healing here – Fosuansa – is less institutionalized than the rest of the other communities.

With regards to actual usage, there is wide variation in terms of residence and the type of health systems, respondents are using to meet their health care needs. The percentage of respondents using biomedicine in Fosuansa is far lower than the rest of the communities, whereas the percentage using traditional medicine is higher than the rest of the communities. Although in Asikuma and Bedum there is a near balance between respondents using biomedicine and self-medication to meet their health needs, the picture of Fosuansa is quite different. Also usage of traditional medicine is relatively high in Fosuansa compared to Asikuma and Bedum. This phenomenon thus indicates some level of association between place of residence and the choice of treatment respondents use in meeting their health needs as confirmed in the statistical test of hypothesis for this occurrence ( $\text{Chi square} = 36.011, \text{df} = 8, p < 0.05$ ). Location is therefore an important determinant of health care usage for both biomedicine and traditional medicine. This study indicates that location as a factor is not only vital in determining health seeking behavior in terms of usage of biomedicine, but also in terms of traditional medicine, thus affirming the conviction to the study the need to look at health seeking behavior in the developing world from a holistic health perspective instead of in isolation.

#### **6.4 Using both Biomedicine and Traditional Medicine to Address Health Needs**

A common health care behavior observed among patients in the developing world is the combine usage of biomedicine and traditional medicine in treating a single episode of sickness. This combination of biomedicine and traditional medicine is healing therapy may be done simultaneously or in a sequential manner. In the case of the former, patients use drugs obtained from biomedical health care together with traditional medicine, especially herbs or charms that they obtain from the traditional healer. It is worth noting that the drugs or charms used in such healing behavior may have been obtained either by prescription from healers in both health care systems or by purchase from chemical shops and drug peddlers. The activities of drug peddlers and the type of medicine they sell are well known in Ghana. These ‘informal health care providers’ sell a wide range of drugs from everyday biomedical pills and tablets, traditional herbal and plant medicine to charm substances believed to have special powers to, treat people’s infirmity. These charm substance may be in the form of water, olive oil, powder, ointment or cream, which has been prepared and blessed by a traditional diviner or spiritualist, an Islamic Mallam or sheikh, or a Christian prophet or pastor. The drug peddlers provide their customers with the needed instructions on how to use these charms when they sell their products. Thus, the change in the mode of practice and commercialization of traditional healing has created a situation where the traditional health seeker do not need to be in physical contact with their healers before getting treatment for their ailment even for their spiritual health needs. However, certain health situation may require a direct contact with the traditional healer. Thus traditional healing practices in the developing world and for that matter Ghana is gradually taking the shape and form of biomedicine in terms of access, usage and practices.

To have an in-depth understanding of this health seeking behavior, the motivations and rationale behind it, quantitative survey was used to establish the general extent of this behavior and qualitative interviews used to gain insight and explanations for such behavior. From the quantitative survey, 115 respondents – representing 51% – responded in the affirmative in using both biomedicine and traditional medicine in the treatment of an ailment in the course of the health care life. The remaining 112 respondents – representing 49% – stated they have never combined biomedicine and traditional medicine in treating a single episode of sickness. This quantitative data, however, does not provide the full picture of the reasons for such responses.

This limitation is a recognized feature of quantitative method as it provides less detailed information on the behavior, attitudes and motivation that can explain the conclusions to be drawn; thus this limitation is complemented by the use of qualitative research interview. During the qualitative interview, some form of discrepancies with the quantitative survey question on this health seeking behavior was noted. Informants were confused as to whether the question was referring to the use of the two medical systems at the same time or one after the other for the same disease or ailment; hence their responses to the question was made based on their perceived conclusion of what they thought might be the meaning of the question.

In explaining the reasons, motivations and rationale behind using or not using biomedicine and traditional medicine for treating a single episode of disease and sickness, informants pointed out that their behavior in this regard is informed by the nature and type of disease or sickness, their history with that disease or sickness and information available to them concerning the effect of combining both medical systems for treatment. They explained that if the ailment has been persistent in their course of medical history and the health systems employed in the previous cases failed to eliminate the disease or sickness then they resort to the other medical system. Some informants indicated that to them biomedicine relief them of the pains and symptoms of the ailment without necessarily removing the disease completely from their bodies. In such situation, they resorted to traditional medicine to totally eliminate the disease from their body irrespective of whether they perceived the root cause to be physical or spiritual or both. These are what a 52 year old female shop owner, a 55 year old male farmer a 46 year old male galamsey miner had to share:

“To me the hospital drugs just lessen the pains and agonies we feel when we are sick but the sickness is still in your system. For example, 3 years ago I was diagnosed with hypertension and have been taking hospital drugs for it over the years. But a couple of weeks ago, one of my church members recommended this traditional medicine for me and it has improved my situation. She said she had a similar problem and a family friend recommended that medicine for her and ever since she started drinking that medicine her hypertension is completely gone. She asked me to get “abrofo nkatie” - terminalia catappa – boil it and add lemon to it. But she advised me not to use the hospital drugs and the medicine she recommended at the same time as doing that will create problems for me, so I finished my hospital drugs before after two weeks I started the medicine she recommended.” (Informant 1)

“Well, to use our local herbs and hospital medicine it depends on the disease and the nature of the hospital medicine. Some hospital medicine cannot be mixed with other drugs not only the local one, but even hospital medicines as well. Some other hospital medicine can be taken with any other drugs without and problems. I remember my daughter some years back was suffering from typhoid fever and while she was taking the hospital medicines I also prepared herbal medicine from sugar cane, juice grass (referring to – dandelion - *Taraxacum officinale*). I boiled them for her to drink daily like water; and she got well with a matter of two weeks with no traces of the typhoid fever in her body when she went to the hospital.” (Informant 6)

“As Africans, we are very spiritual so even you are sick and go to the hospital there is the need to have some form of spiritual protection as well. You can never tell if the sickness is caused by witches or someone who is envious of your progress. So if you are a Christian or Muslim, then you pray while taking the drugs from the hospital, but if you are a traditional man then you can get some charms to protect yourself. But in terms of using the local herbs with the hospital drugs that depends on the individual and the advice he gets from the doctor concerning that or wherever he purchased both drugs.” (Informant 4)

## **6.5 Sources of Health Information and How They Affect Health Seeking Behavior**

Information is a key component in decision making. As social beings information we gain through interaction influence and guide our actions and behavior. This information such as the dos and don'ts of society we live in, help shape how we interact with others and the social institutions within the society we live in. Similarly, information about health also guides and shapes our health seeking behavior. According Conner and Norman (1996) two basic assumptions makes information relevant to health seeking behavior: that a large proportion of mortality and morbidity we suffer as humans is largely due to our socio-cultural behaviors and that these behaviors can be modified. It is in view of this that MacKian (2003) points out that recent attempts by governments and international health partners in recent decades have been to provide knowledge and information about causes of ill health and the choices available (in the biomedical field) which will help individuals will change their behavior towards a “more beneficial health seeking behavior.” The relevance of information and it vital role in shaping

health seeking behavior of the population in developing world as well as their health status is evident through educational campaigns by governments and international health partners. Campaigns on health issues such as the six childhood killer diseases, Malaria, Tuberculosis, HIV/AIDS and other STDs have helped reduce the prevalent rates of these diseases and in some cases eliminated the diseases completely like polio in most countries in the developing world. These educational campaigns broaden people’s knowledge about health problems, their etiology and how to prevent or treat them; and these information in turn are utilized in the decision making process of individuals in health care. However, most of these national and international health campaigns are oriented towards biomedicine.

