SPATIAL ANALYSIS OF THE USE OF TRADITIONAL MEDICINE IN URBAN AREAS OF GHANA: A CASE STUDY OF KUMASI METROPOLIS

BY

MIKE KUSI-BEMPAH, BA (HONS)

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY,
KUMASI

COLLEGE OF ART AND SOCIAL SCIENCES

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF GEOGRAPHY AND RURAL DEVELOPMENT

OCTOBER, 2011
SPATIAL ANALYSIS OF THE USE OF TRADITIONAL MEDICINE IN
URBAN AREAS OF GHANA: A CASE STUDY OF KUMASI METROPOLIS

BY

MIKE KUSI-BEMPAH, BA (HONS)

This thesis is submitted to the Kwame Nkrumah University of Science and Technology in partial fulfilment of the requirement for the award of MPhil degree in Geography and Rural Development.

FACULTY OF SOCIAL SCIENCES
COLLEGE OF ART AND SOCIAL SCIENCES

OCTOBER, 2011
DECLARATION

I do hereby declare that this work has not been partially or wholly presented elsewhere and that this work is based on a study undertaken personally by myself under the supervision of Prof. Dr. Dr. Daniel Buor and Dr. (Mrs.) Charlotte Monica Mensah.

-----------------------------------------------
Mike Kusi-Bempah                                 Date
(Candidate’s Index No.PG2370208)

I have supervised the student in undertaking the study submitted herein and confirm that the student has been in constant consultation with me and therefore has my permission to present this paper for assessment.

-----------------------------------------------
Prof. Dr. Dr. Daniel Buor                        Date
(Principal Supervisor)

-----------------------------------------------
Dr. (Mrs.) Charlotte Monica Mensah               Date
(Second Supervisor)

-----------------------------------------------
Dr. Alexander Yao Segbefia                        Date
(Head of Department)
DEDICATION

To my son, Eldridge Kusi-Bempah
ACKNOWLEDGEMENTS

I will forever be indebted to God for His abundant grace and mercies towards me. His mercies endure forever.

I would like to express my sincere gratitude and appreciation to my supervisors, Prof. Dr. Dr. Daniel Buor and Dr. (Mrs.) Charlotte Monica Mensah for taking time to go through the work and making the necessary inputs despite their busy schedules as the Provost of the College of Art and Social Sciences and a lecturer at both undergraduate and graduate schools respectively. Both lectured me at the undergraduate level as well.

I will also like to express my unqualified appreciation to the following people who helped in one way or the other for this success to be achieved – they are Mr. Benjamin Offei-Nyako, Department of Painting and Sculpture, KNUST; Mr. Seth Acheampong, Central African Gold; Mr. Emmanuel Yeboah Ababio, Narcotics Control Board and Mr. Eric Kwabena Adade of AZAY Electricals, not forgetting all my lecturers at the Graduate School, Department of Geography and Rural Development, KNUST.

The following institutions cannot go unmentioned: Ghana Statistical Service, Kumasi Metropolitan Assembly, Kumasi Metropolitan Health Directorate, Department of Herbal Medicine, KNUST and the Cartographic Unit of the Department of Geography and Rural Development, KNUST.

Lastly, I salute my family – Mr. Emmanuel Kwasi Bempah, Mr. Collins Owusu Bempah and Madam Christiana Akosua Fremah – for their support. I also give thanks to all my friends for their moral support. Special thanks to my wife, Mrs. Winifred Kusi-Bempah, who stood by me through thick and thin.
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CAM</td>
<td>Complementary and Alternative Medicine</td>
</tr>
<tr>
<td>GMP</td>
<td>Good Manufacturing Practice</td>
</tr>
<tr>
<td>GSS</td>
<td>Ghana Statistical Service</td>
</tr>
<tr>
<td>KMA</td>
<td>Kumasi Metropolitan Assembly</td>
</tr>
<tr>
<td>KNUST</td>
<td>Kwame Nkrumah University of Science and Technology</td>
</tr>
<tr>
<td>MBM</td>
<td>Modern Biomedical Medicine</td>
</tr>
<tr>
<td>NHIS</td>
<td>National Health Insurance Scheme</td>
</tr>
<tr>
<td>MM</td>
<td>Modern Medicine</td>
</tr>
<tr>
<td>MMC</td>
<td>Modern Medical Centre</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>TM</td>
<td>Traditional Medicine</td>
</tr>
<tr>
<td>TMC</td>
<td>Traditional Medical Centre</td>
</tr>
<tr>
<td>TMP</td>
<td>Traditional Medical Practitioner</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
</tr>
<tr>
<td>UNPD</td>
<td>United Nations Population Division</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>TITLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover Page</td>
<td>i</td>
</tr>
<tr>
<td>Title Page</td>
<td>ii</td>
</tr>
<tr>
<td>Declaration</td>
<td>iii</td>
</tr>
<tr>
<td>Dedication</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>v</td>
</tr>
<tr>
<td>Acronyms</td>
<td>vi</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>vii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>xii</td>
</tr>
<tr>
<td>List of Tables</td>
<td>xiii</td>
</tr>
<tr>
<td>Abstract</td>
<td>xiv</td>
</tr>
</tbody>
</table>

## 1.0 General Introduction | 1

1.1 Background of the Study | 1

1.2 Statement of the Problem | 4

1.3 Research Objectives | 8

1.4 Conceptual Framework | 9

1.4.1 Andersen and Newman Framework Of Health Services Utilization | 9

1.4.2 Modified Model of the Use of Traditional Medicine | 11

1.5 Research Hypotheses | 12

1.6 Research Methodology | 13
2.10 Definition of Terms

3.0 Background of the Study Area

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Introduction</td>
<td>39</td>
</tr>
<tr>
<td>3.2</td>
<td>Religion</td>
<td>40</td>
</tr>
<tr>
<td>3.3</td>
<td>Location and Site</td>
<td>40</td>
</tr>
<tr>
<td>3.4</td>
<td>Socio-Demographic Characteristics</td>
<td>42</td>
</tr>
<tr>
<td>3.5</td>
<td>Physical Environment</td>
<td>43</td>
</tr>
<tr>
<td>3.6</td>
<td>Socio-Economic Characteristics</td>
<td>43</td>
</tr>
<tr>
<td>3.7</td>
<td>Health Care</td>
<td>44</td>
</tr>
</tbody>
</table>

4.0 Background of Respondents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Introduction</td>
<td>46</td>
</tr>
<tr>
<td>4.2</td>
<td>Age and Gender Composition of Respondents</td>
<td>46</td>
</tr>
<tr>
<td>4.3</td>
<td>Residence, Duration of Stay and Type of Medicine Used</td>
<td>48</td>
</tr>
<tr>
<td>4.4</td>
<td>Educational Status and Form of Medicine Used</td>
<td>50</td>
</tr>
<tr>
<td>4.5</td>
<td>Employment Status and Profession of Respondents</td>
<td>51</td>
</tr>
<tr>
<td>4.6</td>
<td>Household Size</td>
<td>53</td>
</tr>
<tr>
<td>4.7</td>
<td>Income Levels and Percentages Used in Health Care</td>
<td>53</td>
</tr>
<tr>
<td>4.8</td>
<td>Religion</td>
<td>55</td>
</tr>
</tbody>
</table>

5.0 Access and Use of Traditional Medicine

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Introduction</td>
<td>57</td>
</tr>
</tbody>
</table>
5.2 Factors That Influence Access to and Use of Traditional Medicine ........58

5.2.1 Introduction ......................................................................................58

5.2.2 Distance ............................................................................................59

5.2.3 Time ..................................................................................................60

5.2.4 Effectiveness .....................................................................................61

5.2.5 Side Effects .......................................................................................63

5.2.6 Cost ...................................................................................................64

5.2.7 Accessibility and Tastes and Preferences .........................................65

5.2.8 Convenience .....................................................................................66

5.3 Factors that Discourage the Use of Traditional Medicine ..............66

5.3.1 Introduction ......................................................................................66

5.3.2 Preparation .......................................................................................66

5.3.3 Dosage ..............................................................................................67

5.3.4 Packaging ..........................................................................................68

5.3.5 Taste and Application of Drugs .......................................................68

5.3.6 Preservation ......................................................................................69

5.4 Source of Acquiring Traditional Medicine and Length of Use ..........70

5.5 Number of Times Respondents Fell Sick and Reported at a Traditional

    Health Facility in the Last Three Months ...........................................71

5.6 Diseases Most Reported at a Traditional Medical Centre and which are

    Effectively Addressed ...........................................................................72

5.7 Type of Traditional Medicine Most Patronised ..................................74

5.8 Patronage of Traditional Medicine by Family Members of Respondents ......75
5.9 Mysticism and Divination……………………………………………………………75
5.10 Contradiction of Religious Beliefs with Traditional Medicine………………76
5.11 Societal Perception of the Use of Traditional Medicine……………………77
5.12 Improving Traditional Medicine………………………………………………77
5.13 Research Findings (Test of Hypotheses)………………………………………79

6.0 Summary, Conclusion and Recommendations……………………………..81
6.1 Introduction……………………………………………………………………81
6.2 Summary of Findings…………………………………………………………81
6.3 Conclusion……………………………………………………………………83
6.4 Recommendations……………………………………………………………85

Bibliography…………………………………………………………………………88

Appendices ………………………………………………………………………92

Appendix A……………………………………………………………………92
Appendix B……………………………………………………………………98
Appendix C……………………………………………………………………100
<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1.1  Andersen and Newman Framework of Health Services Utilization</td>
<td>9</td>
</tr>
<tr>
<td>Figure 1.2  Modified Model of the Use of TM</td>
<td>11</td>
</tr>
<tr>
<td>Figure 1.3  Map of Kumasi Metropolis</td>
<td>16</td>
</tr>
<tr>
<td>Figure 3    Map of Ashanti Region Showing the Study Area</td>
<td>41</td>
</tr>
<tr>
<td>Figure 4.1  Gender and Use of Traditional Medicine</td>
<td>48</td>
</tr>
<tr>
<td>Figure 4.2  Number of Respondents Drawn From Places of Present Residence and the Type of Medicine Used</td>
<td>50</td>
</tr>
<tr>
<td>Figure 4.3  Educational Status and Form of Medicine Used</td>
<td>51</td>
</tr>
<tr>
<td>Figure 4.4  Professional Status</td>
<td>52</td>
</tr>
<tr>
<td>Figure 4.5  Salary Levels and Form of Medicine Used</td>
<td>55</td>
</tr>
<tr>
<td>Figure 4.6  Religion of Respondents</td>
<td>56</td>
</tr>
<tr>
<td>Figure 5.1  Diseases Reported at Traditional Medical Centres in the Last 3 Months</td>
<td>73</td>
</tr>
<tr>
<td>Figure 5.2  Diseases Addressed by TM Using Mysticism or Divination</td>
<td>76</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 4.1 Age and Gender Composition of Respondents</td>
<td>47</td>
</tr>
<tr>
<td>Table 4.2 Duration of Stay in Residence of Respondents</td>
<td>49</td>
</tr>
<tr>
<td>Table 4.3 Percentage of Salaries into Health Care</td>
<td>54</td>
</tr>
<tr>
<td>Table 5.1 Accessibility Factors to Health Care</td>
<td>59</td>
</tr>
<tr>
<td>Table 5.2 Distance Taken to Access Traditional Medicine</td>
<td>60</td>
</tr>
<tr>
<td>Table 5.3 Time Taken to Access Traditional Medicine</td>
<td>61</td>
</tr>
<tr>
<td>Table 5.4 Effectiveness of Traditional Medicine</td>
<td>63</td>
</tr>
<tr>
<td>Table 5.5 Top Factors that Encourage the Use of TM</td>
<td>65</td>
</tr>
<tr>
<td>Table 5.6 Top Factors that Discourage the Use of TM</td>
<td>70</td>
</tr>
<tr>
<td>Table 5.7 Source of Acquiring Traditional Medicine</td>
<td>71</td>
</tr>
<tr>
<td>Table 5.8 Number of Times Respondents Fell Sick in the Last 3 Months</td>
<td>72</td>
</tr>
</tbody>
</table>
ABSTRACT

This study aims at analysing the use of traditional medicine in urban areas of Ghana with Kumasi Metropolis as the case study area. The study focuses on finding the mode of use of traditional medicine in urban areas and why people choose a particular medicine at the expense of the other. The researcher finds the effect of urbanization on the use of traditional medicine as well as the percentage of urban dwellers that access traditional medicine. The role gender plays in the use of traditional medicine is also factored in the equation. The discussion also focuses on the type of diseases that traditional medicine effectively addresses. To understand the effectiveness of traditional medicine, comparison has to be made with modern medicine.

To achieve the objectives of the research, both quantitative and qualitative methods of data analysis are used. Multiple regression model as a tool is used to test for the validity of views expressed by respondents. Interviews and questionnaires were used to collect data from the field to support maps and other data collected from related institutions. Views were sampled from 20 selected suburbs in the Kumasi metropolis using a sample size of 320.

Analysis of data indicates that education plays a very important role in the utilization of traditional medicine. There is a significant negative correlation between education and use of traditional medicine in both the core and the periphery. Other variables such as place of residence, gender and income levels did not show a significant correlation with the use of traditional medicine. Though the study reveals that more females use traditional medicine than males, the difference is not significant. The other 2 variables (residence and salary) follow a similar trend as in gender.
It is recommended that traditional medicine should be incorporated into the Primary Health Care (PHC) system because of its efficiency and affordability. For this integration to be effective, government must seek to regulate the activities of practitioners of traditional medicine. This can be achieved when government’s health policies make provision for the setting up of educational institutions to train people in the field of traditional medicine. Moreover, if practitioners of traditional medicine come together in small groups to share knowledge and expertise, they can do better than they are doing now.

Admittedly, this study addresses only a fraction of the problem associated with traditional medicine and the researcher accepts that other areas of further research must be considered. Areas such as “Ethnicity and use of traditional medicine” and “The problem of distribution and application of traditional medicine” are strongly recommended to anyone aspiring to research into traditional medicine.
CHAPTER ONE

1.0 GENERAL INTRODUCTION

1.1 BACKGROUND OF THE STUDY

The quest for health care has compelled many people far and wide to seek medical attention of various forms. Whatever form it may take is informed by one’s cultural beliefs as well as accessibility and affordability factors. Basically there are two forms of health care: Traditional Medicine (TM) and Modern Biomedical Medicine (MBM). Different cultures and environments choose different health care systems for reasons of efficacy, cost, acceptability, flexibility and suitability. Health, by the World Health Organization’s (WHO) standard is defined as a state of complete physical, mental and social well-being of the individual, and not merely the absence of disease or infirmity (Fritjof, 1982). People’s attempt to seek health care leads them to the two options discussed.

The World Health Organization (WHO) defines traditional medicine as the sum total of the knowledge, skills, and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in prevention, diagnosis, improvement or treatment of physical and mental illnesses (WHO, 2000).

On a global scale the use of traditional medicine has now attracted a bit of attention and Chinese and Indian Ayurvedic medicine, especially, are the most commonly used. They are considered the two most developed systems of traditional medicine in the world, and are used in Asia in conjunction with allopathic treatment. “They are well
established, recognised, accepted, and in some instances, preferred over allopathy due to their greater effectiveness” (Davies, 1994).

Many Asians seek traditional healers for treatment of a wide range of illnesses. Chinese traditional medicine is probably the best-known alternative to Western medicine. Techniques such as acupuncture, acupressure, and the use of herbal medicines are widely used by Chinese people throughout Asia, and many of these techniques are practised in Western countries (Microsoft Encarta, 2008).

Europeans sometimes use the term *phytomedicine*, from *phyto* (Greek for “plant”), to describe herbal or botanical medicine. The other forms, according to Twumasi (1988), involve Spiritualists, Faith Healers and Traditional Birth Attendants. There are also Traditional Bonesetters. Traditional medicine takes into account traditional beliefs and institutions which are best practised and observed more in rural settings than in urban areas.

In Africa, the general perception of people is that TM is better in terms of efficacy and application. The perception stems from the fact that the minds of some Africans and for that matter Ghanaians have been brainwashed to believe that everything introduced by the Whiteman is better than the local/traditional one (Davies, 1994).

