

**HEALTH SEEKING BEHAVIOUR AMONG PEOPLE SUFFERING
FROM CARDIOVASCULAR DISORDERS**

BY

The background of the page features a large, faint watermark of the University of Ghana crest. The crest is a shield divided horizontally. The top half is light blue with three golden palm trees. The bottom half is light blue with a golden cross-like symbol. Below the shield is a golden scroll with the Latin motto 'INTEGRITAS PROCEDEMUS'.

**ISAAC ACHEAMPONG SARFO
(10097648)**

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DECLARATION

I, Isaac Acheampong Sarfo, author of this thesis hereby declare that except for the reference to other people's work which have been duly acknowledged, the work presented here was done by me as a student of the Department of Psychology, University of Ghana, Legon, under the supervision of Professor S. A. Danquah, Dr. Matilda Pappoe and Dr. Maxwell Asumeng. This work has never been submitted in whole or part for any degree in this University or any other University.

PhD Candidate

.....
Isaac Acheampong Sarfo

.....
Date

Thesis Supervisor (1)

.....
Professor S. A. Danquah

.....
Date

Thesis Supervisor (2)

.....
Dr. Matilda Pappoe

.....
Date

Thesis Supervisor (3)

.....
Dr. Maxwell Asumeng

.....
Date

DEDICATION

My Father, Rev. Fr. Enoch Yaw Sarfo and Brother, Dennis Addo Sarfo, both of blessed memory. Daddy, you told me the destination, and I found the path. Your toils and instructions have not been in vain. Kwaado, we will always love and remember you for your short and exciting stay with us. We love and appreciate you.



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For everything there is a season and a time for every purpose under heaven. HE hath made everything beautiful in its time (Ecclesiastics 3:1; 11a).

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“Ingratitude is monstrous”

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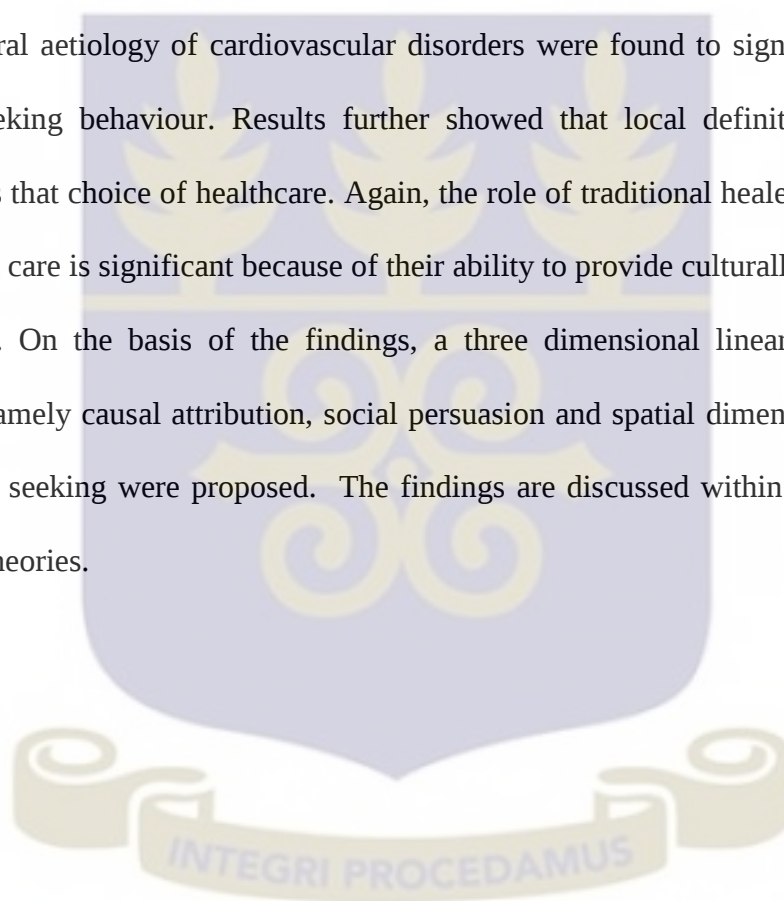
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ABSTRACT

The study explores health seeking behaviour among people suffering from cardiovascular disorders in the New Juaben Municipality of Ghana, as a result of relationship between their personal experiences and their cultural worldview. This study was undertaken in an environment predominantly inhabited by Akans who hold the notion that health is maintained when there is a harmonious relationship between the individual and the environment and that there is no distinction between the physical and the supernatural worlds. The worldview that guides the people is the supernatural attribution to various health-related issues and that helps them to deal with matters related to their health. This contrast the views held by western trained clinicians who use solely the biomedical approach to explain health and illness and that this approach fails to take cognizance of the cultural explanation and local explanations of diseases into consideration. Limited studies on how such cultural beliefs influence health seeking behaviour for cardiovascular disorders, and that the few that have been undertaken have heavily relied on western conceptualisations to explain health and help seeking. Using a concurrent mixed method design, this study set out to understand health seeking behaviour using both qualitative (study 1) and quantitative (study 2) approaches. Study 1, was made up of (n=46) participants, involving 33 participants for focus group discussions and 13 key informants. The study explored the cultural values and belief systems that influence health seeking behaviour for cardiovascular disorders. Participants were of diverse age, sex, educational and occupational background. Using the thematic content analysis, the study showed that cultural factors such as definition, aetiology, enemysm and sale of diseases, communality, spirituality, relational tensions and multiple health seeking

influence health seeking behaviour for cardiovascular disorders. To cross validate the findings of the qualitative study a quantitative study (study 2) was undertaken to explore health seeking behaviour for cardiovascular disorders. Quantitative data was collected from a different sample of 560 respondents. Hierarchical and categorical multiple regression and t-test were used to analyse the quantitative data. Results corroborated the findings of the qualitative study that cultural values and beliefs including belief in the supernatural aetiology of cardiovascular disorders were found to significantly influence health seeking behaviour. Results further showed that local definition of a disorder influences that choice of healthcare. Again, the role of traditional healers in the provision of holistic care is significant because of their ability to provide culturally accepted service to clients. On the basis of the findings, a three dimensional linear decision making process namely causal attribution, social persuasion and spatial dimensions and a model for health seeking were proposed. The findings are discussed within the framework of existing theories.



CHAPTER ONE

1.0 HEALTH SEEKING BEHAVIOUR IN CONTEXT

1.1 Background to the Study

Health seeking behaviour (HSB), refers to those activities undertaken by individuals in response to symptom experience (Tones, 2004). This behaviour is initiated with symptom definition where upon a strategy for treatment action is devised (Lindelov, 2004). Health-seeking behaviour is a part and parcel of an individual's family's or community's identity being the result of an evolving mix of personal, experiential and socio-cultural factors. It is therefore, an important indicator of cultural, social, economic and political realities of a group of people (Iyalomhe & Iyalomhe, 2010). It involves a myriad of factors related to illness type and severity, pre-existing lay beliefs about illness causation, the range accessibility of therapeutic options available, and their perceived efficacy (Azari, 2002; Bell, Kravitz, Thom, Krupat Kleinman, 2007; Kleinman, 2002).

The World Health Organisation (WHO, 2006), regards health as a state of complete, physical, mental and social well-being. It is also asserted that health may be seen as a state of dynamic equilibrium between an organism and its environment. Good health, therefore, corresponds to dynamic stability, normal function and homeostatic control, as ill-health corresponds to a state of instability, loss of function and failure of self-regulation. In the words of Nobel laureate Sen (1999), health, like education, is among the basic capabilities that gives value to human life. Health therefore contributes to both social and economic prosperity. Good health, in itself is of great value, as it enables people to enjoy their potential as human beings. The absence of good health therefore,

has far-reaching implications on the overall well-being of the individuals involved (Oguyigbe & Liasu (2007).

1.1.1 African Cultural Beliefs and Worldviews

An Africentric (African centered) worldview is a set of beliefs, values, and assumptions that is founded on African cultural traditions and that relate to definitions of the self, others, and the relationship of the self with the environment (Myers, 1993; Utsey, Adams & Bolden, 2000). Understanding of African Cosmology “the African worldview”, which is centered within the African experience is essential to an understanding of African (Black) psychology (Baldwin, 1991p. 131). Azibo (2002) argues that worldview consists of a Deep Structure of culture, and refers to the way in which a people view and philosophically understand reality. Worldview functions as a philosophical framework that gives explanation when interpreting phenomenon.

The African worldview is the primary lens for interpreting all phenomenon. Africentric or African centered principles are essentially codes of conduct for daily life that represent the minimum set of values that African Americans need to build and sustain an Africentric life, family, community, and culture (Grills & Longshore, 1996; Karenga, 1988). According to Karenga (1965, 1988), there are seven core principles that govern Africentric worldview. These include unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith (Belgrave, Townsend, Cherry, & Cunningham, 1997).

Based on the Nguzo Saba, Belgrave, Townsend, Cherry, and Cunningham (1997) developed a scale to measure three Africentric values for African American children and adolescents: collective work and responsibility, cooperative economics, and self-

determination. The first value, *collective work and responsibility*, is the belief that African Americans are responsible for one another and should work together for the betterment of family and community. The related value of *cooperative economics* reflects a belief in sharing and maintaining resources among and within the African American community. *Self-determination* refers to a belief that African Americans should make decisions for themselves, their families, and their communities (Belgrave, Chase-Vaughn, et al., 2000). The endorsement of Africentric values and beliefs is believed to lead to a reduction in psychological symptoms such as depression, anxiety, and anger and may promote a greater sense of well-being and resiliency among adolescents (Dubois, 1999). Africentric values and behaviors can provide a reservoir from which protective factors and coping strategies are drawn (Constantine & Blackmon, 2002).

Other scholars have noted additional primary Africentric values of spirituality, harmony with others and nature, balance, orientation to time as a social phenomenon, authenticity, and an emphasis on oral tradition (Mattis & Jagers, 2001; Mbiti, 1986; Nobles, 1976).

Culture is so embedded in one's mind that its structures, values, and ideals are experiences which are seen as normal. Culture thus communicates people's world-view in that it operates like a communication system, an operating system in a computer, or a neural network within the neo-cortex of one's brain (Kirwen, 2005). Culture shapes the worldview in that it interprets experiences, determines and animates over 90% of an individual's daily activities (Kraft, 2000). The term culture in the African thought is very inclusive. It takes account the religious, social, psychological, linguistic, political, economic, and many other aspects of life. Helman (1994; p 48) defines culture as set of guidelines (both explicit and implicit) which individuals inherit as members of a

particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in relation to other people, to supernatural forces or gods, and to the natural environment. World-view is seen as the way people see or perceive the world; the way they know it to be (Kraft, 2000). What people see is in part what is there; it is partly who they are. World-view is humanity's idea of the universe; the organization of ideas that answers questions such as, *Who am I? Among what do I move? What are my relations to other people, things, or events?* (Chima, 1999). World-view is therefore taught to people from birth, and it is so persuasive that most of people think that their view of reality is the only accurate one and that culture is closely related to world-view.

In African people's worldviews of societal and cosmological relationships, there is a strong understanding of respect for self, other people, and all of nature, especially the land, trees and the water (Mbiti, 1989). The African worldviews look at existence from the point of view of cultures and social structures which make up communities. A communal ideology and unique worldview exists between and among African people. This common thread is inherent in most African cultures and customs despite the impact of Westernisation (Mpofu, 2006). From these worldviews, knowledge is not necessarily based on what is researched and verified. The experience of the individual acquired from others and passed down from elder members of the community is more valued.

As Ivey and Meyers (2008) point out, this acquired and passed on knowledge and experience is treated as norms and adhered to irrespective of whether they are scientifically validated. How a traditional circumciser and a medical doctor qualify and

practice can be seen here as an area of a clear conflict between Western and African worldviews.

Makwe (1985 p. 65) defines these African worldviews as ‘an abstraction which encompasses the total way of life of the African society. It is a psychological reality referring to shared constructs, shared patterns of belief, feeling and knowledge which members of the group that subscribe to this reality carry in their minds as a guide for conduct and the definition of reality’.

The philosophy of these worldviews among Africans is *‘holism’*. It has an approach that focuses on the whole living organism. This is evident in the traditional life styles of African tribes that still keep their traditional way of life; this can be seen in the San people of Southern Africa and the Maasai people of Kenya. For these traditional African tribes, God is seen in all their spheres of life. For example, God is invoked in times of drought, good harvests and outbreak of diseases. Matters pertaining to their life are interconnected to God, nature and other relations (living or dead). Sow (1980) explains that this indivisible cosmic whole can be theoretically distinguished, namely *macro-*, *meso-*, and *micro-cosmos* though blending together in everyday lives of people.

According to Sow (1980) the *macro-cosmos* is the area of activity and existence where God is experienced. This is the area where most traditional African people interact and experience God in their human functioning. Traditional African people experience and communicate with God in the fields when growing crops, when looking after their animals and in times of happiness and sadness. God is not limited to Sunday services in churches, though there are sacred places for various communities where God is invoked through some special rituals.

For example, in times of drought when cows are dying, a Maasai leader will go to this sacred place to offer sacrifices to God for the drought to end.

Meso-cosmos is the sphere where ancestors, malignant spirits and sorcerers are encountered and experienced (Sow, 1980). It is the world of animals and human beings, forests, bushes, trees, rivers, wind, rain, darkness and light. From an African perspective, this is an African worldview in which conflicts; events such as accidents, sicknesses, deaths, failures as well as successes of various kinds are explained.

Certain aspects of human behaviours, if not all, are explained and understood from these African worldviews. External agents tend to determine human behaviours in these worldviews. Spirits of the departed ancestors are believed to look after the best interest of their descendants and at the same time can also send them illness and misfortune when they are moved to wrath (Hammond-Tooke, 1989). Today people communicate and relate to ancestors who, for example among the Akans of Ghana are called “*nananom nsamanfoɔ*” and also, through anniversary celebrations of deceased family members, tomb stone services and other activities like “*mpho ya badimo*” among Sotho speaking people of South Africa.

The *Micro-cosmos* is regarded by Sow (1980) as the level where the individual is seen to exist within the context of the collective. This individual existence nevertheless, does not rest on the principle of individual survival enshrined in the theory of evolution of Western perspective. Every human being has relatives, living or dead. Every human being encounters and experiences nature in some way; rain, trees, and the like.

In the African philosophical thought, no one is an island of himself or herself. As the Basotho say '*motho ke motho ka batho*' (I am because we are). A person exists because others exist. The collective existence of the individual gives room for individuality. This individuality is manifested in the use of names unique to the individual in the family and not collective family names as Mbiti (1969) points out. Among the Akans and Ewes of Ghana and Sotho people of South Africa, surnames or family names are not normally used to address the individuals; instead they are used when collective existence of the individual in a particular tribe, clan or extended family is referred to.

This collective existence does not necessarily make the individual lose his/her individuality. It is evident that psycho behavioural modalities from an African view of the person and the worldview emphasises groupness, sameness and commonality. Values and customs are reinforced by cooperation, collective responsibility, co-operation and interdependence (Viljoen, 2003).

1.1.2 Religious Beliefs and Medicine

Religion is virtually inseparable from every aspect of Ghanaian life and is important in the determination of worldview. Religion most often describes a person's search for sacred meaning or ultimate truth (Exline, 2002; Pargament 2002b) and is usually accompanied by a social or group component. Increasing empirical research has pointed to the particular importance of spirituality and religion in the lives of many individuals, of diverse racial and ethnic backgrounds (Tarakeshwar et al., 2003); especially when responding to stressful, adverse, and even life-threatening circumstances (Constantine, Alleyne, Caldwell, McRae, & Suzuki, 2005; Joseph & Kuo, 2009; Utsey, Adams & Bolden, 2000).

Religion commands central place in the organisation of social, political and cultural life, and regulates the relationship between people and their physical and spiritual environment. Some researchers have described religion as the medium through which spirituality is expressed (Utsey et al, 2007). The concept of God, divinities and spirits in African traditional religious ontology has been so misunderstood by many scholars to the point of seeing Africans as people who did not know the Supreme Being nor worship Him (Ekeke & Ekeopara, 2010). Religiosity, whether rooted in an organized community or not, varies a great deal from person to person.

Historically, religiosity, which is the belief in a higher power or a divine order, has represented a form of strength and/or hope for marginalized groups such as African Americans, the elderly, women, and the less educated. This helps to explain why studies often find higher levels of religiosity within these groups (Argue, Johnson & White, 1999; Faigin & Pargament, 2010; Pargament, 2002a; Strawbridge et al, 1998; Yohannes, et al, 2008). God or the Supreme Being in African Religious Ontology is referred to as the living eternal Being who is the source of all living and whose life existed from the dateless past. He is self-existed and is the one whose power sustains the universe. He is an all-knowing Being who knows and sees all things at the same time without any modern instrument. He even knows the end from the beginning.

The foundation of the worldview among Akans in Ghana for example, lies in the belief that a Supreme God created the world, and that God is the source of all good and evil things. The way in which a person sees the spiritual nature of the human body relates directly to the way they relate to other people and the environment around them. This

worldview is further shaped by the belief in two separate but connected worlds: the world of spirits and the world of the living. The spirit world contains a hierarchy of powers that includes the Supreme God, lesser gods, ancestors, witchcraft and magic. This hierarchy reflects on how people view the composition of personal nature. The Akans, for example, see individuals as a combination of four components that stress the importance of a Supreme God, the spiritual world and the father and the mother. The Ga and Ewe have a similar approach to the makeup of an individual, but it also varies because of the different emphasis on matrilineal and patrilineal kinship (Opoku, 1978).

A close observation of the African traditional society reveals that religion is at the root of people's culture and in fact, the determining principle. Opoku (1978) and Parrinder (1961) have emphasized the fact that in the life and thought of the traditional African and for that matter, the traditional people, religion is life and life is religion - religion permeates every endeavour of the traditional African, be they moral, social, economic, or political. In view of this, it is not uncommon to see religion playing an active role in the practice of medicine in the African traditional milieu. And, indeed, there are overwhelming evidence among the traditional Africans to show that the practice of medicine is closely tied up with religion. Osborne collaborates this when he says among other things that: 'indigenous African healing stems from ancient, fundamental, philosophical and religious beliefs... and that their concerns about bodily well-being cannot be separated from their spiritual beliefs (Osborne, 2003).

In view of this, it is believed that God is the ultimate source of all medicine and thus, medicine is viewed as a gift from the creator and it is dispensed through the agency of the divinities. In Ghana, all herbalists recognize God as the healer and hence the saying 'If

God gave you sickness he also gave you medicine.’(Rattray, 1923 p 142). In recognizing the fact that God is the source of healing, traditional medical practitioners often tell their clients when consulted that ‘if God permits you will be healed’ (Vanderpool & Levin, 1990). The divinities also have a role to play in the practice of medicine. In Ghana, *Tan Kwasi*, the state god of Berekum, for instance, is said to be famous for her prowess in handling infertility problems (Opoku, 1978).

The quest for health, therefore easily shades into issues of religion because it plays a significant role in social life (Iyalomhe & Iyalomhe, 2012). There is the belief that western medicine can cure diseases provided the right conditions are fulfilled. Treatment of diseases classified as “common” or “ordinary” is diffused using either traditional or allopathic medicines while those classified as “severe” or “extraordinary” usually require special (traditional) attention (Olujimi, 2006; Ewhrudjakpor, 2007; Omotosho, 2010).

The basic explanatory theory is that in serious illness, there is an underpinning of the supernatural. The most frequently evoked agency is ancestor spirit anger or bewitchment (Ivey & Meyers, 2008). Ghanaian terms usually used is witchcraft (*bayie* – Akan, *aye-Ga*, *adze* – Ewe, *anyen* – Fanti. Ancestor spirits constitute part of the ordered structure of the African cosmology (Busia, 1954; Mbiti, 1987; Idowu, 1973). The Akans of Ghana conceptualize naturally caused diseases that attack the physical body (*onipadua*) as originating from the belly (*yafunu*) and have a connection with the blood (*mogya*)(Ventevogtel, 1996). This explains why tradition medicine frequently administers enemas.

Diseases that result from an imbalance between humans and nature/environment are naturally caused. Twumasi, (1975) identifies various tropical infections such as malaria,

wonn infection, yellow fever, sleeping sickness and yaws, as naturally caused diseases resulting from imbalance between humans and nature (environment). According to Brafi (1997) disease is man-made and can be cured by man himself.

Further explanation is that good health exist when there is a harmonious relationship between the individual and the deities. Upsetting the ancestors produce a disturbance of this order and hence disharmony and illness. In the African philosophical thought, all living things including man are linked in harmonious relationships with the gods and the spirits, so that reality consists in the relation not of man with things but of man with man and of all with the spirits. Such relationship is ascribed to vital forces which each entity generates. A state of health therefore exists when there is perfect harmony between man and his environment. This belief is inherent in those who practice African Traditional Religion as well as in many Christians and Moslems (Mbiti, 1987; Ewhrudjakpor, 2008).