Recognizing the relevance of information in the health seeking behavior of people, many traditional healers in Ghana including faith healers and diviners have employed electronic and print media to advertise their enterprise as well as educate people on health matters in relation to their products. It is against this background that majority Ghanaians including respondents in this study continue self-medication to address their health problems. From the quantitative survey, respondents were asked to indicate their main source of information on health and a vast majority - 63% - indicated the media as their main source.

Table 20 Respondents’ Main Source of Health Information

Main Source of Health Information	Frequency	percentage(%)
• Media	142	63
• Health Centers	31	14
• Family and Friends	12	5
• Government Information Services	40	18
• Others	2	1

Source: Fieldwork

Through the qualitative interviews informants shed light on how information from the media influences the health seeking behavior. This is what a 49 year old female trader had to say:

“Today, there is everything on the radio, from preachers to herbalists who are talking about their products. Some companies also advertise their new products on the radio and television. Because of my work as a trader, I listen to the radio a lot from morning till evening, it keeps me entertained while doing my job. When am sick or not feeling to well se headache and body pains I just go and buy some of

the drugs they advertise on the radio at the drug store. For example, the ‘Kinapharma APC’ drug advert says it is for headache, body pains and feverish conditions so when I experience that condition that is what I buy. There are occasions I also hear of local herbal medicine or a Chinese drug that I also buy to cure or prevent something am suffering from... Sometimes too you hear of pastors, Mallams and traditional priests who offer help to my problems including health problems.” (Informant 2)

## **6.6 Belief Systems and Health in Ghana: To what extent does spiritual beliefs affect the choice of health care systems?**

The influence of spirituality and religion influence on human health and behavior is a well know phenomenon. Religious resources figure prominently among the methods that people call on when coping with life stress and illness (Dein and Stygal 1997, Koenig 1997, Pargament 1997, Pargament, Smith, Koenig and Perez 1998, Cole and Pargament 1999 cited in Miller and Thoresen 2003). According to the 2010 Population and Housing Census of Ghana, about 94.7% – representing 23 million of the country’s estimated 24.6 million population – belong to one religious group or another. These religious groups professed belief in God or a higher power, and have sets of morals, norms, belief systems and values that guide and influence the behavior of its members. This high percentage of population with belief in higher powers that influence their lifestyle is not only peculiar to Ghanaians but to most inhabitants of the developing world and to some large extent even in the developed world. However, despite this fact the role of religion and spirituality in health studies until recently had been relegated to the background with the fallacious assumptions that spirituality and religion are unscientific; hence have no place in modern scientific studies of social phenomenon. Miller and Thoresen (2003) points out two basic assumptions that contributed to the neglect of research in this area: (a) the assumption that spirituality cannot be studied scientifically, and (b) the assumption that spirituality should not be studied scientifically. They, nonetheless stress out that neither of these assumptions is scientifically sound and that spirituality can be studied scientifically. They buttress this assertion with a large body of scientific research on spiritual/religious processes that already exists (Hood,

Spilka, Hunsberger and Gorsuch 1996, Koenig, McCullough and Larson 2000, Larson, Swyers and McCullough 1998 cited in Miller and Thoresen 2003).

Growing recognition of the relevance of non-tangible aspect of human experience and lifestyle, have brought once elusive phenomena such as complex cognitive processes, emotional states, and the inner workings of psychotherapy, into recent scientific study. According Miller and Thoresen (2003) to the concept of that which is spiritual can be defined in diverse ways; they, however, provide the definition of Thoresen and Harris (2002) as being usually in distinction from material reality as experienced by the physical senses. Thus, that which is spiritual is generally understood to transcend ordinary physical limits of time and space, matter and energy; however, some features of spirituality are quite observable (e.g., spiritual practices, the spiritually motivated behavior of caring for others) (Miller and Thoresen 2003). The concept of spirituality is considered to be a complex, multifaceted construct that manifests in the process of an individual's behavior, beliefs, and experience (Miller and Thoresen 1999 cited in Gall et al. 2005).

Until recently, discussions of the relationship between spirituality/religion and health have often had a negative undertone; religious beliefs and practices are commonly criticized for their potential negative effects on health and well-being. These belief systems have often been seen as counterproductive to efforts to make biomedical health accessible and the main form of health care provision in the developing world. Such criticisms are often illustrated by persuasive examples. Miller and Thoresen (2003) indicate that for decades, almost anything religious was labeled within psychology as unscientific, if not pathological. However, changing worldview of major stakeholders in international health including the world health organization have embraced the relevance of spiritual or religion in satisfying the mental health needs of patients in the developing world.

Despite these changes in worldviews and conceptions on spirituality/ religion and health in terms of mental health needs of patients in the developing world, little have been done to address and meet mental needs in the developing world. The main focus of governments and international health partners has been on preventive and curative health care in the developing

world, including Ghana. Over the years, millions of US dollars have been channeled by these health stakeholders into preventing and curing physical infirmities such as malaria, HIV/AIDS, Tuberculosis and Bilharzia. Provision of mental health care in biomedical health in the developing world is in jeopardy; this aspect of biomedicine has not been fully developed to meet the health care needs of patients in this aspect of health. In Ghana, for example, there are only three psychiatric hospitals for its estimated population of over 24 million people. These mental health facilities are not evenly distributed as they are all concentrated at the coastal belt of the country: two in the Greater Accra region and one in the Central region. Aside this geographical disparity, there are also other issues that affect the accessibility and usage of these facilities such as inadequately trained personnel in this field of biomedical health, lack and shortage of essential drugs, overcrowded facilities and social stigmatization towards mental health patients. Incidentally, religion and spirituality still remain at the core of the social life of people in the developing world, hence there is the need to pay attention to this in addressing the health care needs of people in this part of the world.