Early in human history, the practice of herbal medicine was in a form of magical or religious healing art. This was because people believed in the metaphysical and had no or less regard for science. There has been an improvement in the use of traditional medicine in recent times with people moving slowly away from the former to the latter. Twumasi (1988) defines traditional medicine as a term which is used to mean the practice in which there is no conceptual separation between natural and supernatural entities.
The efficacy and the flexibility of taking modern medicine cannot be gainsaid, but it is also derogatory for someone to suggest that traditional medicine is inferior and primitive. Each of the two systems mentioned has advantages and disadvantages over the other. The choice of one over the other is however a matter of acceptability, affordability and accessibility by the individual (Twumasi, 1975).

Indisputably urbanism as a way of life has come to stay and every society’s dream is to advance from ‘rurality’ to ‘urbanism’. With improvement in the economic system with its associated change from agrarian to industrial economy, there have been widespread urban areas from the latter part of the twentieth century to date. Although, to define an area as urban or rural is basically a subjective matter, there are some indicators that guide one in their classification.

Urban areas are characterized by high population densities, industrial and commercial activities, social heterogeneity, limited free space, higher concentration of governmental activities, and higher rate of literacy, etc. Above all these an area of population more than 5,000 is considered urban in Ghana (Encarta, 2008). Urban population growth is fueled by natural growth (the excess of births over deaths), migration from rural areas, and cities’ incorporation of rural surroundings (redefinition of administrative boundaries).

The link between urbanization and use or otherwise of traditional medicine is that of extent of literacy, affordability, and belief in traditional values. Traditional herbal medicine which is a subset of traditional medicine involves the application of herbs and other parts of medicinal plants such as roots and barks for the cure of various forms of diseases. In herbal medicine, the word *herb* applies to any plant used for its
medicinal, flavouring, or fragrant properties. Leaves, flowers, stems, roots, seeds, fruit, and bark can all be constituents of herbal medicines (Encarta, 2008).

Though urban residential structure is often explained in terms of socio-economic variables, it should be recognized that its dynamics of change can better be understood by reference to: the growth of the area, incidence of obsolescence (that is, aging and decaying structures), economic and technological advancement and demographic dynamics. These factors go a long way to determine the type of people that live in a particular area with regard to their socio-economic background.

People from different socio-economic background choose different forms of health care with no or less regard for efficacy. Economic challenges deny many people from enjoying what they would have wished for. Some people who live in squatter areas are of low economic status and find it difficult to afford modern medical care. In contrast many people who can afford modern medical care are those with sound economic background and these people on a greater scale live in first class residential areas.

1.2 STATEMENT OF THE PROBLEM

Traditional medicine has contributed immensely to health care delivery in Kumasi. Despite its efficacy, traditional medicine is often used as a last resort when a variety of reasons does not permit the patient to access modern biomedical health care. This is very much acute in the Kumasi metropolitan area where there are many modern biomedical health facilities. Some people in Kumasi disregard traditional medicine as inferior and belonging to the lower class of society (Author’s Preliminary Investigations, 2010).
The belief that traditional medicine is backward and ineffective still occupies the minds of some people, even though not as strongly as it once was. Traditional medicine, according to Buor (1993) is largely patronized by the rural folk who constitute a greater proportion of the population. In the view of the researcher, even in urban areas, traditional medicine is largely patronized by those in the low income bracket.

More people in the core than in the periphery of Kumasi disregard the use of traditional medicine because of the crude method of preparation and application. That notwithstanding, traditional medicine has proven to be very potent and effective and therefore the need to refine its method of preparation and application. Some diseases are better cured using traditional medical practices than using modern biomedical practices, but the mindset of people, especially those in the developed world toward the former discourages them from using traditional medicine. Modern pharmaceuticals cannot treat every condition effectively, and some drugs have other side effects (WHO, 2008)

In most cases traditional medicine does not employ scientific principles in its approach and thereby neglecting proper and acceptable methods of doing things. Some practitioners of traditional medicine work in secrecy – they do not document their methods of preparation of drugs – so their knowledge is not passed on to the future generation in the event of their sudden demise. Most of these drugs are in a form of concoction which is sometimes very difficult to drink. The environments of many traditional medical practitioners are just an eyesore, and many patients disregard their activities irrespective of the potency of their drugs.
The people of Kumasi resort to the use of various types of traditional medicine to cure a variety of diseases (Author’s field investigations, 2010). Spatially, those in the periphery use more herbal drugs than those in the core. Apart from the use of herbal medicine as the main source, there are other forms such as faith healing, spiritualism, and traditional birth attendants. Not only do the people use indigenous form of traditional medicine, but also foreign or imported ones. The proliferation of Chinese and Indian traditional medicine as well as that of Malaysia is now the talk in town. Indigenes of Kumasi have embraced these medicines, though, some users may not be sure of their medicinal values.

The practitioners of traditional medicine specialise in particular areas of their profession, in the same way as orthodox medical practitioners do. Thus we find some traditional medical practitioners who are experts in the use of herbs (herbalists), others who are proficient in spiritual healing, especially the use of incantations, while still others combine both (Author’s field investigations, 2010). The researcher’s field investigation reveals that practitioners in the periphery are more into herbal medicine and fetishism while faith healing, divination and spiritualism are more prevalent in the core. There are also traditional bonesetters and birth attendants. In some cases, one type of healer provides several or all therapeutic services, whereas others have separate practitioners for different functions.

Traditional medicine is generally more used by market women who are always in contact with peddlers of these drugs. With the cost of modern biomedical medicine coupled with the hustle one has to go through before receiving treatment, people in the low income bracket use more traditional medicine. Another group that patronises traditional medicine is the Zongo community – these people have faith in their
“malams” to deliver potent and efficient medicine. Another group that cannot be glossed over is those who claim their source of illness is spiritual. These people therefore seek spiritual sources of medication. Some people in Kumasi believe that some diseases can only be addressed by traditional medicine using mysticism and divination (Author’s field investigations, 2010).

Patronage of traditional medicine varies from the core (first class residential area) to the periphery (squatter area). Many of those in the core area are well-to-do and can afford modern medicine. In contrast, many of those in the periphery are not particularly well-to-do and therefore resort to traditional medicine. Most modern medical facilities are also over-concentrated in the core region, making it quite more accessible to those in the core than those in the periphery. Distance and time to modern health facilities in the core areas compel those in the periphery to resort more to traditional medicine which is more readily accessible. Also most of these traditional practitioners are located in the periphery where they have ready access to their raw materials (WHO, 2002).

The use or otherwise of traditional medicine is also informed by the social structure of the people. People with high educational background tend to believe more in the use of modern medicine than traditional medicine. Some of the reasons they give are that modern medicine is more hygienic and flexible to use than traditional medicine. People of high social class sometimes feel “inferior” using traditional medicine. They pride themselves going for high-cost medical care, and these are mostly found in modern health facilities (Author’s preliminary investigations, 2010).

In Kumasi, traditional medicine is variously supplied in public places; public transport, market areas, churches, schools, work places, in streets and in residential
areas. Those involving spiritual and faith healing processes always need special attention and therefore patients have to visit these spiritualists and faith healers at their own backyard. Depending on the seriousness of the ailment, patients are kept in “camps” for periods as determined by their healers. Those with mental problems are sometimes chained to trees and pillars to avoid bolting away and also harming others in the case of violent ones (Researcher’s preliminary investigations, 2010).

What is so problematic in the study area that warrants research is that patients are found in long queues at the various modern health facilities to seek health care at the expense of traditional medicine which is relatively easily accessible. With varying distribution of modern health facilities between the core and periphery, there is the need to study differences of use of traditional medicine by place of residence, hence, the core and the periphery.

1.3 RESEARCH OBJECTIVES

The study generally aims at finding the mode of use of traditional medicine by place of residence in the Kumasi metropolis and possibly come out with why people choose one form of health care or the other. The study specifically aims at examining:

1. the effect of urbanization on use of traditional medicine.
2. proportion of the use of traditional medicine by core and periphery.
3. gender disparity in the use of traditional medicine.
4. Strategies to incorporate traditional medicine into the Primary Health Care (PHC) system.
1.4 CONCEPTUAL FRAMEWORK

The conceptual framework is a theoretical explanation of how urbanization impacts on the use of traditional medicine in Ghanaian cities, vis-à-vis modern biomedical medicine. This is explained using causal relationships. The conceptual framework shows the linkages of the various components with one another.

1.4.1 Andersen and Neuman Framework of Health Services Utilization

Figure 1.1 Andersen and Neuman Framework of Health Services Utilization

![Andersen and Neuman Framework](image)

Source: Andersen and Neuman (1995)

The purpose of this framework is to discover conditions that either facilitate or impede utilization. The goal being, to develop a behavioral model that provides measures of access to medical care. The framework was first developed in the 1960s and has since gone through four phases. Developed in the 1990s, figure 1.1 represents the fourth
phase. An individual's access to and use of health services is considered to be a function of three characteristics:

1) **Predisposing Factors:** The socio-cultural characteristics of individuals that exist prior to their illness. Social Structure (Education, occupation, ethnicity, social networks, social interactions, and culture). Health Beliefs (Attitudes, values, and knowledge that people have concerning and towards the health care system). Demographic (Age and Gender).

2) **Enabling Factors:** The logistical aspects of obtaining care. Personal/Family (The means and know how to access health services, income, health insurance, a regular source of care, travel, extent and quality of social relationships). Community (Available health personnel and facilities, and waiting time). Possible additions (Genetic factors and psychological characteristics).

3) **Need Factors:** The most immediate cause of health service use, from functional and health problems that generate the need for health care services. "Perceived-need better helps to understand care-seeking and adherence to a medical regimen, while evaluated-need will be more closely related to the kind and amount of treatment that will be provided after a patient has presented to a medical care provider." (Andersen, 1995). **Perceived:** "How people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help." (Andersen, 1995). **Evaluated:** "Represents professional judgment about people's health status and their need for medical care." (Andersen, 1995).
1.4.2 Modified Model of the Use of Traditional Medicine

Urbanization which is associated with overall growth of all sectors of a country’s economy can be said to bring about improvement in the lives of people which are made better as a result of the establishment of more industrial and commercial jobs, thereby increasing the purchasing power of the people. This gives rise to environmental determinism. The global trend of urbanization, especially in Africa suggests that more people are drawn into urban areas as against the countryside. With more people being drawn into urban areas without a corresponding increase in residential facilities, the situation of more demand of residential facilities than supply arises. This situation rather triggers the emergence of squatter settlements.

Figure 1.2: Modified Model of the Use of TM

Income as a factor also determines one’s use or otherwise of TM. The exceptionally more expensive forms of traditional medicine are mostly patronised by the very well-to-do and educated people in the city. Not many people are willing to access traditional medicine at higher prices, because the general perception is that indigenous products must always be cheaper. Some people therefore are reluctant to spend more
money on locally prepared drugs. Some people in the high income bracket resort to the use of modern biomedical medicine regardless of the cost involved. These people also disregard the use of traditional medicine without taking into consideration its efficacy and cost. The use of traditional medicine therefore declines in favour of the modern biomedical medicine within the higher earning group.

The other determinants of the use of TM are acceptability, efficacy, affordability, taste, preferences and suitability. One’s culture and beliefs determine to a large extent, the kind of health care to choose. Efficacy of a particular drug also influences one’s choice of a particular medicine, as well as, taste and preferences.

In conclusion, it can be said that the environment of an individual is a determinant of the kind of health care they choose. There are other predisposing factors (gender, education, attitudes) that also account for the kind of medicine used. According to Anderson and Newman (1995), factors like income and health insurance are enabling factors of the use of a particular health facility.

1.5 RESEARCH HYPOTHESES

The following hypotheses were tested:

1. H₁: Place of residence has effect on the use of traditional medicine.

   H₀: Place of residence does not have any effect on the use of TM.

2. H₁: Gender has effect on the use of traditional medicine.

   H₀: Gender does not have any effect on the use of traditional medicine.
3. $H_1$: Educational level has effect on the use of TM.

$H_0$: Educational level does not have any effect on the use of TM.

4. $H_1$: Income levels have effect on the use of TM.

$H_0$: Income levels do not have any effect on the use of TM.

Significance level = 0.05

1.6 RESEARCH METHODOLOGY

1.6.1 Introduction

This involves specific statements on data sources, sample size, sampling methods, data collection, processing and analysis.

1.6.2 Data Sources

The research work made use of both primary and secondary sources of data collection. With the primary sources of data, observation, interviews and questionnaires were used. The formal or structured form of interview was used to collect data, as well as both the open and close-ended questions for the questionnaire. Books, journals, research reports, newspapers and other available materials were also consulted for the secondary data collection. Aside these, reports of the Ministry of Health (MOH) and other books and publications as well as the Internet were used.
1.6.3 Sampling

In order to get proportional sample of views from all communities, stratified and simple random sampling methods (probability sampling) were used. On the basis of the study, the researcher divided Kumasi Metropolis into two parts: first class residential (the core) and squatter areas (the periphery). This division was based on residential land use patterns; housing facilities, in some cases by the main occupancy of the area, the rate of expansion and the density arrangement of land use in the area. Squatter areas develop as a result of more rural folks migrating into the urban centre for non-existent industrial jobs. Views from each stratum were sampled randomly.

The population of Kumasi is estimated to be 1,517,000 (United Nations Population Division, 2005). A sample size of three hundred and twenty (320) people was used. The ratio of the sample to the population was 1:4,974. This means that out of every 4,974 people, the researcher interviewed one person. A sample size of 320 was used based on the formula: \( n = \frac{N}{(1+N)(x^2)} \), where “n” is sample, “N”, population and “x”, standard error of deviation.

The localities sampled were Adum, Asokwa, Amakom, Ahodwo, Paraku Estate, Buokrom Estate and Nhyiaeso for the core region while Aboabo, Moshie Zongo, Asawasi, Sepe Timpon, Duase, Ayigya and Kotei represented the periphery. The sample was proportionally allocated to the core and periphery and residents from these suburbs were picked randomly and interviewed.
1.6.4 Data Analysis

To give a vivid explanation to the research work, quantitative and qualitative methods were used in the data analysis. Quantitatively, the statistical method of analysis was undertaken using the Statistical Product for Service Solution (SPSS) which is a software programme for data analysis. Multiple regression was used in testing the hypotheses. Analysed data were presented in the form of frequency tables, graphs and pie charts. Maps were also used to give a clear visual impression of some phenomena. In analysing qualitative data, views expressed by some respondents were either quoted or paraphrased to give a balance of both forms (Qualitative and Quantitative).

1.7 SCOPE OF THE STUDY

Geographically, the study covers some selected areas of Kumasi metropolis which consists of about 90 suburbs (Regional Statistical Office, Kumasi, 2000), some of which are Asokwa, Buokrom (including the estates), Asawasi, Ayigya, Atonsu, Duasi, Adum, Moshie Zongo and Kotei. As noted earlier, Kumasi is the capital of the Ashanti region situated in a dense forest belt. Figure 1.3 shows the study area. Kumasi shares boundaries with Kwabre East District to the north, Atwima District to the west, Ejisu/Juaben Municipality to the east and Bosomtwe District to the south (Kumasi Metropolitan Assembly, 2006).

Demographically, the study took into account the professional statuses of males and females vis-à-vis their form of medication and disease prevalence. Also, population size, density, growth and distribution were factored in. Socially, the rich and the poor, the literate and the illiterate were looked at. The study does not take into consideration
Figure 1.3: Map of Kumasi Metropolis

Source: Kumasi Metropolitan Assembly, 2010
the religious affiliation of respondents. However, if one’s religion did not permit one form of health care or the other, the researcher was curious to look into that. The magico-religious aspect of health care was also investigated.

1.8 JUSTIFICATION OF THE STUDY

The study is necessary because it enables the writer to find out exactly the cause of discrimination against traditional medicine. When the reason for people’s discrimination against traditional medicine is ascertained, then an acceptable conclusion can be drawn as to how to make traditional medicine “better” and acceptable to all. Also the study is justified because it could serve as a source of knowledge to readers who aspire to delve into the study of traditional medicine.