On the other hand, ill health and other misfortunes can result from a disturbance in the relationship between man and his social and spiritual environment, or from forces directed by witches, wizards, sorcerers, evil spirits or angered ancestors because of infraction of totemic principles (Mbiti, 1987). The popular notion is that “people do not just suffer illness by chance” therefore, serious illnesses like stroke and hypertension are believed to have their origin in a primary supernatural cause. There is no difficulty, however, in accepting biomedical explanations based on the presence of viruses, bacteria, parasites, cancer or high blood pressure; these are simply seen as secondary causes. The idea of primary causation provides an explanation as to why a particular individual, and

not others in the group, is afflicted by these infectious agents (Kroeger, 1983; Twumasi, 1988).

1.1.3 Disease Specific Health Seeking Behaviour

Historically, diseases whose aetiology could not be readily explained, an example being convulsion, have been given supernatural explanations among the various ethnic groups in Ghana (Awusabo-Asare & Anarfi, 1997). Such an explanation of disease causation influences people's attitude towards the disease as well as toward infected persons, and this influences the health seeking behaviour of infected persons. In a number of societies, the occurrences of diseases such as cardiovascular disorders with no known cure or origin may be attributed to the commission of an offence against one's spirits, the ancestors or the gods, or an omission of duty on the part of an infected person. It could also be attributed to a curse from a jealous neighbour, co-wife and even a family member or somebody who has been wronged (Danquah, 2008; Twumasi 1988).

At different times in Ghana, the occurrence of diseases such as hypertension, stroke, tuberculosis, measles and guinea worm has been attributed to supernatural sources (Amoah, 2003). The mainstay of the African philosophy of health and illness is the reverence and respect for the ancestors (Oladipo, 1998). Ancestral spirits, God and witches and sorcerers were and still are believed to influence health and illness. There is a belief that Western medicine can provide neither an explanation nor a cure for certain diseases. Such orthodox medicinal practices teach for instance that once an individual is hypertensive, the condition is for life and one may have to be on medication until death (Dokosi, 1998).

Such an explanation has not been embraced by all, for which reason people seek explanation from other sources. Therefore, people suffering from cardiovascular diseases the origin of which has been attributed to supernatural causes, may seek explanation and possible cure for the disease at fetish shrines, diviners or spiritualists. If it was divined that the illness resulted from an offence by the sick person, then he or she would be expected to cleanse himself or herself of the offence and pacify the community. Some of these procedures for identifying the cause of a disease have been adopted by the Ghanaian-based spiritual churches in their healing processes (Agyemang & Owusu-Dabo, 2008).

An event is attributed to ‘divine intervention’ in the affairs of people when they are not able to deal with a new or unusual circumstance within the context of existing knowledge and practice (Abe-Kim, Gong & Takeuchi, 2004). Although African societies have undergone dramatic socio-cultural changes during the last century in such areas as formal education, conversion to Christianity and Islam as well as changes in patterns of socialization, the old and new ways of life co-exist and people continue to give supernatural explanations to events.

Larbi (2001) observed that among the Anafo in Ghana, converts to Christianity when confronted with problems employed ‘traditional solutions, “syncretic” solutions that were orthodox in appearance but traditional in aim (West African Orthodoxy)’. Larbi concluded that ‘one could become Christian without ever confronting or redirecting one’s religious problem solving nexus’. Mbiti (1989) also observed that ‘beliefs connected with magic, witchcraft, the spirits and the living-dead are areas of traditional religions which

are in no danger of an immediate abandonment' in the face of changing socio-economic and educational circumstances.

The relationship of traditional to modern medicine is crucial in the provision of proper health care, and attitudes towards traditional medicine will have an impact on control programmes. Pillsbury (1978) cited in Singer, Davidson and Gerdes (1989 p 68) wrote:

"In many cases prejudice on the part of health planners against traditional... aspects of their own cultures has precluded understanding of traditional therapies. However, health care for the rural and urban poor cannot be satisfactorily provided without a basic understanding of the traditional and other local practices of the intended beneficiaries and the value and belief systems that underpin health-related behaviour."

1.1.4 Trends of Cardiovascular Disorders

The WHO (2013) has estimated that about 17.1 million people die yearly from cardiovascular diseases, (CVD) mainly from heart diseases and stroke globally. An estimated 17.5 million people died from cardiovascular disease in 2005, representing 30% of all global deaths. Of these deaths, 7.6 million were due to heart attacks and 5.7 million due to stroke. Over 80% of CVD deaths take place in low- and middle-income countries and by 2030 more than 23 million people will die annually from CVDs (WHO, 2013) further asserts that about 80% of deaths from cardiovascular disorders occurred in low- and middle-income countries. By 2015 an estimated 20 million people will die from cardiovascular disease (mainly from heart attacks and strokes). If the current trend continues, studies indicate that by 2020 mortality rate from CVD is expected to increase by 120% for women and 137% for men (Yach, Hawkes, Gould & Hofman,

2004). Majority of the estimated 32 million heart attacks and strokes that occur every year are caused by one or more cardiovascular risk factors – hypertension, diabetes, smoking, high levels of blood lipids, and physical inactivity.

Ghana, as an African country has not been spared the high prevalence rate of cardiovascular disorders. According to Kadiri (2005), cerebral haemorrhage is a leading cause of death in Ghana, and the average age at which people die from this cause is 55 years. Chronic diseases have a longer history in Ghana than is usually thought. Cases of stroke were presented and treated at Korle-Bu Hospital when it opened in the 1920s (Pobee, 2006). Between the 1920s and the 1960s, data gathered from Korle-Bu hospital showed a steady increase of stroke and other cardiovascular diseases (Pobee, 2006). Hospital-based and community-based studies conducted since the 1950s provide important information on prevalence and morbidity trends for hypertension, diabetes, cancers and sickle cell disease.

In the 1970s, the World Health Organisation (WHO) - sponsored Mamprobi Cardiovascular Disease (CVD) study recorded hypertension prevalence of 13% in the community (Pobee, 2006; 1993). A non- communicable disease survey conducted in 1998 recorded a national prevalence of 27.8% for hypertension (Bosu, 2007; Mensah, 2002). Studies conducted after the national survey showed higher prevalence rates across different groups in different regions: 28.7% in Kumasi in the Ashanti Region; 32% prevalence in Bawku/Zebilla in the Upper East Region; 36.9% in Keta-Dzelukope in the Volta Region; and 47.8% among a cohort of women in Accra (Pobee, 2006; Hill, Anarfi, Darko, Duda, 2005; Cappuccio, Micah, Emmett, Kerry, Antwi, Martin-Peprah, Phillips,

Plange-Rhule, Eastwood, 2004; Nyonator & Kutzin, 1999). In Accra, cardiovascular diseases rose from being the seventh and tenth cause of death in 1953 and 1966 respectively, to becoming the number one cause of death in 1991 and 2001 (Agyei-Mensah, 2004). By 2003, at least four conditions - stroke, hypertension, diabetes and cancer – would be among the top ten causes of death in at least each regional health facility in Ghana (Bosu, 2007).

1.2 Statement of the Problem

Cultural practices in terms of beliefs and values play very significant roles in the health seeking behaviour of people (Addo, Amoah & Koram, 2006). People often depend on their cultural beliefs when dealing with health conditions and seek help from traditional healers; and make minimal use of hospitals and other health facilities in Ghana, they prefer to seek help from traditional healers (Agyemang, 2006). Medical, psychological, socio-cultural, economic and structural factors have been implicated in the concept of health seeking (de-Graft Aikins & Arhinful, 2010). This study seeks to understand health seeking practices of Ghanaians. Conceptual and practical responses to cardiovascular disease burden in Ghana have been largely biomedical, with primary emphasis on epidemiological and clinical activities.

Current research practice and policy regarding cardiovascular disorders is detrimental to the Ghanaian public health system (de Graft Aikins, 2005; 2006), as there is no “culturally congruent” research and policy concerning the Ghanaian Health system that seeks to view health from the socio-cultural perspective (Abdool, Zigubu-Page & Arendse, 1994; Cherepakho, 2008). Early studies on health-seeking behaviour in Ghana have largely dwelt on Western conceptualisations that have failed to take cognizance of

the local religious beliefs (Danquah, 2008). Health belief systems among Ghanaians make provision for the idea that sickness has been caused deliberately by enemies, for which reason a supernatural or mystical explanation is sought (Fields, 2001). Extensive search of literature has revealed that there has not been much research into this domain to enable us understand the extent to which religion and spirituality inform people's choice of treatment for their ailments, and the effects of such actions on their health. Moreover, these assumptions are based on anecdotic evidence for which sound empirical data are lacking.

While studies outside of Ghana, most of which are Western-oriented have established different determinants of health-care seeking behaviour based on demographic considerations (Grover, Kumar & Jinda 2006; Vu 2008; Williams, Gonzalez, Neighbors, Nesse, Abelson, Sweetman & Jackson 2007), this cannot be assumed to apply within the Ghanaian context, because of the different environment in which the research took place. The few studies that have been undertaken in Ghana have only managed to scratch the surface by engaging mainly in clinical studies of patients without seeking the views of the general trend of health seeking among the population (Pobee, 1993).

Furthermore, the few studies that have examined health seeking behaviour in Ghana have been predominantly quantitative (Osafo et al., 2011). These quantitative studies have sought to examine relationships that exist between and among variables but do not go further to explain the whys and hows of these relationships. There is therefore the need to undertake the perceptual experiences and meanings behind the statistical explanations (Osafo et al., 2011) offered for health seeking behaviour for cardiovascular disorders in Ghana. For instance what meaning does stroke or hypertension constitute for a person

who is reported to be suffering from either of these conditions? In such an instance, an answer to such a question requires a method which is meaning-driven, such as the use of qualitative method (Silverman, 2006).

In spite of the accumulated knowledge about cardiovascular disorders in sub Saharan Africa in the last decade, knowledge about the socio-cultural practices and beliefs of patients suffering from these conditions is fragmentary (Awusabo-Asare & Anarfi, 1997). Though several studies have emphasised the role of culture on health seeking behaviour (Hennis, Wu, Nemesure & Leske, 2002; Iyalomhe, 2007; Mari, Ukai & Yamamoto, 2006; Ong, Cheung, Man, Lau & Lam 2007; Petrella, Merikle & Jones, 2007) there is little understanding of the socio-cultural factors that influence people suffering from cardiovascular disorders and their families in terms of their health seeking behaviour (Iyalomhe, 2007; Mari et al., 2006). There is the proposition that a large number of people believe in supernatural causation of cardiovascular disorders and such people desire to be cured completely, in spite of the available information to the contrary that these conditions are chronic (Tesfaye, Byass & Wall, 2009).

Resting on the assertion of Pobee (2006), that research on health seeking behaviour has largely been undertaken without much reference to cultural belief systems and that they are mainly quantitative, which tends to give 'surface meanings' to these cultural beliefs, as a point of departure, this thesis set out on the premise that earlier studies have missed a very vital element in health seeking research in Ghana. This missing element is the cultural values and beliefs that impact on people's health seeking behaviours (Makanjuola et al. 2000; Adelekan et al. 2001; de Villiers & Ledwaba 2003; Pinkoane et al., 2005; Danquah, 2008; Abubakari, Lauder, Agyemang, Jones, Kirk & Bhopal, 2008).

Such research effort is critically needed in health seeking research in the country since it can facilitate the development of valid theories of health seeking behaviours and to provide “culture congruent” explanations to people’s beliefs about disease causation and its influence on health care seeking. This is the crux of the present study.

1.3 Significance of the Study

As indicated earlier, this study sought to examine the health seeking behaviour of people suffering from cardiovascular disorders. It is anticipated that findings of the research will contribute to a better understanding and appreciation of the health-seeking behaviours of people informed by socioeconomic factors and cultural variables such as level of education, proximity to health facilities, belief systems and religious practices. The importance of why people seek medical care is undoubtedly critical in health policy planning and, this particular area has not been adequately researched into thus making this study not only relevant but also timely. Furthermore, it is anticipated that findings of the study could be useful for advocacy, to drive home to policy makers and other stakeholders on the need to realise the multi-faceted cultural context of health seeking among Ghanaians so that appropriate policies are formulated and culturally relevant programmes planned and implemented to meet the needs of the Ghanaian population in terms of healthcare seeking.

Specifically, the research findings may prove useful to the contemporary Ghanaian society as well as for posterity. Literature search has identified the lack of local research and studies on health-seeking behaviour in Ghana thus making this research area a virgin area. It is anticipated that the findings will provide baseline information on health

seeking behaviour of the people of Ghana upon which other researchers can build. Findings may trigger further research interest in related areas in other parts of the country and in the context of other diseases of public health importance and concern.

Based on the set objectives for the study, findings may bring to fore the need to better integrate traditional and conventional healthcare systems into a holistic system which is sensitive and aligned to the socio-economic and cultural system within which it operates. Since the establishment of the Ghana Federation of Traditional Medicine Practitioners Association (GHAFTRAM), there has been no indication of effort toward formal recognition let alone attempts at the integration of the practitioners into the mainstream healthcare system. The vast majority of the traditional health practitioners appear to be working at the fringes of the national healthcare delivery system. This is at variance with the 5-year Plan of the Ghana National Health Policy (2007), which seeks to foster closer collaboration and partnership within the health sector, communities, other sectors and private providers both allopathic and traditional. This could be attributed to the lack of appreciation of the cultural context within which patients in Ghana seek healthcare and the suspicious manner in which traditional healthcare practitioners are viewed. Findings of this research may thus provide data for advocacy towards policy formulation in relation to education, awareness creation, and integration of alternative medical practitioners into the mainstream healthcare delivery, particularly in the context of the management and control of cardiovascular disorders in Ghana. Moreover, findings from this research may bring to the fore the need to make issues concerning cardiovascular disorders, their management and control essential in public health practice in the country.

This study may further bring to light the decision-making process of Ghanaians and other processes they go through before seeking help for cardiovascular disorders. Information obtained could determine the content and nature of health education and promotion interventions for individuals and families affected by cardiovascular disorders as well as those who are predisposed to such conditions. It may further bring to fore the extent to which the various locus of control variables influence people's health seeking behaviour in terms of benefits and dangers of such orientations.

Findings and pertinent issues raised in the study may serve as a reference point where future researchers in this area may consult for more information and ideas to replicate and/or build on it. As indicated in an earlier section, very little research seems to have been conducted regarding health locus of control of Ghanaians and how such orientation impacts on their health seeking behaviours. It is hoped that findings relating to the locus of control component of this study may help better tailor and target interventions and programmes of public health/ community health, social work practitioners as well as other allied health workers.

1.4 Aims and Objectives of the Study

1.4.1 General Objective

The overall objective of this thesis is to explore the health seeking behaviour for cardiovascular disorders.

1.4.2 Specific Objectives

In order to achieve the above general objective, a number of specific objectives have been developed. These are to:

1. Explore the role of cultural values and belief systems in determining health seeking behaviour for cardiovascular disorders;
2. Assess the influence of efficacy of orthodox and traditional health systems on the health seeking behaviour for cardiovascular disorders;
3. Identify the socio-economic factors that influence health-seeking behaviour for cardiovascular disorders; and
4. Explore the effects of multidimensional health locus of control (MHLC) locus of control orientations on health seeking behaviour for cardiovascular disorders.

1.5 Theoretical Framework of Health Seeking Behaviour

Anderson & Neuman's (1973) theoretical framework guided the current study in an attempt to understand health care utilisation among the study participants. The goal of this framework was to develop a behavioral model that provides measures of access to medical care. It was first developed in the 1960s and has since gone through various revisions. The framework was initially developed specifically to investigate the use of biomedical health services but was later extended to include other health care. According to Anderson, an individual's access to and use of health services is considered to be a function of three major characteristics. These include:

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 will better help 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, 1973)

- 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, 1973)
- Evaluated: "Represents professional judgment about people's health status and their need for medical care." (Andersen, 1973)



Figure 1.1 Diagrammatic Presentation of the Healthcare Utilisation Model

Anderson & Newman, (1973)

This model is cross culturally relevant because of its flexibility in allowing researcher to choose independent variables related to the specific objectives of the study. Further, the flexibility of the model to study different outcome variables in later life, spanning the utilisation of health care (Wolinsky & Johnson, 1991), formal social care (Bass & Noelker, 1987) and informal care (Gaugler & Kane, 2001), demonstrate its usefulness for gerontological research. This model has become one of the most widely used frameworks to predict healthcare use (Phillips, et al., 1992). The concept of predisposing factors look at the sociocultural characteristics that take into consideration factors influencing the social system and social interactions, especially unique socio cultural factors that define the way of life and the flexibility offered by the framework makes it relevant to the Ghanaian, baring the influence of ethnicity. It also talks about health beliefs, which include attitudes, values and knowledge that people have concerning the health system. It is a truism that in Ghana, people's belief about the efficacy of health system influences their health seeking behaviour and generally, the use of the traditional system has mostly been regarded as the first option. This model therefore takes cognizance of the various relationships among variables and the eventual health seeking behaviours.

Enabling factors in the framework relates to issues like income, health insurance and access to health facilities that potentially influence health seeking behaviour among the people under study. They also include the availability of health services in the community and the amount of time spent at a particular setting and its implications on subsequent health seeking behaviours.

The relevance need factors in the framework to the population under study is gleaned from an argument advanced by Andersen that these need factors is a social construct, which is determined by health beliefs, such as whether or not people think their condition is serious enough to seek health services. Health belief and its relationship with health seeking behaviour is very relevant in understanding people in their choices of health care. This health seeking encompasses both orthodox and traditional healthcare services (Phillips, et al., 1992). This model includes cultural factors which were barely taken into account to study health seeking behaviour (Hausmann-Muela, Ribera & Nyamongo, 2003). This elaboration further included predisposing factors like religion, general attitude towards health series, knowledge about illness, cultural adaptation, and formal education.

The enabling factors include individual's perception of CVD, whether acute or chronic, belief in aetiology, expected benefit or treatment, belief in orthodox or traditional system. The need factors include appeal of health system, opinions and attitudes of the sick person towards the health systems, appeal, accessibility, affordability and costs. These factors are followed by the health response, whether orthodox or non-orthodox health system. Taking cognizance of the biopsychosocial(s) approach of health seeking behaviour, the spiritual aspect of decision-making, which is ingrained in the belief systems of Ghanaians and for that matter Africans are seen as playing a vital role in understanding of health seeking behaviour in the African/Ghanaian context. Africans are seen as 'notoriously religious' and religion, and for that matter, spirituality play a vital role in every decision- making in every aspect of the life of individuals. Inability to explain the cultural context of belief system in terms of religion and spirituality as far as

health seeking behaviour is concerned will result in incomplete understanding of the Ghanaian context of health seeking.

Summary

Health acquires a broader dimension to include the physical, spiritual, sociological, and physiological factors. Many people in Ghana integrate both the indigenous and modern approaches to health and healing into their lives and manage to comfortably harmonize these seemingly incongruent approaches. The presence of hospitals and clinics that provide health services to many Ghanaian people attest to the fact that on many levels biomedicine continues to be utilized. Yet the acceptance of biomedicine is only partial, and that patients routinely consult indigenous healers like the Okomfo, Diviners, herbalists and prayer camp operators before or after their hospitalization to complete their treatment, and perhaps to determine “who” caused the illness or “why” the illness came. Anderson’s (1973) healthcare utilisation model which looks at predisposing, enabling and need factors was used to guide this study, as its flexibility allows for easy adaptation to the Ghanaian social system.



CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents an overview of available research and programme reports which are pertinent to the thesis topic. Areas covered in the review include culture, belief systems and how these affect health seeking behaviour, who traditional priests and priestesses are, the training they go through and the role they play in the diagnoses and treatment of diseases. It also covers the socio-economic status and health seeking behaviour, the plurality of medical systems and their use and, health locus of control orientation and its effect on health seeking behaviour.

2.1 Cultural Belief Systems and Health Seeking Behaviour

Culture according to Giddens (2006 p 143) is “the ways of life of members of a society, or of groups within a society”. Leininger (1997 p 248) defines culture as “the learned, shared, and transmitted values, beliefs, norms, and life ways of a particular group that guide their thinking, decisions, and actions in patterned ways”. Culture is generally transmitted intergenerationally. It also determines people’s definition of mental and physical health and their interpretation determines how they deal with illness (Sonowal & Praharaj, 2007). According to a classical definition by Taylor (1871), cited in Sardar and van Loon, (1997) culture is "that complex whole which includes knowledge, belief, art, morals, law, customs, and many other capabilities and habits acquired by members of society." Culture means the total body of tradition borne by a society and transmitted from generation to generation. It thus refers to the norms, values, and standards by which people act, and it includes the ways distinctive in each society of ordering the world and

rendering it intelligible. Cultural values regulate behaviour and social interactions with others and cultural beliefs are those aspects of culture that attach meanings to events, things, and people. With a better understanding of why people use or do not use particular health care services, health care providers can seek to improve the quality of human life and this can better be understood if there is a proper appreciation of the cultural values and belief systems of a group of people. Culture has been proposed to affect health in many ways, where people use culturally specific explanatory models to think about, talk about, and direct care for health problems. This can lead to different patterns of health-seeking and prevention, as well as mismatched provision of care (Hunt & Bhopal, 2004; Lannin, Mathews & Mitchell, 1998).