From the quantitative survey, 211 respondents – representing 93% – out of the 227 respondents used in the study stated that indeed supernatural forces can influence the health of a person. This view of the influence of spirit beings and forces on one's health transcends socio-demographic boundaries such as gender, level of education, place of residence and religion as well as one's health seeking behavior in terms of the particular health care system one is using. In all these variables, a vast majority indicated the belief that supernatural forces can determine one state of health. This picture together with information provided by informants in the qualitative interviews indicate that indeed spirituality/religion still holds a place in the life of the respondents and as such influence their health seeking behavior; thus supporting the second qualitative preposition of this study that, the belief of spirit caused illness is a wide social phenomenon independent of an individual's religious orientation, level of education, economic status, place of residence and/or gender. The table below provides the quantitative overview of this phenomenon.

Table 21 Respondents' View on Whether Supernatural Forces can cause Illness.

Socio-demographic and health Variables	Do Supernatural forces cause sickness?		
	Yes ( <i>Row %</i> )	No ( <i>Row %</i> )	Total ( <i>Row %</i> )
Place of residence			
• <i>Asikuma</i>	94 (92)	8 (8)	102 (100)
• <i>Bedum</i>	76 (99)	1 (1)	77 (100)
• <i>Fosuansa</i>	41 (85)	7 (15)	48 (100)
Gender			
• <i>Male</i>	94 (96)	4 (4)	98 (100)
• <i>Female</i>	117 (91)	12 (9)	129 (100)
Level of Education			
• <i>Basic Education</i>	108 (96)	5 (4)	113 (100)
• <i>Secondary Education</i>	39 (95)	2 (5)	41 (100)
• <i>Tertiary Education</i>	31 (91)	3 (9)	34 (100)
• <i>No Education</i>	33 (85)	6 (15)	39 (100)
Religion			
• <i>Christianity</i>	186 (93)	15 (7)	201 (100)
• <i>Islam</i>	23 (96)	1 (4)	24 (100)
• <i>Traditional</i>	1 (100)	0 (0)	1 (100)
• <i>Others</i>	1 (100)	0 (0)	1(100)
First Choice of Treatment			
• <i>Self-medication</i>	113 (94)	7 (6)	120 (100)
• <i>Biomedicine</i>	87 (91)	9 (9)	96 (100)
• <i>Traditional Medicine</i>	11 (100)	0 (0)	11 (100)

Source: Fieldwork

### **6.6.1 Identifying/Diagnosing Illness with Spiritual Cause and Factors that Induce Spiritual Oriented Health Problem.**

In biomedical health system, symptoms, laboratory test and other physiological tests help doctors and other health professionals in this field to diagnose illnesses and provide the necessary cure for it. In similar facton, certain symptoms as well as divination help traditional healers who deal with spiritual phenomena to diagnose illnesses which spiritual causation and know what ought to be done to appease or repel the spiritual forces that are responsible for illness. The question of whether an illness is naturally caused or supernaturally caused can only be determined by ‘gifted members’ of the society with the special ability to see and divine spiritual phenomenon. These gifted persons can be ordinary members or society or traditional healers or faith healers. Although in many literatures on traditional healing in Africa and for that matter in Ghana, clearly distinctions are made of the different types of traditional healers, it is worth noting that these distinctions are made solely for academic and study purpose; practice a traditional healer’s

practices may transcend these distinctions. For example, a traditional bonesetter may also have the ability of divination or a faith healer with capabilities in herbal medicine.

However, the distinction of healers that deal with spiritual phenomena in relation to health care in Ghana can be made based on religion. In Ghana there are three main types of healers that deal with spirituality and health; these healers are the traditional healer with beliefs and practices enshrined in the indigenous religion, the modern day Christian faith healers and the Islamic Mallams. These are the healers that provide spiritual healing for patients in Ghana. It is, however, worth noting that as a result of interactions between the two predominant non-indigenous religions – Christianity and Islam – in the country with the local traditional religion over the course of time and history, some spiritual healers in the former religions have practices and beliefs that converge with the local traditional religion. These different types of spiritual healers have different ways of diagnosing whether an illness is of spiritual cause base on their religious practices and beliefs. Whereas indigenous traditional religion healers as well as some Islamic Mallams identify the cause of an infirmity through divination by consulting with their oracles or bone casting, faith healers do that through prayers or visions. The qualitative interview with informant number 7 – who can be considered a key informant in this subject matter due to her profession as a faith healer – provides an insight into how illnesses of spiritual causation are identified. This is what a 43 year old female faith healer had to say:

“There are some many ways through which the Holy Spirit reveal to me when a person comes to me with a problem be it social or health. There are times and occasions where I even see the person and what is causing his/her predicament before they come to my place. Sometimes through dreams and visions while praying, sleeping or having service with my congregation the Lord reveal these things to me and tells me how to help the person suffering. There are occasions too, where the person first comes to tell me his/her problem, then I do 30 days of fasting and prayer with the person before the Lord reveals to me the cause of the person’s problem.” (Informant 7)

In some cases, patients identify spiritual causation with their health problems after prolong sickness where biomedicine has not been able to heal their infirmities; or in some cases through advice or recommendation from families and friends. After a long episode of illness where a

patient use biomedical treatment and/or herbal medicine and there is no positive outcome, a patient may resort to an alternative view on his/her ailment from healers who specialize in spiritual matters. From the qualitative interviews some informants also indicated that they identify a supernatural force as the cause of their health problems through dreams they may have had. This is what a 37 year old male taxi driver and a 55 year old male farmer had to say:

“My father had an accident on the farm when the metal of the hoe he was farming with removed and hit his temple. Since that incident, he started having problems, behaving in strange manners and always talking to himself. We took him to the hospital in Offinso where we live and the doctors referred us to Ankaful Psychiatric Hospital in Cape Coast. However, over six months still, there was no improvement in his condition so some family members recommended we try herbal medicine. We did that and still the result was the same. He had some land dispute with one elder in the town we live so some even suggested it may be because of that. I called my big brother in Obuasi and told him about the situation; he agreed to our consulting some spiritualist about our father’s condition. He took him to some native doctors in Offinso, Obuasi and even Kasoa but still the problem was there. It even got worse until a lady suggested we bring him to this Prayer Camp at Bedum. I have drinking problems so I decide to also seek help with that when I brought my father. I thought there was something spiritual about my drinking habit because previously I didn’t like alcohol; even the scent of it irritated me. But a year after my return from Nigeria where I was living, I started having strange dreams. After those dreams, about a couple of months later I went to a funeral with some friends and they persistently asked me to take a sip of their drink.... since then I am always drinking from morning till evening.” (Informant 5)

“It is difficult to tell whether an illness has supernatural origin. Most at times someone with ‘gifted eyes’ to see those things will have to tell you before you know. When a sickness becomes incurable after going to the hospital and using local herbs, then I think one should get the opinion of a spiritualist. If you are a Christian then you can see your pastor and if you a traditionalist like me then you can go to the priest for sacrifices to be performed to know the cause of the sickness. So one cannot easily tell that this one is normal sickness and that is supernatural sickness; because even the normal ones have spiritual tendencies as well. In today’s world, there are so many strange diseases hitherto we never knew of, so what we may consider abnormal sicknesses are becoming normal.” (Informant 6)

The information given by informants above, do indicate that there is no one way or method of diagnosing illnesses believed to have been caused by supernatural forces. Whereas, in some cases simple dreams or vision reveals the cause, in others a complex process of prayers and divinations are needed to reveal the causative factor and how to heal/treat the illness.