Researching into this area of study has become very necessary since it will offer the opportunity to ascertain people’s choice of health care. Judging by the fact that the study area (Kumasi Metropolis) is located in a region of vast vegetation with plenty of medicinal plants, it is a mystery why traditional medicine, especially, herbal medicine has not attracted the necessary attention.

1.9 LIMITATIONS OF THE STUDY

The following constraints were met in conducting the research:

1. As a student researcher the problem of finance was encountered.

2 The problem of non-response of some members of the sample population.
3. Apathy on the part of officials of the Ministry of Health and other institutions to release the necessary information was also a setback.

4. There were some biases in the responses sampled and the researcher had to amend the sampling procedures.

5. Lastly, the problem of coverage was also encountered, since the area under study is very broad.

Notwithstanding all these, the researcher found ways to overcome the problems by getting most of the information needed.
CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

The literature review discusses opinions and concerns expressed by other researchers. It is basically a summary of existing publications and researches. The idea of reviewing existing literature is to offer a constructive critique of existing literature by indicating their shortcomings and find out the methodologies used. The literature review also seeks to point out whether there are gaps in existing literature for which further research is needed. It also guides the researcher.

2.2 CONCEPT OF TRADITIONAL MEDICINE

Traditional Medicine, as the name connotes, has to do with ways and practices common to a particular group of people whose experiences have taught them to believe in a particular way of seeking and maintaining health using methods identifiable with their culture. The World Health Organization (WHO) therefore defines Traditional Medicine as the sum total of the knowledge, skills, and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in prevention, diagnosis, improvement or treatment of physical and mental illnesses (WHO, 2000).

For decades, the preparation of traditional medicine was wholly based on unscientific methods. However due to development, practitioners of traditional medicine have
realised the need to adopt some scientific principles in their preparation and application. Traditional medicine generally involves the application of drugs in the treatment and prevention of diseases using ‘unscientific’ approach. Traditional medicine identifies three sources of diseases, viz. physical, mental and psychological or psychical which may be caused by either physical or spiritual factors.

Traditional medicine is also very well applicable to social and psychological causes of diseases, as well as spiritual causes. It is in view of this that Buor (2002), suggests that “the fundamental theory in traditional medicine is that, there is a triune nature of man, that is, physical, mental and spiritual and the diagnosis and therapeutic approaches should be buttressed on that basis.”

The development of traditional medicines has been influenced by the different cultural and historic conditions in which they were first developed. Their common basis is a holistic approach to life, equilibrium between the mind, body and environment, and an emphasis on health rather than on disease. Generally, the treatment focuses on the overall condition of the individual patient, rather than on the ailment or disease. This more complex approach makes evaluation highly difficult, since so many factors must be taken into account (WHO, 2002).

**2.3 IMPORTANCE OF TRADITIONAL MEDICINE**

In all countries of the world there exists traditional knowledge related to the health of humans and animals. According to the World Health Organization (2000), the definition of traditional medicine may be summarized as the sum total of all the knowledge and practice, whether explicable or not, used in the diagnosis, prevention
and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing. Traditional medicine might also be considered as a solid amalgamation of dynamic medical know-how and ancestral experience. In the mind of the researcher the above definition by the WHO is a complete summary of what traditional medicine is. It is however silent on the mode of supply or application – which is a very important feature of traditional medicine – irregular distribution and unregulated supply.

In Ghana, for example, in Kwahu district, for every traditional practitioner there are 224 people, compared to one university trained doctor for nearly 21,000 people. The same applies to Swaziland where the ratios are that for every traditional healer there are 110 people while for every university trained doctor there are 10,000 people (WHO, 2002). Based on the statistics given above, it is prudent for policy makers in developing countries to help improve on traditional medicine. When this is done, then, inhabitants will have easy and ready access to well-qualified medical practitioners.

Though the efficacy of traditional medicine cannot be overemphasized, people in developing countries who should take the most advantage of its use, due to its low cost, rather shun it (Davies, 1994). In the past, modern science has considered methods of traditional knowledge as primitive and during the colonial era traditional medical practices were often declared as illegal by the colonial authorities. Consequently doctors and health personnel have in most cases continued to shun traditional practitioners despite their contribution to meeting the basic health needs of the population, especially the rural people in developing countries (WHO, 2002).
Every region has had, at one time in its history, a form of traditional medicine. We can therefore talk of Chinese traditional medicine, Arabic traditional medicine or African traditional medicine. This medicine is traditional because it is deeply rooted in a specific socio-cultural context, which varies from one community to another. Each community has its own particular approach to health and disease even at the level of ethno pathogenic perceptions of diseases and therapeutic behaviour. In this respect, we can argue that there are as many traditional medicines as there are communities. This gives traditional medicine its diverse and pluralist nature (De Smet, 1999).

Traditional medicine has been described by the World Health Organisation (WHO) as one of the surest means to achieve total health care coverage of the world’s population. In spite of the marginalization of traditional medicine practised in the past, the attention currently given by governments to widespread health care application has given a new drive to research, investments and design of programmers in this field in several developing countries (Lebeau, 1998).

In some Asian and African countries up to 80% of the population rely on traditional medicine for their primary health care needs. When adopted outside of its traditional culture, traditional medicine is often called complementary and alternative medicine. Herbal medicines can be very lucrative, generating billions of dollars in sales, but adulteration or counterfeit herbs can also be a health hazard (WHO, 2005).

The WHO also notes, though, that "inappropriate use of traditional medicines or practices can have negative or dangerous effects" and that "further research is needed to ascertain the efficacy and safety" of several of the practices and medicinal plants used by traditional medicine systems (WHO, 2000). Core disciplines which study traditional medicine include ethnomedicine, ethnobotany, and medical anthropology.
The researcher totally agrees with WHO’s assertion, but it should also be noted that inappropriate use of modern medicine can as well lead to dangerous health effect—generally, the inappropriate use of anything is dangerous and should be condemned in no uncertain terms.

An indication of the importance of herbals is that some modern pharmaceutical drugs are derived from herbs. “The pharmaceutical industry uses around 120 different compounds derived from plants in the drugs it manufactures, and it discovered nearly three-quarters of these compounds by studying folk remedies. Examples of drugs from plants include quinine, from the bark of the South American cinchona tree, used to treat some strains of malaria; digitalis, a widely prescribed heart medication, derived from the foxglove plant; salicylic acid, the source of aspirin, from willow bark; and taxol, for treating ovarian cancer, from the yew tree (Encarta, 2008)”.

The role of traditional medical practitioners in health care delivery in Ghana, and for that matter Africa, cannot be underestimated. Due to the vast difference between the ratios of modern medical practitioners to patients in African countries, it is very imperative to empower and resource traditional medical practitioners to undertake health care delivery assignments. In contrast with western medicine, which is technically and analytically based, traditional African medicine takes a holistic approach: good health, disease, success or misfortune are not seen as chance occurrences, but are believed to arise from the actions of individuals and ancestral spirits according to the balance or imbalance between the individual and the social environment (Posey and Dutfield, 1996).

The activities of traditional medical healers range from herbals through faith healing to fetishism and bone setting. In other words they undertake all forms of healing
processes by using different approaches. Some specialize in one particular way of healing whiles others combine 2 or more methods. It is in view of this that Marshall (1998) said “The practitioners of traditional medicine specialize in particular areas of their profession, in the same way as orthodox medical practitioners.

Thus we find some traditional medical practitioners who are experts in the use of herbs (herbalist), others who are proficient in spiritual healing, especially the use of incantations, while still others combine both. There are also traditional bonesetters and birth attendants. In some African societies, one type of healer provides several or all therapeutic services, whereas others have separate practitioners for different functions”.

Traditionally, rural African communities have relied upon the spiritual and practical skills of the traditional medicinal practitioners (TMPs); whose botanical knowledge of plant species and their ecology and scarcity are invaluable (Twumasi, 1975). Throughout Africa, the gathering of medicinal plants was traditionally restricted to TMPs or to their trainees. It is estimated that the number of traditional practitioners in Tanzania is 30,000 – 40,000 in comparison with 600 medical doctors (World Bank, 1993)

Similarly, in Malawi, there are an estimated 17,000 TMPs and only 350 medical doctors in practice in the country. For this reason, there is a need to involve TMPs in national health care systems through training and evaluation of effective remedies, as they are a large and influential group in primary healthcare (Nshimo, 1888). It is difficult to characterize a typical African healer, because there are many different kinds, and the cultural diversity and complexity of their practices are encyclopaedic, when considered in detail.
Inadequate use of scientific principles in the application of traditional medicine is as a result of over-reliance on the supernatural. Most Africans attribute many things to the supernatural and practitioners are no exception. It is in the light of this that Kerwegi (2001), asserts that most African healers explain illnesses in terms of social interaction and that they act on the belief that religion permeates every aspect of human existence.

Their concepts of health and illness are more comprehensive than those of biomedical doctors, and health as we know it cannot be adequately translated in many African languages. The indigenous terms, which come closest usually, have a much wider meaning; other prominent features of traditional healers are a deep personal involvement in the healing process, the protection of therapeutic knowledge by keeping it secret, and the fact that they are rewarded for their services (WHO, 2002).

The researcher’s field study shows that some time past patients only had to offer goods or services in exchange for health care. Some of the goods they offered were eggs, fruits, vegetables and clothing. They also offered services like working on the farms of practitioners and even giving their daughters to male practitioners in marriage. That system of barter trade has now given way to paying for services in monetary terms, although not completely.

Traces of the old system of “barter” can still be found in some rural areas. The social context of the therapeutic process requires reciprocity and this payment contributes to the effectiveness of the treatment. Over the years, the types and methods of payments for traditional healing have changed. Especially in urban settings, practitioners are increasingly demanding monetary payments (UNESCO, 1994).
In the course of serving their “masters”, cured patients are taught the practice of healing, and become practitioners themselves. Some healers have learnt their trade by undergoing treatment as a patient. Upon their recovery, they decided to become practitioners themselves. Another avenue is through spiritual calling, in which case the healer diagnoses and treatments are strictly determined by the supernatural. A third route is through informal learning from a close family member, such as a father or uncle (or a mother or aunt in the case of a female healer). A fourth possibility is through a long formal apprenticeship under an established practitioner. The trainees pay their tutor a basic fee as well as a fee for each step of advancement (WHO, 2000).

The magical inclination of African traditional medicine takes nothing away from the fact that many healers are experienced and skilled in biomedical components of their profession. They have an array of biomedical methods at their disposal, ranging from fasting and dieting to herbal therapies and from bathing and massaging to surgical procedures (UNESCO, 1994 and Mensah, 2003).

Gyasi, Mensah, Osei-Wusu and Agyemang (2011) suggest that Traditional Medicine is effective as it is employed in treating numerous medical conditions such as malaria, typhoid fever, arthritis, jaundice, impotency, infertility, stroke, broken bones, boils, piles, HIV/AIDS and mental illness.

2.4 URBANIZATION AND USE OF TRADITIONAL MEDICINE

Urbanization has increasingly concentrated large numbers of Africans in an environment where there is stronger competition for Western medicine; because it is generally nearer than in rural areas (Walter et al., 1993). Traditional healing is also flourishing in such urban settings, however, because it adapts itself to these new
surroundings. In other words, African traditional medicine is more than a static and inflexible institution, which cannot survive the test of time (Tuley, 1997).

African healing is an inextricable part of African religion and the act of healing is therefore a religious act. When an African patient is taking herbal infusion, he expects to benefit from the life force of its ingredients and from the power of his ancestors of any other spirits which may have been invoked. This spiritual significance is more important than the bioactive properties of the remedy (Mwangi, 2000).

As soon as the religious framework of African healing is understood, it no longer appears as an incoherent collection of rational and irrational acts but as a condensed expression of basic beliefs concerning life, good and evil, and the etiology of illness. In this respect, there is an obvious parallel with alternative medicine in Western countries. The women healers generally have specialized knowledge of medicine used during prenatal and post-natal delivery for the care of women and children. In urban areas, women healers still make use of traditional medicine to meet primary health needs or who depend on the provision of these services or the sale of products from medicinal plants for their livelihood (Mwangi, 2000).

2.5 GHANA’S POLICY ON TRADITIONAL MEDICINE

In the Republic of Ghana, the national policy on Traditional Medicine (TM) or Complementary and Alternative Medicine (CAM) was issued in 2002. Laws and regulations on TM/CAM were issued in 1992, and the national programme in 2000. The national office on TM/CAM was established in 1999 under the direction of the Ministry of Health. The expert committee was also established in the same year. A
National Research Institute on herbal medicines was established in 1975 (WHO, 2005).

Herbal regulation in Ghana began in 1992 through the Food and Drugs Law, which also establishes regulations on conventional pharmaceuticals. Herbal medicines are regulated as over the counter medicines and as a separate regulatory category. By law, medical, health and nutrient content claims may be made. The Ghana herbal pharmacopoeia was published in 1992; it is not considered to be legally binding. The national pharmacopoeia also contains monographs on herbal medicines (WHO, 2005).

Regulatory requirements for manufacturing of herbal medicines include the same Good Manufacturing Practice (GMP) rules that apply to conventional pharmaceuticals and special GMP rules. While a large proportion of manufacturers of herbal medicines in Ghana are small scale industries, efforts have been made to provide training in GMP compliance. Implementation of the manufacturing requirements is ensured through annual inspections. Safety assessment requirements include traditional use without demonstrated harmful effects, reference to documented scientific research on similar products and phytochemical analysis. Compliance with these requirements is ensured through the pharmacovigilance centre (WHO, 2005).

There are 340 registered herbal medicines in Ghana; however, none is included on the National essential drug list. The national post marketing surveillance system has included adverse effect monitoring of herbal medicines since 2000. In Ghana, herbal medicines are sold in pharmacies as over the counter medicines, in special outlets and by licensed practitioners (Adapted from National Policy on Traditional Medicine and Regulation of Herbal Medicines Report of a WHO Global Survey, 2005).
2.6 AFRICAN TRADITIONAL MEDICINE AND PUBLIC HEALTH

The majority of African countries are currently geared towards the privatization of state corporations and government services. This includes the privatization of large hospitals where goals of financial independence have precluded the dispensation of free care and free medicine (Mwangi, 2000). Analysis of various national policies related to public health and medicinal plants usage has highlighted some important issues. Among them is the failure to meet basic health conditions due mainly to the following factors: inadequate decentralization of health services; isolation of some rural communities; and persistence of traditional beliefs regarding pathology. This has led to under utilization of available services in health centres and high cost of services provided by hospitals in relation to the income of the rural population (WHO, 2000).

Another issue that can be singled out is the absence of local pharmaceutical production. Purchase of pharmaceutical imports leads to a heavy loss of foreign currency, which a development policy focused on available local resources (mainly medicinal plants) would otherwise have prevented. The current trend of government policy in African countries to charge for healthcare shows the inability of governments to ensure provision of quality services at an affordable price to everyone, and especially, to the most vulnerable groups (WHO, 2000).

In the rural areas, one sometimes travels for several days before finding the nearest dispensary and pharmacy. In addition to losing working days, transport fares and the high cost of medicine must also be taken into consideration. In the past few years, most developing countries, recognizing that they did not have the means to provide comprehensive health care like some industrialised countries, have started to become more interested in traditional remedies.
In order to solve the problem in part, many health-oriented ministries are now encouraging the use of local medicinal plants. Certain countries have established departments of traditional pharmacopoeia within these ministries so as to implement this policy. Education ministries have started to introduce conservation of biodiversity into their school programmes. The recent establishment of the Ministries of Environment and Natural Resources and Offices of Protected Areas and National Parks in various countries also demonstrates the political will of African governments towards the conservation of nature and the sustainable use of bio-diversity (Marshall, 1998).

The lack of health care facilities in rural areas forces local people to treat themselves, either by using medicinal plants or by buying high-cost medicine in the rural markets. In the rural areas, as a whole, people begin by treating themselves before going to a traditional practitioner or a modern doctor. Medicinal plants are used at an early stage of the disease at low cost and conveniently replace the indiscriminate consumption of drugs without prescription (Tuley de Silva, 1997).