Culture shapes health seeking behaviours and serves as the lenses for perceiving and interpreting experiences (Dutta-Bergman, 2004). Awah, Kengne, Fezeu and Mbanya (2009) in a study found that among 72 patients with hypertension and diabetes, there were multiple indigenous labels for hypertension and diabetes, which translate to phrases such as 'excess blood' more blood sickness and 'sugar, sugar sick' or illness that originates from "too much sweet things". These indigenous names also change through time. Furthermore, studies done by Awah, Unwin and Phillimore (2009) revealed that some participants in this sample attributed the cause of hypertension and diabetes to a curse or witchcraft. In a South African medical center Kagee, Le Roux and Dick (2007) interviewed patients with hypertension and found that patients may attribute the cause of hypertension to psychological states such as anger.

Lifestyle interventions and education programmes need to account for local interpretations of disease origins and names in order to be effective. While some

traditional practices or interpretations may seem different, examining the socio cultural context within which such practices take place provides better insight into the cultural influences on health seeking behaviour for cardiovascular disorders.

Pramukh and Palkumar (2006) in their study among the Bogatha found that they attribute diseases to which they have no logical explanation to certain deviant acts of self and others towards elders, nature, and divine rules. Thus, their first priority when they perceive ill-health is to get spiritual cure in a traditional way. They believe in the power of prayers and rituals that enable some herbs to act as medicines to heal diseases among them. The researchers in their quest to understand these cultural influences on health seeking behaviour did not indicate the other sources of health seeking, in case of failure of the first line of treatment. Despite the fact that there are multiple sources of treatment, emphasis was laid only on the conventional healthcare delivery system.

Studies done by Toliver-Weddington (2000) on cultural considerations for the treatment of cardiovascular disorders among African Americans revealed that they still believe in magic, folk medicine, spirits, and other signs of witchcraft. The notion of supernatural causation of disabling conditions continues to persist to some degree. Concepts of divine intervention are also present. Such beliefs suggest that when man displeases his gods in some way he is punished for it. This study, however, did not take into consideration other factors like economic and other need factors that influence health seeking behaviour of the people.

Walker (2006) reports that the Ngwas of Nigeria believe that the spirits of their loved ones and enemies from the spirit world return to inflict punishment. Nigerian women for example, believe that hypertension was caused by evil spirits; and that the spirits were

angered by the mothers staying in the sun too long or the spirits were sent by others (Akinkugbe, 2004). With this belief system, orthodox treatment is not an option. They tend to seek treatment from traditional healers who they believe, have antidotes to their problems. Some researchers and cultures believe that allopathic medicine can only explain certain disease conditions within the limitations of its own medical model and by frequently violating local cultural understandings (Yawney, 2005). Medical science can describe illness clinically without recourse to cultural factors, but it cannot explain or treat all illnesses successfully without taking into consideration non-biological aspects.

Mwenesi (2004) states that a number of studies conducted in the last decade have highlighted the fact that recognition/definition of hypertension is based on a people's belief system, as it relates to the aetiology of illness. The belief system forms the basis of categorization of illnesses into serious, mild or mundane, which in turn determines the promptness with which care is sought and the type of care sought which include home, traditional or modern; and the social network that will be involved in decision making for treatment seeking. The studies conducted did not however, take into consideration the nature and type of social network that involve enabling and need factors.

Studies conducted in Ghana, Kenya and Tanzania indicate that a significant proportion of caregivers perceive uncomplicated malaria, for example, to be a mild disease for which home remedies are generally sought. However, they associate severe or cerebral malaria with evil spirits (Mwenesi, Harpham & Snow, 1995; Hausmann-Muela & Muela, 2000; Asenso-Okyere, Dzator & Osei-Akoto, 1997; Ahorlu, Dunyo, Afari, Koram & Nkrumah, 1997). In such cases, spiritual and other traditional healers are usually approached for

healing. D'Andrade (2005), revealed that when cultural values are applied to all illnesses, and for that matter, cardiovascular disorders, the culture, beliefs and values of a group influence perceptions about the meaning of an illness, the types of treatment or remedies that are useful, and the likely outcome of health behaviours related to the prevention and control of disease (Coreil, Wilke & Pintado, 2004; Barg, 2000).

Ethnic belief system in religiosity may lead to greater rates of religious coping among Africans, Konadu (2008) noted that among the Akans of Ghana, there are cultural beliefs related to hypertension which influence people's health seeking behaviour. In these societies, people's ideas and behavioural pattern conflict with the knowledge on diseases for which reason health services are underutilized and several healthcare instructions are ignored. Weller (2007) revealed that the understanding or knowledge that hypertension is caused by supernatural power is rife and may lead them to seek treatment from traditional healers. This situation still occurs in many parts of Indonesia, although western allopathic medicine is increasingly becoming more widely accepted (El Bashir, 2008). The people still believe in supernaturalism so they view western medicine as a system that merely provides symptomatic or supportive therapy. Health seeking behaviour among these cultures is not based on affordability, accessibility or proximity but the belief system plays an integral part in decisions about health.

Treviño (2001) found in Guatemala that *nervios* or 'nerves' was a culture bound disease where the blood turns black after one has been frightened. When this happens some traditional healers are invited to say a prayer from the book Santa Cruz de Caravaca. The individual then becomes well after the prayers have been said. It is their beliefs that these nerve-related conditions are caused by the supernatural for which prayers are more

effective than any other remedial action. According to Treviño (2001), an option to seek help from the orthodox source is ruled out in such conditions since they believe it is not a sickness for orthodox medicine. This study was done in a very traditional setting where access to modern healthcare was almost non-existent. It thus, did not take into consideration the possibility of seeking help from the modern healthcare system due to lack of exposure. In a study to examine the beliefs and community responses to mental illness in Ghana,

Beal (2006) found that the use of traditional healers for gynaecological problems amongst women is common to all cultures. These cultural practices and beliefs have been prevalent regardless of age (Geissler, 2000), socio-economic status of the family and level of education (Stuyft, Sorenson, Delgado & Bocaletti, 1998). Beliefs also affect awareness and recognition of the severity of illness as well as acceptability of the service (Hasan & Khanum, 2002). In addition, the cooperation, empathetic attitude and active listening offered by the traditional healer attract more clientele as compared with modern allopathic practitioners (Stekelenburg et al., 2005). Pramukh and Palkumar (2006) showed that some tribal groups of India, namely, the Savaras, Bogatha, Konda, Valmiki, and Koya believe in the power of prayers and rituals that enables some herbs to act as medicines to heal cardiovascular diseases. They attribute diseases to certain deviant acts of self and others towards elders, nature, and divine rules. Thus, their first priority is to get spiritual cure in a traditional way. There was however, no indication of the availability of other health facilities and whether or not these were being patronised. Furthermore, there was no information about the impact of other non-traditional treatments that had informed their decision to rely mostly on traditional treatment.

Chanita et al. (2006) found in a study that cultural differences do not necessarily have any influence on health seeking behaviours. Their findings demonstrated that while ethnicity is important to some cultural values such as religiosity, clinical experiences with disease may also be important to values related to temporal orientation. They thus underscore the importance of evaluating the context within which cultural values are expressed in addition to characterizing ethnic group differences. They did not, however take a critical look at the various cultural values and belief systems which influence health seeking behaviour and as a result inform every decision the people took concerning their health.

Another study by Weller, Ruebush and Klein, (2005) that aimed to predict patient treatment seeking behaviour in Guatemala found that there was very little influence of culture on their health seeking behaviour. Their treatment choice was based on efficacy of treatment but not on cultural beliefs. Johnson, Elbert-Avila and Tulskey (2005) in a study that reviewed the literature on the influence of spiritual beliefs on treatment decisions of Africans. They found spiritual beliefs and practices as sources of comfort, coping, and support. God is held to be responsible for physical and spiritual health and the doctor is seen as God's instrument of healing (Johnson, et al., 2005).

2.2 Healers in Ghana

There are many more types of healers as Ibrahim et al. (2010) note in the research about the market. There are, for example, traditional spiritualists, special bone setters, fortune tellers, herbalists, traditional birth attendants, traditional psychiatrists, and so on (Mafimisebi & Oguntada, 2010). There are also diviners that consult the spirits to help them cure diseases or track down witchcraft. They are 'those concerned with oracles and divination' (Parrinder, 1961) who can give messages from the gods and consult oracles

about difficult questions. Generally, these healers, especially the traditional Priests 'dedicate themselves to the god for life' (Parrinder, 1961: 75), but they usually have a job on the side so that they can earn a living. These people, often also called priest-healers, are highly respected in a community. The *Akomfoɔ*, for example, as they are called in Twi, 'combine the roles of religious specialist and healer' (Ventevogel, 1996). Not all these priests are also healers, but when they do diagnose and treat people, they use various plants, minerals and/or parts of animals and religious rituals.

They are attached to certain shrines and offer sacrifices. They are very important when a ritual is taking place. A shrine 'is any potential abode for a spiritual force ... the shrine can be a brass-pan, a clay pot, or small statues' (Ventevogel, 1996: 33). These artefacts are kept in a room in the priests' residences or if there is a separate house, they keep it there. In this house, there is a room where the linguist lives, a place for the drummers and the dancers and a kitchen or cooking area. A linguist is a 'spokesman of a chief or deity' (Ventevogel, 1996: 140), in this case he would be the spokesman of the deity. But most important 'is the actual room or "shrine" of the god' (Adinyira & Hyland, 1972). When a person has a disease that is believed to have been caused by a deity, an experienced priest-healer should be able to see the difference between that and an ordinary disease. Ventevogel (1996) also notes that a priest-healer can get into a full trance, during which he is possessed by his or her god. The upkeep of the shrines mostly depends on the donations that the public offer to them.

A new priest or priestess is not always appointed by birth. Most of the time, the spirit chooses the next priest by consulting an oracle. The new priest will get a 'calling' (Tsey, 1997) or be 'called' (Ventevogel, 1996: 33) by the *obosom*, spirit or deity. Then they will

enter a period of intensive training. Among the Akan, this was a 'formal period of seven years in which each served as an apprentice and learned how to make use of medicinal herbs'.

The documentary 'Traditional Religion in Ghana' (2008) demonstrates how a woman is chosen to become a new priestess for a shrine. When snake spirit possesses this woman, she does not know what she is doing anymore and she starts to talk in a strange way. This is a sign that the god is speaking. They feed her the food the spirit likes (raw eggs) and the spirit is satisfied. Unlike what Parrinder states, in the documentary it is also shown that priestesses who belong to a certain shrine can become possessed by the spirit. Mafimisebi and Oguntada (2010) state that traditional medicine 'practitioners possessing this ability enter into a trance as soon as a patient arrives or when people come to consult them about an ancestral problem' (Mafimisebi & Oguntada, 2010: pp 5). The practitioner speaks about what he is seeing. In the documentary, it is not shown if the woman who is possessed by the god is also able to cure people. She is the divine medium through whom the god can speak.

Another very important type of healer is what the Akan call a *Nnunsinfoo* in Twi. This can be translated as 'herbalist' (Ventevogel, 1996: pp 35). These herbalists also have another job on the side. Most of the time they are farmers (Ventevogel, 1996). These herbalists do not go through extensive training, but they 'acquired their knowledge mainly through family members'. Other 'healers claimed that no one had taught them anything about herbs and that the knowledge came to them in supernatural ways' (Ventevogel, 1996: pp 30). These doctors are called *odunsinni* in Twi, which means 'he who has roots'. They speak in this way about someone who works with medicinal plants (Ventevogel,

1996; Parrinder, 1961). There is a great variety in this group as well. Herbalists do not get possessed by spirits, but 'they can work with less powerful spirits and can use medicines that enable them to diagnose spiritual diseases' (Ventevogel, 1996). Some herbalists are also said to be able to make bad medicines and use magic practices to make people's lives miserable. Others do not do this and would oppose it for other religious reasons.

2.3 The Role of *Akomfoɔ* (Traditional Priests) in Health among the Akans

This part of literature focuses on the role of the *Akomfoɔ*, traditional spiritual healers who combine both herbs and spiritual mechanism in their healing. The focus here is the use of the *akomfoɔ*, because they are predominantly found in the study area where majority (over 50%) of the residents are Akans.

2.3.1 The Akan People of Ghana

The Akan are the dominant group in the modern Ghana. They constitute nearly fifty percent of the population of Ghana. The Akan comprise the Asante, the Fante, the Akuapem, the Akyem, the Akwamu, the Kwahu, the Nzema, the Ahanta, the Wassa, the Bono, the Safwi and the Ahafo. The Akan are predominantly found in the southern part of Ghana. The Akans are organised both matrilineally and patrilineally. There are eight matrilineal groupings or *Abusua*, (family) and their clans are *ekoɔna*, *Asona*, *Aduana*, *Atwea*, *Oyoko*, *Bretuo*, *Agona*, *Asene*, and *Asakyiri*. The patrilineal sub-groups or Akra are *Bosommuru*, *Bosompra*, *Bosommram*, *Bosomtwe*, *Poakwa*, *Nkatia*, *Afram*, and *Abankwaade*. Evans-Anfom (1986) puts it that every Akan must belongs to one of the matrilineal and one of the patrilineal.

2.3.2 The Akan Religious Worldview

Worldview always determines the whole life of a group of people, and it influences the true identity of a people group. Worldview defines the being of a person, and it also directs the way one thinks. One is exactly what he or she thinks. The common concept of reality shared by a particular ethnic group of people is referred to as a culture. Worldview is an individual as well as a group phenomenon and is the way the group of people live, think and behave. Braffi (1990), states that “expressions of community in individual worldviews make up the cultural worldview of the group. In the Akan worldview the spirits are real in everyday experience as natural objects are. This Akan sacred worldview articulates a physical and spiritualised universe and does not distinguish one from the other. “It is considered in the Akan worldview that, the “spiritual beings” can change into “physical beings” in order to interact with the human being.

The Akan believe that *ewiase* (world) did not come into existence of its own volition but was created or brought into by somebody known as *ɔdomankoma-ɔboadee* (Eternal creator) (Opoku, 1978). The Akan people, like all African people, believe in a supernatural being, *Onyankopon* the (Supreme Being), who is the source of all creation, and is involved in all things but seen at a distance and sometimes unapproachable (Idowu 1973). In the Akan religious view, apart from the belief in the existence of *Onyankopon*, the (Supreme Being), they also believe that there are *abosom*, (lesser divinities or deities), who are believed to be intermediaries between God and man. *Abosom* are easily approachable. The Akan think that *Onyankopon* (God) is too powerful and sacred and as a result becomes too dangerous for a sinful man to come close to him. The axiom is *Wopɛ asem aka akyerɛ onyame a, ɛna woka kyere mframa*, literally, (To speak to God one has

to speak to the wind). The belief is that God can only be approached either directly or indirectly through His chosen priests or priestesses. The priests or priestesses are responsible for keeping the welfare of the people, and because of this they have been entrusted with sacred rituals of worship. This brings the idea of *abosom* (gods). *Abosom* are for God, they are the “ear” and “mouth” of God. He created them for himself and for the welfare of humanity.

2.3.3 The Akan Concept of *Abosom*

The African, and for that matter the Akan of Ghana, have *abosom* (gods) of different realms of influence and fall into groups such as:

1. The tribal god - those that are worshipped by one tribe
2. Area gods or those worshipped by the natives of a particular traditional area or locality.
3. Family gods, which are worshipped by a small community or family
4. Community god and a national deity. These are worshipped by the community as a whole. It is generally believed by the Akan that *abosom* have been in existence since creation. The Akan never confuse the identity of *Onyame* and the identity of the *abosom*. God created them for a purpose. God could not come to our world every day to address the problems of his children and therefore created the *abosom* to represent him and also take care of his children on earth.

The *abosom* can either be created, purchased or received from rivers, streams, lakes, skies and sometimes a forest or any sacred place. The traditional *abosom* are made by a well experienced traditional priest or priestess from medicine, materials that are believed to have special powers such as clay from the sacred River Tano; plants, *homakyem* (a fearful plant normally found in the thick forest), certain herbs and roots, ancient beads,

cowries, shells and prehistoric stones or tools. Sometimes these materials are pounded together into a mixture and then placed in a brass basin or under *Nyamedua* (sacred plant). The shrine is then considered the potential abode of a supernatural presence, which has the power of temporarily entering into a priest, who then becomes the mouthpiece of the god. There are many mysterious things connected with the building of an *abosom*. There are mysteries that go beyond the comprehension of the ordinary person.

Some African scholars like Idowu (1991), Braffi (1990), and Coffie (1998) have observed that, the African people including the Akan believe in the spiritual and universality of *Onyankopon*, (God) and equate him with heaven (sky), wind, air, and the breath of life. God has never had temples or shrines rather the *abosom* (deities or gods). The *abosom* (deities) are the representatives of God on earth. They are also seen as the intermediaries between God and man. They are appointed by God himself to serve him and humanity in general. The *abosom* are there to receive offerings and sacrifices on behalf of God. In African traditional belief, no human approaches or speaks to God directly except through his *abosom* “subordinates.”(A priest, Obuotabiri Shrine).

The *abosom* (gods) are the intermediaries between *Onyame* (God) and human. *Abosom* in Akan concept carry our petitions to God and at the same time interpret God as well as the ancestors to the people. They are consulted in all matters concerning African people’s day to day activities. They are part and parcel of life in Africa. Some African scholars rate them as the first officers of every Akan traditional society. They are not only acting as intermediaries between God and men but they are the mouthpiece, consultants, lawyers

and deputies of the Akan traditional kings. The *abosom* are consulted for directives on all matters concerning the Akan communities. They are seen by the Akan as the “eyes”, “ears” and “mouth” of every Akan community. It is the *abosom* that listen, see and confirm before any action can be taken by the Akan people. The Akan view their *abosom* as means to an end. Their popularity waxes or wanes if they are responsive or unresponsive to human demands. Busia sums it when he says:

The abosom are treated with respect if they deliver the goods, and with contempt, if they fail... The Akan, like other tribes, esteem the Supreme Being and the ancestors far above gods and amulets. Attitudes to the latter depend upon their success and vary from healthy to sneer contempt (Busia 1954 p 143).

2.3.4 The Akan Concepts of Nsamanfo, Asaase Yaa, Abayie, Mmoatia

Central to the Akan religious ideas is the belief in the multiplicity of spirits in the universe. The Akan cosmos, like other African peoples, is divided into “two interpenetrating and inseparable, yet distinguishable, parts” namely, the world of spirits and the world of human (Okorochoa, 1987). The Akan of Ghana, like other ethnic groups in Africa believe in *Nsamanfo*, (ancestors) *Asaase Yaa* (mother Earth), *abayie* (witchcraft) and *mmoatia* (dwarfs). The ancestors are the living-dead. They once lived on earth but have died physically. They are living because they are remembered. They are believed to be the real owners of the land and everything the living have.

There is the belief that “*Onyame akyi no obiara nni ho a ɔkyɛn asaase. Asaase so na yenante, ɛso na yedidi, ɛso na yɛda. Asaase na ɛma nnipa, mmoa ne nnua nyinaa aduane, nsuo, mmepɔ, ne abɔdeɛ nyinaa dan Asaase Yaa. Ɛden na onipa betumi aye, agye asaase*

Yaa mu. Sɛ onyame pɛsɛ ohyira nnipa a ɔdefa asaase Yaa so anaa ne mu. (Besides God nothing else is as important as Asaase Yaa (Earth). We walk and sleep on Asaase Yaa. Also, it is Asaase Yaa who gives food for humans, animals, and all plants. The rivers, mountains and all creatures depend on Asaase Yaa. What could we do without Asaase Yaa? If God wants to give blessing, he has to pass through Asaase Yaa.

The Asaase Yaa is believed to be a goddess immediately after *Onyankopon* (God). Every *ɔkɔmfo* (priest or priestess) has to consult her before he or she does anything. *Asaase yɛ ɔbosom kesee, obi ntumi nkwati no nnye biribi wɔ yen Akan man mu ha. Akomfoɔ na ɛte Asaase Yaa kasa enti na yetete wɔn.* (Earth is a goddess, there is no way one may escape Asaase Yaa and succeed. It is only traditional priests and priestesses who understand her language. That is why they are trained to interpret her language to humans). The Akan in general believe in the existence of *abayie* (witchcraft) whom they perceive as human beings functioning in spiritual bodies, engaging in errands during the day and night. They are secretive; they are believed to be either *bayiepa* (good witch) or *bayikwasea* (foolish witch); but in general the Akan perceive them as malevolent spirits. The *abayifo* are feared in Akan communities. Thus, people secretly visit *abosom* and or prophets and prophetesses for protection against them.

The *Mmoatia* (dwarfs) are believed to be short creatures that sometimes live usually in the thick forest; they are powerful and good in herbal medicine. They live in the forest and are quite proficient in the use of herbs. They specialize in working with nature spirits for healing body, mind and spirit and to address personal, family, social, financial and environmental issues. They can be playful, mischievous generally, or very cruel to evil doers and those who try to ignore them. They are considered by the people as the

spiritual gatekeepers. They are sometimes very cruel to human beings, especially evil doers and witches. *Mmoatia* train individual to become *akomfo*. They are perceived to be playful and mischievous. They cannot be seen physically by any human being apart from *Mmoatia akomfo*. Since the *nsamanfo*, *Assase Yaa*, and *abayifo* and *mmoatia* are powers believed to be in an existence in Akan communities and are consulted in all matters concerning the living, would-be *akomfo* are trained on how to communicate with them.