Peltzer (1999 citing Turner 1979 and Peltzer 1987) reveal that some common features and healing elements can be identified with spiritual healing in Zionist and Apostolic churches noted for such practices in South Africa are baptism, possession by the Holy Spirit, healing through prayer, holy water and laying on of hands, sabbatarianism, prohibitions against alcohol, cannabis, tobacco, traditional and modern medicine. He categorized the healing process of this Christian based faith healing into three categories: healing during church services, healing by immersion, and healing through consultation with a prophet. West (1972 cited in Peltzer 1999) asserts that the prophet in these Christian based healing churches is a healer and they possess the abilities to predict, heal, and divine; the healer's power to do these three vital healing practices is drawn from God. Similarly, the healer in the traditional religion and the Islamic healer also draw their power from the oracles and 'Allah' respectively. On the contrary, these healers perform their healing by means of sacrifices and rituals to appease or expel the offended spirituals as is the cause of the healers in traditional religion or through incantations and verses from the Quran as is the case with the Islamic healer. Despite, the differences in the way healing is performed the concept of healing is the same among healers in these three religions – to seek the intervention of a higher power to address the health problem at hand. This is what a 43 year old female faith healer a key informant on spiritualist had to say:

“I personally have no power to heal those who come to me. Their healing and solution comes from God, so whenever anyone comes here with a problem I take them through prayers and bible teachings. Through these they get their healing. I always tell anyone who comes here that if you don't have faith that your problem will go away, then no matter how many hours I spend praying and fasting the problem will still be there. Faith is very important in receiving healing, just like it is demonstrated in the bible. In the book of Acts, there is a story of Paul healing a man cripple from birth; if the cripple did not have faith in what Paul said to him he wouldn't have be healing. The verse 9 of that scripture said 'The same heard Paul speak: who steadfastly beholding him, and perceiving that he had faith to be healed'. Sorry the bible verse is Acts 14:7-10. So you see faith together with prayer and fasting is what heals those who come to 'Great Jesus Prayer Camp'

with their problems. I am also a herbalist so I also use herbs in healing together with prayer and fasting. The Voltic bottles you see close to me contain my herbal preparations.” (Informant 7)

Aside this institutionalized healers, some patients who identify their health problems as being of spiritual causation may also resort to purchasing ‘special oil, creams or holy water’ that are sold by drug peddlers or Christian evangelists at market places. These substances are believed to be blessed and specially prepared by renowned spiritualists; and they are sold just like the way other drugs and herbs are sold by drug peddlers. It is common practice to find Christian preachers who sell these substances in their course of evangelism at market places, travelling vehicles.

#### ***6.6.2 Factors That Bring About Spiritual Related Health Problems***

In biomedical science, certain factors are noted as being risk factors for the occurrence of certain diseases. For example, unhealthy dietary is associated with cardiovascular diseases such as hypertension, type 2 diabetes and obesity; some diseases may be hereditary whereas others are acquired during one’s lifestyle. Likewise in traditional medicine, certain factors are associated with the occurrence of spiritually caused illness. The origins and factors that cause spirit-related illnesses are not alien to most Ghanaians. This knowledge is gained through social interaction with other members of society; through socialization members of society get to know the norms, morals and taboos that govern the society and the consequences of breaking such social codes of conduct. Others learn the origin of these illnesses from their own experience or stories they hear from other members of society. In contemporary African Christian churches such as the Pentecostal, Zionist and Charismatic churches, teachings on spiritual matters form part of the sermons. Aside these avenues, some radio and television programs are also centered on topics of spirituality and health/lifestyle where renowned spiritualist explains the factors that bring about problems of health and social life that are caused by spirits. Thus knowledge of the causative factors of this type of illnesses is common among Ghanaians. These factors range from breakdown in social relations to the breaking of taboos. Most often, illnesses that are thought to be of supernatural origin are perceived to be brought about by either one or multiple of the

following factors: witchcraft and sorcery (often motivated by jealousy towards the patient), breaking of taboos, breakdown of social relations, and curses.

Some informants through the qualitative interviews explained these factors and how they contribute to the occurrence of spirit caused illnesses. These are what a 43 year old female faith healer and a 52 year old female shop owner had to say:

“There are many ways a person can get spiritual diseases. Sometimes it may result from sheer envy or jealousy; someone sees his/her neighbor doing well in life and out of jealousy he/she use sorcery or witchcraft to destroy the person through deadly sickness. I have seen cases in my camp where people who were diagnosed with HIV/AIDS and when they came to me, I realized it wasn't natural, but the diseases was bought for them in the spirit realm; I prayed for such people and the disease went away. Their conditions were caused by witchcraft and sorcery. Sometimes too they come about due to our own actions and behavior; like the quarrelsome woman I told you about earlier who was pregnant for twelve months... There are some situations and circumstances where the factor or cause of a spiritual problem has nothing to do with the patient or what he/she did but something his/her forbearer may have done. For instance, there is a popular real life story of a family in Agona Swedru whose great grandmother had a sacred covenant with some spirits. The woman is believed to have changed the long life of her descendants for wealth... So for spiritual matters they come about is many diverse ways, not necessarily because the patient did something bad or wrong.” (Informant 7)

”Well as a Christian I believe the devil and his agents are always working against the children of God. He can use witches and wizards to advance his course, by afflicting you with sickness and diseases. Also when unbelievers break certain rule and taboos in the community they can incur the wrath of the lesser gods. Curses are also can contribute to the origin of supernatural illness. In this part of our country, cursing is very common. When people have social disputes, some of them resort to cursing either to punish those they feel have offended them or to vindicate their case in a dispute. I have heard stories of people who suffered from strange illnesses, such as swollen lymph and other body parts which was as a result of curses. Some of these curses may either be a severe illness or quick death.” (Informant 1)

### ***6.6.3 Collaboration between Biomedical Professionals and Traditional Healers in Addressing Spirit Caused Ailment***

The collaboration between the government and religious institutions is providing biomedical health care for the Ghanaian populace also leaves some room for the practice of religion in biomedical health care provision. For instance, it is common to see religious edifices and praying centers with biomedical health centers, which were built by religious organizations such as the Catholic Church. As indicated earlier in the field observation section of this study, the presence of grottos of the Catholic Church in the only hospital in the study district – Asikuma-Odoben-Brakwa – is an illustration of how faith/spirituality intertwines with biomedicine in the district and for that matter in Ghana. Some form of informal cooperation exists among biomedical health professionals and traditional healers who specialize in spirituality. This level of cooperation is not only restricted to traditional healers or faith healers, but encompasses all religious groups or organizations that make praying for the sick part of their ministry. Thus in Ghana biomedical health centers it is a common practice to see Christian prayer groups that go around hospital wards praying for the patients. Often there are some level of understanding between the biomedical health administrators, nurses and these religious groups which help to coordinate the activities of these religious groups. For example, special visiting times are set aside for these groups to come and perform their religious activities for the sick. Aside this, there are cases where biomedical nurses recommend some spiritualists and faith healers to patients whose health problem seem to be non-responsive to biomedical treatment.