Research has shown that alternative medicine is flourishing in African society neither because users are dissatisfied with conventional medicine nor because they seek self-control over their healthcare decisions. The driving force of the majority of users appears to be the holistic belief that the health of body, mind and spirit are related and that this should be taken into account by whoever cares for their health (WHO, 2000).

It is important to note that even in contemporary rural Africa; there is no doubt about the efficacy of herbal medicine. Many Africans, especially rural people and the urban poor, rely on the use of herbal medicine when they are ill. In fact, many rural communities in Africa still have areas where traditional herbal medicine is the major
and in some cases the only source of health care available. Thus there can be no doubt about the acceptability and efficacy of herbal remedy within African society (WHO, 2002).

However, in many oriental countries, traditional medicine is officially recognized. China, for example, is able to provide adequate and constantly improving health care coverage for its vast urban and rural population precisely because it harnesses the precious legacy of traditional medicine (WIPO, 1998). Consequently, the inability of most African countries to develop their own legacy of traditional medicine, because it is denied official recognition, is partly responsible for the current health care crisis in Africa.

Modern health care has never been, and probably never will be, adequately and equitably provided everywhere in Africa, due to financial limitations related to rapid population growth, political instability and poor economic performance, to mention only a few. For instance the problem of ensuring the equitable distribution of modern health care has become very more serious, as the gap between supply and demand has continued to widen (UNESCO, 1994).

Hence, the majority of people lack access to health care, and even where it is available, the quality is largely below acceptable levels. This situation is further exacerbated by severe financial constraints, the high depth burden, a rapidly growing population, and political instability, high inflation rates, declining real income and deteriorating growth rates (WHO, 2000).
2.7 RELEVANCE OF TRADITIONAL HEALERS

Traditional healers are prime examples of local resources that could be mobilized into Primary Health Care (PHC) programmes. They are a part of the medical culture of society, and therefore less likely to overlook the important cultural factors in health care. As socially sanctioned authorities of health care, they can give culturally relevant and effective advice needed by their patients to understand and follow both traditional and non-traditional prescribed treatments. Moreover, their approach to health care is, in general, holistic, considering environmental, social, psychological, and spiritual factors (Davies, 1994).

A second reason for incorporating traditional medicine with PHC as the role of the patient is that, the treatment a patient chooses depends on issues of cost, accessibility, and convenience. In a pluralistic medical environment, the norm in developing countries, patients normally resort to various systems, even for the same illnesses. The patient does not consider one system absolutely superior to all others. There are no assurances that health care problems will be addressed even if there is an effective PHC program within the community. As a result, the onus lies with PHC planners to cooperate with traditional medical institutions, thereby incorporating the best of both worlds (Bishaw, 1991).

In Westerlund (1989), Feierman gives a third reason for integrating TM to PHC: The symbolic and social content of popular African therapies contributes to the process of healing. It also alleviates suffering in chronic illness, an area in which biomedicine is weak. But at the same time, popular African medicine has strong pragmatic elements and gives weight to natural explanations.
Practitioners of modern medicine realize that the holistic approach of traditional medicines can work to calm a patient and facilitate healing through the elimination of stress that may result from unfair treatment. A patient who has faith in the healing powers of traditional medicines can derive from it a sense of belonging and an awareness of self in the midst of fear and death, thereby helping to alleviate pain and suffering, and as a consequence, facilitate healing (Atadou, 1985).

2.8 CHALLENGES IN DEVELOPING TRADITIONAL MEDICINE

According to the WHO Traditional Medicine Strategy, 2002-2005, to maximize the potential of Traditional Medicine (TM) or Complementary and Alternative Medicine (CAM) as a source of health care, a number of issues must first be tackled. They relate to: policy; safety, efficacy and quality; access; and rational use.

2.8.1 Policy

Relatively few countries have developed a policy on TM and/or CAM — only 25 of WHO’s 191 Member States (WHO, 2000). Yet such a policy provides a sound basis for defining the role of TM/CAM in national health care delivery, ensuring that the necessary regulatory and legal mechanisms are created for promoting and maintaining good practice, that access is equitable, and that the authenticity, safety and efficacy of therapies are assured. It can also help to ensure sufficient provision of financial resources for research, education and training.
In fact, many developed countries are now seeing that CAM issues concerning safety and quality, licensing of providers and standards of training, and priorities for research, can best be tackled within a national policy framework. The need for a national policy is most urgent, however, in those developing countries where TM has not yet been integrated into the national health care system, even though much of their population depends on TM for health care. An increased number of national policies would have the added benefit of facilitating work on global issues such as development and implementation of internationally accepted norms and standards for research into safety and efficacy of TM/CAM, sustainable use of medicinal plants, and protection and equitable use of the knowledge of indigenous and traditional medicine.

2.8.2 Safety, Efficacy and Quality

TM/CAM practices have developed within different cultures in different regions. So there has been no parallel development of standards and methods — either national or international — for evaluating them. Evaluation of TM/CAM products is also problematic. This is especially true of herbal medicines, the effectiveness and quality of which can be influenced by numerous factors. Unsurprisingly, research into TM/CAM has been inadequate, resulting in paucity of data and inadequate development of methodology. This in turn has slowed development of regulation and legislation for TM/CAM (WHO, 2000).

National surveillance systems to monitor and evaluate adverse events are also rare. So although many TM/CAM therapies have promising potential, and are increasingly used, many of them are untested and their use not monitored. As a result, knowledge of their potential side-effects is limited. This makes identification of the safest and
most effective therapies and promotion of their rational use more difficult. If TM/CAM is to be promoted as a source of health care, efforts to promote its rational use and identification of the safest and most effective therapies will be crucial.

2.8.3 Access

Although many populations in developing countries are reported as depending heavily on TM to help meet their health care needs, precise data are lacking. Quantitative research to ascertain levels of existing access (both financial and geographic), and qualitative research to clarify constraints to extending such access, are called for. The focus should be on treatments for those diseases which represent the greatest burden for poor populations. Buor (2002) and Mensah (2003) shared similar sentiments.

Also, if access is to be increased substantially, the natural resource base upon which certain products and therapies depend must be protected. Raw materials for herbal medicines, for instance, are sometimes over-harvested from wild plant populations. Another major challenge concerns intellectual property and patent rights. The economic benefits that can accrue from large-scale application of TM knowledge can be substantial. Questions about how best these benefits can be shared between innovators and the holders of TM knowledge have not yet been resolved though.

2.8.4 Rational Use

Rational use of TM/CAM has many aspects, including: qualification and licensing of providers; proper use of products of assured quality; good communication between
TM/ CAM providers, allopathic practitioners and patients; and provision of scientific information and guidance for the public. Challenges in education and training are at least twofold. Firstly, ensuring that the knowledge, qualifications and training of TM/CAM providers are adequate. Secondly, using training to ensure that TM/CAM providers and allopathic practitioners understand and appreciate the complementarity of the types of health care they offer.

Proper use of products of assured quality could also do much to reduce risks associated with TM/CAM products such as herbal medicines. However, regulation and registration of herbal medicines are not well developed in most countries, and the quality of herbal products sold is generally not guaranteed. More work is also needed to raise awareness of when use of TM/CAM is appropriate (and cost-effective) and when it is not advised, and why care should be taken when using TM/CAM products” (Adapted from 2002-2005 WHO Traditional Medicine Strategy).

2.9 SUMMARY

It is now evident that the importance of the use of traditional medicine has gained global recognition and health care professionals cannot, but add to the health care delivery system. It is about time health care policy makers gave it special attention by establishing more accredited institutions to take care of its preparation, packaging and dosage procedures. The mode of supply and application of traditional medicine has not gotten the necessary attention.

The traditional medical industry is essentially unregulated. Until recently there was no formal practice of botanical medicine, and still the vast majority of medical and
pharmacy schools do not teach herbal medicine. This lack of regulation and organized practice leaves consumers essentially on their own in determining how to use traditional medicinal products. Some herbs have potentially harmful side effects, so it is important to understand the full range of their biological activity and to talk to a physician.

The Kwame Nkrumah University of Science and Technology (KNUST) which is situated right in Kumasi is one of the few universities that offer Herbal Medicine as a higher learning discipline. KNUST as an institution of higher learning can now offer professional and technical advice to practitioners of traditional medicine for them to improve on their activities. The contribution of traditional medical practitioners to health care delivery, especially, in Africa cannot be underestimated. Their therapeutic processes have been proven to be working perfectly well, and must be encouraged. Traditional healing has been doing well in urban areas in the last few decades and if government’s policies are made favourable, TM can compete favourably with modern medicine.

2.10 DEFINITION OF TERMS

**Acculturation:** A change in the cultural behaviour and thinking of a person or group of people through contact with another culture.

**Agrarian:** Dominated by or relating to farming or rural life.

**Biomedical:** The employing of the principles of biology, biochemistry, physiology, and other basic sciences to solve problems in clinical medicine.
**Concoction:** A new and unusual mixture of drink created by mixing together various ingredients of herbals.

**Divination:** The act of finding out and saying what will happen in the future.

**Herbals:** Characteristic of, consisting of, or made with aromatic herbs.

**Magical:** The act of using supposed supernatural power to make impossible things happen.

**Metaphysics:** The branch of philosophy that deals with the nature of existence, truth and knowledge.

**Mysticism:** The belief that knowledge of God and of real truth can be found through prayer and meditation rather than through reason and the senses.

**Obsolescence:** The state of becoming old-fashioned and no longer useful

**Supernatural:** That cannot be explained by the laws of science and that seems to involve gods and magic.

**Urbanism:** The typical way of life of people who live in a city or town.

**Urbanization:** The act of people living in cities or towns at the expense of rural areas (Referenced from Oxford Advanced Learner’s Dictionary, New 7th Edition).
CHAPTER THREE

3.0 BACKGROUND OF THE STUDY AREA

3.1 INTRODUCTION

This chapter discusses the background of the study area of Kumasi which is the second largest city in Ghana after Accra, the national capital. Kumasi is a city in Ghana and it is the capital of the Ashanti region, situated in a forest belt. Kumasi is the commercial and transport centre for a rich cocoa-producing area. The principal industry is food processing. Kumasi was founded in 1700 as the capital of a confederacy of “Asante” states and remains the seat of the Asante kings (Microsoft Encarta, 2005). It can boast of about 90 suburbs, many of which were absorbed into it as a result of the process of growth and physical expansion. Some of the suburbs are Old and New Tafo, Ashanti New Town, Adum, Asawasi, Atonsu, Breman, Amakom, Oforikrom, Asafo, New Suame, Buokrom, etc. (Kumasi Metropolitan Assembly, 2008).

Given its strategic location and political dominance, Kumasi as a matter of course, developed into a major commercial centre with all major trade routes converging on it (KMA, 2008). The metropolitan nature of the city makes it a good place for all forms of activities, including those related to health care. Like any other city in Africa, Kumasi is drawing more and more people in search of economic opportunity. The majority of these people end up living in informal settlements: slums and squatter areas. The urban population is growing at a much faster rate than the population as a whole, and by larger annual increments than ever before. This increasing urbanization
has led to pervasive poverty, overcrowded and undue pressure on health facilities as well as relatively higher rate of unemployment.

3.2 RELIGION

The city is also endowed with a lot of religions, the most dominant being Christianity (77.5%), Islam (13.2%) and pagans and traditionalists form 7.3% (Ghana Statistical Service, 2002). According to Nana Osei Gyeabour (a fetish Priest), traditionalists are now being drawn into the outskirts of Kumasi where they can have plots of land large enough to accommodate their activities. Most of these traditionalists offer health care to patients most of whose diseases are perceived to be spiritually inclined. These priests and priestesses basically use divination and mysticism in their activities of healing.

3.3 LOCATION AND SITE

Kumasi is located about 270 km north of the national capital, Accra. It is between latitude 6.35°N and 6.40°N and longitude 1.30°W and 1.35°W. The unique centrality and economic activities of the city serve as centripetal force that draws resources and educated people into it. The metropolitan area shares boundaries with Kwabre East District to the north, Atwima District to the west, Ejisu/Juaben Municipality to the east and Bosomtwe District to the south (Kumasi Metropolitan Assembly, 2006). Figure 3.1 shows a map of Kumasi within Ashanti region.
Figure 3: Map of Ashanti Region Showing the Study Area

Source: Geography Drawing Room, Dept of Geography and Rural Dev’t, KNUST
3.4 SOCIO-DEMOGRAPHIC CHARACTERISTICS

The city is a rapidly growing one with an annual growth rate of 5.47 per cent. The 2000 Population Census kept the population at 1,170,270. This accounts for about 32.4% of the Region’s population. This number is made of 587,012 males and 583,258 females with the male-female ratio being 100.6:100 (Ghana Statistical Service, 2002). The City has a population density of 5,419 persons per sq/km. The population of Kumasi was however projected to 1,610,867 in 2006 and 1,889,934 by 2009 (Regional Statistical Office, Kumasi, 2008). It has a multiplicity of ethnic groups, apart from the indigenous Ashantis. Some of these ethnic groups are the Ewes, the Gas, the Fantes, the Hausas and the Frafras. The official language of the people is Asante Twi, which surprisingly has dominated almost the entire nation.

There is a high migration rate resulting in an average daily population of about 2.5 million people. Kumasi has attracted such a large population partly because it is the regional capital, and also the most commercialized centre in the region. Other reasons include the centrality of Kumasi as a nodal city with major arterial routes linking it to other parts of the country and also the fact that it is an educational centre (KMA, 2008). One such great institution is the Kwame Nkrumah University of Science and Technology (KNUST).

The average household size in the Metropolis is 5.1. The average number of households per house is 3.4. Children below 15 years constitute 39.9%, the highest proportion of household members in the metropolis. The remaining 60.1% are those between 15 and 64 and 65 or more years (Kumasi Metropolitan Assembly, 2008).
3.5 PHYSICAL ENVIRONMENT

The elevation of Kumasi ranges between 250 and 300 metres above sea level with an area of about 254 square kilometres and is approximately ten (10) kilometers in radius. There are a number of small streams and rivers, which though, not so important in terms of popularity, serve the people who are close to it by way of water for domestic activities and for small scale sugar cane plantation. One such river which drains the city is the Aboabo River. The area experiences an annual rainfall of 1,270mm and two rainy seasons. The major rainy season starts from April to August and the minor season, from mid-September to the end of November. From mid-December to February is dry, hot and dusty. Generally, the average daily temperature is about 27 degrees Celsius (80º Fahrenheit), (Ghana Statistical Service, 2002).

3.6 SOCIO-ECONOMIC CHARACTERISTICS

The economically active population in the area is 71.4 percent. A lot of people here are in the service industry where majority are self-employed or are in the private informal sector of the economy. The proportion of females into sales is higher than that of males (Ghana Statistical Service, 2002). There are a number of cottage industries producing clothes, saucepans, furniture and carving. There are also a number of book industries; among the prominent ones is CITA Printing Press.

Given the educational opportunities present in the city, the literacy rate is among the lowest in the country, with a notably high gender gap (62% males and 38% females). Greater proportion (40.50%) of the people either have no formal education or have only pre-school education. 51.3% of the population is currently in the primary schools.
and 22.4% are in the Junior Secondary Schools. Illiteracy rate is about 26% (Ghana Statistical Service, 2002).

### 3.7 HEALTH CARE

The geographical perspective on health care is the process of taking care of health, including, personnel and facilities. The health care system of the Kumasi metropolis is a subsidiary of the Ghana Health Service under the Ministry of Health (MoH). The Ghana Health Service provides clinical and public health services through hospitals and clinics and static and outreach stations (Public and Private).

Kumasi Metropolis has one Teaching Hospital (Okomfo Anokye Teaching Hospital), which also serves as the Regional Hospital. There are two Quasi-Government Hospitals (one for the Kwame Nkrumah University of Science and Technology and the other for the Military), five (5) Polyclinics, 207 known Private Clinics, 13 Industrial Clinics, Nine (9) Maternal Health Posts and 169 Outreach Stations. There are 15 Private Laboratories in the various hospitals. Also, Kumasi has offices in all the ten Sub-Metros for the National Health Insurance Scheme where people register and receive assistance in health delivery (Kumasi Metropolitan Assembly, 2008).