2.3.5 The Akan Traditional Priesthood

Priesthood in Akan traditional religion is, a solemn vocation centering on the choice of *abosom* themselves regarding who should become their priest and priestess. Any person who manages his way into Akan priesthood will be denied recognition and honour given to priests Ekem (2008). In Akan traditional belief, for one to be chosen as a traditional priest, there are criteria for measuring a genuine call into priesthood. Ekem further says that there must, principally, be evidence of possession by a particular deity who desires to enlist the possessed individual in its service Ekem (2008). The person cannot just become a priest simply by expressing the desire to enter into the profession and finding a tutor to direct his training. There must be evidence of the call; the principal among them is the deity that possesses the person. A senior priest who is very experienced and familiar with the characteristics of the deity will determine this evidence. It is the community's responsibility to ensure that appropriate steps are taken to determine the source of the possessed individual's experience (Ekem 2008).

The training of a traditional priest begins immediately after his or her "call." Among the Akan, individuals do not become *akomfo* by their own choice. The initiative rests

entirely with the deities. This belief underscores the fact that in African societies one cannot just get up to be trained as a priest; the person needs to be called by a deity. There are two main ways for choosing a priest or priestess. The first is by divine calling, and the second by choice of the traditional owners or elders of a cult. On the other hand, one also may inherit it from a family but even that one needs to get approval from the family deity. In African traditional belief, for one to be chosen as a traditional priest or priestess, it means he or she is responding to a highest calling a person could respond to in the structured world of tribal life. The call into the priesthood means that the priests or priestesses are entering into a world in which honour awaits him or her.

2.3.6 The Call

“In Akan religion, unlike the Christian religion, no ordinary person can get up and say ‘I have got an inner conviction and therefore I want to be a priest or priestess’. The call in Akan is an ‘individual’ but also a ‘public’ affair” (Coffie 1998). The Akan have three expressions for call. The first is, *Akɔm asi ne so*, which is translated as (an *ɔbosom*, deity, has descended on him or her). The second is *Akɔm aka no* (an *ɔbosom*, deity, has mounted him or her). The third expression is *ɔbosom aforo no*, (an *ɔbosom* has possessed him or her). According to Coffie (1998), all these expressions point out the fact that *ɔbosom* mounts human beings, just as a rider mounts a horse. A devotee is a “horse” and the *ɔbosom* is the “rider.”

The priests or priestesses are sometimes “called” by the gods because of their love for them. More often the person who is “called” to the profession is made to tell stories about how he or she has been called to become an *ɔkɔmfo*. One thing that is common among the novice is that most do not initially understand all that is involved in the initiation and

practice process. A person is subjected to possession by some spiritual influences through an ecstatic trance when he or she is alone carrying out his or her daily activities or sometimes during religious ceremony. Braffi (2008) gives a typical example of a girl who was seized by the spirit when she was gathering firewood in the bush. The girl ran home dancing and trembling and became emotionally disturbed for some weeks. The girl, who was regular at church service and a member of the singing band was seized by the spirit of Tano Kwadwo, a local god in the Brong Ahafo Region of Ghana on one Sunday during church service. She was asked by a diviner to go and train as *ɔkomfo*. She resisted, as she was a devout Christian. She nearly became deaf and dumb. She became well after yielding and began the training.

The Akan believe that God is great and fearful and cannot be dealt with directly by human being that is the reason why He has appointed agents, *abosom*, (gods). They also believe that as God cannot be dealt with directly so the *abosom* also cannot be dealt with directly rather through their appointed people, *akomfo*.

Such people undergo some period of training to prepare them very well for the task. Braffi, confirms this when he said that, the local deities calls persons to undergo years of austere professional training until they attained the highest socio-religious and spiritual state, to get into the integrities of the profession in order to ensure ritual efficacy. Sometimes the call comes through sickness or by possession during which the person becomes ecstatic, and then it is believed *ɔbosom* has taken him or her.

According to Coffie (1996), this may happen at any time, but it is during some ceremony connected with cultic dancing. The person may be just standing apart watching, or be dancing as one of the worshippers. In Akan traditional religion if *ɔbosom* wants to

“marry” a person and he or she refuses the “proposal”, the person’s refusal may result in madness or failure in economic ventures or develop a strange disease like seizures, intermittent fits and frequent convulsions, abnormal behavior, and sometimes both. The person sometimes goes through a series of crisis both mental and physical which sometimes defy any form of treatment. The person may sometimes run into the bush and then be brought back by a search team in a forest. Such acts and diseases come and disappear. When such happen, the family seeks healing by either seeking prayer from prophets or prophetesses, hospital, care or consulting with diviners.

When the situation seems not to improve, the family sometimes begins to suspect that the person may be possessed by a particular deity, especially if the family has any linkage with a deity. The person will be sent to a senior and experienced priest or priestess to diagnose to find out if the person has been possessed. If it is found out that the person is possessed by a particular deity, a preparation is made for the person to begin training. However, if the person decides not to “marry” the *ɔbosom*, that is if he or she refuses to be a priest or priestess of the deity, he or she only has to ask or plead for his or her release. If it accepted by the deity to release the candidate, some series of rituals will be performed to satisfy the deity else calamity will befall the person and sometimes his or her family.

In the Akan tradition, there are two main ways of choosing a priest. The first is by divine calling that is by the deities, and the second is by choice of the traditional owners or elders of a cult. In this situation the *ɔkɔmfopanin* (chief priest or priestess) looks through the young people in the family and recommends one who possesses and exhibit qualities

such as respect, studios, teachable, courageous, secretive, confidentiality, frugality and kindness to become a priest or priestess. Coffie (1998) in reports that, “Some people become *akɔmfo* on a hereditary basis.” For instance, the Antoa *kɔmfo* said that he inherited that role because his family has provided a custodian for the Antoa shrine. He explained that when a candidate is selected, he will be groomed by his predecessor, the *ɔkɔmfopanin*. The potential candidate would accompany the chief priest or priestess, his or her mentor, to the shrine and other important places just to observe what his or her mentor does and how he does them. The chief priest or priestess throughout that period teaches the candidate on protocol, diagnosis, herbs, divination, interpretation and dancing. The young man in the case of Antoa shrine, takes over after the death of the *ɔkɔmfopanin*. The takeover cannot be done until it has been declared by the deity.

Ekem (2008; p. 98) writes that “possession alone does not automatically make one a priest or priestess. Those possessed must normally undergo a period of training to be instructed in the ways of the deity and equipped for effective service to their communities.

2.3.7 Training of Akan Traditional Priest

There are institutions among the Akan which train young *akɔmfo*. The numbers of years spent on training are not the same; it varies from shrine to shrine. The period of training ranges from six months to two years, as pointed out by Obuortabiri Kɔmfo. But Nana Oparabea of the Akonnedi shrine also said that due to modernity the number of years spent to train young traditional priest and priestesses has been reduced. She further remarked that, some trainees come from America to be trained and one cannot keep such people here for a longer period of time. In such situations, the training period is

structured to suit the training by reducing the training period to at least two to three years depending on the ability of the trainee and smartness in learning at her shrine. Each deity has a way of “taking” a priest. After a deity has chosen a priest, he goes through many processes of discipline.

According to Ekem (2008), the training period “ranges from six months to four years or more, depending mainly on the trainee’s submissiveness and ability to learn.” The training time is a period of both physical and spiritual transformation. During the training the person has to bury all his or her personal beliefs, personal traits, behaviour, perspective, values and habits. The training challenges one’s personal philosophy, culture, superstitions and acquired mannerisms. The training period aims to cause a personal transformation for each trainee.

The way the trainee behaves in public transforms completely, he or she has now become a public figure. The public also watches closely, all that he or she does. He or she cannot eat in public, talk anyhow; involve himself or herself in certain games in public, such as *dame*. The novice or trainee is prohibited from challenging the chief priest or priestess on any issue whatsoever. The novice has to be submissive and obedient to the trainer or mentor. The *ɔkɔmfopanin*, (chief priest) the *abosom* (god) and *nsamanfoɔ* (ancestors) partner in the training of the novice.

Many African scholars including Mbiti (1969), Busia (1954), Braffi (1990), Coffie (1998) and Ekem (2008) have described the training of traditional priests or priestesses as long, strict, tiring and dangerous. (A deity can kill one during training). As Braffi (1990) puts it, “the training of a *ɔkɔmfo*, (priest) is long, tiring and very serious business; the

profession is no sine cure; it takes about three years to go through the training.” Opoku (1978; p. 106) has said:

entry into the ranks of training, lasts three years or more under tutelage of a senior priest or priestess. The training process is described as quite arduous, rigorous and lengthy. The novice is charged with learning the character, songs, dances, and loads of information about their personal deity as well as other known Deities. Other pertinent information such as family and community rituals, medicines and protocols are taught. They become the repositories of Akan history, community knowledge and traditions, customs and taboos that are revealed during this period of training. Most of the information is privileged information and shared only on a need to know basis, perhaps not on the same level as other akɔmfo. Every ɔkɔmfo has the opportunity to acquire knowledge of traditional medicine, use of herbs, roots, and other items nature provides.

The training of Akan traditional priest or priestess begins immediately after his or her call. The training of the Akan traditional priests and priestesses involves the parents and relatives of the novice. For the training to begin, the parents or relatives of the novice must accept and be prepared to support the training. After the acceptance and preparedness by the family to support the trainee, the chief priest or priestess receives the novice to begin formal training. The novice generally receives his or her first ritual bath for seven days by a senior priest or priestess. The ritual bath involves a combination of herbs into concoction.

Ekem (2008) reveals that, the would-be ɔkɔmfo is regularly given ritual baths with special leaves sacred to the deity. There are some leaves, which help strengthen the ankles for dancing, while there are others which help the spirit of his or her god within him or her. There are many and varied bathing as part of rituals, which bring the nkɔmoa, (the spirit of possession). The novice’s nails are usually clipped and his or her hair is cut down, and

allowed to grow from then on into long strands. Generally, the novice is forbidden to shave any part of his body during the training; this can be done after the graduation.

According to Mbiti (1969), there are different methods used in training the novice in Akan traditional religious practices, from simple to complex or elaborate. These may include the separation or seclusion from the “world.” (the world here means the community). The trainee spend all the training period either in the forest or any other place designated by the deities and this could take up to about three years or more.

2.3.8 The First Year

Ceremonial ablutions occupy the first year and these consist of bathing a mixture of leaves, herbs and bark of trees by the trainer. There are some leaves to help strengthen the ankles for dancing, while there are others to help the spirit of his or her god within him or her. The purpose of these ablutions is to obtain help from the spirit of his god within him or her. There are many and various bathing, which bring the *nkɔmoa*, (the spirit of possession). (Rattray, 1954) mentions the leaves and their uses. Leaves of *krampa* tree are used to strengthen the ankles and those of the *asoa* tree “cause the god to stay with him.” some of the leaves are also meant to arouse spirit possession if the ecstasy is slow in recurring.

According to Nana Amoah, Obourtabiri Komfoɔ, plants are gathered from the *nsamanpomu* (graveyard) and are placed in a pot for sacrifices. After the sacrifice the novice or trainee sends the plants back to where it was taken alone at midnight and bathes with the medicine for seven nights. The bathing at the cemetery is to enable the novice to get into contact with spirits of the departed. As indicated earlier in the introduction,

ancestors are key factors in all activities of the living. They are part and parcel of the living. They need to be informed about whatever is going on concerning a family member. The Akan see them as though dead but still living. A priest at Akonnedi shrine emphasises that no African can disconnect from his or her ancestor. The African is always connected. During this period, certain secrets are not revealed to the novice. His or her basic assignments are to help the master (experienced priest or priestess) in his or her work and sleeps in a temple near the shrine. The hair of the novice is left uncut and he or she has a number of charms and amulets around the arms and waist.

The novice is compelled to sleep early during the first year, must use cold water, and should use neither sponge nor soap. He or she goes to his or her town on sacred days to offer sacrifices to his or her own god. On such days the novice stays without food. He or she is also instructed in dancing and is enjoined to abstain from tapping palm wine, to set traps to catch fish, to pluck palm nuts and to wander about in other peoples' houses Amponsah (1975). This first stage is referred to as "stage of separation," because the novice is separated from the public to a secret place.

2.3.9 The Second Year

In the second year the novice is introduced to other taboos and laws of the god. The novice wears *asuman* (charms) and is informed of special taboos attached to each. At this stage he or she is not taught how to make the charm. There are taboos, which have to be observed by the novice. The observance of these taboos set the novice apart for the work of his or her god. He or she is then separated from normal secular life. His or her life then becomes sacred and his or her god has an absolute claim on him or her. Therefore any "breach of moral purity could lead either to expulsion from the shrine, or to fresh

beginning as novice, following the performance of rituals to restore the trainee to favour with the deity” Ekem (2008).the trainee begins to salute the elders by bending on his or her right knee and touching the ground with his or her right hand.

Sarpong (interviewed on 14th December, 2014 at his residence) referred to this stage as stage of liminality - neither here nor there. A stage as very dangerous and crucial because the novice is not yet *ɔkɔmfo* and at the same time not an “ordinary person.” He or she is in between. During this stage there would be no sexual intercourse, bath, or eating of any favourite food is allowed. Failure to adhere to the laws will lead to one’s death, or to start the whole thing afresh.

2.3.10 The Third Year

The third year is often regarded as the final year for the training depending on the deity. The novice should be able to identify different types of herbs and their uses with the help of *suman* (lesser spirit). Therefore instructions in herbal medicine become an integral part of the training programme. He or she is also taught water gazing (object in the water with a special meaning), divining, how to hear nature, and how to read omens from, for example, the colour of a fowl’s kidney. Dancing lessons continue and the new priest or priestess dresses in *doso* (raffia-fiber kit). The symbol of the traditional priest or priestess office is the ceremonial sword with *doso* which he or she always uses, while performing his or her duties.

The traditional priest or priestess *ɔkɔmfo* has the ability to foretell future events when he or she is under possession of his or her god. Since the language of a god is always strange, an *ɔɔfo* (chosen interpreter) is appointed either by the deity or the *ɔkɔmfo*

subject to the approval of the deity. Ekem (2008) writes that human relations as well as the history and traditions of the community in which the trainee will serve after graduation are taught. This particular lesson is learnt through constant observation of the *ɔkɔmfopanin* (experienced priest or priestess or the teacher). Sarpong again refers to this final stage as “stage of integration.” That is the stage at which the novice is supposed to appear public. This happens after one has been able to go through the training successfully.

2.3.11 Training the Priestess at the Akonnedi shrine

The unique nature of the the Akonnedi shrine makes it a point of discussion for literature for this study. Akonnedi shrine trains only women to take the office of *ɔkɔmfo*. The office is strictly for women. An interview with Nana Oparebea (12th November, 2014 at her shrine, Larteh), the chief priestess, said that, the first thing they look for before one begins the training is whether the candidate is truly “called” by Akonnedi or any of her associate deities. Opoku (1978; p 126) puts it right when he writes that, “... it is firmly believed that no one on her own accord volunteers to become a priestess, the initiative rests with the deities.”

Training at the Akonnedi shrine in spite of its uniqueness is generally not far different from the normal procedure used in training the *akɔmfo*. If all obstacles such as the readiness of the novice to begin the training, ability of the family of the novice to pay the training fee charged, and their preparedness to support the novice throughout the training and others are removed, the training begins, with ritual bath for seven days by the *ɔkɔmfopanin*. She goes through all the process earlier explained.

At the Akonnedi shrine the novice is taught about the taboos before he or she starts training. It has been discovered that observance of taboos is very important during and after the training. The novice has to remain ritually clean during and after the training in order to avoid incurring the wrath of the deity.

Nana Oparebea enumerated the following as some of the taboos of Akonnedi:

- (a) The trainee should not go out of the precincts of the shrine without the permission of the chief priest; she can only go out when on errands for the chief priest.
- (b) She should strictly abstain from sexual relations during the training. According to Braffi, (1990) preservation of sex force which accelerates spiritual development in every religion is required to be strictly adhered to, by the new traditional priest or the novice
- (c) The novice is strictly forbidden to eat sweet things, such as ripe plantain, sugar and honey.
- (d) No alcoholic beverage during training. She may be given a drink by having it poured on her wrist, on ordinary occasions; or she can also have a drink by having it poured on her back, when she is possessed.
- (e) A novice under the tutelage of the Akonnedi chief priest is strictly forbidden to eat kenkey on Tuesdays and Fridays, which are Akonnedi's days; she is also instructed never to bring dough to the shrine.
- (f) Under no circumstances can a novice of Akonnedi shrine eat pork, or chew kola
- (g) She should voluntarily absent herself from the shrine for seven days each month during her menstrual period.

(h) She should not go back to her home till the end of her training; she is also not allowed to talk or shake hands with her relatives except by the permission of the *ɔkɔmfopanin*

(i) The novices should be obedient to elders.

Onyina (2002) explains the reasons behind these restrictions. According to him, the first prohibition is part of the general expectation that the novice should be obedient. It is the responsibility of the chief priestess to keep watch over her and guide her activities. That is the reason why the novice should always remain constantly within the precincts of the shrine to enable the trainer watch diligently. Any move that will be made by the novice must be permitted by the chief priestess. The novice's whole life during the training is monitored and scrutinised by the chief priestess. This is actually done to prevent the novice from falling into temptation to deviate from the fixed code of behaviour.

It is generally believed in Akan traditional religion that when one is "called" by a deity, the person is married to that particular deity. That is why the would-be priest or priestess is prohibited from having sexual relationship during training. Onyina put it well when he said that, marriage to the deity is not restricted to the training period; it is for the rest of his or her life. However, the person can do so after training and rituals are performed. The marriage to the deity signifies that the novice is supposed to dedicate her full life to the service of the deity; hence sexual intercourse is strictly prohibited to avoid divided attention. That is why in some instances, the trainee could be granted a divorce from his or her spouse to enable him or her to concentrate on the training.

The person has to go through some purification exercise or rituals and many sacrifices, if he or she goes contrary to the orders of the deity. In addition to the purification exercise and sacrifices the trainee may be asked to start his or her training all over again and in some occasions he or she is banned completely from the shrine.

Nana Oparabea said that, abstinence from sexual intercourse on some specific days are still observed, the reason is that on such days rituals are performed for the deity. It is believed that if the *ɔkɔmfo* is involved in sexual activities before the performance of such sacred rituals, he or she may incur the wrath of the deity, because the act makes him or her ritually unclean. The trainee is prohibited from eating sweets. The Akan believe that sweet things have power to arouse one's sexual desire. In order for the trainee not to think about sex, anything that will lead to arouse his or her sexual desires is prevented. The novice is banned from taking any alcoholic beverages.

In the Akan tradition alcohol is very important because it is used for spiritual matters. The alcoholic beverage is prohibited because many of the rituals involve the use of alcoholic drinks; this is done to prevent trainees who might be tempted to take alcoholic beverage which might ruin them and their profession. In addition to this, one of the basic functions of *ɔkɔmfo* is to listen to the gods and interpret them accurately; this cannot be properly done by someone who is under influence of alcohol. Hence one is forbidden from drinking alcoholic beverage in order to be accorded the respect due *ɔkɔmfo* and above all to interpret the gods well to the people.

The trainees are prohibited from eating certain foods; this varies from shrine to shrine. For instance those receiving training at Akonnedi shrine do not eat kenkey on Tuesdays

and Fridays. It was brought to light that such days are sacred days for Akonnedi. The chief priestesses receive visitors or clients, and since kenkey and dough are taboo to the deity, all priestesses and priestesses-in-training are expected to observe this taboo. The trainees at Akonnedi shrine are prohibited from eating pork and this has been discovered to be common rule in many of the deities in Akan as well as religions of the world. Many religions see the pig to be an unclean animal. This, Nana Oparebea said, the priestesses-in-training are prohibited to eat pork in order not to defile themselves.

In Akan traditional religion, menstrual blood is considered to be impure; hence women in their menses are prohibited from shrines and other places of ritual importance. The priest-in-training is banned from talking to any relative. This is done to enable the novice to concentrate on the training, and it symbolises a break from her previous life for he or she has entered into a new life. However, her relationship would be restored after the training. A cardinal virtue to priesthood is obedience. The novice is to serve the deity and elders at the shrine and the general public. He or she is dedicated to the service of deity and the general public. Any priestess who abides by these prohibitions normally finishes his or her training in the minimum time of three years; failure to obey these rules would affect the training period.

It was discovered at the Akonnedi shrine that the priestesses-in-training are trained to do household chores. The training begins with learning to do household chores around the shrine, going on errands for the chief priestess and learning to live and cooperate with other priestesses-in-training, quarrelling is strictly forbidden among them (Onyina, 2002). She learns how to dance and sing.

Another important area the trainees are taken through is the art of divination, and a divining pot. A concoction is rubbed into the eyes and ears of the trainees in order to see and hear the deity when they look into the divining pot. The trainee has to practice this skill regularly throughout the entire training. The success or failure of the priestess depends on one's ability to hear and correctly interpret the deity. The number of years a trainee spends on training mainly depends on the acquisition of this ability. This skill is described by priestesses to be the most difficult skill for one to acquire easily. During this period the novice learns to identify spirits such as ancestral spirits and other spirits other than her own deity. Other skills are also learnt by the would-be priestess including how to diagnose diseases and call for other spirits for support or spiritual assistance.