During the qualitative field interview with the key informant on spirituality and health – informant 7 – she pointed out such collaboration between herself and some nurses at the district hospital. Also, some informants pointed out from their own experiences and that of their friends and family that such collaboration do exist between biomedical health professionals and traditional healers not just in matters relating to spirituality but also all other forms of health care. These are what a 43 year old female faith healer and a 49 year old female trader had to share:

“Yes, there are some instances where the nurses at the Asikuma hospital, I call me to go and pray for a patient in terrible condition and are not responding to hospital treatment. Sometimes when patients like that are discharged from the hospitals because of they are not responding to treatment the nurses bring them to me here

and I pray for them to be healed. I also send my members here to the hospital, especially the woman when they are pregnant. I believe that the Lord uses these doctors and nurses as well because the knowledge and talent they possess comes from the Lord. All sickness can be cured by the Lord, but there are instances where there is the need for the doctors to also use their God given talents to heal people. I did indicate to you earlier that sometimes people diagnosed with HIV/AIDS come to me, those whose conditions are natural and not spiritual, I advise them to go to the hospitals go the treatment as well as give them some of my herbal medicines so they can be healthy. For me, in particular, I have a cordial relationship with the nurses at the hospital and even the community nurses here in Bedum.” (Informant 7)

“There are cases you go to hospital and the doctors and nurses tell you your sickness is not hospital sickness so you should see someone else. Some even recommend the healers to you if they have knowledge of any; not only spiritualist, but herbalist and bone setters as well. Personally, I have not experienced this before, but my younger sister had such experience where the nurse recommended she consult the spiritualist since all laboratory tests she did could not reveal what was wrong with her. She couldn’t walk and threw up anytime something entered her stomach; she became very weak and lean. The nurse asked her to visit Auntie Grace at Adumfa; she did that and she got well from her sickness.” (Informant 2)

From information provided by these informants, there is an indication that the collaboration between these two health professionals of different etiological orientation is not just one sided but mutual. Thus it is clear that health professionals in biomedical health care systems do recognize the relevance of spirituality in the health care needs of patients in the Asikuma-Odoben-Brakwa district. This recognition is not only limited to the study district, but is evident in the health care provision in the entire country and some countries in the developing world such as South Africa and Nigeria. This form of collaboration between these two types of health professionals dispel the illusion created in many literatures on health pluralism in the developing world that seems to portray that there are no forms of collaborations between these to professional at the ground level. Often, such literatures tend to forget that the biomedical health professionals are also members of the societies within which the patients in the developing world come from hence they do shared and understand the total health care needs of these patients.

Some of these biomedical professionals still hold in high regards, the role of spirituality in the lives of not only their patients, but themselves as well, thus influencing them to make recommendations on such matters to their patients when their conditions are non-responsive to biomedical treatment. Neither is the traditional healer ignorant of the potency of biomedicine in meeting the health care needs of members of the community. The medical revolution in health care in the developing world has deepened the understanding of these indigenous healers of biomedicine and it is such an understanding that has created the informal collaboration that currently exist between these health care professionals.

### **6.7 Role of Family and Social Relations in Health Seeking Behavior**

The health of individuals within a society is of vital concern not only to individuals, but to all members of the society especially an individual's immediate social relations. It is this concern that has contributed to the collective efforts of governments and international partners of health in addressing the health needs and problems of people around the globe, especially in the developing world. Whereas these broader efforts are visible in the national and community levels, the same efforts exist at the individual level. The decision and the choice of health system in addressing health needs is not only made by the patients; family and other social relations also play a major role in influencing and shaping health seeking behavior as exhibited by individuals within a given society. Through the act of socialization members of society share ideas and experiences; these ideas and experiences become part of the information pool available to an individual in the society. These information pool come to bear when the individual has to make a decision that affect his health hence in this aspect social relations have a latent influence in the decision making process of the health patient.

The existence of a strong and vibrant external family system in Ghana and in the developing world means important decisions that people in this part of the world make are made in connection with the views and opinion of the relations in the social group one finds him/herself in. from the qualitative interview it became evident that on the initial of an illness that is mild, the decision making in selecting which remedy to use in addressing the illness is mostly individual. However, when the illness is severe there is a shift to a collective decision

making process that involve immediate social relations such as husbands, wives and children; as the illness becomes more complicated the boundary of the social relation is expanded to include extended family members. This phenomenon is not limited to spirituality and health problems, but to all forms of health including physical or natural occurring health problems. The quantitative table below provides an overview of this phenomenon.

Table 22 Role of Family and Social Relations in Health Seeking Behavior

Role of Family and Social Relations in Health Seeking Behavior	Responses		
	Yes ( <i>Row %</i> )	No ( <i>Row %</i> )	Total
Does Social Relations Make Recommendation When Sick?	154 (68)	73 (32)	227
Do Social Relations Determine The Choice of Treatment?	123 (54)	104 (46)	227

Source: Fieldwork

In the qualitative interviews, informants provided information on the role of social relations in the decision making process in health care. Informants indicated that the role and the influence of social relations in their health seeking behavior or in the choice of treatment for an illness becomes more vibrant when the illness is of a serious nature and the initial remedies employed to address the health problem yielded no result. These are what a 46 year old male galamsey miner and a 37 year old male taxi driver had to share:

“I only tell my wife about my sickness if it is something serious; it is not every trivial thing that I have to tell my wife about it. In cases where the problem is very serious then my parents or my wife’s parents and her family have to be informed about the situation. I remember when my wife was pregnant with my third child; the doctor said it was an ectopic pregnancy so they will have to operate on her. I was very disturbed by the news because all our previous children were born normal without any operation; also the doctor did indicate her condition is life threatening. Although she is my wife, she is also belongs to a family and I had to involve her extended family in the matter.... So I informed her father and uncles and they went to the hospital with me for the doctor to explain the situation to them as well.” (Informant 4)