Some orthodox health facilities in the Kumasi metropolis are St. John’s Clinic at Tafo, KNUST Hospital at Ayigya, Kwadaso S.D.A. Clinic at Kwadaso and Rabito Clinic at Adum. Others are Keffam Hospital at Buokrom, Moshie Zongo Clinic at Moshie Zongo and Mary’s Maternity Home at Asokwa.

Aside these, there are uncountable number of traditional medical practitioners who offer their services to complement the existing modern health facilities. By the nature
of their preparation and administration of health care, it is difficult to identify and locate these traditional healers and have any proper records of their activities. Their contribution to the general health care delivery to the people of Kumasi cannot be underestimated. Some notable ones are Angel Medical Products, Adutwumwaa Bitters, Chocho Herbal Products and Adom Herbal Clinic at Kwadaso.
CHAPTER FOUR

4.0 BACKGROUND OF RESPONDENTS

4.1 INTRODUCTION

The background information discusses respondents’ past and current residences, their gender and age compositions, duration of stay and their household sizes. This chapter also seeks to discuss the socio-cultural characteristics of respondents – educational and employment statuses, as well as their religious affiliations. In all, the researcher selected a sample frame of 20 suburbs to represent the views of the population of Kumasi. The study captures both genders and four (4) age groups. The duration of stay has also been categorized into four (4), as well as household sizes. The importance of finding out the past and current residences of respondents is to ascertain whether or not a person’s residence affects their way of life in general and the kind of medical facility they use in particular.

4.2 AGE AND GENDER COMPOSITION OF RESPONDENTS

Four age groups were used for the analysis. Those of ages 18 or less years constitute 3.8% of the total number of people interviewed and are mostly students who do not earn any living and are more or less dependent on others. Those from 18 to 30 years form the majority and constitute 36.6% of the total sample of 320. This large percentage of 36.6% of respondents constitutes a variety of the employed, the unemployed as well as students of tertiary institutions. The third group of respondents have their ages ranging from 30 to 45 years, and are mostly in the work force. They
make 35.6% of the entire respondents as table 4.1 shows. The fourth age group forms 24.1% and their ages are either 45 years or above, some of whom have retired from active work.

Gender-wise, more males than females were interviewed, the percentage being 51.6% and 48.4% for males and females respectively. The researcher must admit that the ratio of males to females is per chance, since the respondents were chosen at random.

The categorization into different age groups and genders is to find which age group and gender use more traditional medicine than the other.

### Table 4.1: Age and Gender Composition of Respondents

<table>
<thead>
<tr>
<th>Age and Gender Composition</th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>0 - 18</td>
<td>7</td>
<td>2.2</td>
<td>5</td>
<td>1.6</td>
<td>12</td>
<td>3.8</td>
</tr>
<tr>
<td>18-30</td>
<td>60</td>
<td>18.8</td>
<td>57</td>
<td>17.8</td>
<td>117</td>
<td>36.6</td>
</tr>
<tr>
<td>30-45</td>
<td>59</td>
<td>18.4</td>
<td>55</td>
<td>17.2</td>
<td>114</td>
<td>35.6</td>
</tr>
<tr>
<td>45 or more</td>
<td>39</td>
<td>12.2</td>
<td>38</td>
<td>11.9</td>
<td>77</td>
<td>24.1</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
<td>51.6</td>
<td>155</td>
<td>48.4</td>
<td>320</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*

As figure 4.1 demonstrates, more females than males use traditional medicine. On the other hand, males use more modern medicine than females. One reason to justify the female dominance of the use of traditional medicine is that the activities of females bring them closer to traditional medical practitioners than males – in the typical Ghanaian culture, it is the responsibility of females to buy food items from the market where most of these practitioners sell their drugs. These females are therefore more likely to be wooed to buy these drugs.
An interviewee had this to say, “Females are naturally more caring than their male counterparts, and therefore make every effort to secure medicines for their household at the least sign of a disease. The males are most times adamant with regard to seeking health care at the initial stages of an outbreak of a disease – they wait till the disease escalates before they rush to, in many occasions, modern health facilities”.

**Figure 4.1: Gender and Use of Traditional Medicine**

![Gender and Use of Traditional Medicine](image)

*Source: Field work, 2010*

### 4.3 RESIDENCE, DURATION OF STAY AND TYPE OF MEDICINE USED

In all, 20 places of residence of respondents were covered. These places are grouped into core (first class residential) and periphery (low class residential) areas. These divisions are based on the type of economic activities, as well as the built of the area.

Figure 4.2 gives a clear picture of the number of respondents drawn from each suburb and the type of medicine they use most. The research shows that the people in Asawasi use both systems of medicine equally. The most contrasting use of TM and
MM is found at Aboabo and Anloga, which are considered to be in the periphery of Kumasi. It is believed that people of these two places use more traditional medicine than modern medicine by a very wide margin.

**Table 4.2: Duration of Stay in Residence of Respondents**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1 year</td>
<td>49</td>
<td>15.3</td>
<td>15.3</td>
</tr>
<tr>
<td>1-5 years</td>
<td>88</td>
<td>27.5</td>
<td>42.8</td>
</tr>
<tr>
<td>5 -10 years</td>
<td>94</td>
<td>29.4</td>
<td>72.2</td>
</tr>
<tr>
<td>10 years or above</td>
<td>89</td>
<td>27.8</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>320</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*

Generally, the research reveals that, though respondents from all the twenty selected suburbs use both systems of health care, there are varied use of either form at different places of the core and the periphery. Though people in the periphery use more traditional medicine than those in the core, the difference is not too significant. The study reveals that 37.8% of respondents at the periphery use TM as against 32.2% in the core. On the contrary, 19.7% in the core use MM as against 10.3% at the periphery. Questionnaires were used to sample views from respondents.

From the research, as table 4.2 shows, 15.3% of the people had stayed in their present residence for at most a year. Those who had stayed in their present residences from 1-5 years constitute 27.5% whiles 29.4% had stayed in their locations for 5 to 10 years. The remaining 27.8% had stayed in their present locations for 10 or more years, and had no intention of leaving soon. The relevance of knowing the length of stay in this regard is to know their previous residence vis-à-vis the type of medicine residents used. This helps to determine if residential patterns influence the type of medicine used.
4.4 EDUCATIONAL STATUS AND FORM OF MEDICINE USED

The educational status of respondents helps to ascertain whether or not residents’ choice of a particular health care system is influenced by their level of education. The field study reveals that people with different educational backgrounds have different mindsets concerning the use of traditional medicine. Many of those who have had tertiary education or higher believed in the potential of traditional medicine in curing diseases, but were not so much into its use due to factors they think render its use ineffective or inappropriate.

On the contrary, those with low level of education who also form majority of low level salary workers had had their lives mostly depended on traditional medicine.
They claim they have always depended on traditional medicine because of its comparative low cost, coupled with its efficacy. Among those interviewed, 4.4% had never been to school, 27.5% and 30.9% had had basic and tertiary levels of education respectively. The rest are 33.4% for undergraduate and 3.8% for Master’s degree level and beyond (Higher). Figure 4.3 shows that apart from those who have had Master’s degree or beyond, the rest use more TM than MM. The difference between the use of TM and MM is very wide among those who have had secondary education than those with tertiary education. There is however a slight difference in the form of medicine used between those who have had secondary and tertiary levels of education.

**Figure 4.3: Educational Status and Form of Medicine Used**

![Bar chart showing educational status and form of medicine used](image)

*Source: Field work, 2010*

**4.5 EMPLOYMENT STATUS AND PROFESSION OF RESPONDENTS**

The study reveals that people’s employment status, one way or the other affects their choice of health care. While those who are gainfully employed, and for that matter, earning income could decide what form of health care to choose, those who are not
employed, and are not earning any income have to depend on others as to the choice of health care. The study reveals that 90.6% as against 9.4% of the respondents were employed.

With regard to professional status, the relevance is to ascertain whether or not people are influenced by the kind of work they do. The study reveals that respondents undertake a wide variety of professions, ranging from white-collar jobs, through blue-collar jobs to artisanship. The study reveals that many of those that are into higher-earning professions use less of traditional medicine. Generally, their reasons were not for the efficacy of traditional medicine, but for other factors like unhygienic preparation and packaging. Those in the low-earning professions on the other hand use more traditional medicine mostly for their low cost. This is not to play down its efficacy though. Figure 4.4 represents respondents’ professional status.

**Figure 4.4: Professional Status**

![Figure 4.4: Professional Status](Image)

*Source: Field work, 2010*
4.6 HOUSEHOLD SIZE

From the results, a considerable percentage of 34.1 of the respondents have a household size of 6 or more. This means that there are many dependants on the bread winners’ limited income. From the field study, many of those who were found in such situations told the researcher they could not afford modern medical bills, and therefore relied mostly on traditional medicine, which they claimed is more affordable. The remaining 65.9% of respondents who have household sizes of 1-2 and 2-6 are not so much burdened with the number of dependants and therefore could afford any health care system of their choice – this is relative though, because it so much depends on other factors such as income levels and tastes and preferences of respondents. The cost factor of accessing health care was not so much of a concern to them.

4.7 INCOME LEVELS AND TYPE OF MEDICINE OFTEN USED

Response gathered from the field indicates that, though a greater proportion of the people go for one form of health care or the other based on how much they earn, other factors like accessibility, type of medical facility and tastes and preferences also had a greater influence on respondents’ choice of medication. Income levels, inevitably, determine to a large extent the type of medical facility respondents use. It was also realised that those in the low income brackets use a greater percentage of their incomes on health care as against a lesser percentage of income by those in the high income bracket. In real money terms though, those in the high income bracket spend more.
Analysis of the study indicates that the higher one’s income level, the less their use of traditional medicine. This is shown at figure 4.5, where those with their salaries more than Gh¢1,000 use more MM than TM. Those in this category form 8.6% of income earners. Though the 19.2% whose salaries range between Gh¢500 and Gh¢1,000 use more TM than MM, the difference is minimal. Those who earn not more than Gh¢100 and between Gh¢100 and Gh¢500 constitute 25.8% and 46.4% respectively.

On the basis of the relevance of the study, those in the white-collar and blue-collar job categories are mostly in the formal sector of employment who earn monthly salaries. They were therefore able to compute the percentage of their salaries that go into health care. Though, many of those in the other category were not able to give a clear computation of what percentage of their earnings that goes into health care, judging by their levels of earning and the type of medicine they use, the researcher was able to compute something along with respondents.

Respondents’ unwillingness to disclose their salaries cannot go unmentioned. The researcher sometimes had to plead with respondents before they would disclose their salaries. Table 4.3 summarises the percentages of income that go into health care of respondents.

### Table 4.3: Percentage of Salaries into Health Care

<table>
<thead>
<tr>
<th>Percentage Salary</th>
<th>Core</th>
<th>Periphery</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
</tr>
<tr>
<td>0 - 5%</td>
<td>130</td>
<td>44.7</td>
<td>122</td>
</tr>
<tr>
<td>5 - 10%</td>
<td>11</td>
<td>3.8</td>
<td>10</td>
</tr>
<tr>
<td>10 - 20%</td>
<td>5</td>
<td>1.7</td>
<td>8</td>
</tr>
<tr>
<td>20% or more</td>
<td>2</td>
<td>0.7</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>148</td>
<td>50.9</td>
<td>143</td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*
Figure 4.5: Salary Levels and Form of Medicine Used

Source: Field work, 2010

4.8 RELIGION

Religion plays a very important role in one’s use of a health care system. The study reveals that medicines that are alcohol-based are shunned by many christians and moslems alike, irrespective of their efficacy. Except a few traditionalists who patronise medicines from fetish priests and shrines, others not only reject their use, but look down upon medicines and users of medicines from these sources. Those who refuse to use medicines from shrines do not consider the efficacy of these drugs at all. Figure 4.6 gives details of respondents’ religious affiliations.
Figure 4.6: Religion of Respondents

Source: Field work, 2010
CHAPTER FIVE

5.0 ACCESS AND USE OF TRADITIONAL MEDICINE

5.1 INTRODUCTION

In all 70% of respondents said they use traditional medicines of various forms. This figure includes 41.6% of those that combine traditional medicine with modern medicine. Generally, those in the periphery (37.2%) use more TM than those in the core (32.2). Some respondents say they use different health care systems for different diseases whiles others alternate them – they use alternative form after the other form has failed to cure their ailments. Many of those who use only traditional medicine claim that everything traditional is better and referred to them as the source of modern medicine. Others claim modern medicine is an adulteration and has more side effects, and therefore the need to go for the “original”.

The reason for usage varies among different users. Some of the factors considered were the potency of the medicine, affordability, less side effects, convenience and easy accessibility. Others were education, income and religion. All those who were interviewed claimed to have physical access to one form of health care or the other, but some factors impinge on their use. Factors like distance, time (both travel and waiting), financial ability and tastes and preferences however deny some potential users access. Response to the question of whether or not respondents have all forms of access to health care was in the affirmative, but there were discrepancies in their use.
5.2 FACTORS THAT INFLUENCE ACCESS TO AND USE OF TM

5.2.1 Introduction

Many factors affect one’s potential access to and use of health care. Amongst the most prominent are distance and time (travel and waiting). The research findings show that 21.3% are denied access to a health care of their choice because of time constraints. They claim spending an average of five hours a day to access health care is very discouraging – they rather choose an alternative form without regard for its efficacy. Many of these potential users say more annoying is the time spent at medical facilities. Patients’ medical conditions are further deteriorated in the event of seeking medical care at some orthodox medical facilities.

Comparatively, distance travelled to access health care is not too much of a problem to potential users. Due to the centrality of Kumasi and the number of health care facilities available, users do not have to travel for long distances before reaching health care facilities. The only problem they face is the time spent in traffic in some areas of the metropolis, especially in the morning rush-hour. This situation of distance is further aggravated when patients choose medical facilities far from their residences in the name of tastes and preferences. Some patients have developed love and built trust in some health facilities to the extent that they overlook the distance and traffic situations. Table 5.1 gives a visual impression of what percentage of respondents is affected by distance, time, financial ability and tastes and preferences.

Many factors influence utilization of TM, some of which are financial ability and tastes and preferences. The most dominant influence is financial ability of potential users. To a very large extent, people’s finances influence the kind of health care they choose. Beside financial ability, potential users also face the problem of time. The
research reveals that only 30% of respondents do not use traditional medicine of any form. They give various reasons for not using traditional medicine. Some of which are that traditional medicine is inferior and belongs to those that cannot afford modern biological medicine. Others said they do not use traditional medicine because it is beset with so many side effects. Many were those who admired the efficacy of traditional medicine, but rejected its method of preparation, packaging and application.

Table 5.1: Accessibility Factors to Health Care

<table>
<thead>
<tr>
<th>Accessibility Factors</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance</td>
<td>52</td>
<td>16.3</td>
<td>16.3</td>
</tr>
<tr>
<td>Travel and Waiting Time</td>
<td>68</td>
<td>21.3</td>
<td>37.5</td>
</tr>
<tr>
<td>Cost</td>
<td>135</td>
<td>42.2</td>
<td>79.7</td>
</tr>
<tr>
<td>Tastes and Preferences</td>
<td>65</td>
<td>20.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*

5.2.2 Distance

Distance is a variable factor that affects one’s choice of health care. All things being equal, a patient will choose to visit a nearby health centre more than a distant one. The multiplicity of traditional medicine in the Kumasi metropolis brings all people closer to them, and therefore the question of distance as a factor to consider when seeking medical care becomes irrelevant. Potential users of medical facilities rather consider other related factors like time, tastes and preferences, effectiveness, convenience and cost in determining the type of medicine to use. A section of the respondents said they do not want to visit nearby health facilities all because they do not want to be seen indisposed.
The fact that 66.3% of respondents travel a maximum of 1 km to access traditional medicine is an indication that the people are so close to traditional medical facilities and therefore in terms of potential accessibility, there is no problem for users. Some respondents, when asked, said they get medicinal herbs and other plant parts from their houses and backyards for preventive and curative purposes. Comparison between the core and the periphery indicates that those in the former travel less distance to access TM than those in the periphery. Table 5.2 shows distance taken to access traditional medicine by core and periphery.