If the chief priestess is satisfied about the performance of the trainee, she recommends the trainee for the graduation. Ampofo (1994 p.10) said that:

at the Akonnedi shrine if the trainee distinguishes herself well and gives evidence of her fitness and aptitude for the job, she is tattooed on her right shoulder, back and joints at the end of the first year. This ceremony marks the beginning of an important phase of her training, for she is from now on confirmed and stabilised. The tattooing is intended to "toughen" the trainee, it helps her to develop stability and resistance to dizziness when she dances; and it also renders her immune to poisoning by her enemies.

In the many shrines of Akan priesthood, the training does not end immediately after the graduation, in order for the priests or priestesses-in-training to become professionally perfect, they keep on consulting their mentor for another two more years. In Africa particularly in the west, the traditional priests or priestesses have very important roles to

play and for one to be able to perform them satisfactorily one needs to go through intensive training; else, one will fail to get the recognition of the society.

Among the roles are medicine man or woman and religious leader. A traditional priest may be a medicine man who is expected to fulfill the function of a medical doctor or herbal healer. In Africa, some diseases are bound up in mystery. A disease is believed to be rooted in the supernatural and the priest who begins by getting in constant touch with the supernatural realms through his or her deity has an effective control over diseases. While some traditional priests are very good at administering fertility herbs on barren women, others are also good at the treatment of diseases affecting children.

Some specialize in the treatment of impotence among men, while others may be good at treating cases arising from accidents of all kinds. He or she is the religious head in his society, and is charged with religious duties in the temple, shrine, or sacred grove. He or she does not only look after the “soul” of the entire community but plays a great role of the installation of chiefs. Traditionally, the priest or priestess is regarded as the next person to the chief. Although he might be a young person, he or she is still addressed as Nana (a title given to the elderly people in Akan). There are major roles that they perform in society such as witch doctor, counselor and politician.

2.3.12Akomyi (Graduation)

The novice has to go through all the training experience satisfactorily before he or she is recommended by the chief priest or priestess for graduation. The novice goes through different kinds of experience each year of the training though, there is generally, a certain level one must reach before he or she is recommended for graduation. The period of

graduation is described by many of the graduands as an exciting moment, because it is moment of “freedom.” The person is now free from certain limitations and prohibitions; free to eat certain foods he or she was prohibited to eat during the training; the hair can be now kept well; the dress code can now change. The wearing of certain prescribed cloths characterised the period of training is now no more. The person is now seen wearing white cloths signifying victory over all obstacles during the training.

It was discovered that most of the graduation ceremonies take place in the night, because of the initiation aspect in it. Some of the activities that go on during the night, according a priestess some involve “jumping over” a bonfire.

From the Akan traditional perspective, the ability of a person to walk through fire indicates the level of spiritual and intellectual competence and readiness for the task ahead. That is why in Akan community any person who is believed to be spiritually powerful is described as *ɔbenfo* having been “baked” or “cooked.” They measure the level of spiritual and intellectual prowess of their leaders such as kings, elders and the *akomfo*. That is the reason why Akan people address somebody who has been able to study to the PhD level as *ɔbenfo*, because it believed that the person has gone through fire. He or she has been “cooked.” The Akan people believe that if the novice is able to go through the fire successfully, the person has now become a master and can now deal with both physical and spiritual cases professionally.

Amponsah (1975) also explains that among the Fanti, the ceremony starts in the evening when the novice is dressed in white calico shirt with charms around the body. White clay is sprinkled on him, and there is a lot of drumming and dancing for all the priests or

priestesses. At midnight the novice is sent to the sea-shore carrying a big pot containing dried chewed sugar cane pieces. Fire is set into it and flames come out as the person carries this to the seashore. This rite is known as *wonhyia* (should not meet). It is regarded as a taboo for the novice and his or her attendants to meet anybody on the way when he or she is being led to the shore. If one meets them accidentally the novice is bathed with water and the clothes are changed and new ones are used to dress him or her up. The person is then brought home. The following day is a day of rejoicing and sacrifices to the god. In some places such as Brosankro, in the Brong Ahafo Region, logs are collected, a fire is kindled, and the assembled priests jump over the fire in turns. The hair of the new priest is shaved off and the old priest or priestess inspects the head of the new priest and takes off spiritually any bad thing he or she might discover. The relatives of the new priest or priestess come to thank the old priestesses and sacrifices are performed to the gods. Sometimes the old priest or priestess demands a fee for the training. The fee presented to the instructor is usually in cash plus a bottle of gin.

2.4 Culture and Traditional Medicine Utilisation

The utilisation of TM/H is widespread in Sub Saharan Africa (SSA), where up to 80% of the population rely on it for a variety of health needs (WHO 2002). Affordability, accessibility and availability have all been put forward as key reasons for utilisation (Anyinam,1987; World Health Organization,2009) and accordingly quantified (for example, Hausmann-Muela, et al., 2000; Leonard & Zivin, 2005; Peltzer, 2009). Yet, very few econometric studies have explored the cultural acceptability dimension, perhaps owing to difficulties in defining and measuring the concept of ‘culture’. In this study, culture is defined as ‘customary beliefs and values that ethnic, religious and social groups

transmit fairly unchanged from generation to generation' (Fernandez & Fogli, 2006; Guiso, et al., 2006) and is measured by a series of attitudes and beliefs held by individuals about the use of TM/H. This definition is employed alongside a unique test to test how culture affects traditional medical utilisation in Ghana.

Many existing studies investigating the role of culture and TM utilisation are anthropological in nature and evaluate health-seeking behaviour within a social constructivist framework (Anyinam, 1987; Evans-Pritchard, 1937; Hielscher & Sommerfeld, 1985; Stoner, 1986; Tsey, 1997; Twumasi, 1979b). Culture is central to anthropological approaches, because individual behaviour is influenced by preconceptions, including those related to illness (Winkelman, 2009; Wiredu & Nyame, 2001). Rivers (1924) argues that we must first start with an understanding of how an individual perceives disease before we can understand observed actions: all health-seeking behaviour is the result of a process involving identification of causation, followed by aetiology, diagnosis then prognosis. While biomedical diagnoses would consider disease to be caused by, or the result of, biological, physical or chemical abnormalities within the body (informed in large part but not exclusively by germ theory), anthropological understandings would deem illness to involve more than simply a biomedical explanation, placing the individual within a societal context.

Rivers (1924) illustrates differences in interpretation by depicting a person falling from a tree. Modern medicine would characterise this as an accident, perhaps owing to a loose branch or carelessness whereas traditional explanations would blame a sorcerer or spirit for loosening a branch. In these two scenarios, given that the theory of causation differs, it naturally follows that the appropriate treatment, or response, is divergent. In one causal

schema, often found in folk theories of causation in Africa and elsewhere, societal ills can also manifest within an individual, at which point social responses are crucial (Hevi, 1989). Thus, legitimacy of medicinal products is attributed to local communities, institutions, and symbolic values (van der Geest, Whyte, & Hardon, 1996).

In another example, Bierlich (1999) and Kirby (1997) both demonstrate how Ghanaians ascribe colours to medicines to distinguish their potency, type and use, and to label various stages of illness. At the start of an illness, the 'white' stage, individual self-help is the dominant action. If the situation worsens, the colour 'red' is assigned and society is expected to step in with prescribed and agreed upon interventions. Further, it is believed that some plants are inactive as medicines until prayers and libations to ancestors are carried out. Under such scenarios healers would be important sources of care for their perceived 'ability to cure' and complementary rituals. The idea that cultural beliefs linger and evolve only slowly, however, is documented. Some argue that when individuals emigrate, people hold ethnically-linked beliefs over their lifetime. Owusu-Daaku and Smith (2005) show that Ghanaian women who have moved to the UK uphold Ghanaian perspectives about health and illness while adapting to the British system.

Barimah and Teijlingen (2008) studied attitudes toward TM of Ghanaians living in Canada and found that 73% of respondents had not changed their views about TM as a result of emigration. There were no significant differences in results between individuals who had been abroad for a long and short period of time and individuals show strong acts of agency, whereby Ghanaians import TM back to Canada from their homeland in order that supplies do not run out. Ransford et al (2010) and Senah (1988) highlight the importance of cultural alternatives for Mexican immigrants as a result of belief and

structural barriers to accessing formal health care in the United States. Sometimes, cultural alternatives were shown to be a coping strategy (i.e. a preference was held for modern care but were not used), but similarly individuals had considerable control over their health and explicitly chose TM.

However, cultural beliefs are not always the dominant force for explaining utilisation of health facilities. Jenkins et al (1996), for example, show no significant associations between traditional beliefs held by Vietnamese immigrants and access to modern preventive care. Additionally, Young and Garro (1994) examine medical choices made in two Mexican villages and found that, despite similar attitudes and beliefs toward traditional and folk medical knowledge, the village with better accessibility (easier transport links and cheaper cost of care) utilised physicians significantly more than the village with poor accessibility. Young and Garro calculate that only a fifth of traditional care users stated cultural preference as a key reason for utilisation.

Since traditional medicine has been with Ghanaians and mostly rural dwellers for generations and also for the fact that orthodox medicine is often in short supply, people's approach in times of suffering from cardiovascular disorders is first towards traditional medicine. It is when this fails that they resort to chemist shops or medicine vendors and then the hospital as a last resort (Katung, 2001). In traditional medicine, divination (consulting the oracles), confession, ritual sacrifices, incantations and potions made from plant and animal parts are essential components of illness management (Sallah, 2007). These are aimed at restoring the patient to a harmonious relationship with his environment and/or counteract the effect of evil forces. In every instance where an illness is diagnosed to be due to ancestor spirit anger, there is usually an antisocial act of

commission or omission by the person who must usually confess the misdemeanor, followed by ritual sacrifices to appease the offended supernatural agency before he can be expected to recover (Danquah, 2008; Badru, 2001).

Confession, that is admission of guilt, is crucial for therapeutic success. In other words, although the illness is attributed to ancestor spirit anger, the trigger for this is the sin against moral laws committed by the afflicted person (Calhoun, 1992; Jegede & Onoja, 1994; Sallah, 2007). It is only after rituals have been performed to appease the gods and ancestors that the individual could be restored to this or her normal health. For example, among the Akans, there is the concept of “*funusoa*” where an individual who has angered the ancestral spirits has to carry a coffin with a dead body inside from one end of the town and paraded through the town to the other end before he or she could be restored to normal health status.

2.5 Medical Systems and Health Seeking Behaviour

Conventional medical practice is a system in which medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery among other techniques (NCCAM, 2011). This practice is variously called allopathic medicine, biomedicine, mainstream medicine, orthodox medicine, and Western medicine. According to World Health Organization (2002: p 64), “Traditional medicine (TM) refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.”

The WHO (2001) thus considers the traditional healer to be a person who is recognised by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as on the knowledge, attributes and beliefs that are prevalent in the community, regarding physical, mental and social well-being and the causation of disease and disability. This domain has taken the new name complementary and alternative medicine (CAM) which encompasses all therapeutic and diagnostic disciplines that exist largely outside the institutions where conventional healthcare is provided (Zollman & Vickers, 2002). According to the WHO (2001), there has been an unprecedented and increasing interest in these systems of therapeutics on a global level. According to one estimate, over 80% of the developing world's population still depends on the complementary and alternative systems of medicine, while about half of the population in industrialized countries use CAM (WHO, 2008; Bodeke & Kronenberg, 2002).

The World Health Organisation has consistently estimated that 60–80% of the population of developing countries rely on traditional health care for their basic health care needs, either on its own or in conjunction with modern medical care. The report further asserts that the rate of increase global market for traditional medicines has been exponential. It has always been an ‘invisible mainstream’ within the health care delivery system (Penson, Castro, Seiden, Chabner & Lynch, 2001). For many people in developing countries, particularly those living in rural areas, this is the only available, accessible and affordable source of health care. According to the Ministry of Health (MOH) traditional medicine in Ghana is a major source of healthcare for many Ghanaians and it is estimated

that about 70-80% of Ghanaians use traditional medicine as their front line service (MOH, 2005). Ghana has about 45,000 traditional healers and many churches offer spiritual healing, which is a blend of traditional medicine and Christianity (Akosah-Sarpong, 2007). In addition to orthodox medicine, traditional medicine has often been part of the culture of the people that use it, and as a result it is closely linked to their beliefs (Sofowora, 1993).

Quinn (2007), in a study on health care in Ghana stated that health care is provided by both biomedical and traditional healthcare providers. The biomedical healthcare, according to Quinn is those services provided in the hospitals, clinics, health centres and pharmacies. The traditional healers vary enormously from small traditional practitioners in the north of the country to large healing centres in the south of Ghana who provide various services to the people. The results of Quinn's research indicated that the church or mosque was an important source of support, and respondents in all areas spoke of receiving spiritual help from their religious communities. Many people mentioned the role of prayer in helping them cope better with their situation, and religious leaders provided emotional support and spiritual guidance. Methodological considerations of Quinn's study concentrated highly on the role of traditional health care with less emphasis on the orthodox healthcare system, thus skewing the findings more favourably towards the traditional healthcare system.

The main difference between African TM and Western biomedicine is the way in which health and illness are conceptualised. Illness in TM implies a social, spiritual and physical imbalance that requires a natural remedy. Additionally, traditional healers try to explain who or what caused the disease and why this person is affected at that particular

time (Bamidele, Adebimpe & Oladele, 2009). It is the supernatural elements of traditional healers that probably underscore the suspicion many proponents and practitioners of biomedicine have towards TM and their reluctance to recognise and work with these practitioners even when they belong to the same cultural belief system (Babbie, 2006).

According to van der Kooi and Theobald (2006) the traditional belief system of the Tswana of Botswana is rooted in African tradition and strongly influences the social significance of cardiovascular diseases. They perceive the need for protection from the orthodox clinics and hospitals for cardiovascular related issues in order to save them from being harmed by evil spirits from traditional healers. The traditional healers explain that the ultimate cause of a CVD related problem may for example be due to a person who is angry with another. The offer of such vague and simplistic explanations to illness conditions by traditional healers provide the impetus for most people to visit them, in addition to the medical care they receive from the hospitals. Conco's (2001) research findings showed that there was a combination of sources of healthcare from the hospitals, clinics, traditional healers and the church and they are all part of the therapeutic arsenal of the Tswana of Botswana. But this practice has been contested by Young (2005) that this may exacerbate adverse effects due to the (unknown) contents of decoctions and mixing of allopathic and traditional medicine, which hampers adequate assessment and intervention when complications occur.

Literature from studies done by Awusabo-Asare and Anarfi (1997) in Ghana showed that among Ghanaians there is a belief that Western medicine can provide neither an explanation nor a cure for certain diseases. Therefore, people suffering from a disease

whose origin has been attributed to supernatural causes, and their families, may seek explanation and possible cure for the disease at fetish shrines, diviners or spiritualists who claim to have answers to their problems.

Notwithstanding all the facts about traditional medicine, El Bashir (2008) has shown that there are also diseases that only biomedicine can cure and although doctors fail to cure spiritual ailments, witchcraft and *koqob'al* as well as culture bound diseases, biomedicine is still an essential component of health care among the Zunil of Guatemala. Hence, biomedicine and traditional medicine can only be considered as complimentary and the existence of traditional medicine does not necessarily imply the failure of chemical medicine, and neither does the existence of chemical medicine suggest the incapacity of natural medicine (MacKian, 2005). Yet a consistent finding in other studies is that, for some illnesses, people will choose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or government health facilities (Ahmed, Islam, & Barket-e-Khuda, 2001). People from Katutura of Namibia have access to various forms of western and traditional health care. However, patients make choices based on their perception of the cause, reason and origin (aetiology) of the illness, rather than access related factors such as time needed to obtain treatment and relative cost (LeBeau & Gordon, 2008).

The complementary roles of both orthodox and traditional healing practices and practitioners in health care delivery in Sub Saharan Africa cannot be ignored (Moodley, Sutherland & Oulanova, 2009). In Ghana, traditional healers have been incorporated as providers into their National Healthcare Delivery System (Pinkoane, Greeff & Koen, 2008; Pinkoane, Greeff & Williams, 2005). Traditional and faith healers are often sought

after to care for cardiovascular disorders (Abo, Fred-Jaiyesimi, Jaiyesimi, 2008), hypertension or adverse CVD outcomes such as stroke (Hundt, Stuttaford & Ngoma, 2004). Due to cost of biomedical care and medications, traditional and faith healers often offer more accessible and affordable services. Additionally some healers claim to offer complete "cure" for cardiovascular disorders, which gives the patient the hope of eliminating any future burden related to his or her condition. A study among traditional healers in the northern province of South Africa indicated that traditional and faith healers prescribe cures for patients suffering from cardiovascular disorders and diabetes, as opposed to treatment or management offered in the orthodox healthcare setting. The people believe that cardiovascular disorders and diabetes can be reversed or cured (Sengwana & Puoane, 2004; Peltzer, Khoza, Lekhuleni, Madu, Cherian & Cherian, 2001).

Case, Menendez and Ardington's (2005) findings on health seeking behaviour among people suffering from cardiovascular disorders in South Africa revealed that length of illness prior to death has a significant effect on the probability that medical treatment is sought particularly from traditional healers and non-prescribed treatments—and on the amount spent on all types of medical care. Case et al (2005) in their findings revealed that fully 88 percent of individuals sought care from a public doctor or clinic. Importantly, among adults who had fallen ill, 97 percent had some contact with Western medicine, either through a public clinic or a private doctor. The researchers concluded that services provided by traditional healers appear to be complements to, rather than substitutes for those provided by public and private doctors.

Addo, Smeeth and Leon (2007) observed that most patients who suffer from cardiovascular disorders engage in multiple health seeking behaviours. Such patients who commonly access conventional medical care also use CAM and TM. Other findings (Ruff, Alexander, & McKie, 2005) showed that it is common in developed and developing nations that most CAM usage complements conventional care. Straus (2004) provides evidence from Kenya that patients are likely to use more than one type of provider from the range of those available, such as government facilities, mission clinics, private clinics, pharmacies, and traditional healers. Furthermore, the choice of provider depends on patients' illness, condition, socioeconomic status, and education. If an initial visit to one kind of provider did not resolve the disease satisfactorily, a follow-up visit was made to a different kind of provider. Most traditional healers surveyed in a second study referred patients to Western practices for treatment when necessary (Jain, 2003). The weaknesses of these findings were that certain economic indicators like social factors were not taken into consideration, which have enormous influence on the health seeking behaviour of any group, were not considered. Furthermore, while a plethora of choices exist for people to engage in different health seeking behaviours, the researchers did not take into consideration organismic factors involved in health seeking decision making.

Markowitz, Donovan, DeVane, Taylor, Ruan, Wang and Chavin (2003) have shown that there is remarkably little correlation between the use of traditional medicinal approaches and scientific evidence that they are safe or effective. These researchers believe that herbals and concoctions used by non-orthodox practitioners are highly variable in quality and composition, with many marketed products containing little of the intended ingredients and containing unintended contaminants, such as heavy metals and

prescription drugs. For example, traditional drugs like comfrey and kava have been associated with liver failure, aristolochia with genitourinary cancer (De Smet, 2002), and ephedra with heart attacks and strokes (Shekelle, Rogers & Newhouse, 2003). More important, herbals contain ingredients that can accelerate or inhibit the metabolism of prescription drugs. The most notorious of these is St. John's wort, which affects the metabolism of nearly 50 percent of all prescription drugs (Markowitz et al., 2003).

According to the WHO (2002) there are problems associated with traditional medicines related to clinical data. The quantity and quality of the safety and efficacy data on traditional medicine are far from sufficient to meet the criteria needed to support its use worldwide. The reasons for the lack of research data are due not only to health care policies, but also to a lack of adequate or accepted research methodology for evaluating traditional medicine. It should also be noted that there are published and unpublished data from research in traditional medicine in various countries, but further research in safety and efficacy should be promoted, and the quality of the research improved. More research is thus required in this direction to fully establish the efficacy of the claims of traditional medical practitioners and the effectiveness of services they provide.

The WHO (2011) further states that traditional medicines are not completely safe. There could be potential risks if not used appropriately. It is the issue of quality control in product manufacture, combined with a lack of understanding about the active ingredients of traditional medicines and their therapeutic mechanisms that has hitherto hindered their advancement. Research on safety and efficacy is of primary importance to the continued development of traditional medicines. Further research (Chen, 2009; Zhang, 2008; Lu,

Chow & Tse, 2007; Zhong, 2007) have revealed that each product produced by traditional medicinal practitioners may contain several different plants and potentially hundreds of chemical constituents, some of which may be present in very low concentrations; these factors combine to make laboratory investigation both complicated and expensive.