“In serious and desperate situations it is always good to involve your family when it comes to health and other issues that may be life threatening. We are born into a family or clan and when you do take decisions on serious matters without consulting or informing them, your kinsmen can even disown you or fine you when you later go to them for help. Before I brought my father here because of his mental problem, I informed my brother in Kumasi who agreed, then I went to see my father’s kinsmen to inform them about the decision my brother and I have taken. His kinsmen agreed with our decision because right from the onset of the problem they were with us when we took my father to the hospital and various traditional priests without even good results. So we had their blessing before coming to this prayer camp.” (Informant 5)

## **6.8 Summary**

In this chapter, I have examined the existing health seeking behavior in Asikuma-Odoben-Brakwa district and the rationale behind the existing behavior. Although respondents preferred biomedical treatment to address their health needs, they are resorting to self-medication. Factors such as financial challenges and time were identified as dominant reasons behind the prevailing health seeking behavior. The changing phase of traditional medicine coupled with its commercialization means that this form of health systems is increasingly becoming inaccessible especially with its institutionalization. Media was identified as a major source of health information to respondents and as such plays a crucial role in the prevailing health seeking behavior in the study area. Spirituality also plays a major role in respondents’ health and they use means available to them to address their health concerns in this regards. Although health care decision making mostly individual based, in situations where health problem of an individual is serious and life threatening, social relations play an important role in the decision making of what treatment or remedy must be employed to heal the patient.

## **CHAPTER 7      CONCLUSION AND IMPLICATIONS FOR FUTURE RESEARCH, THEORY AND POLICY**

This chapter presents a summary of the key findings of the study, based on the formulated research questions of the study in conjunction with literature reviewed during the study. Also, it points out areas for future research as identified through the study as well as some noted implications and suggestions for theory and policy in the field of health seeking behavior in Ghana and the developing world at large.

### **7.1 Conclusion**

This study offered a pluralistic perspective of health seeking behavior in Ghana. This pluralistic perspective affords a view of health care accessibility and utilization often not seen using traditional or normative approaches. The pluralistic view affords health planners, policy makers and stakeholders to view health care in the developing world with its different systems as a holistic phenomenon rather than separate components of the health sector. This approach thus offers a holistic approach to tackle the health care problems in the developing world without overly concentrating on one health system to the neglect of the other.

#### ***7.1.1 What is the existing health seeking behavior?***

From the study, it is evident that self-care the prevailing health seeking behavior in the study district. This phenomenon is not different that which have been cited by other researchers on health seeking behavior in the developing world; for instance Sermsri (2002) points out that among the Thais, the predominant health care practice was self-treatment and the use of drugstores, this health care option affords the patients access and usage of both modern biomedical drugs and traditional medical drugs without needing a physician's prescription to purchase. The occurrence of this health behavior despite efforts by government and international health agencies to reverse this trend was noted to be largely as a result of financial constraints and time in accessibility and usage. Although these factors have been noted to affect biomedicine

access and usage (Waddington and Enyimayew 1989, Knauth 1991, Briertwum 1993, Asenso-Okyere 1995 cited by Asenso-Okyere et al. 1998 and Ashford et al. 2006), the changing phase of traditional medicine has also created financial constraints on patients in terms of access and usage, hence the popularity of self-care or self-treatment.

In spite of self-care being the predominant health care practice, however, biomedicine remains the preferred choice of treatment for most people in the study area. This finding is similar to that of Sermsri (2002) on the study of health seeking behavior among Thais. In Sermsri (2002) explanation to the occurrence of this phenomenon, he pointed out that Thais perceived modern medicine as efficient and superior to traditional medicine. In contrast, this study found out that, the reason for this occurrence in the study area (Asikuma-Odoben-Brakwa district) is that most informants viewed scientific agro-technology as the major cause of most their ailment, hence were of the view these ailments can be better treated with the same scientific medicine rather than traditional medicine. Thus to the patients the “efficient and superior” care for these health problems created by “science” is biomedicine; comparatively this finding is therefore similar to Sermsri (2002) finding in some degree.

Using both biomedicine and traditional medicine is a common practice; however, this practice is dependent on available information on the benefits and disadvantages of using these therapies. Thus, until the patient knows that using both biomedicine and traditional medicine will not compromise his/her healthy, the patient will not mix the two therapies as they are considered harmful for certain type illness. Whereas the use of physical therapies from both biomedicine and traditional medicine require knowledge of its pros and cons, the combination of spiritual therapy to physical ailment and treatment is not considered potentially harmful. Patients may, together with using physical remedies such as biomedical drugs and traditional herbs, pray to his/her object of belief to ensure the effectiveness of these remedies as well as his/her total recovery.

### ***7.1.2 What is the role of media and social relations in health seeking behavior?***

Information is considered a vital resource in modifying and changing human behavior. In light of this, national and international health partners have devoted effort to changing health seeking behavior of people in the developing world towards a “more beneficial health seeking behavior” as MacKian (2003) puts it. The print and electronic media play a key role in this information dissemination through providing educative information on healthy lifestyle and sanitation as well as platforms for various healers in the African health sector to advertise their profession. From the quantitative survey a vast majority of respondents indicated the mass media as their main source of information on health. Informants shed light on how radio and television programs on health influence their health seeking behavior by applying knowledge they gain from the programs as well as purchasing drugs and medicines advertised on these channels for their health needs. Thus the media plays a vital role in shaping the health seeking behavior of people in the study area as well as Ghana.

Although health care decision making has the tendency of being viewed as individual based, social relations play a vital role in the health seeking behavior of patients. The extent and degree of influence, however, is dependent on the degree and state of illness. Whereas the decision making and choice of therapy for a benign illness do not usually involve social relations, health care decision making for malignant and persistent illness often involves a high degree of social relation involvement. Health as a collective social phenomenon in terms of decision making on treatment, thus dependent to some degree on the nature and type of illness.

### ***7.1.3 What is the link between spirituality and choice of health care?***

Religion and spirituality still remain a vital part of the worldview of many in the developing world, including Ghana and the study area – Asikuma-Odoben-Brakwa district. The prominence of spirituality in the worldview of Ghanaians transcends to all aspects of their social and economic life including health. In this study a majority of respondents believed supernatural forces do influence the state of health of an individual irrespective of their socio-economic background. The presence of spirituality in health as this study found is similar to that reported by literature on traditional medicine in Africa by Kleinman (1976), Press (1978), Good (1987) and Twumasi (1987). However, this aspect of social health determinant is often relegated to the background in

health care policies and implementation because it is often regarded as unscientific. However, Levin (2009) points out the relevance of this concept of spirituality in modern scientific healing practices; he discusses the cognitive importance of this concept and its healing processes in dealing with mental health needs of patients.