### Table 5.2: Distance Taken to Access Traditional Medicine

<table>
<thead>
<tr>
<th>Distance</th>
<th>Core Frequency</th>
<th>Core Percent</th>
<th>Periphery Frequency</th>
<th>Periphery Percent</th>
<th>Total Frequency</th>
<th>Total Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 100 m</td>
<td>53</td>
<td>16.6</td>
<td>38</td>
<td>11.9</td>
<td>91</td>
<td>28.5</td>
</tr>
<tr>
<td>100 - 1 km</td>
<td>62</td>
<td>19.4</td>
<td>59</td>
<td>18.4</td>
<td>121</td>
<td>37.8</td>
</tr>
<tr>
<td>1 km - 2 km</td>
<td>32</td>
<td>10.0</td>
<td>41</td>
<td>12.8</td>
<td>73</td>
<td>22.8</td>
</tr>
<tr>
<td>2 km or more</td>
<td>19</td>
<td>5.9</td>
<td>16</td>
<td>5.0</td>
<td>35</td>
<td>10.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>166</td>
<td>51.9</td>
<td>154</td>
<td>48.1</td>
<td>320</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*

#### 5.2.3 Time

Time taken to access medicine is deemed a problem to many respondents. Many were those who complained bitterly about the time spent in hospitals and clinics in their bid to access MM. The major problem patients face is waiting time at the various health facilities, especially government-owned hospitals and clinics. It is in view of this that some respondents have chosen to use TM. Table 5.3 shows time respondents have to spend before accessing traditional medicine. Unlike the case of modern health care facilities where time is a major factor that could hinder access by potential users, users
of traditional medicine do not complain of time being a hindrance. Some users claim they use traditional medicine because of time convenience.

Comparison between the core and the periphery indicates that those in the former region spend less time accessing TM than those in the latter. One practitioner said, “Because the market in the core areas is far more lucrative than those in the periphery, most of us practitioners prefer to sell our drugs in the former”.

<table>
<thead>
<tr>
<th>Time</th>
<th>Core Frequency</th>
<th>Core Percent</th>
<th>Periphery Frequency</th>
<th>Periphery Percent</th>
<th>Total Frequency</th>
<th>Total Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 30 minutes</td>
<td>90</td>
<td>28.1</td>
<td>79</td>
<td>24.7</td>
<td>169</td>
<td>52.8</td>
</tr>
<tr>
<td>30 - 60 minutes</td>
<td>49</td>
<td>15.3</td>
<td>50</td>
<td>15.6</td>
<td>99</td>
<td>30.9</td>
</tr>
<tr>
<td>1 - 2 hours</td>
<td>24</td>
<td>7.5</td>
<td>16</td>
<td>5.0</td>
<td>40</td>
<td>12.5</td>
</tr>
<tr>
<td>2 hours/more</td>
<td>3</td>
<td>0.9</td>
<td>9</td>
<td>2.8</td>
<td>12</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>166</strong></td>
<td><strong>51.9</strong></td>
<td><strong>154</strong></td>
<td><strong>48.1</strong></td>
<td><strong>320</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*

### 5.2.4 Effectiveness

Comparison between traditional and modern medicines reveals that the latter is more effective than the former. Those who say TM is more effective represent 42.2%, while the remaining 57.8% think MM is more effective. Some of the reasons respondents gave were that modern medicines have been scientifically tested to cure particular diseases, but most traditional medicines are used on experimental basis – a particular medicine is claimed to cure, in some cases, over 20 different diseases. This is what an interviewee had to say, “How can one medicine be used to cure many unrelated diseases? This is absurd”. Another respondent said modern medicines are clinically tested to know exactly how much of it to take. It also has a quicker impact. It will be
very difficult to convince such a person to use traditional medicine, no matter the circumstance.

Those who claim traditional medicine is more effective generally talk about the fact that modern biological medicines are obtained from traditional sources and that “the original is always better than the duplicate or the adulterated one”. On the effectiveness of traditional medicine given per the various consultations with practitioners, the result was very encouraging. From table 5.4, one can conclude that the effectiveness of traditional medicine cannot be underestimated.

The affirmation by 44.2% of respondents that traditional medicine is very effective tells how respondents have come to accept TM. More respondents in the core believe in the effectiveness of TM than those in the periphery by a very small margin. A greater percent of respondents think they use TM because of its efficiency. Other factors are important, but the bottom line, they claim, is to be cured. Interestingly, one respondent said that the period of convalescence is shorter in the use of TM than that of MM.

Only 6.2% of respondents claim their medicines were not effective when they consulted in the last three months. These people however alternate traditional and modern medicines. They use one when the other did not work for them. If 61.9% of users were completely healed by the use of traditional medicine in the last three months when they consulted, then it is evident that the effectiveness of TM cannot be disputed. Some of the remaining 38.1 percent who said they were not completely healed also told the researcher that somehow they were healed, but the disease resurfaced after a short period of time. The effectiveness of TM shows a slightly higher percentage in the periphery (40.8%) than in the core (39.4%).
Table 5.4: Effectiveness of Traditional Medicine

<table>
<thead>
<tr>
<th>Suburb</th>
<th>Very Effective</th>
<th>Effective</th>
<th>Less Effective</th>
<th>Not Effective</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core</td>
<td>23.8</td>
<td>15.5</td>
<td>5.7</td>
<td>3.1</td>
<td>48.1</td>
</tr>
<tr>
<td>Periphery</td>
<td>20.4</td>
<td>20.4</td>
<td>8.0</td>
<td>3.1</td>
<td>51.9</td>
</tr>
<tr>
<td>Total</td>
<td>44.2</td>
<td>35.9</td>
<td>13.7</td>
<td>6.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*

5.2.5 Side Effects

The study reveals that 76.1% of respondents believe that modern medicine has more side effects than traditional medicine. Many people prefer to use TM for this reason.

One reason that cuts across all views shared by respondents is that modern medicines are prepared using artificial bases. These bases, respondents claim, render modern drugs impure – these impure substances accumulate in the system and result in other fatal ailments, they claim. These additive compounds may also produce more toxic substances which may be injurious to the body. Most artificial medicines have long lists of possible side effects on their labels or instruction leaflets attached to them, and this is a clear testimony that modern medicine has more side effects.

Those who say traditional medicine has more side effects constitute 23.9% (10.2% and 13.7% in the core and periphery respectively). They attribute this to the inadequate dosage information given, which cause patients to abuse drugs. Also due to self-medication, people abuse the use of drugs oblivious of the subsequent effect.

Only a few respondents complained of having side effects upon taking traditional medicine. When further interrogated, it was realised that most of these people did not
go by the dosage instructions that were given them. One respondent said that there are no diagnostic procedures to know exactly what the cause of a disease is, so medicines administered may not work for the intended purpose, which may cause other reactions.

5.2.6 Cost

Ninety percent of respondents believe that modern medicine is more expensive than traditional medicine. One interviewee said the difference in cost between the two forms is simply unfathomable. From the data collected, a considerable number of users of traditional medicine get their medicines freely prescribed and given by close relatives. These are mostly herbals. Others exchange medical services with few eggs or other items, the cost of which cannot even match that of securing identity card at the modern health facilities. Some traditional medicines can be very expensive though.

On the question of whether or not the cost of a particular health care system discourages potential users from using them, there were varied views. Seventy four percent of those who say modern medicine is more expensive were more discouraged in their use than those who say traditional medicine is more expensive. The latter group go by the axiom that things considered cheaper are more expensive in disguise.

Ten percent of respondents think TM is more expensive. Cost is one major reason that makes respondents go for TM. When asked, 31.9% of interviewees think they are moved to use TM mostly because of its cost effectiveness. Equal percentage (5% each) of respondents in the core and periphery think TM is more expensive than MM.
5.2.7 Accessibility and Tastes and Preferences

The other reasons that were given for the use of TM as against MM have to do with accessibility and tastes and preferences. Of course, there were other reasons that respondents felt reluctant to share. Accessibility, both physical and revealed were quoted as factors to be considered when seeking health care. The general consensus of respondents is that it is more stressful to use MM than TM. Some of the reasons they gave were that there were more traditional medical practitioners than modern medical practitioners so the ease with which they were able to consult either of the practitioners cannot be compared.

A very small percent of respondents also believe in tastes and preferences as factors that lure them into accessing a particular health care or otherwise. Patients share similar cultural and social values with practitioners of traditional medicine and they (the former) find them (the latter) more approachable, thereby developing some tastes and preferences for their medicines. Table 5.5 shows these details.

Table 5.5: Top Factors that Encourage the Use of TM

<table>
<thead>
<tr>
<th>Factors</th>
<th>Core</th>
<th></th>
<th>Periphery</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Convenience</td>
<td>11</td>
<td>4.9</td>
<td>21</td>
<td>9.3</td>
<td>32</td>
<td>14.2</td>
</tr>
<tr>
<td>Affordability</td>
<td>31</td>
<td>13.7</td>
<td>41</td>
<td>18.1</td>
<td>72</td>
<td>31.9</td>
</tr>
<tr>
<td>Efficiency</td>
<td>40</td>
<td>17.7</td>
<td>36</td>
<td>15.9</td>
<td>76</td>
<td>33.6</td>
</tr>
<tr>
<td>Accessibility</td>
<td>24</td>
<td>10.6</td>
<td>16</td>
<td>7.1</td>
<td>40</td>
<td>17.7</td>
</tr>
<tr>
<td>Good Taste</td>
<td>2</td>
<td>0.9</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.4</td>
<td>3</td>
<td>1.3</td>
<td>4</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>109</td>
<td>48.2</td>
<td>117</td>
<td>51.8</td>
<td>226</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Field work, 2010
5.2.8 Convenience

The basic aim of using any form of medicine is for preventive or curative purposes. To achieve this aim therefore, different people use traditional medicine at the expense of modern medicine, taking some factors into consideration. One reason why people choose traditional medicine is its convenience. One respondent said that unlike the modern health system where patients are under obligation to follow strict procedure at hospitals and clinics, traditional medicine allows for less restrictive measures for accessing health care. Another respondent said that patients are able to express themselves more freely at traditional medical centres (TMCs) than at modern medical centres (MMCs).

5.3 FACTORS THAT DISCOURAGE THE USE OF TM

5.3.1 Introduction

People loathe the use of TM for a number of reasons. Some of the reasons respondents gave as factors discouraging their use of TM were unhygienic ways of preparation, poor packaging, lack of or inadequate dosage instructions, taste and mode of application and inadequate preservation methods.

5.3.2 Preparation

Analysis of data gathered from the field indicates that most manufacturers of TM do not have standardised methods of preparation so one cannot always be sure about quality. Also, most manufacturers and practitioners work in their various homes, and
do not attract quality assurance agencies to certify their products before releasing them onto the market. They therefore produce without sufficient care, knowing very well that nobody is watching them from behind. Sometimes the water they use to mix their drugs are not purified and this can result in other diseases when used.

One interviewee said, “The preparation of some traditional medicines put potential users off – it is hygienically unattractive”. Many respondents who are not users of traditional medicine were of the view that, they would have loved to give it a try, but the preparation of it puts them off. They complained of the nature of the environment of some places where TM are prepared. In total, 20.8% of respondents frown the use of TM because of what they refer to as unhygienic ways of preparation. A greater percent of these people were found in the core (13.3%).

5.3.3 Dosage

The issue of dosage regarding this study does not so much influence the choice of one’s use or otherwise of a particular form of medicine. Only 8.4% users of traditional medicine claim lack of proper dosage discourage them from using, though when asked the question of whether or not a dosage level is prescribed, only 39.8% answered in the affirmative. Spatial analysis shows a greater percent of people in the periphery (4.9%) show more concern with issues of dosing than those in the core (3.5%).

It is quite impressive to find that 82.4% (41.2% each for the core and the periphery) go by the dosage instructions given them. The remaining 17.6% do not follow dosage instructions and they give varied reasons. One interviewee said, “The type of medicine given cannot be taken to the work place so after taking a dose in the
morning, the next dose can only be taken in the evening after I have returned from work. Because I might have missed the afternoon dose, I combine it with the evening dose”. It is interesting to note that other people follow similar practices.

5.3.4 Packaging

Packaging as a factor also discourage utilization of TM by prospective users. Some respondents were of the opinion that some traditional medicines on the market do not even have labels, let alone dosage instructions. One respondent had this to say, “Manufacturing and expiry dates are most times missing. Some very effective drugs, because of their poor packaging as regards their crude labelling, or worse still, the absence of labels, are totally frowned upon by potential users”. The use of old bottles to package medicines by some producers is a major set-back.

Related to packaging is dosage, which is usually absent in many cases of drugs other than those manufactured using modern equipment. Most of these drugs are not tested and approved by the Food and Drugs Board (FDB), yet they make their ways to the market. The study shows that 16.8% of respondents do not like how TM is packaged. The core and the periphery represent 8.4% each, showing no spatial difference.

5.3.5 Taste And Application Of Drugs

A total of 11.1% of respondents claim a greater percent of traditional medicine, especially the herbals, are liquid-base and most of them have bitter or sour taste, making it very difficult to drink. The core and periphery represent 6.2% and 4.9%
respectively. Other discouraging factors are how TMs are applied. Most medicines that are associated with shrines and spiritualists have very crude methods of application and potential users rather refrain from their use irrespective of their efficacy. Their over-reliance on the metaphysical makes spiritualists and fetish priests and priestesses prescribe medicines, the application of which is simply unfathomable.

5.3.6 Preservation

Table 5.6 shows that amongst the 226 users of traditional medicine interviewed, only 47.3% say traditional medicine is better preserved for longer use. The rest think otherwise. Some claim most traditional medicines are water-based, and so if proper preservatives are not added, they easily get spoilt. Of the 119 (52.7%) respondents who say traditional medicine is not better preserved, 63.9% say they are discouraged by the perishable nature of the drugs. They give this as one of the reasons people frown on traditional medicine. The remaining 35.8% are not perturbed at all. One respondent said that since the medicine is efficient and can cure the disease, all other concerns are not important. Preservation of TM is not very encouraging at all. Only 47.3% of all users are enthused about the preservation of TM.
Table 5.6: Top Factors that Discourage the Use of TM

<table>
<thead>
<tr>
<th>Factors</th>
<th>Core</th>
<th>Periphery</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Taste</td>
<td>19</td>
<td>8.4</td>
<td>35</td>
<td>15.5</td>
</tr>
<tr>
<td>Preparation</td>
<td>30</td>
<td>13.3</td>
<td>17</td>
<td>7.5</td>
</tr>
<tr>
<td>Packaging</td>
<td>19</td>
<td>8.4</td>
<td>19</td>
<td>8.4</td>
</tr>
<tr>
<td>Dosage</td>
<td>8</td>
<td>3.5</td>
<td>11</td>
<td>4.9</td>
</tr>
<tr>
<td>Application</td>
<td>14</td>
<td>6.2</td>
<td>11</td>
<td>4.9</td>
</tr>
<tr>
<td>Preservation</td>
<td>19</td>
<td>8.4</td>
<td>24</td>
<td>10.6</td>
</tr>
<tr>
<td>Total</td>
<td>109</td>
<td>42.8</td>
<td>117</td>
<td>51.8</td>
</tr>
</tbody>
</table>

Source: Field work, 2010

5.4 SOURCE OF ACQUIRING TM AND LENGTH OF USE

Different users have different sources of acquiring their medicines. A greater majority (55.8%) of traditional medical users get their medicines from public places such as drug stores, homes of producers, in commercial vehicles, at churches, in schools, on markets and from pedlars. Others told the researcher they get their medicines from clinics, faith healing centers, shrines and others. These different practitioners use different methods of administering their medicines. There is one thing however in common among the various practitioners; they all believe in the medicinal powers of herbals, and use one form or the other to complement their methods. This is represented in table 5.7.
Table 5.7: Source of Acquiring Traditional Medicine

<table>
<thead>
<tr>
<th>Place</th>
<th>Core</th>
<th>Periphery</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
</tr>
<tr>
<td>Clinics</td>
<td>27</td>
<td>11.9</td>
<td>15</td>
</tr>
<tr>
<td>Faith Healing Centres</td>
<td>18</td>
<td>8.0</td>
<td>14</td>
</tr>
<tr>
<td>Shrines</td>
<td>3</td>
<td>1.3</td>
<td>4</td>
</tr>
<tr>
<td>Public Places</td>
<td>52</td>
<td>23.0</td>
<td>74</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>4.0</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>109</td>
<td>48.2</td>
<td>117</td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*

A third of the respondents had used their products for a minimum of 10 years. Most of these people had used them since birth and promise to continue till death. The general consensus here is that, the use of traditional medicine has become a habit to them and will continue to use them, no matter what. Those who had used traditional medicine for less than 10 years were either introduced to it by relatives or friends or better still, commercials on television or radio and they constituted 66.8%.