2.6 Socioeconomic Factors and Health Seeking Behaviour

Socioeconomic status (SES) is a combination of factors including income, level of education, income, social status and occupation (Liu, Hermalin & Chuang, 2006). It is therefore a way of looking at how individuals or families fit into society using economic and social measures that have been shown to impact individuals' health and well-being. Socioeconomic status and health are closely related, and SES can often have effects on a person's health seeking behaviour due to differences in ability to access health care as well as dietary and other lifestyle choices that are associated with both finances and education. Socioeconomic status has long been noted to be a cause of health disparities among populations (Gwatkin, 2000). Both income and wealth are significant predictors of the likelihood to develop a chronic condition (Uzochukwu & Onwujekwe, 2004); however, SES plays an even greater role in the functional ability of an individual, once they have already been diagnosed with a chronic condition like hypertension or a disabling condition like stroke (Ostrove, Adler, Kuppermann & Washington, 2000).

Socioeconomic status has been implicated to influence the health seeking behaviour of all manner of persons, irrespective of geographical location or racial background. Tipping and Segall (2005) have demonstrated that the decision to engage with a particular

medical channel is influenced by a variety of socio-economic variables, which include sex, age, the social status, the type of illness, access to services and perceived quality of the service. Health seeking behaviour is thus influenced by the living standards, level of education, family size and income (Ankrah, 2004). Other studies (Mbugua, Bloom & Segall, 2005; Chen, 2007; Gallo, Bogart, Vranceanu & Matthews, 2005; Gorman & Sivaganesan, 2007) have also demonstrated that socioeconomic variables have a very significant role on individuals' choice of healthcare and these appear in many forms. These include the care received by patients either at home or at hospitals (Anarfi 1992, 1994b), cost-benefit analysis as well as the direct and indirect cost of treating a patient (Ainsworth & Over, 1994), evaluations of the cost of intervention programmes (Asamoah-Adu, Weir, Pappoe, Kanlisi, Neequaye & Lamptey, 1994) and the economic consequences of disease condition on families (Barnett & Blaikie, 1992; Caldwell et al. 1993; WHO, 1994).

Socioeconomic statuses are critical factors that influence the utilization of health care services among many societies (Haddad & Fournier, 2006). Poor people and people in the lower socioeconomic ladder seek assistance of religious healers, practitioners of folk medicine, home remedies and over-the-counter medications. They believe that alternative health practices are less costly and end in the reduction of symptoms. Anderson and Armstead (2005), believe that people from higher socioeconomic background tend to utilize orthodox medicine more than paying visits to traditional healers. These research methodologies laid a lot of emphasis on socioeconomic factors that influence health seeking behaviour but not much attention was paid to perception of efficacy of treatment and accessibility, all of which influence health seeking behaviour. Other findings by

Ryan (2008), on health seeking for cardiovascular disorders have shown that the decision to seek health at a particular facility is not necessarily dependent on socioeconomic factors. Ryan found that health seeking behaviour is dependent on a combination of factors like belief in the aetiology of the disorder and the length of the illness are some of the determinants that result in whether one would seek help from an orthodox, spiritual or the traditional healthcare system. Most of the respondents in the research engaged in multiple health seeking behaviours, and that cut across social economic status.

Svab and Zaletel-Kragelj, (2007) looked at the SES and racial and ethnic differences of a sample of 9744 men and women aged 51 to 61 who were suffering from cardiovascular disorders. The findings of this study showed that SES did not play a large role in the prevalence of disease; however, SES played a significant role in the functional health status of individuals once they had been diagnosed with hypertension, stroke, and arthritis. Lower SES is related to access to health care. Individuals who are of lower SES are less likely to get the necessary treatment, and are less likely to get treatment at earlier stages of the disease. The problem with the methodology of this study was that participants of this study were mainly those in the middle class without recourse to those at the lower socioeconomic level. According to Ward, Mertens and Thomas (2004), there may be structural barriers such as lack of health insurance, lack of financial support, geographical distance to treatment facilities, and access to transportation that prevent individuals from getting the care they need. For such groups of people, visits to traditional healers are more probable. Though this research looked at people from the lower socioeconomic background, there was no mention of belief systems which influenced the decision to seek help from a particular healthcare provider. Cooper,

Rotimi, Ataman, McGee, Osotimehin, Kadiri and Muna (2007), in a study on cardiovascular disorders found that though socioeconomic factors influence health seeking behaviour to some extent, factors like culture and belief systems of the people cannot be ignored since cultures differ.

Swanepoel (2008) posits that home remedy and non-traditional healers serve as substitute product that are used more by rural dwellers than others, because of the retention of the African tradition. While urban and other town residents were exposed to this culture and socialization, their higher level of education, access to more information and financial resources account for resocialization and re-adaptation to traditional medical care utilization. The researchers failed to take into consideration the level of acceptability and the belief in the efficacy of treatment of orthodox medicine for which reason the rural dwellers sought help from non-traditional healers, but not necessarily socioeconomic factors.

Bourn and McGrowder (2009) have however showed that where cultural practices are more pervasive, one's status in terms of level of education, marital status, income and social standing have no effect on the health seeking behaviour of the people. Whilst it has been established that higher rates of consultation for cardiovascular disorders are associated with a range of socio-economic factors, the precise relationship between these factors and frequent attendance is unknown (Carr-Hill, Rice & Roland, 2006).

There has been considerable research to assess the impact of cost recovery in the form of cost of healthcare on health care seeking behaviour of people (Asenso-Okyere, 1995; Mbugua, Bloom & Segall, 2005; Hussei & Mujinja, 1997). In Ghana Asenso-Okyere (1995) has asserted that there is a drop in attendance at health facilities, especially in rural

areas and the reason given was the high cost of care. In Kenya, Mbugua, Bloom & Segall (2005) put it that there was a drop of 42% in attendance for curative services in fee-charging Kibwezi health centres while in Tanzania, there was 50% decline in use of out patients' facilities after the introduction of user fees (Hussei & Mujinja, 1997). However, there is no existing information on how user fees affect healthcare seeking in Ghana for diagnosis and treatment of cardiovascular disorders. Studies have also investigated the impact of user fees on the demand for particular types of services and there appear to be no studies on its effect on the cardiovascular conditions under study. Other studies have examined health seeking behaviour in African communities but there were no conclusive findings on the link between socioeconomic status and health seeking behaviour (Shea & Swinkels, 2004; Sentell & Halpin, 2006).

Low literacy and lack of awareness about services, schemes, and entitlements, poverty, and cultural factors are among the crucial factors that determine the health-seeking behaviour in the state (Prasad, 2009). Recent surveys by Iyalomhe, (2007) reveal that the continuing deficiencies in the awareness, treatment and control of hypertension were closely associated with certain socioeconomic factors. They concluded that in many cases, failure to achieve BP goals may be attributable to the poverty of patients' knowledge, perception, attitudes and life-style practices (Hennis et al., 2002; Mari, Ukai & Yamamoto, 2006; Ong et al., 2007; Petrella, Merikle & Jones, 2007). Iyalomhe, Omogbai and Ozolua (2008) showed that distance to health facilities was found to be an important factor associated with decrease in healthcare demand for cardiovascular disorders. This finding revealed that distance has significantly large and negative effect on health seeking behaviour for cardiovascular disorders. This suggests that the

probability of seeking healthcare for cardiovascular disorders would increase significantly if accessibility were easier. The studies, however, focused only on economic factors that influenced the health seeking behaviour of the people, without taking into consideration other factors relating to their culture and belief systems that have profound influence on people's health seeking behaviour.

Matthews, Räikkönen, Gallo and Kuller (2008) in a study among people suffering from cardiovascular disorders showed that for each extra 1 km travelled to the health facility unit, usage for the facility fell by approximately 1%, and the poor were more willing to pay a higher price to reduce the time. Deininger and Mpuga (2003) found user fees to be particularly important in determining access to health services, particularly for the poor.

Liu, Lin, and Xu (2003) showed that financial considerations are rarely the primary factor in choosing a traditional healer, ranking behind such reasons as confidence in the treatment, ease of access, and convenience. They further found in a survey that the average cost of a single visit to a traditional healer was US\$388, and the average annual cost of using a traditional healer represented roughly a fifth of the reported annual income of respondents. The high cost of using a healer was cited as the most common barrier to seeking care from this source.

Verpoorte, Choi and Kim (2005), examined socioeconomic factors and health seeking behaviour for cardiovascular disorders and found the poor are more likely to use TM.

Ahorlu and others (1997) showed that traditional medicine is not always more expensive than conventional medicine. Survey respondents in Ghana reported that the cost of malaria treatment at a health clinic ranged from ₵1,900 to ₵3,000 (US\$1.30 to US\$2.00 in 1997), treatment at home using drugs bought from pharmacies or health care workers

ranged between ₵200 and ₵1,000 (US\$0.10 to US\$0.70), and treatment by an herbalist was virtually free.

2.7 Health Locus of Control and Health Seeking Behaviour

Health Locus of Control (HLC) is defined as one's belief that the state of one's health is determined by internal or external factors, as well as, the level of perceived control over desired outcomes (Bane, Hughes & McElnay, 2006; Takaki & Yano, 2006; McDonald-Miszczak, Maki & Gould, 2000; Howat, Veitch & Cairns, 2006; Sarkar, Fisher & Schillinger, 2006). It is also defined by Thompson and Schlehofer (2008, p 257) as beliefs about the locus of reinforcements: whether or not people in general can get good outcomes and avoid bad through their own actions (internal locus of control) or whether external factors control these outcomes (external locus of control). HLC theory consists of three dimensions: 1) Internal HLC, 2) Powerful Others HLC, and 3) Chance HLC (Wallston, Wallston, & DeVellis, 1978). Internal versus external locus of control is the generalized orientation that has received the most attention.

Historically, health researchers and health care providers, have long recognized that individual beliefs and values about maintaining or regaining health as evidenced by one's behavior falls under the theoretical domain of locus of control (LOC) as defined by J.B. Rotter's social learning theory (Rotter, 1954). After decades and many empirical studies, this psychological construct was generally accepted as having a three-dimensional structure: Internal LOC, Powerful Others LOC, and Chance LOC (Wallston, Wallston & DeVellis, 1978). Studies have shown positive correlations between internal locus of control and health information seeking behavior (Wallston, Maides, & Wallston, 1976) as well as compliance behavior with recommended medical regimens such as encountered

in hypertension (Norman, Bennett, Smith & Murphy, 2008), and weight reduction (Colditz, Willett, Stampfer, Manson, Hennekens, Arky & Speizer, 2007), programmes.

However, other studies have shown positive correlations between internal locus of control and smoking (Schnoll, Rothman, Newman, Lerman, Miller & Movsas, 2004), an association that is inconsistent with other health and risk behavioural theories (Hashimoto & Fukuhara, 2004). The results and conclusions of this study were however limited to the utilization of the classification approach. The analysis calls for identifying individuals as oriented toward internal, powerful others, or chance as the agent of control, either with high or low health values, and as belonging to different levels of experience groups.

In a study to establish the Locus of control and health behaviour Steptoe and Wardle (2001) concluded that high chance locus scores were associated with more than 20% reductions in the likelihood of healthy options for six behaviours, while powerful others scores showed more variable associations with healthy actions. Inclusion of health value within the analyses did not change the nature of the relationships observed between variables. People with external locus of control were less likely to engage in healthy behaviours and this was no different from those that were in the powerful others category. Most of the original research using HLC and MHLC tended to ignore situational factors and showed that internals were more proactive and thus, more likely to take charge of their health and change undesirable situations. Bairan (2005) found that people who valued health highly exhibited more health seeking behaviours and tended to take matters in their own hands concerning their medication regimen. Bairan also found that internals were more noncompliant compared to other groups. These studies were all done among people with western and individualistic orientation whose culture is very

different from the collectivist cultures like that of Africa and Asia and may not necessarily be applicable. Furthermore, the role played by significant others in the health seeking behaviour in Africa, and for that matter Ghana, is very prominent and this cannot be easily discounted. This was not touched on by the researchers.

Molassiotis' (2002) findings showed that HLC was a factor associated with compliance to medication regimens. People with internal locus of control were more compliant and responded to treatment better than those with external locus of control. Those with chance locus of control were more unresponsive to treatment. They believed that getting treatment is a matter of luck but not by taking responsibility of one's health related issues. Takaki and Yano (2006) found that individuals with higher self-efficacy scored highest on attributing their health outcomes to their personal control and reported more health seeking behaviours. However, Snyder (2006) and Banes, Hughes, and McElnay (2006) found that individuals who attributed their health status to internal factors were more noncompliant in medication taking.

Howat, Veitch and Cairns (2006) found that people who scored highly on Powerful Others generally believed that health professionals could control one's health outcomes. Therefore those with high Powerful Others HLC scores were more compliant with medication instructions (Howat, Veitch & Cairns, 2006). O'Hea (2005) also found that individuals who believe their health control lies with their physicians will be more likely to follow their physicians' instructions and turn decisions over to those they think control their health. Much as various behaviours of locus of control have been documented, the extent to which chance LOC and powerful others' LOC have received very little attention, especially in Africa and particularly in Ghana, where religiosity plays a major

role in people's lives. Furthermore, very little research has been undertaken in chance locus of control as compared to internal and external locus of control.

Murphy (2006) undertook a study which measured health locus of control, health value and a number of health behaviours as part of the Health in Wales Survey. Measures of smoking, alcohol consumption, exercise and diet were combined to form a health behaviour index, representing key 'lifestyle' indicators. In line with predictions, scores on this measure were positively associated with internal health locus of control scores, and negatively associated with scores on the chance and powerful others dimensions. Classifying respondents according to Wallston and Wallston's (1981) by health locus of control typology revealed that 'pure internals' performed the most health behaviours. Much as some evidence was found to suggest that health value moderates the relationship between health locus of control and health behaviour, although overall the health locus of control construct was found to be a weak predictor of health behaviour.

Stephoe and Wardle (2001) found an inconsistent and small association between health locus of control and health behaviour compared to what was found in previous studies and concluded that this may be due to the use of small samples, and an overreliance on correlations as measures of association. The study was strictly quantitative, which was able to identify significance levels of analyses but failed to provide answers to the why, how and to what extent of the behaviours of participants, which could better be dealt with when qualitative methods are rather employed.

Norman, Bennett, Smith and Murphy (2008) hypothesized that those who perceive the cause and course of their illness to lie beyond their personal influence may adhere poorly

to treatment, and the theory was tested cross-culturally in the areas of hypertension and diabetes with inconclusive results (Wallace, Rogers, Roskos, Holiday & Weiss, 2006). This notion of 'locus of control' has been applied in clinical anthropology and in cross-cultural research on both diabetes and hypertension (Sturmer, Hasselbach & Amelang, 2006). A group in Yugoslavia, for example, worked to strengthen the sense of social support for elderly people with hypertension. They identified culturally relevant institutions upon which to style their efforts, and the resulting self-help groups met with some success and were not necessarily based on locus of control (Graham, 2006).

A study of Hindus in 1997, who regularly prayed, showed 70% of immunity to coronary heart disease (Cohen, 2007). Webb and Sheeran, (2006) stated in their research on locus of control and spiritual healing that having faith benefits physical and mental health related to thoughts of hope, optimism, and positive expectation; and when persons who are prayed for by prayer groups are compared with persons not prayed for, there is indication of a positive relationship in health improvement due to perceived divine intervention. This is more applicable to those with external locus of control. For this reason, none of the respondents had ready medicine in their homes although taking medicines is not prohibited by the church. The researcher failed to extend to how such belief systems could impact on the lives of the respondents. The questions is, is the sole reliance on faith enough to solve all their health problems. What about when surgery is involved? These questions went unanswered. Examining the relationship between health locus of control and helpfulness of prayer as a direct-action coping mechanism in patients before having cardiac surgery, Saudia, Kinney, Brown and Young-Ward (2001) issued to the Multidimensional Health Locus of Control Scales and the investigator-developed

Helpfulness of Prayer Scale were 100 subjects 1 day before cardiac surgery. Ninety-six subjects indicated that prayer was used as a coping mechanism in dealing with the stress of cardiac surgery, and 70 of these subjects gave it the highest possible rating on the Helpfulness of Prayer Scale. No relationship was found between health locus of control and helpfulness of prayer. Individuals of each locus orientation perceived prayer to be helpful.

Findings suggest that prayer is perceived as a helpful, direct-action coping mechanism and warrants support by health personnel. It is recommended that further research explore the effect of prayer on patients' ability to cope with stressful situations. Other studies by Toner and Manuck (2008) examined the relationship between health locus of control and health seeking behaviours for cardiovascular disorder patients found that those with chance LOC were more religious and largely depended on external forces like doctors and the supernatural for their healing. They however could not further tell the extent to which those with chance LOC depended on these external forces and the effect of such dependence.

Burish (2004) investigated the relationship between locus of control and health seeking behaviour and suggested a positive relationship between health locus of control and participation in health related behaviour. He asserted that engaging in positive health behaviours will likely result in positive health benefits for individuals. The study however, failed to indicate how the various loci of control orientations influence health seeking behaviour. Furthermore, it could not determine the extent to which locus of control affect behaviour. The study concluded that empirically evaluating the relationship between spirituality, health locus of control and participation in health/wellness

behaviours is currently limited. Gary (2000) examined health locus of control and helpfulness of prayer in preoperative cardiac surgery patients and found that gaining knowledge about the individual's use of prayer as a coping mechanism in dealing with stressful situations can facilitate incorporating support of this mechanism into a plan of care for the patient. He found that those who scored high on powerful other LOC and chance LOC were more reliant on prayer for successful surgery as compared to those who scored high on internal LOC.

Findings suggested that while prayer is perceived as a helpful direct action coping mechanism and warrants support by health personnel, others also believed that it is their will power that sustains them. The study was however silent on the effect of the various orientations on the overall health of respondents. That is while some overly rely on external forces, others rely on their own strength, both of which could have negative repercussions on them.

2.8 Statement of Hypotheses

1. Cultural values and belief systems will have a moderating effect on the relationship between cardiovascular disorders and health seeking behaviour.
2. There will be a positive relationship between the efficacy of treatment and health seeking behaviour for the orthodox and the traditional healthcare systems.
3. People with high socioeconomic status are more likely to seek help from the orthodox health system for the treatment of cardiovascular disorders, compared to those with low socioeconomic status.
4. Multidimensional Health locus of control orientation will have a mediating effect on relationship between cardiovascular disorders and health seeking behaviour.

2.9 Operational Definition of Terms

The following operational definitions have been used for the key words used in the study.

Health Seeking Behaviour: This refers to the sequence of remedial actions that individuals undertake to rectify perceived ill health (Ward et al., 2004; pp 24). It can also be referred to those activities undertaken by individuals in response to symptom experience

Cardiovascular Disorders: According to the WHO (2013) cardiovascular diseases are a group of disorders of the heart and blood vessels and include: high blood pressure, coronary heart disease, peripheral arterial disease, rheumatic heart disease, congenital heart disease, and deep vein thrombosis and pulmonary embolism. For the purpose of this research they include high blood pressure (hypertension) and coronary heart disease, which are the two most prevalent conditions in the area under study.

Conventional/Orthodox Medicine: A system in which medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery in the hospitals or formal settings. Also called allopathic medicine, biomedicine, conventional medicine, mainstream medicine, and Western medicine.

Traditional Medicine (TM): This refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly, or in combination to treat, diagnose and prevent illnesses or maintain well-being (WHO, 2008). They are also called

traditional medicinal practices and are termed “Complementary” and/or “Alternative” Medicine (CAM).

Traditional Priest/Priestess: This is a respected person next to the chief in the community. He/she stands between the deities and the people. The people make their request to the deities through him/her and he/she receives the reply. His/her word is final. His/her commands are obeyed. He/she heals not only bodies but hearts too.

Herbalists: They are the most numerous among the traditional medical practitioners. They approach healing mostly through the use of and application of herbs. They cannot be possessed by a deity, but some of them can work with less powerful spirits and can use "medicines" that enable them to diagnose supernatural diseases.

Faith Healing: It is a concept that religious belief ("faith") can bring about healing—either through prayer or rituals that, according to adherents, evoke a divine presence and power toward correcting disease and disability in particular indicated individuals. It also refers to notably overt and ritualistic practices of communal prayer and gestures (such as laying on of hands) that are claimed to solicit divine intervention in initiating literal physical.

Prayer Camps: They are places of worship which are usually owned by individuals and their immediate families. These camps are private facilities run by self-professed ‘prophets’ and healers where people are taken in attempts to get an antidote to their problems or cure their illness.