The determination of illness as spiritually caused comes through a complex process of social identification either by the patient or by a recognized healer. Through the acts of divination, trance and dreams traditional healers are able to identify the source of the spiritual infirmity as well as what ought to be done to heal the patient. This finding is similar to Peltzer (1999) description of the disease and illness recognition by faith healers in Zionist and Apostolic Christian churches in South Africa. On some occasions patients also sign supernatural causation to their illness when the use of physical healing practices in both biomedicine and traditional medicine fails or after a long episode of illness which is reoccurring. Also, social relations may recommend the use of spiritualist for a patient after the patient's long period of illness. The healing process for supernatural illness varies and how the healing process is carried out is dependent on consultation between the spiritualist and the supernatural force of worship as well as the religious base of the spiritualist. Whereas libation and sacrifice may be performed by healers in traditional African religion, healers in Christian based faith may employ prayer and fasting together with items such as oil, water and cream believed to possess spiritual potency. These items may be administered by the healer or with recent changes to the operations of traditional healers, purchased from drug peddlers plying their trade in commercial vehicles.

Many factors are believed to bring about supernaturally caused illness. These factors ranges from those that are individual based on those that are social based. Whereas individual actions such as breaking of taboos, offending one's neighbor can bring about these types of illness, break down in social relations such as heritance dispute, quarrel among family members can also bring about supernaturally caused illness. Aside these acts, such as jealousy, envy, witchcraft and sorcery are also believed to cause such illness. These factors, as informants pointed out are similar to those pointed out by Twumasi (1987). In the situation where the illness as a result of individual action, the offended spirit or person must be appeased whereas in situations of social breakdown such socials relations must be repaired in order to restore good health to the patient.

## **7.2 Recommendations for Future Research and Implications for Theory and Policy**

Existing on health seeking behavior has always portrayed traditional medicine as more popular and favorable among the indigenous population in the developing world, including Ghana. These studies have, however, failed to understand the changing of traditional medicine in view of recent socio-economic changes in the developing world; similarly they have failed to appreciate the changes in policies and resource allocation to biomedical health care in the developing world. As this study showed, traditional medicine in Ghana has undergone changes mode of operation and practices. This has created the institutionalized traditional healing which has a commercial orientation and a non-institutionalized type that tends to be less commercialized. In commercialized institutional traditional healing, financial accessibility remains a challenge just as was noted for biomedical medicine in literature on health seeking behavior in the developing world. In light of this dynamism in the operations and practices traditional medicine, there is the need to examine the changing phase of traditional medicine in the developing world in view of these changes, as well as distinguish between commercial institutionalized traditional medicine and non- commercial institutionalized traditional medicine in terms of accessibility and utilization.

Furthermore, biomedicine in Ghana and many parts of the developing world have also undergone transformations with regard to access and usage through policies such as community and national health insurances and community based health care provision (CHPs of Ghana). Over the last decades corporation between governments in the developing world and international health partners such as WHO, UNICEF, The World Bank and USAID have tailored programs and policies to increase accessibility and usage of biomedicine among the populace in this part of the world especially the poor and vulnerable like the elderly, women and children. In view of these changes which are engineered towards improving access and usage among the people of Ghana and the developing world as large, there is the need to reexamine the accessibility and utilization patterns of biomedicine in developing world, especially in Ghana in light of the changes that have been made over the years to address the issue low accessibility and utilization.

Radio, television and print media are integral part of the everyday life of people, not only the educated but even the uneducated as well. Aside entertainment, these media channels provide

knowledge and information to their listeners, viewers and readers. The media, incidentally play a major role in health seeking behavior with regards to information on health problems and health care. This information from the media ranges from health advertisement of drugs and healers to educative information on healthy living. This information plays a major role in shaping the health seeking behavior of people. In light of this insight, there is the need to look and probe the role of the media in the health seeking behavior of Ghanaians and people in other parts of the world with regards to content of health information from the media and how they shape and influence decision making.

The complexity of health seeking behavior in the developing world calls for more advance and multidisciplinary research methods and techniques to capture this social reality. Although efforts have been made to improve access and use of biomedicine among the populace in Ghana, still self-treatment remains the predominant health care practice. This phenomenon is because researches and policies on health seeking behavior have been narrowed and lacks holistic approach in understanding the behavior patients and the populace exhibit in meeting their health needs. The use of multidisciplinary research approach is relevant for an in-depth understanding of prevailing health seeking behavior in Ghana and the developing world; this will also provide a holistic perspective of this behavior which will be vital for policy making and implementation in the health care sector of this part for the world.

Drugstores and chemical shops play a vital role in the health care system in Ghana. Self-treatment as a predominant health care practice in the study area is mainly supported through these drugs and chemical shops as well as through the activities of drug peddlers. Considering the vital role of these drugs and chemical shops in the prevailing health seeking behavior as exhibit by people in the study area as well as in many parts of the world as Sermsri (2002) noted in Thailand, there is the need to examine as a matter of policy how to integrate drugstores and chemical sellers into the health care policy to ensure effective and responsible health seeking practice. Giving basic paramedic training to the attendants of these chemical shops will be vital to ensure the drugs they hand out to their clients and customers will not be harmful to them. Furthermore, there is the need to maintain a corporation between these shops and health care institutions with the communities to ensure cases that require the attention of professional health workers such as nurses and doctors are referred to these health centers.

## APPENDIX 1

### RESEARCH SURVEY QUESTIONS

*This questionnaire is to help solicit information on health seeking behavior and it is for academic purpose only. All information provided will be treated with confidence*

Area code .....

#### Personal information

a) Gender:  Male  Female

b) Age.....

c) Occupation.....

d) Ethnicity:  Akan  Ga  Ewe  Mole-Dagabani  
 Others (please specify) .....

e) Religion:  Christian  Muslim  African-Traditional  
 Others (please specify).....

f) Measure of socio-economic status:  Poor  Lower Middle Income  
 Middle Income  High Income

g) Educational level:  Primary  Junior High School  Senior  
 High School  Tertiary

h) Marital/civil status:  Single  Married  Widow  
 Divorced  Other (please specify) .....

i) Do you control money in the home?  Yes  No

j) Are you the decision maker in health care spending?  Yes  No

### General use of health care facilities

a) Have you ever visited health center (Hospital)?  Yes  No

b) Have you ever visited a traditional healer/faith healer?  Yes  No

c) Which of these is your preferred choice of treatment?  Self-medication  
 Hospital/clinic  Traditional healing methods

d) Which of these is your first choice of treatment?  Self-medication  
 Hospital/clinic  Traditional healing methods

e) How far is the nearest hospital?  Very close  Close  Far  
 Very far

f) How far is the nearest traditional healing center/prayer camp?  Very close  
 Close  Far  Very far

g) Does the time in getting to a health center and getting treatment affect your choice of treatment avenue?  Yes  No

h) Do you have health insurance?  Yes  No

i) Which of these is costly when used in treatment of illness?  Hospitals  
 Traditonal Healing Center/Prayer Camps