### 5.5 NUMBER OF TIMES RESPONDENTS FELL SICK AND REPORTED TO A TRADITIONAL HEALTH FACILITY IN THE LAST THREE MONTHS

From Table 5.8, in the last 3 months, 46.9 percent of traditional medical users had not fallen sick. The remaining 53.1 percent had either fallen sick once or twice or thrice. In all these times, only 38.7 percent reported to practitioners of traditional medicine. The remaining 61.3 percent was by self-medication. This figure includes those who did not fall sick, but still used traditional medicine for preventive purposes.
Averagely, more people fell sick in the core than in the periphery in the last three months prior to the interview.

In the number of times respondents fell sick, the core and the periphery had equal percent (19.4% each) of patients consulting TMPs. However, the study shows that those in the periphery had attended more times than those in the core.

**Table 5.8: Number of Times Respondents Fell Sick in the Last 3 Months**

<table>
<thead>
<tr>
<th>No. of Times</th>
<th>Core</th>
<th></th>
<th>Periphery</th>
<th></th>
<th>Total Frequency</th>
<th>Total Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once</td>
<td>24</td>
<td>10.6</td>
<td>31</td>
<td>13.7</td>
<td>55</td>
<td>24.3</td>
</tr>
<tr>
<td>Twice</td>
<td>28</td>
<td>12.4</td>
<td>15</td>
<td>6.6</td>
<td>43</td>
<td>19.0</td>
</tr>
<tr>
<td>Thrice</td>
<td>12</td>
<td>5.3</td>
<td>10</td>
<td>4.4</td>
<td>22</td>
<td>9.7</td>
</tr>
<tr>
<td>None</td>
<td>49</td>
<td>21.7</td>
<td>57</td>
<td>25.2</td>
<td>106</td>
<td>46.9</td>
</tr>
<tr>
<td>Total</td>
<td>113</td>
<td>50.0</td>
<td>113</td>
<td>50.0</td>
<td>226</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Source: Field work, 2010*

**5.6 DISEASES MOST REPORTED AT TRADITIONAL MEDICAL CENTRES AND WHICH ARE EFFECTIVELY ADDRESSED**

Figure 5.1 shows the various diseases respondents had reported at traditional medical centres in the last 3 months. Malaria and typhoid were the two major diseases that respondents reported at the various medical centres and they constitute 22.6% of the total 28 diseases sampled. This presupposes that the outbreak of malaria and typhoid are on the ascendancy. The study shows equal percent (5.3% each) of reported cases of malaria and typhoid in the core and the periphery. Contrary, malaria showed a higher percentage in the core (6.2%) than the periphery (5.8%).
Closely followed are haemorrhoids and boils, which together form 12.8% of the total. Also, haemorrhoids and boils showed equal percent (1.3% each) of reported cases in the core and the periphery. The percentage of reported cases of haemorrhoids in the core (5.3%) was however higher than that at the periphery (4.9%). The least reported case of disease was leprosy (0.35%) which is not strange because of the fewer number of leprosy patients in the study area. Only one leprosy patient was interviewed, and was in the core area. Four percent more people said malaria is effectively addressed by traditional medicine than typhoid and the two together form 42.0% of the total. The analysis shows that diseases like tuberculosis, influenza, chicken pox and bilharzia are the least effectively addressed. The others are hepatitis, gonorrhoea, syphilis, hypertension and asthma. All these 9 diseases form only 3.6% of diseases that in the minds of respondents, are effectively addressed by traditional medicine.

**Figure 5.1: Diseases Reported at TMCs in the Last 3 Months**

Source: Field work, 2010
5.7 TYPE OF TRADITIONAL MEDICINE MOST PATRONISED

Patronage of traditional medicine varies among users, but the most patronised form is herbalism which forms 66.8% of the total. The study further shows a higher percentage patronage of herbalism in the periphery (37.6%) than the core (29.2%). Close to 90% of those who indulge in self-medication use herbals either processed or in their raw state. Boiling medicinal leaves, barks and roots to extract their medicinal content is a common practice in the study area. In some homes, it is a common practice to see everybody in the household take a glass of the liquid concoction before setting off for work or school.

The next most patronised form of traditional medicine is spiritualism, most of the patrons of which are women who are easily convinced into believing in the supernatural. Spiritual form of healing is more patronised in the core than the periphery, showing 9.3% and 3.1% in the core and periphery respectively. Faith healing follows closely with a total of 7.8% for the core (4.9%) and the periphery (6.2%).

It is surprising that 100% of the respondents who had had a bone fracture used traditional medicine. They claim bones are better set and healed using traditional medicine. There were however not too many people interviewed who had had bone fracture. Amongst those interviewed, 2.7% were in the core whiles the remaining 0.4% were in the periphery. Traditional birth attendants constitute 1.8% in the core and 2.7% in the periphery. The remaining 2.2% of respondents use other forms of TM apart from those mentioned.
5.8 PATRONAGE OF TM BY FAMILY MEMBERS OF RESPONDENTS

Patronage of traditional medicine by family members of respondents shows an increase of 10.6% over that of respondents themselves. One reason that can be assigned to this difference is that many of the respondents who do not use traditional medicine claim when their families used them, they were either not effective or were less effective. This rather discouraging report from their families stop potential users from using them. On the question of whether or not a family member has used TM before, 80.6% responded in the affirmative as against 19.4% for the negative. Table 5.9 shows these details.

5.9 MYSTICISM AND DIVINATION

A total of 25.6% respondents are of the view that some diseases are only addressed by TM using mysticism or divination. Some of those who share this belief mention leprosy, fit, dyslexia and erectile dysfunction as diseases “bought” by the devil to punish patients who might have offended someone one way or another. Such diseases, they claim can only be addressed outside modern biomedical health centres – only traditional powers can cleanse the victim using incantations. They further claim patients of such diseases might have either offended the gods or someone else, and the person involved might have summoned them to the gods. The gods in question must therefore be pacified before the patient receives treatment.

Others believe family curses and the activities of witches and wizards can cause diseases which can only be addressed by spiritualists. The remaining 74.4% think otherwise. The highest on the list of diseases thought of as being addressed only by either mysticism or divination are psychosis and leprosy at parity (17.1% each). Next
on the list are asthma (14.6%) and fit (14.6%). Least on the list is bone fracture (2.4%). Some people still believe that some diseases like AIDS and bone fracture are caused by spiritual factors and therefore could only be addressed by mysticism and divination.

**Figure 5.2: Diseases Addressed by TM Using Mysticism or Divination**

![Diseases Addressed by TM Using Mysticism or Divination](image)

*Source: Field work, 2010*

### 5.10 CONTRADICTION OF RELIGIOUS BELIEFS WITH TM USE

Almost equal number of respondents believe either in the affirmative or negative when asked whether or not their religious beliefs contradict some aspect of traditional medicine. The responses were 49.4% and 50.6% respectively for “Yes” and “No”. The two main contradictions are fetishism and alcohol as a base for some medicines. Most of those who responded in the affirmative were either pentecostals or charismatics. They claimed their religious beliefs did not allow them to visit shrines or take alcohol.
They would therefore not seek health care from shrines for whatever reason. Neither will they take drugs which must be mixed with alcohol to be effective.

5.11 SOCIETAL PERCEPTION OF USE OF TRADITIONAL MEDICINE

There is a lingering perception that TM belongs to those who cannot afford MM. The field investigation suggests that this belief was so much the case in some time past, but now people are beginning to appreciate its efficacy, and the fact that governments are now encouraging their use. There are varied reasons why society thinks TM belongs to the poor. One reason is that most TMs are administered by non-professionals who come very cheap with their services and drugs.

Those who are into faith healing sometimes only offer prayers which come even cheaper, so can be afforded by even the poor. Some people however think that the potency of the drugs overrides any other factor so people’s negative comments should not be taken seriously. When asked whether or not society considers the use of TM to be associated with poverty, the response was 50-50. A greater percent of people in the core (26.9%) than in the periphery (23.1%) believe that TM belongs to the poor. There is so much commercialization of faith healing in Kumasi.

5.12 IMPROVING EFFICACY OF TRADITIONAL MEDICINE

Seventy nine percent of the respondents were of the opinion that though, traditional medicine was efficient and served a very good purpose in complementing modern medicine, some aspects of it must be improved. The use of modern technology in the
preparation and administration of traditional medicine is very necessary. The problem of dosage is one aspect that respondents think when improved, will go a long way to improving the quality of TM. One respondent said a thorough research should be done to ascertain the quantity of drugs that should be taken at a time, and this can be done by summoning all practitioners and giving them the necessary education and training.

Partnering with well established pharmaceutical industries will also help boost their capacity. This will help in the commercial production of TM. A typical example is Adom Herbal Clinic which liaises with the Department of Herbal Medicine at the KNUST for research and testing of herbal products. There is also the need to establish more formal educational centres to train and issue licences to prospective practitioners so that those that are not licensed should not be allowed to operate. Expert advice should always be sought when preparing drugs. A lot of education should also go in to disabuse people’s minds of seeing traditional medicine as inferior. One respondent said that when prices of TM are increased, people’s minds will be disabused of seeing them as inferior. He added that society believes that cheap things are inferior.

Interview with the head of Department of Herbal Medicine at KNUST reveals that the Faculty of Pharmacy is not doing much to improve the quality of traditional medicine with regard to research. He further explained that not enough resources are injected into research by both faculty members and students. He also regretted the fact that research works are left on the shelves for years without any effort made to implement the ideas. He however said that the Department now relates closely with the Traditional Medical Council which has the mandate to oversee the activities of all subsidiary groups.
The Traditional Medical Council, as part of its mandate, offers professional advice, develops ethics and conducts professional examination to all its members. Some of the subsidiary associations are the Herbal Medicine Council, the Ghana Federation of Traditional Medical Practitioners and the Herbal Medical Graduates Association. The Department of Traditional Medicine at the KNUST gives technical advice to practitioners by sending fresh graduates to established herbal institutions. Adom Herbal Clinic is one such institution that makes use of graduates from the KNUST Herbal Department.

5.13 RESEARCH FINDINGS (TEST OF HYPOTHESES)

On the evidence of Appendix C, the Null hypotheses (H₀) for Educational Status and Suburb are rejected in favour of the Alternative hypotheses (H₁) since the respective significance values, 0.000 and 0.030 for Educational Status and Suburb are less than 0.05. It is therefore evident that, at 5% significant level, educational status and suburb (place of residence) have significant effects on the Use of Traditional Medicine. Respondents’ use of traditional medicine are influenced by their levels of education. This is irrespective of their residences.

It can further be said that there is a negative relationship between educational status and use of traditional medicine. This means that the higher the educational level, the less use of TM. This is shown by the negative value of Beta (-0.243) on the Educational Status row in Table 4 and it is applicable to both the core and the periphery. Respondents from these places share similar attitudes on this score. Also place of residence has weak, but significant relationship with the use of TM. This
relationship is a positive one. Respondents’ choice of traditional medicine is dependent on their places of residence. Those in the periphery are noted to be using more traditional medicine than those in the core.

On the contrary, from Appendix C, the significant values for Gender (0.134) and Income (0.601) show that there is no significant relationship between gender and use of TM and income and use of TM. This is explained by the higher values for Gender (0.134) and Income (0.601) which are greater than the significant level of 0.05. The alternative hypotheses are therefore rejected in favour of the null hypotheses. This suggests that gender and income do not determine the use or otherwise of traditional medicine.

The researcher chose these four variables – gender, education, income and suburb – because of the perceived lack of respect for use of traditional medicine by males against females; literates against illiterates; high income earners against low income earners and residents of the core against those of the periphery.
CHAPTER SIX

6.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter summarizes the entire research work and gives recommendations as to how traditional medicine can be made better, particularly regarding preparation, packaging, dosage instructions, marketing and mode of application. With improvement in the aforementioned factors, it is hoped that people’s minds will be free from the thought that traditional medicine is backward and ineffective. The recommendations that follow are a summary of views genuinely sampled from the field survey and not entirely those of the researcher.

6.2 SUMMARY OF FINDINGS

Fundamentally, the study aimed at finding the reason for people’s disregard for traditional medicine as a form of health care system and imbibe wholly, that of modern medicine. Some of the sentiments expressed by users and potential users of the former suggest a general lack of trust in practitioners of traditional medicine. Generally, their sources of ingredients and methods of preparation are a matter of concern to the people. A few of them, though, are genuine and trustworthy, the multiplicity of the “bad ones” has rather overshadowed the whole spectrum of TM and therefore people’s discomfort.
Also, the study generally aimed at finding the mode of use of traditional medicine in urban areas and possibly ascertain people’s reason for choosing traditional medicine at the expense of modern medicine and vice versa. Not only this, but how TM can effectively address diseases and their integration into the primary health care is a matter of concern. Whether or not traditional medicine has helped to better the lives of the people who use them is still a subject of debate as different studies give different outcomes. Of course this is greatly dependent on the study area and the research instruments used.

Stratified and simple random sampling methods of data collection were used. Data were sourced using both primary and secondary sources such as interviews, questionnaires and observation. Also used were data sourced from the Internet. With an estimated population of 1,517,000 as given by the United Nations Population Division, 2005, Kumasi was divided into core and periphery on the basis of economics, infrastructure and social factors. A sample size of 320 was used, representing a ratio of 1:4,974.

The study is also based on the concept that with improvement in the living standards of the people resulting from urbanization, people choose to be more associated with modern medicine than traditional medicine because they can afford the former. There are many other factors that potential users consider other than monetary consideration in the utilization of a particular health care system.

The conceptual framework showed a link between the use of TM and determinants like acceptability, efficacy, suitability, taste and preferences. Other determinants were: gender, education, income, exposure, nature of illness and kind of treatment. It was hypothesized that those in the urban core use less traditional medicine than those in
the urban periphery and more females use traditional medicine than males. Also stated were the beliefs that traditional medicine is less used by literates than illiterates and lastly, low income earners use more traditional medicine than high income earners.

The outcome of the research is that the level of education and place of residence determine one’s use of traditional medicine. While those who have attained higher levels of education use less traditional medicine than those with little or no formal education, those in the urban core use less TM than those in the urban periphery. Gender and income levels do not determine the use or otherwise of traditional medicine.

6.3 CONCLUSION

From the research, it is axiomatic that people place so much emphasis on the two main forms of health care. It is also evident that discrimination of one form against the other is based on many reasons apart from efficacy. Though the potency of traditional medicine was hailed by many interviewees, many were those who did not like their use because of certain avoidable problems associated with them. This, notwithstanding, the researcher believes that traditional medicine still occupies an enviable position in the health care delivery system of Kumasi in particular and Ghana in general. It is realized that without integrating TM with MM, no effective health care system can be achieved. These sentiments are expressed by both residents of the core and the periphery.

The research has also shown that traditional medicine better addresses some diseases more than modern medicine. Diseases that are directly associated with the mind are
proven to be effectively addressed by TM, as well as diseases like boils, malaria, skin rashes, bone-setting and typhoid. It is also realized that traditional healers adopt a holistic approach to their system of health delivery. They do this by incorporating aspects of spiritual, social, psychological, as well as environmental factors. Moreover, because these traditional practitioners are so physically and socially close to their clients, they are easily approachable, so patients easily relate to them and share their medical problems.

One major setback, however is the fact that the dispensation of traditional medicine is mostly in the hands of illiterates who may have the knowledge on types of herbs and other medicinal stuff, but not well trained enough to have effective delivery skills. Secondly, there are many quack traditional medicine men in the system who sell just anything to make money. This is attributed to the unregulatory nature of TM.