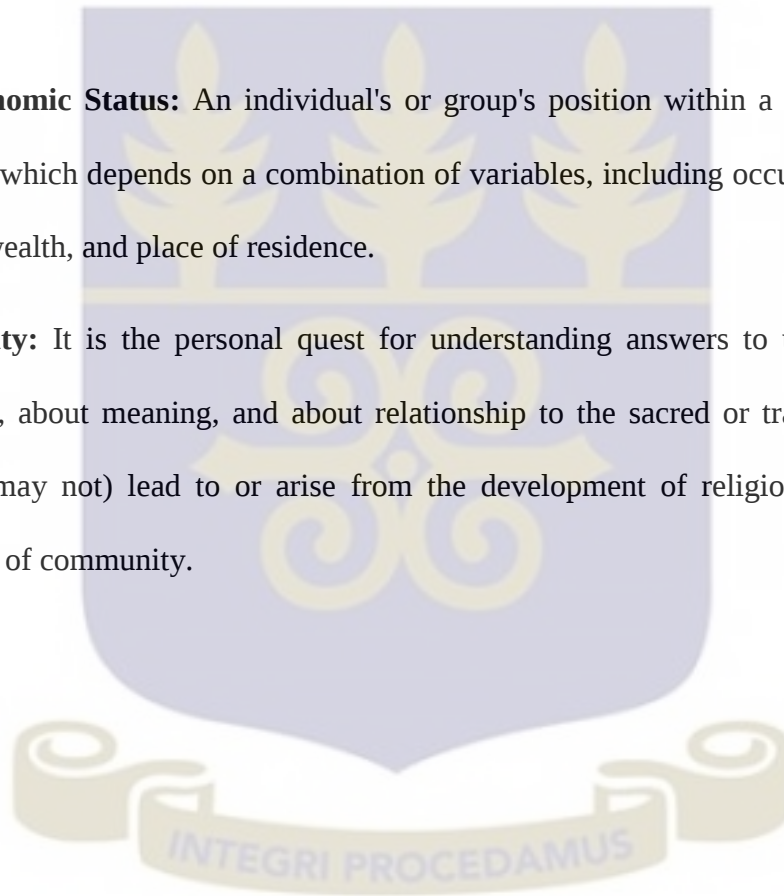
Highly Educated: People who have attained the equivalent of college education or higher.

Low education: People who have no formal education or have attained educational level up to Senior High School (SHS).

Religiosity: Adherence to the beliefs and practices (rituals) of an organized church or religious institutions.

Socioeconomic Status: An individual's or group's position within a hierarchical social structure, which depends on a combination of variables, including occupation, education, income, wealth, and place of residence.

Spirituality: It is the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community.



CHAPTER THREE

METHODOLOGY

Introduction

This chapter describes the methodology for the study. Specifically the chapter includes the study design, sample selection, setting, and procedures for recruitment and data collection, human participants' protection, measurement of variables, validity and reliability of instruments. It aims to make each stage of the research process explicit, and to provide a clear 'audit trail' of the research and development processes. It attempts to explain the study's analytical decision trail, illustrating the type of data collection methods used and how they were carried out. These include questionnaires, focus group discussions (FGD) and key informant interviews (KII) which were aimed at finding out how cultural beliefs, socioeconomic and locus of control factors influence people's health seeking behaviour for cardiovascular disorders

3.1 Design of the Study

The study used a cross-sectional, exploratory design to investigate the demographic cultural and socio economic factors which influence health seeking behaviour for cardiovascular disorders. This is a non-experimental method in which a researcher collects data from two or more groups of participants during the same time within a limited time-span on some topic or issue that is of interest to the researcher (Smith & Davis, 2004). A cross-sectional study design was chosen (Calder, Phillips & Tybout, 1981) because the data collected relate to a single specified time. The characteristics of a cross sectional exploratory study makes it more appropriate for the study (Heiman, 2002), include the fact that it gathers information on the sample about their beliefs, opinions and

attitudes towards the phenomena which have not previously had much studies undertaken on the area of research under review measures attitudes, beliefs, behaviors, personal or family history, genetic factors, existing or past health conditions (Cohen & Manion, 1994).

This study was conducted using the independent predictor variables of the development and experiences of cardiovascular disorders and the dependent variable of willingness to seek medical help, both traditional and orthodox. This design is useful in describing the demographic characteristics of the respondents, exploring relationships and getting reasons for their health seeking behaviours for cardiovascular disorders. This design was appropriate for describing the association between knowledge and experience with CVDs, as well as an individual's ability and willingness to seek medical helping (Barnes, 2001). It measured the effect of cultural influences and socio demographic factors based on the participants' worldviews, and their association with willingness to seek medical help. The exploratory methodology attempted to investigate areas that have yet to be studied to obtain new information, insight, and awareness, and to determine new patterns between the impact of knowledge and experience with CVDs. It promoted a better understanding of the relationship between all study variables.

3.2 Study Setting

The description of the study area includes characteristics such as geographical location, population structure, health, education and other social and economic activities relevant to the research topic.

3.2.1 Geographical Location

The study was undertaken in the New Juaben Municipal area. The New Juaben Municipality falls within the Eastern Region of Ghana. The Municipality covers an estimated area of 110 square kilometres constituting 0.57 % of the total land area of the Eastern Region. The Municipality shares boundaries with East-Akim Municipal on the North-East, Akuapem North District on the East and South and Suhum-Krabo-Coaltar District on the West. Koforidua, which is 85 kilometres from the national capital Accra, serves both as the municipal and regional capital.

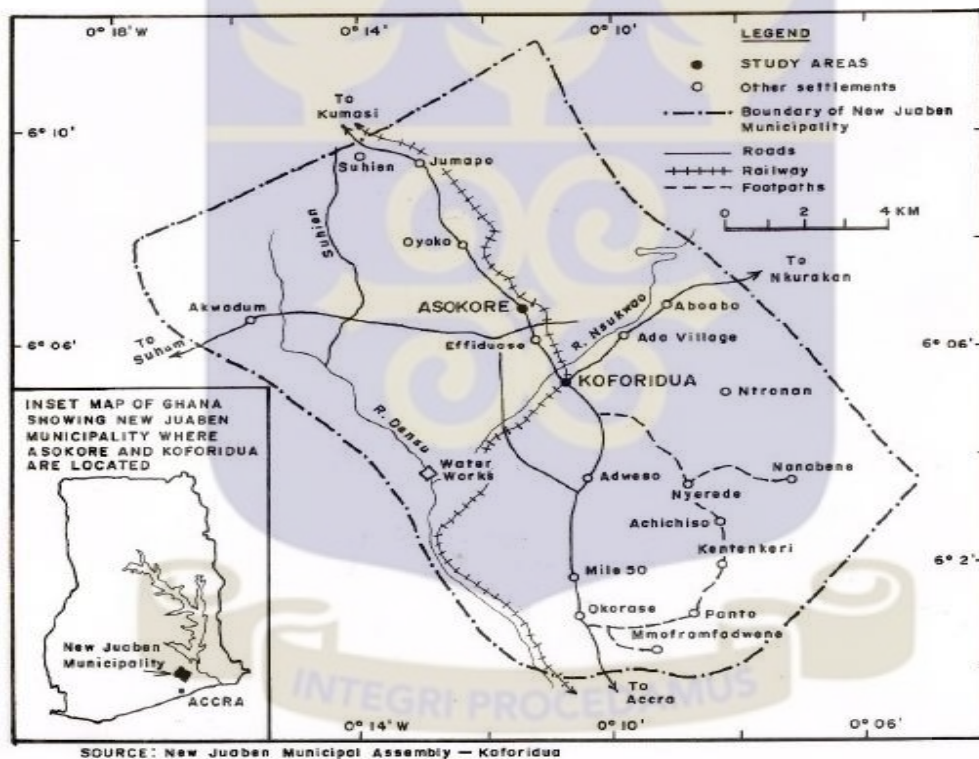


Figure 3.2 Map of New Juaben Municipal Area

3.2.2 Population

The 2012 national housing and population census figures released by the Ghana Statistical Service put it that the municipality has a population of 147,528, with a growth

rate of 2.6%. Females are the dominant group and constitute 51.5% and males 48.5 % of the population. According to the 2012 Census, people under 15 years constitute 35% of the population; those between 15-64years constitute 60% while those above 65% years constitute 5% of the population. This signifies that New Juaben Municipality has a fairly young population with a dependency ratio of 64.7 per 100 persons in the 15-64 age groups.

The Municipality is heterogeneous in terms of ethnicity with a high dominance of Akans. There are four major ethnic groups in the Municipality, namely, the Akan (52.1%), the Ga-Dangme (18.9%), the Ewe (15.9%), the Guan (7.2%). The northern tribes (5.9%). The relevance of this information is associated with the examination of the demographic background of participants for the study. It is also the group within which sample for the study was selected.

3.3 Study Population and Sample

The population for the study was all persons aged 35-75 years who were currently living in the New Juaben Municipal Area in the Eastern Region of Ghana. The participants for the quantitative study included male and female residents of the New Juaben Municipality aged between 35 and 75 years.

3.3.1 Inclusion/Exclusion Criteria

To be considered for selection for the research, patient based participants were made up of males and females within the age group of 35 – 75 who were suffering from cardiovascular disorders, of sound mind and had insight into their conditions, but have not suffered any complications that might have impaired their cognitive functioning so

that they could adequately and appropriately express their beliefs, perceptions and opinions on the subject under study. Individuals who did not meet the above criteria were excluded from the study, and those who were incapacitated to the extent that they could not talk or provide logical answers to questions on the questionnaire were also excluded. Participants for the health systems component included those who had been working with patients/clients for at least five years and had had enough exposure with regards to the dynamics of providing of care to patients.

Based on the methods of data collection and analysis, the study was organised into two, which were qualitative and quantitative. Study 1 involved the qualitative data collection method and Study 2 comprised the quantitative aspect of the study.

3.4 Triangulation

Although use of mixed methods in research has been debated due to lack of congruency in philosophical positions (Lincoln & Guba, 1985; Crotty, 1998; Yates, 2004), other researchers have argued that such classification is not exclusive as such mix could strengthen the reliability of the research results. The mixed method approach was used to allow each research method's weaknesses to be overcome by the strengths of the other method (Brewer & Hunter, 1989).

Some researchers have also applauded that combining qualitative and quantitative methods could be considered as a step in the right direction to avoid dichotomy between them (Patton 1987; McPherson & Leydon, 2002). Dzurec & Abraham (1993) suggested that objectives, scope, and nature of inquiry should guide the choice of research methods rather than the qualitative-quantitative method divide as Silverman (2001; p 25) recently argued:

The value of a research method should properly be gauged solely in relation to what it is trying to find out and should not be based on some empty or glossed version of what qualitative and quantitative methods mean

Based on the arguments stated above, the study employed the mixed method design to investigate the health seeking behaviour among the people of the New Juaben Municipality. The *Journal of Mixed Methods* (2006), defines mixed methods as ‘research in which the investigator collects, analyses, mixes, and draws inferences from both quantitative and qualitative data in a single study or a program of inquiry’.

In this study, a concurrent mixed method approach was used. Data variables for the study were classified on the basis of the source of data for the study (Creswell & Plano, 2007). In this design, data were obtained from two sources, that is, qualitative and quantitative sources (Creswell & Plano, 2007). The design was employed to compare people’s health seeking practices for a clinical sample and the general population in order to establish whether the quantitative data which was collected form a representative sample of the population would corroborate the findings of the qualitative data which was collected form a clinical sample. This approaches was therefore used to “confirm, cross-validate, or corroborate findings within the study” (Creswell, Plano, Gutmann & Hanson, 2003). By using multiple methods, the researcher strives to decrease the “deficiencies and biases that stem from any single method” (Kopinak, 1999: p. 19) creating “the potential for counterbalancing the flaws or the weaknesses of one method with the strengths of another” (p. 21). In this study there was a combination of qualitative data and quantitative data sets, which included a combination of participant interviews, focus group discussion and questionnaires in the same study (Denzin & Lincoln, 1998).

CHAPTER FOUR

STUDY 1 – QUALITATIVE

Introduction

This qualitative study provides in-depth exploration of an array of issues related to health-seeking behaviour for cardiovascular disorders. Since the intended study outcome was to provide information likely to influence health policy, health seeking and care service provision, selection of participants for the study was done carefully to capture the perspectives of the patients and orthodox health care providers including the perspectives of doctors and nurses as well as key stakeholders such as key traditional medical practitioners like the herbalists, fetish priests/priestesses and diviners. The study further collected information from the patients' caregivers and community members who by virtue of living with people with cardiovascular disorders are better positioned to provide relevant perspectives related to health seeking behaviours (Strauss & Corbin, 1990).

4.1 Rationale for Qualitative Research

Qualitative research was chosen as a strategy of choice in studying the health seeking behaviours for cardiovascular disorders. This approach allows an in-depth exploration of patients' own perceptions, attitudes and behaviour in relation to health care seeking. It also enables in-depth views of patients' caregivers, health care workers and community members in relation to the overall process of health care seeking and service delivery in their natural settings. Qualitative research is an approach which encompasses many disciplines, fields and subjects. It has neither a theory that is distinctly its own nor a single method that is given priority over another (Corbin & Strauss, 1990). Denzin and Lincoln (2005) for example, give the following definition in their seminal textbook on qualitative research:

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them.

The current research applies qualitative methods aimed at exploring the health seeking behaviour among people suffering from cardiovascular disorders in the New Juaben Municipality in the Eastern Region of Ghana. According to Patton (1990), qualitative research enables researchers to get particularly close to the problems under study during field work and brings their personal insights and experiences into any recommendations that may emerge from the data. Indeed, in this research, the researcher became more familiar with the challenges in health seeking among the participants under study. Further, Guba and Lincoln (Guba & Lincoln, 1994, p. 112) had this to say about qualitative research:

Qualitative research methods are able to expose contextual information that is often missed or lost in quantitative designs. The dominant paradigms of quantitative research are to apply methods that measure exposure as simple, independent variables so as to maximize the study's rigor in identifying causation. However, this reductionism approach results in a loss of information about meaningful context and may tend to investigate how exposures influence outcomes in interaction with other outcomes. Inherent to those exclusionary designs is the loss of the human factor, which often injects the small quantity that gives meaning and purpose to an outcome. Equally so, the quantitative paradigm of objective of enquiry by the 'disinterested

scientist' may often have the unintended result of producing results that have no meaning to the studied or affected group".

Guba and Lincoln's (1994) approach to qualitative research has certainly influenced the current study. Their observations were influential on my decision to use qualitative methodology, as was their focus on human behaviour in generating information and knowledge that has meaning to the group being studied in this thesis – people with cardiovascular disorders.

The use of qualitative methods enabled me to explore why people suffering from cardiovascular disorders behave the way they do. The approach enabled the researcher to engage the patients to describe their experiences of living with cardiovascular disorders and the challenges they face in terms of health seeking. Through qualitative methods the present study was able to generate information which provides a better understanding of people's beliefs and attitudes that influence the use of biomedical care services as well as alternative care services in managing cardiovascular disorders.

4.2 Aims of the Study

The aims of the qualitative study were as follows:

- i. To identify the effect effects of culture on help seeking or CVDs.
- ii. To assess participants' views on health seeking for orthodox and traditional health systems.
- iii. To examine socioeconomic factors and their effect on health seeking behaviour for CVDs.

- iv. To examine the relationship between multidimensional health locus of control (MHLC) locus of control orientations and health seeking behaviour for cardiovascular disorders

4.3 The Research Process

This section describes the research process and methods employed in the current research. According to Ken (2003) research methods include specific research techniques used to collect and analyse data.

4.3.1 Ethics Approval

Letters of introduction for the present research was first sought through the University of Ghana to the various facilities where data were taken from (Appendix). After this the various logistics for data collection were worked on for the data collection to take place.

In the New Juaben Municipality, where the study was conducted, the researcher met separately with the Medical Director of the Eastern Regional Hospital, in Koforidua. The researcher introduced himself, presented a copy of the study's introductory letters and briefly presented the purpose of the intended study.

Furthermore, the researcher to all the questions raised by the Medical Director regarding the proposed study, after which he issued the researcher with formal letters officially permitting me to carry out the study at the hospital (Appendix V). With these letters at hand, the researcher was able to set up meetings with the medical officers in charge of the Internal Medicine Department of both the Regional and St. Joseph Hospitals, a Department that has the responsibility of treating all cases related to cardiovascular disorders.

The meetings with the medical officers in charge of the Internal Medicine addressed and clarified a number of logistical issues related to the data collection process. The meetings were followed with other official letters permitting the researcher to carry out the main study in the respective units of the Department. The whole process from the applications for approval to the final permits from the doctors in charge of the respective diabetes clinics took seven months.

4.3.2 Pilot Study

The pilot study for the present research was carried out in Suhum, a town that was outside the study scope. This was done in order to avoid the possibility of having the same person being used twice in the study, a situation that has the potential to confound the study responses. The pilot study was in two session. The first was a focus group discussion that was carried out among people suffering from CVDs in the Suhum–Kraboa-Coaltar district. The second involved pilot key informant interview among both traditional and orthodox healthcare givers. In each session after introducing myself I shared the information sheet and/or its contents for those who could not read, after which consent to participate in the study was obtained. Similarly, in each interview permission was sought from the respondent before using a tape recorder to document the conversation.

Through this process oral and/or written consent from all the participants was granted. A focus group discussion session was held with a group of 8 participants at the Suhum Government Hospital, with the researcher acting as the moderator. Given the lack of defined street names and absence of house numbers it was difficult to locate the majority of the patients not only in the pilot phase but also during the main study. In an effort to

get to the homes of the patients the researcher had to be escorted by other patients at the clinic who knew where they lived. This was a method designed during the pilot study to get around the problem.

For this component of the study, key informant interviews were carried out: one with a fetish priest (*okomfo*), an herbalist (*odunsini*), a traditional spiritualist and a prayer camp operator. Similarly, other interviews were carried out with two health care workers at their workplace: a registered nurse and a doctor. Overall, this pilot study component went well.

4.3.3 Data analysis of Pilot Study

The pilot study held one focus group discussion session and key informant interviews of the six participants who are all healthcare providers. Information gathered (which was mainly in Twi, a local Ghanaian language) were transcribed followed by translation into English. The researcher met with the research assistant to double check the translation. The research assistant was a social scientist, a native Twi speaker fluent in English with extensive experience in transcription and translation. The data for the pilot study was analysed manually, after which a meeting was held with the research assistant to review the raw information.

4.3.4 Lessons learnt from the Pilot Study

- The pilot study helped the researcher to test the appropriateness and clarity of the study data collection instrument.
- The in-depth study instruments for patients and health care workers turned out to be far too long. On average each interview took about two hours.

- Some of the questions were repetitive which made the questionnaire unnecessarily long. The instrument was revised to eliminate the repetitive questions.

4.3.5 Methodological responses to the experience from the Pilot Study

- i. Following the pre-testing of the study instruments research assistant and the researcher incorporated the relevant changes into the study instruments including rewording or eliminating some of the questions that were repetitive. The study tools were now more realistic and ready for use in the main study.
- ii. The highlighted ambiguities in the study instruments were adjusted to ensure comprehension of the questions by all study participants.
- iii. To maintain data quality for the main study, the researcher decided to do the transcription and translation himself.
- iv. Clinic attendance days were used to get participants for the study.

4.4 Sampling Strategy for the Main Study

The current study sought to recruit participants utilizing a purposive sampling strategy which is commonly used in qualitative research, was used to select patients who have ever visited the various healthcare delivery systems over the past 12 months and have first-hand experience on the activities of these healthcare providers, and had, specific characteristics of interest to the research. This method was used because patients with different ailments visited the various hospitals, prayer camps, spiritual and herbal centres for treatment. According to Patton (1990; 2002) a purposive sampling technique is used to select participants for a study to ensure that the information collected is rich and clearly addresses the issues in question. Similarly, Peers (1996) states that purposive sampling is often used to select people with different backgrounds (different sexes, ages,

education levels, employment status, duration of disease, experiences with the health care system) to enrich the nature of information gathered.

One challenge of this method is that generalising findings from a purposive sample could be risky. However, using purposive sampling provides the best way to sample the opinions of participants who are the direct recipients of services relating to the variables under study. Furthermore, they fit the criteria with regards to people suffering from cardiovascular disorders and have direct experience of the condition (Guba & Lincoln, 1994).

The rationale for the use of patients suffering from cardiovascular disorders in relation to the study aim is that the patients are individuals who have suffered from the condition and thus have first-hand information regarding the nature of the condition, their experience of it and the remedial actions they have undertaken in order to get a cure.

Furthermore, as deduced from the topic of the thesis, which seeks to look at health seeking behaviour among people suffering from cardiovascular disorders, the use of patients suffering from CVDs is more appropriate because they best fit the criteria for selection of study participants.

Lastly, using patients suffering from CVDs and getting first-hand information from them helps the researcher to gain in-depth knowledge and understanding of the factors influencing health- seeking and health related behaviour for cardiovascular disorders.

Data collection in the current study was carried out using multiple qualitative methods such as focus group discussions and key informant interviews. The literature suggests that qualitative methods provide the most appropriate research tools for gathering meaningful data about human behaviour (Denzin & Lincoln, 2000; Holloway & Wheeler,

2002). Two main sampling groups were used for the qualitative study. The first was the use of focus group discussions (FGD) for patients suffering from cardiovascular disorders. The second was the use of key informant interviews (KII) for practitioners who offer services to people suffering from CVDs.

In this study, four different groups of patients suffering from cardiovascular disorders were used for the FGD. Each group was made up of 6 to 9 members comprising male and female participants who sought healthcare from the both traditional and orthodox settings. These include sets from the prayer camp, spiritualists and herbal treatment centres (traditional) and those from the hospital (orthodox) setting. Participants were men and women from different backgrounds who were suffering from CVDs and have been seeking treatment at those settings over the past 12 months. They were aged 35 to 68 years. Selection of participants is described in details below. The purpose for doing FGDs with patients was to gain information on the awareness, knowledge and understanding that people suffering from CVDs.