### Health seeking behavior

a) What are your main sources of information on illness and diseases? (please as many as applies)  
 Media  Hospitals  Friends/family  government information services  others

b) When were you last ill?  Within 1 months       2-6months       6-12months  
 over 1year

c) What kind of ailment did you suffer from?       Malaria       Diarrhea  
 Upper Respiratory Tract Infection       Skin diseases ulcer  
 Hypertension       Pneumonia       Anaemia       others (please specify).....

d) What treatment did you use?       Hospital/clinic       Traditional Healing methods  
 Self-medication

e) Have you ever had that ailment before?  Yes       No

f) What treatment did you used?       Hospital/clinic       Traditional Healing methods  
 Self-medication

g) Have you ever used both hospital and traditional medicine/prayer camps in the treatment of a sickness?       Yes       No

h) In the table below are list of diseases please indicate which treatment method you consider most appropriate for them, you can choice more than one.

<i>Disease</i>	<i>Method of treatment</i>	<i>Perceived Aetiology</i>
A. Infectious Diseases <ul style="list-style-type: none"> <li>• Malaria</li> <li>• Pneumonia</li> <li>• Cholera</li> <li>• Typhoid Fever</li> <li>• Diarrhea</li> </ul>	Modern Medicine  Traditional Medicine  Both	Physical  Spiritual  Both
B. Sexually Transmitted Diseases <ul style="list-style-type: none"> <li>• HIV/AIDS</li> <li>• Gonorrhoea</li> <li>• Syphilis</li> </ul>	Modern Medicine  Traditional Medicine  Both	Physical  Spiritual  Both
C. Respiratory Diseases <ul style="list-style-type: none"> <li>• Tuberculosis</li> <li>• Asthma</li> </ul>	Modern Medicine  Traditional Medicine  Both	Physical  Spiritual  Both
D. Cardiovascular Diseases <ul style="list-style-type: none"> <li>• Hypertension</li> <li>• Heart attack</li> <li>• Obesity</li> </ul>	Modern Medicine  Traditional Medicine  Both	Physical  Spiritual  Both
E. Neurological Diseases <ul style="list-style-type: none"> <li>• Epilepsy</li> <li>• Lunacy</li> </ul>	Modern Medicine  Traditional Medicine  Both	Physical  Spiritual  Both
F. Lifestyle Disorders <ul style="list-style-type: none"> <li>• Alcoholism</li> <li>• Drug and substance Abuse</li> </ul>	Modern Medicine  Traditional Medicine  Both	Physical  Spiritual  Both
G. Sexual Disorders <ul style="list-style-type: none"> <li>• Impotency</li> <li>• Infertility</li> </ul>	Modern Medicine  Traditional Medicine  Both	Physical  Spiritual  Both
H. Neoplastic or Cancerous Diseases <ul style="list-style-type: none"> <li>• Breast Cancer</li> <li>• Prostate Cancer</li> <li>• Cervical Cancer</li> <li>• Leukemia</li> </ul>	Modern Medicine  Traditional Medicine  Both	Physical  Spiritual  Both

## The Role of Family, Peers and Spiritual Belief in Health Care Decision Making

- a. Who do you consult first when sick?  Friends/family  doctor  
 pastor/priest  chemical seller  others
- b. Has a family member, a friend or your partner ever recommended a type of treatment for you when sick?  Yes  No
- c. Do your partner or family members have a say in the type of medicine or treatment to seek when sick?  Yes  No
- d. Have you ever consulted a faith or divine healer for treatment of a sickness?  
 Yes  No
- e. Do you agree sickness can be caused by supernatural forces?  Yes  
 No
- f. Which treatment do you seek or recommend for spirit-caused sickness?  
 Hospitals  Shrines/Prayer Camps  Both
- g. How effective are these treatments?  Very effective  effective  
 somehow effective  not effective

## APPENDIX 2 – INTERVIEW GUIDE

*Research title: Health Seeking Behaviour in Asikuma-Odoben-Brakwa District: A Pluralistic Health Perspective*

### Personal information

- k) Sex
- l) Age
- m) Occupation
- n) Ethnicity
- o) Religion
- p) Measure of socio-economic status (income)
- q) Educational level
- r) Marital/civil status

### Health seeking behaviour

- a) Which health system do you use more often?
- b) Have you ever used any of the following in treating sickness (hospital, pharmacy, traditional healer and prayer camps)
- c) Do you know any traditional healers/faith healers in your vicinity?
- d) What are your main source of information on illness and diseases?
- e) When were you last ill?
- f) What kind ailment did you suffer from?
- g) What treatment did you use?
- h) What do you think was the cause of ailment?
- i) Have you ever had that illness before?
- j) If yes what treatment did you use on those previous occasions?
- k) Do you seek alternative health care after prolong illness?
- l) Have you ever used both hospital and traditional medicine in the treatment of a sickness?  
Yes/no
- m) If yes, which type of sickness?
- n) Why did you use both methods of treatment?

- o) What do you think of your healer?
- p) Within the last 3 months how often have you fallen sick?

### **The Role of Family, Peers and Spiritual Belief in Health Care Decision Making**

- h. Who do you consult first when sick?
- i. Has a family member, a friend or your partner ever recommended a type of treatment for you when sick?
- j. If yes which type of treatment and for what sickness?
- k. Do your partner or family members have a say in the type of medicine or treatment to seek when sick?
- l. Have you ever consulted a faith or divine healer for treatment of a sickness?
- m. If yes what kind of sickness and why?
- n. Do you agree sickness can be caused by supernatural forces?
- o. If yes when can you tell that a sickness is a result of supernatural force?
- p. What brings about spirit-caused sickness?
- q. Which treatment do you seek or recommend for spirit-caused sickness?
- r. How effective are these treatments?

### APPENDIX 3

#### Social Characteristics of Qualitative Interview Informants

Informants	Characteristics	Location
Informant 1	Female, 52, Akan, married with four children (currently living with two) secondary level of education, shop owner	Asikuma
Informant 2	Female, 49, Akan, married with three children, basic level of education, Trader	Asikuma
Informant 3	Male, 28, Akan, single and living alone, tertiary level of education (Master Degree), civil servant	Asikuma
Informant 4	Male, 46, Akan, married (currently living alone), basic level of education, galamsey miner	Bedum
Informant 5	Male, 37, married (currently living alone), secondary level of education, Driver	Bedum
Informant 6	Male, 55, Akan, married (currently living alone), basic level of education, Farmer	Bedum
Informant 7	Female, 43, Akan, married, no education, faith healer	Bedum

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