It is also self-evident that utilization of traditional medicine is not mainly by the relatively not-too-well-to-do people in society. This emphasises the point that 50% of respondents debunked the belief that TM is inferior and belongs to the poor. It is imperative to know that even the highly educated group in society use TM as their counterparts on the other side and their reason is definitely justifiable – TM is very effective and potent.

Spatial analysis of the use of traditional medicine indicates that some variables do not show so much difference between the core and the periphery. With respect to educational levels, field study has shown that in both regions, the higher the level of education attained, the less respondents use traditional medicine and vice versa. Other variables such as distance indicates that those in the core are closer to traditional medical practitioners than those in the periphery.
6.4 RECOMMENDATIONS

Fundamental to the health of the people is the provision and utilization of adequate, effective and efficient health care systems with TM playing a major role. To realize these dreams therefore, the following recommendations have been made based on the findings from the study:

Firstly, governments can help improve traditional medicine by their policy frameworks. By instituting measures to regulate the activities of traditional medical practitioners, a lot of good than harm can be done to improve the quality of TM. This can be achieved by firstly making sure that all practitioners are working within identifiable groups with licence to operate – this will help reduce the menace of quack practitioners operating in the system. Within these working groups, members should be initiated only after their medicines have been tested and approved by qualified personnel.

Secondly, governments can help by the establishment of training institutions to train prospective practitioners and at the same time offer on-the-job training to already practising members. These institutions should be subsidized enough to offer the opportunity to many who want to make use of them. The institutionalization of these facilities must come with the introduction of modern equipment in the preparation and packaging of drugs.

The institutionalization of a degree programme in Herbal Medicine at the Faculty of Pharmacy at the Kwame Nkrumah University of Science and Technology (KNUST), Kumasi, is therefore a laudable idea and must be replicated in other tertiary institutions. The Center for Scientific Research into Plant Medicine located at
Akuapim Mampong is also established to undertake research into local herbs and usage.

Another way governments can help with the improvement and utilization of traditional medicine is incorporating it into the Primary Health Care (PHC) system. With this incorporation, the best of both TM and MM will be seen and the inferiority stigma will be eliminated. Also when incorporated, the same modern technology used in the field of MM will be used in the dispensation of TM. The National Health Insurance Scheme (NHIS) should also incorporate some aspects of traditional medicine, especially, herbal medicine into its essential drug list. There must be a balance between the two systems to create an affordable health care system that will be relished by all.

In the formulation of health care policies, traditional healers should be consulted. When this is done, it will be easier to oversee their activities and offer technical advice when needed. The Ministry of Health (MOH) should, in consultation with other ministries like that of Education, educate the general public on the need to patronize traditional medicine and report practitioners who have questionable character.

Apart from what the government can do, the various associations of traditional medical practitioners can help themselves and one another by offering assistance by way of sharing knowledge and experiences. Teaming up with one goal of producing drugs will be of tremendous benefit to individual members and the group as a whole. Both human and capital resources could be put together to achieve a better result in this regard than working individually.

A second solution that can be offered by the associations themselves is the setting up of a task force that will be mandated to fish out all those unlicensed practitioners.
After some people have been arrested and prosecuted, then others without licenses will stop practising. Moreover drugs produced should only be sold in licensed chemical shops by trained and licensed personnel to avoid the sale of “wrong” drugs to patients.

Many of the respondents are of the view that TM should be integrated into the Primary Health Care (PHC) system. They think by so doing, TM will be given the necessary respect and people will now be encouraged to use them without the fear of being tagged as inferior. Seventy-five percent of respondents think integrating TM into the PHC will be an ideal situation as it will give more value to TM. It will receive more patronage when integrated because of its accessibility, reliability and affordability. If traditional medicines are prescribed by our modern health professionals, then people will readily accept them and utilization will improve considerably. This will also give room for variety and alternatives to choose from.

Lastly, users and potential users of traditional medicine must disabuse their minds of the fact that everything, including medicine made locally, is not worth it. Trusting these traditional medical practitioners and their medicines will encourage them to do better to improve on their activities. Users should not downplay the important role traditional medicine plays in the delivery of health care. With all the aforementioned groups reasoning together, traditional medicine will be a potent force in the health care delivery system of Ghana.
BIBLIOGRAPHY

Andersen, R.M. (1995). Revisiting the Behavioral Model and Access to Medical Care: 

Atadou, E. S. (1985). “Traditional Medicine and Biosychological Fulfillment in 
African Health,” *Social Science and Medicine, Vol. 21,* p. 1346.

Buor, D. (1993). The Impact of Traditional Medicine on Health Delivery Services in 
Ghana: The Ashanti Situation. *Journal of the University of Science and 

Buor, D. (2002). Distance as a Predominant Factor in the Utilization of Health 
Services in the Kumasi Metropolis, Ghana. *International Journal of Human 
Geography and Environmental Sciences (Geojournal), Vol. 56(2),* pp. 145-157.

Cunningham, A.B. (1997). An Africa-wide overview of medicinal plant harvesting, 
conservation and health care, *Non-Wood Forest Products 11: Medicinal plants for 
forest conservation and health care,* FAO, Rome, Italy.

Cunningham, A.B. (1993). African Medicinal Plants: setting priorities at the interface 


De Smet Peter, A.G.M (1999). Herbs, health and healers: Africa as 


Kerwegi S. A. (2001). Traditional Skin Care Using Plant Extracts, Kampala, Uganda


APPENDICES

APPENDIX A

SPATIAL ANALYSIS OF THE USE OF TRADITIONAL MEDICINE IN URBAN AREAS OF GHANA: A CASE STUDY OF KUMASI METROPOLIS

QUESTIONNAIRE TO RESIDENTS

This questionnaire has been designed to gather data from the residents of Kumasi and it is solely for academic purpose. Information given will be treated with utmost confidentiality. Please read the questions below and tick or write the correct answer where appropriate. Thank you.

NAME OF SUBURB...........................................................................................................

BACKGROUND INFORMATION

(1) Age: a. 0 - 18 years ☐ b. 18-30 years ☐
   c. 30-45 years ☐ d. 45 years or above ☐

(2) Sex: a. Male ☐ b. Female ☐

(3) Duration of Stay: a. 0 - 1 year ☐ b. 1-5 years ☐
   c. 5- 10 years ☐ d. 10 years or above ☐

(4) Place of Previous Residence: .................................................................

   c. Secondary Education ☐ d. Tertiary Education ☐ e. Higher ☐

(6) Are you employed? a. Yes ☐ b. No ☐

(7) If the answer to question 6 is ‘yes’, what is your occupation?............................... 

(8) Household Size: a. 1 - 2 ☐ b. 2 - 6 ☐
   c. 6- 10 ☐ d. 10 or more ☐
(9) Monthly Salary: 
   a. Up to ₣100 □  
   b. ₣100- ₣500 □  
   c. ₣500- ₣1000 □  
   d. ₣1000 or more □

(10) Percentage Salary that Goes into Health Care: 
   a. 0 - 5% □  
   b. 5-10% □  
   c. 10-20% □  
   d. 20% or more □

(11) Religion: 
   a. Catholic □  
   b. Protestant □  
   c. Muslim □  
   d. Pentecostal □  
   e. Charismatic □  
   f. Traditional □  
   g. Other (specify)……………………………

ACCESS TO HEALTH CARE

(12) Do you have access to health care? 
   a. Yes □  
   b. No □

(13) If ‘yes’, what form? 
   a. Modern medicine □  
   b. Traditional medicine □  
   c. Both □  
   d. Other (Specify)…………………

(14) Factor of accessibility you will consider most when seeking medical care: 
   a. Distance □  
   b. Time (Travel and Waiting) □  
   c. Financial ability □  
   d. Tastes and Preferences □

(15) Length of a modern health facility from your house: 
   a. 0 - 100m □  
   b. 100m - 1km □  
   c. 1km - 2km □  
   d. 2km or more □

(16) Duration of access to a modern health facility: 
   a. 0 - 30 minutes □  
   b. 30 – 60 minutes □  
   c. 1- 2 hours □  
   d. 2 hours or more □

(17) Length of a traditional health facility from your house: 
   a. 0 - 100m □  
   b. 100m - 1km □  
   c. 1km - 2km □  
   d. 2km or more □

(18) Duration of access to a traditional health facility: 
   a. 0 - 30 minutes □  
   b. 30 – 60 minutes □  
   c. 1- 2 hours □  
   d. 2 hours or more □
COMPARING TRADITIONAL MEDICINE AND MODERN MEDICINE

(19) Which of the 2 forms do you consider more effective?

   a. Modern medicine  b. Traditional medicine

(20) Give reason for your answer……………………………………………………………

(21) Which of the 2 forms has more side effects?

   a. Modern medicine  b. Traditional medicine

(22) Give reason for your answer……………………………………………………………

(23) Which of the 2 is more expensive?

   a. Modern medicine  b. Traditional medicine

(24) Does the expensiveness discourage you from using it?a. Yes b. No

FOR TRADITIONAL MEDICAL USERS ONLY

(25) Duration of use of traditional medicine: a. 0 - 1 year  

   b. 1-5 years  c. 5 - 10 years  d. 10 years or more

(26) Place of acquisition of your medicine: a. In a clinic  b. Faith centre

   c. On a shrine  d. In public places  e. Other …………………

(27) Number of times fallen sick in the last 3 months:

   a. Once  b. Twice  c. 3 times  d. None

(28) How many of these (27) did you consult a traditional medical practitioner?

   a. Once  b. Twice  c. 3 times  d. None

(29) If (28) is “None‖, was it by Self-medication? a. Yes b. No

(30) What type of traditional medicine do you patronize? a. Spiritualists

   b. Herbalists  c. Bone setters  d. Faith healers
e. Traditional birth attendants  

f. Other (Specify)  

(31) Was a dosage level prescribed?  

a. Yes  

b. No  

(32) If (31) is “Yes”, did you adhere to dosage instructions?  

a. Yes  

b. No  

USE AND EFFECTIVENESS OF TRADITIONAL MEDICINE  

(33) Which disease(s) have you been reporting to a traditional medical practitioner?  

1. .................................................  

2. .................................................  

(34) Which of the diseases at (33) does traditional medicine effectively address?  

a. 1  

b. 2  

c. 3  

d. All  

(35) Effectiveness of medicines given:  

a. Very effective  

b. Effective  

c. less effective  

d. Not effective  

(36) Were you healed completely for the number of times you consulted?  

a. Yes  

b. No  

(37) Did you have any side-effects?  

a. Yes  

b. No  

(38) If “Yes”, what was it? ............................................................  

(39) Has any family member patronized traditional medicine?  

a. Yes  

b. No  

(40) If “Yes”, how effective was it?  

a. Very effective  

b. Effective  

c. Less effective  

d. Not effective  

(41) Is traditional medicine better preserved for longer use?  

a. Yes  

b. No  

(42) If “No”, does it discourage you from using it?  

a. Yes  

b. No
BARRIERS TO THE USE OF TRADITIONAL MEDICINE

(43) Which of the following encourages you to use traditional medicine?
   a. Convenience □  b. Affordability □  c. Efficiency □
   d. Accessibility □  e. Good taste □  e. Other (specify)……

(44) Which of the following discourages you from using traditional medicine?
   a. Taste □  b. Preparation □  c. Packaging □
   d. Dosage □  e. Application □  f. Other (specify)……

(45) Give reason for your answer………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

(46) Do you think some diseases are ONLY addressed by traditional medicine using mysticism or divination?
   a. Yes □  b. No □

(47) If “Yes”, mention them: 1………………………………………………
                                      2………………………………………………
                                      3………………………………………………

(48) Does your religious belief contradict the use of certain aspects of traditional medicine?
   a. Yes □  b. No □

(49) If “Yes”, what are they? 1……………………………… 2…………………………

(50) Does society consider the use of traditional medicine to be associated with poverty?
   a. Yes □  b. No □

(51) What is your opinion on the above? ………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
ADDRESSING CONSTRAINTS IN THE USE OF TRADITIONAL MEDICINE

(52) In your opinion, how can the problem of dosage be addressed? .................................................................
.................................................................................................................................................................
.................................................................................................................................................................

(53) What do you think should be done to improve the quality of traditional medicine? .................................................................
.................................................................................................................................................................
.................................................................................................................................................................

(54) In your opinion what do you think should be done to disabuse people’s minds of seeing traditional medicine as inferior? .................................................................................................
.................................................................................................................................................................
.................................................................................................................................................................

(55) Would you advocate integrating traditional medicine into the Primary Health Care (PHC)? 
  a. Yes  
  b. No

(56) Give reason for your answer .................................................................................................................................
.................................................................................................................................................................
.................................................................................................................................................................

97
APPENDIX B

SPATIAL ANALYSIS OF THE USE OF TRADITIONAL MEDICINE IN URBAN AREAS OF GHANA: A CASE STUDY OF KUMASI METROPOLIS

QUESTIONNAIRE TO TRADITIONAL MEDICAL PRACTITIONERS

This questionnaire has been designed to gather data from the practitioners of traditional medicine in the Kumasi metropolis and the data is solely for academic purposes and will be treated with outmost confidentiality. Please read the questions below and tick or write the correct answer where appropriate. Thank you.

NAME OF PRACTITIONER…………………………………………………………………………………………

NAME OF FACILITY (If Any)…………………………………………………………………………………………

BACKGROUND INFORMATION

(1) Age: a. 0-18 years □ b. 18-30 years □ c. 30-45 years □ d. 45 years or above □

(2) Sex: a. Male □ b. Female □


(4) Position………………………………………………………………………………………………………………

(5) Duration of Practice: a. 0-1 year □ b. 1-5 years □ c. 5-10 years □ d. 10 years or above □

(6) Is it a lucrative venture? a. Yes □ b. No □

(7) Average monthly earning: a. 0- ₦100 □ b. ₦100- ₦500 □ c. ₦500- ₦1,000 □ d. ₦1,000 or more □
PROFESSIONAL ISSUES

(8) Form of professional training:  a. Degree in TM  b. Divinity
   c. Spirituality  d. Understudy  e. Experience  f. Other

(9) Mode of healing:  a. Herbal  b. Psychological
   c. Faith healing  d. Spiritual  e. Other……

   c. Spiritualism  d. Clinical  e. Other …………………

(11) Place of practice:  a. In a clinic  b. at church
   c. On a shrine  d. In public places  e. Other …………………

(12) Daily average number of patients:  a. 0-5  b. 5-10
   c. 10-20  d. 20 or more

(13) Forms of diseases treated:  a. Physical  b. Psychological
   c. Mental  d. Spiritual  e. All

(14) What disease(s) do you treat best?
   1…………………………………………  2……………………………………
   3…………………………………………  4……………………………………

(15) Challenges faced:  1…………………………………………………………
   2………………………………………………………………………………
   3………………………………………………………………………………

(16) In your opinion how can these challenges be overcome?…………………………
   ……………………………………………………………………………………………
## APPENDIX C

### ANOVA (b)

<table>
<thead>
<tr>
<th>Mode</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>6.491</td>
<td>4</td>
<td>1.623</td>
<td>8.932</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>51.962</td>
<td>286</td>
<td>.182</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>58.454</td>
<td>290</td>
<td>.182</td>
<td></td>
</tr>
</tbody>
</table>

- Predictors: (Constant), Suburb, Sex, Educational Status, Monthly salary
- Dependent Variable: Form of medicine used

### FACTORS FOR INDIVIDUAL VARIABLES

<table>
<thead>
<tr>
<th>Mode</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td>B</td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>1.826</td>
<td>.153</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td>.079</td>
<td>.052</td>
<td>.088</td>
</tr>
<tr>
<td></td>
<td>Educational Status</td>
<td>-.114</td>
<td>.032</td>
<td>-.243</td>
</tr>
<tr>
<td></td>
<td>Income Levels</td>
<td>-.018</td>
<td>.034</td>
<td>-.037</td>
</tr>
<tr>
<td></td>
<td>Suburb</td>
<td>.111</td>
<td>.051</td>
<td>.123</td>
</tr>
</tbody>
</table>

- Dependent Variable: Use of Traditional Medicine