4.5 Participants

4.5.1 The Patients

Through the help of the healthcare providers, both traditional and orthodox, the researcher was able to identify and purposively select applied in each study setting (people with CVDs who were regular attendees to the healing facilities). Regular attendees included patients who had attended the healing facilities frequently as scheduled. The focus in selecting this group was to elicit experiences and patterns of various people suffering from cardiovascular disorders as participants of the study. This

method was health seeking and health related behaviours and challenges of utilisation of both biomedical and traditional and spiritual CVD care services. A number of participants across different socioeconomic divide ranging from people of a lower to middle class population up to upper levels. Fifty six percent of the residents in the Municipality are Akans (predominantly a mixture of Akyem and Ashante people). In all, 33 participants living in the New Juaben Municipality were used for the FGD. There were four focus groups consisting of 6 to 9 people.

The researcher purposively recruited a mix of patients' gender, those who were aged 35 years and above and those who were diagnosed at least one year before the study. There were 15 males and 18 females aged between 35 and 75. Four participants were between 35-40 years, six were between 41-49 years, eight were between 50-59, 10 aged 60-69 and finally 5 were between 70-75 years. The level of education were varied, as some had no education through to the university level. There were 8 participants who had no education, 4 of them had completed middle school form four (old educational system), 4 of them had completed senior secondary school, 9 of them had completed ordinary level, two (2) had diploma, one (1) higher national diploma (HND) and three (3) had university education. In terms of occupation, participants were engaged in various forms of work. Eight were engaged in petty trading, 4 were farming, 2 shop attendants, two retired teachers and 2 office secretaries. There were also a corporate affairs manager of Social security and National Insurance Trust (SSNIT), a cobbler, a revenue collector, a retired headmaster at the rank of director, an accountant, accounting assistant and a “*galamsey*” operator (*galamsey* is a form of mining considered as illegal in Ghana) respectively.

Focus Group Discussions (FGD) were held for patients suffering from CVDs and have come into direct contact with service the services providers of both the orthodox and non-orthodox health systems with the aim of receiving treatment. This method of gathering qualitative data was used for the patient suffering from CVDs. This allowed the researcher to obtain information on group norms as well as information about the private aspects of reasons behind people's choice of particular treatment regimen and sought information on their perception of health systems in general. Questions in the FGDs encouraged respondents to discuss in detail their health seeking behaviour based on their beliefs, value systems, perceptions and attitudes toward cardiovascular disorders.

Focus group utilised the group processes which helped respondents to explore and clarify their own views, and this allowed the researcher to get a first-hand understanding of participants' belief systems (Yin, 2006). The use of FGD helped to assess beliefs, perceptions, opinions and attitudes of participants who have suffered from cardiovascular disorders towards the various health systems. It further helped to check for multiple health seeking behaviours among respondents and its impact on their health and general well-being. The component offered the researcher the opportunity to have an in-depth insight into the health seeking behaviour of this category of participants. The Focus Group discussion gave the researcher the opportunity to gather rich data and first-hand information concerning attitudes, opinions, beliefs and cultural factors that influence their health seeking behaviours, from this group of participants.

Sample size for the focus group discussion were between 6 and 9 discussants, based on the definition that most focus groups consist of between 6 and 12 people (Wong, 2008).

Group members in such a focus group may be homogeneous along a dimension (Krueger & Casey, 2000). The group homogeneous in the sense that members were patients who were suffering from cardiovascular disorders as operationally defined in this study, a condition relevant to the topic of interest to the research. They were patients who had reported at the hospital or a traditional healer within the past 12 months.

Procedure for data collection for the various groups were similar. In the hospital setting a scheduled appointment was booked to meet patients for the FGD. This was done on clinic days for patients with CVDs. With the assistance of the Deputy Director of Nursing Services (DDNS) in charge of the clinic, the essence of the study was explained to the patients. After that patients who fit the criteria for inclusion in the study and were willing to be part of the study were then purposively selected for the discussion. The researcher further explained in detail the purpose of the study and then gave out informed consent forms for them to read and sign. For those who could not read and write, details of the consent form were read and explained to them in the local *Twi* language, after which they thumb printed to show their approval to be part of the study.

For the traditional spiritualist (*Okomfo*), after self-introduction by the researcher, the Priest asked for some moments with the gods in order to seek approval before any such discussion could go on. After a week, the researcher visited the shrine to hear the response from the gods. On arrival and having been seated the priest indicated that approval had been given and that the discussion could be organised. It was therefore agreed that the FGD would be held in a week's time. The researcher went back on the appointed date and met the assistant to the fetish priest, who helped in organising the

discussants. After waiting for 47 minutes, there were 9 people available and it was agreed between the researcher and the *Okomfo's* assistant that they were sufficient to the discussions to take off. A similar procedure took place at the herbal centre, with the only exception that that herbalist did not as to consult the gods before granting the researcher the permission to gather data.

During the FGDs, the researcher served as the moderator and the research assistant (a psychology major graduate) took notes. I was able to conduct two FGDs (one for the hospital and one for the prayer camp) in one day. Then one was done on a different day at the shrine on a different day and another at the herbal centre on a different day, bringing the total number of FGDs among people suffering from CVDs to four. The time for each discussion ranged from 50 minutes to 1 hour 2 minutes.

Though FGDs were undertaken at different places and at different times as mentioned above, the format for discussions were similar. As required in any scientific endeavour that requires human participants, informed consent forms were given out to respondents to read and sign to signify that they had understood the contents and were ready to take part in the discussions. For those who could not read and/or write, the consent forms were read and explained to them in the local dialect before they thumb printed to show that they would take part in the study. The discussions started with introduction and welcoming, followed by statement of the purpose of the meeting by the researcher, who was the moderator of the group discussions. Pseudonyms were assigned to each of the participants to ensure anonymity. For example those at the hospital were designated H¹, H², H³. Those at the herbal centre had the designation HC¹, HC², HC³ and those at the prayer camp were assigned PC¹, PC², PC³, and that at the shrine was SH¹, SH², SH³. The

researcher, taking into consideration all the ethical considerations involved in gathering qualitative data built rapport among members and assured them of utmost confidentiality. The ground rules for the discussion were then set after which the discussions followed.

Prior to the start of each focus group discussion the researcher ensured each participant was still interested to continue with the discussion and they were made to understand that they were free to leave at any time in case any of them experienced any discomfort in the course of the discussions. By its very nature, qualitative inquiry may produce issues that arise during the discussion that could not have been anticipated at the time of consent.

Participants in this study were therefore informed at the beginning of each group discussion that they could choose not to answer any questions or not to participate if they wished. They could also ask for the recording device to be switched-off if they so wished or they could leave the discussion or interview at any time without giving a reason. Again, before the discussions started, participants were asked whether the discussions could be audio taped and were assured that the information would be used only for the purpose of the study. With their permission, all focus group discussions were audio taped. The researcher allowed participants to talk without too many interruptions and moderated the process by listening and probing as appropriate. Probing was used to obtain information, clarify a point, or expand on ideas (Creswell, Plano Clark, Gutmann & Hanson, 2003).

The discussions were conducted based on the objectives of the study. Various themes emerged from the discussions that were used for analysis and discussion of the study. All focus group discussions were conducted in Twi and were fully translated and transcribed

by the researcher with the assistance of an independent transcriber into English. All recordings were transcribed verbatim, and once completed were checked against the original recordings to ensure there were no errors or misquotes. Once the transcripts had been checked against the original recordings two copies were made; one was stored within a folder in Word and a hard copy was produced. All hard copies were numbered and re-checked to ensure all pseudonyms were in place.

The purpose for doing FGDs as earlier explained people was to gain information on the awareness, knowledge and understanding that people with CVDs have about the disease. It also provided an opportunity to explore their experience with the health care system and the nature of various health care services and community cultural norms. The group further provided some insights into factors which influence health- seeking and health related behaviour for other diseases at the community level.

4.5.2 The Key Informants

According to Patton (2002) key informants are people knowledgeable about the subject under study and who can give informed opinions on broad questions and issues pertinent to the subject. The key informants in the present study were identified according to their specialised knowledge of care and management of CVDs in the New Juaben Municipality. Informants in this study were healthcare providers who had special knowledge about the target audience, status among audience members, access to important information, and were willing to share their knowledge and experiences (Hogle & Sweat, 1996). The researcher employed this method to make inquiry into psychological phenomena to understand the target audiences from the perspective of the healthcare provider.

The study used key informant interviews with orthodox and non-orthodox healthcare providers who were directly involved in the care of patients. The participants included physicians, herbalists, traditional priests (*Okomfo*), diviners and prayer camp operators. Each participant was purposively sampled and interviewed. The problem with purposive sampling is that the subjects might be atypical of the population with regard to the critical attributes being measured. Nevertheless, it serves as the surest way of selecting participants who truly meet the diagnostic criteria of the population under consideration.

The doctors were working in the consulting rooms of the regional hospital and St. Joseph Hospital, both in the New Juaben Municipality. Selection of the physician specialists and the cardiologist were based on the fact that they had in depth knowledge about the treatment of cardiovascular disorders and also they were the people who mainly handled cases related to CVDs at the hospital. All the doctors reported to have been in practice between 14 to 22 years. Their ages ranged from 49 to 58 years. They see about 60 CVD related cases every week on the average.

The herbalists were people who had gone through practical (informal) training in the use of herbs in their treatment over a long period of time through understudying their mentors and have now become independent practitioners. They were operating as herbalists as defined by the WHO (2001). Their educational levels were between Middle School levels to Ordinary Level. One had worked in the capacity of an herbalist for 43 years; another, 26 and the other, 18 years. Furthermore the traditional spiritualists and the diviner were practitioners who combine the use of both herbs and spirituality in their treatment

regimen, but with a major emphasis on the interpretation of diseases as having spiritual causation. They had practiced as healers between 18 and 36 years.

The One major feature of the traditional system is that knowledge on herbal preparation is bequeathed to only family members, made up of mainly male children of the spiritual healers and herbalist and in some cases, nephews. They indicated that they see an average of 350 CVD related cases every week and patients come from all parts of the country. Their ages ranged from 43 years to 78 years. Details of sampling procedures have been discussed earlier in the procedure for data collection section.

The prayer camp operators were selected based on the number of years they have been practicing, that is, they have 12 to 22 years of experience. They were participants who claimed to have cured many people suffering from cardiovascular disorders and provided testimonies to that effect. They were between ages 38 and 54.

The use of key informants provided an in-depth knowledge from various stakeholders and documentary analysis helped to understand patients' health seeking behaviour from the perspective of the health care provider. The purpose of this component of the study was to determine the extent to which people suffering from cardiovascular disorders reported to these facilities, at what state they were sent there, the kind of support they offered these patients and their opinion on their health seeking behaviour. It was also to find out the reciprocal views between orthodox and non-orthodox healthcare providers on one hand and views between healthcare providers and their patients. This was used to assess the relationship between healthcare providers and patients and its influence on health seeking behaviours for cardiovascular disorders.

Though there was a bias of the interview method relying on self-reported data, there was a major advantage where informants shared sensitive information and provided details about their personal experiences, views, and behaviours regarding their interactions with different patients over their years of practice. Interviews were conducted with different key informants including, orthodox and traditional health care providers who provided relevant information on the issues under study.

The decision to interview key informants was made after all in order to solicit rich and first-hand information from them, because they come into direct contact with people suffering from cardiovascular disorders and thus have knowledge about their health seeking behaviours. The intention was to again generate additional data to enrich the information already derived from FGDs with other participants. These key informants were used also as a sounding board in clarifying the key issues raised by the participants, particularly patients, with regards to their health seeking behaviours. Some of the tentative policy-related recommendations raised by the participants in the study were also discussed with these key informants. All the key informants on the list were contacted and appointments for face-to- face interviews were made. The list of key informants interviewed during the study is presented in Table 4.1.

Table 4. 1 Participants' Characteristics

Position	Organisation	Number
The Chief Priest and Assistant Priest (Okomfo)	Obuotabiri Shrine, Koforidua	2
Nana Kwaku Nyame &	Diviner	2
Physician Specialist	Regional Hospital, Koforidua	2
Cardiologist	St. Joseph Hospital, Effiduase	1
Deputy Director Of Nursing Services (DDNS)	Regional Hospital, Koforidua	1
The Chief Priest	Sheto Shrine, Tafo	1
Prophetess Patience Adom	Adom Prayer Centre	2
Opanyin Yaw Nyanteh	Enso Nyame Ye Herbal Centre	1
Opanyin Kwayisi	Ayisaa Herbal Centre	1
Total Number		13

Sampling was purposive, and four facilities were selected, including the Koforidua Regional hospital, the spiritualists (Okomfo and diviner) herbal centre, and a prayer camp. These facilities were selected based on their prominence in terms of patronage; years of existence and general recognition, especially among people suffering from CVDs.

Informants were selected from facilities these facilities through snowball technique to participate in the study. Each participant was purposively sampled and interviewed. The first group, were doctors and (orthodox system), the second (traditional medical practitioners), were the spiritualists, herbal medicine service providers and prayer camp operators. In all a total of 13 informants were interviewed; three medical doctors (2

physician specialists and one cardiologist), one DDNS (in charge of hypertension and diabetic clinic) three fetish priests, two diviners, two herbalists, and two prayer camp operators. The problem with purposive sampling is that the subjects might be atypical of the population with regard to the critical attributes being measured. Nevertheless, it serves as the surest way of selecting participants who truly meet the diagnostic criteria of the population under consideration.

The doctors were working in the consulting rooms of the regional hospital. Selection of the physician specialists was based on the fact that they had in depth knowledge about the treatment of cardiovascular disorders and also they were the people who mainly handled cases related to CVDs at the hospital. Selection of the Senior Medical Officer (SMO) was based on them being the direct point of call at the hospital before they are referred to the specialists. All the doctors reported to have been in practice between 8 to 32 years. Their ages ranged from 36 to 58 years. They see about 60 CVD related cases every week on the average.

The herbalists were people who had gone through practical (informal) training in the use of herbs in their treatment over a long period of time through understudying their mentors and have now become independent practitioners. They were operating as herbalists as defined by the WHO (2001). Their educational levels were between Middle School levels to Ordinary Level. One had worked in the capacity of an herbalist for 43 years; another, 26 and the other, 18 years. One major feature of this system is that knowledge on herbal preparation is bequeathed to only family members, made up of mainly male children of the herbalist and in some cases, nephews. They indicated that they see an average of 350 CVD related cases every week and patients come from all parts of the country. Their ages

ranged from 43 years to 78 years. Details of sampling procedures have been discussed earlier in the procedure for data collection section.

The prayer camp operators were selected based on the number of years they have been practicing, that is, they have 12 to 22 years of experience. They were participants who claimed to have cured many people suffering from cardiovascular disorders and provided testimonies to that effect. They were between ages 38 and 54.

4.6 Functions of the Researcher

The researcher was responsible for the development of the interview and FGD guides for the study, and further trained two research assistants who conducted the interviews for the study. The researchers were graduate psychology graduates who were doing their national service. The researcher held three face-to-face meetings with the research assistants and took them through the process of data collection.

During the period of data collection, there was constant monitoring of the activities of the research assistants on daily basis. There were constant feedback from the research assistants on the field to the researcher upon completion of their daily activities. The researcher listened to the audio-recorded interviews and provided feedback to the research assistants. The researcher transcribed all the recorded interviews and discussions. Recorded files were first translated from Twi (a local Akan language) to English, before transcription was done. Coding was done by a team comprising the researcher, and two other assistants who were independent from the field assistants. The researcher kept a reflective journal in which observations that were made while dealing

with the research assistants, from data collection through translation, transcription to analysis were noted. The researcher was responsible for the data analysis and discussion.

4.7 The Use of Bracketing

Bracketing refers to an investigator's identification of vested interests, personal experience, cultural factors, assumptions, and hunches that could influence how he or she views the study's data. In other words bracketing is a method used in qualitative research to mitigate the potentially deleterious effects of preconceptions that may taint the research process (Tufford & Newman, 2012). Conversational encounters, like the interviews and focus group discussions employed in this study, while they afford unique opportunities to construct understanding from the perspective of the informant, also mark an inherently subjective endeavour. This subjective endeavor entails the inevitable transmission of assumptions, values, interests, emotions and theories, within and across the research project. These preconceptions have the potential to influence how data are gathered, interpreted, and presented. In the current study, the researcher was the instrument for analysis across all phases of the research project and therefore used bracketing as a means to deal with all biases and be as objective as possible in order not to taint the findings off the study (Starks & Trinidad, 2007).

Gearing (2004) explains bracketing as a 'scientific process in which a researcher suspends or holds in abeyance his or her presuppositions, biases, assumptions, theories, or previous experiences to see and describe the phenomenon'. Starks and Trinidad (2007) note that the researcher 'must be honest and vigilant about his or her own perspective, pre-existing thoughts and beliefs, and developing hypotheses . . . engage in the self-reflective process of "bracketing", whereby they recognize and set aside (but do not

abandon) their a priori knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind'

Gearing (2004) delineates bracketing as the internal suppositions of the researcher – including history, knowledge, culture, experience, value or academic reflections, such as orientation and theories – and external suppositions of aspects of the phenomenon under investigation, with both internal and external suppositions being bracketed concurrently.

In this study the researcher had a conceptual framework for conducting the study and this could have affected the quality of interview conducted if it had been done by the researcher. To bracket this situation, research assistants, who had no prior knowledge about the study's conceptual framework were used to conduct the interview. The research assistants undertook the interview as disinterested data collection agents and were very less likely to influence the interview process. The researcher further used bracketing by allowing two independent people to code by suggesting themes that emerged from the data. This prevented the researcher from potentially influencing the coding system with his preconceived ideas.

One way in which the researcher used bracketing in this study was writing of memos throughout data collection and analysis. This served as a means of examining and reflecting upon the researcher's engagement with the data (Cutcliffe, 2003). This gave the researcher the opportunity to jot even benign observations that were significant enough to enrich literature, a process Glaser & Strauss (1967a) describes as one of freedom, as opposed to one of constraint, which may lead to important insights on the part of the researcher.

Another method of bracketing employed in this study is the use of a reflexive journal, which begun prior to defining the research question. This method, as used by the researcher to identify preconceptions throughout the research process (Ahern, Hendryx & Siddharthan, 1996). The maintenance of the journal enhanced researchers' ability to sustain a reflexive stance. Aspects that were explored in the reflexive journal included: the researchers' reasons for undertaking the research; assumptions regarding cultural beliefs, religious practices, health care seeking, socioeconomic status; the researcher's place in the power hierarchy of the research; the researcher's personal value system (Hanson, Goodman, Lines, Meek, Bradley & Mills, 2004) potential role conflicts with research participants; feelings such as blame or disengagement (Paterson and Groening, 1996); and whether the researcher chooses to write in the first or third person (Porter, 1993). For example, the use of Spiritual powers by the Okomfo and Diviners to cure disease is considered evil, per the religious background of the researcher. But by taking a reflexive stance in this study, the researcher took cognizance on the African religious practices that have evolved over the years per the African philosophical worldview and the abounding literature that reveal that African, and for that matter, traditional Ghanaian religious practitioners have their own means of relating to the Supreme Being, a method by which people are cured through spiritual means. The researcher deemed it inappropriate to refer to traditional religious practitioners as pagans, a term considered by the researcher as derogatory and impugn on the dignity of the Ghanaian traditional practitioner.

4.8 The Role of the Research Assistants

The research assistants played a very significant role in the data collection process, as they were individuals who were tasked by the researcher to collect data for the study. The research assistants were graduates from the University of Ghana, who were undertaking their national service. They were selected based on their experience in undertaking research activities and had completed research project as part of the requirements for the fulfilment of their undergraduate studies. After being selected, they were taken through the process of undertaking qualitative research, were later made to conduct three pilot interviews in order to be conversant with the process of doing qualitative studies. They learned the skills of interviewing, ethics in undertaking qualitative research, how to use the interview guide, how to ask follow-up questions. They were primarily responsible for undertaking the interviews.

The research assistants further kept methodological journals in which they kept notes pertaining to their observations and emerging trends in the course of data collection. There were constant interactions between the researcher and the research assistants during the process of data collection and discussion centred on issues that emerged from the interviews and how to address teething issues that arose from the field notes gathered by the assistants as they collected the data.

4.9 Procedure

Data were obtained from two main sources. These were the patient and key informants. For the patients, focus group discussion (FGD) was organised for four separate groups: 9 patients who patronised orthodox health system, 9 patients each who used traditional health systems comprising the traditional spiritualist (Okomfo), herbal and prayer centres.

In all there were 36 participants for the FGD. The first FGD took place at the Regional Hospital, Koforidua; the second took place at the Obuotabiri Shrine, at Koforidua, and finally Ayisaa Herbal Clinic and Adom Prayer Camp respectively. The facilities were selected based on their prominence in and the level of patronage by the people in and beyond the area. The time for each discussion ranged from 50 minutes to 1 hour 2 minutes. Though FGDs were undertaken at different places and at different times as mentioned above, the format for discussions were similar.

As required in any scientific endeavour that requires human participants, informed consent forms were given out to respondents to read and sign to signify that they had understood the contents and were ready to take part in the discussions. For those who could not read and/or write, the consent forms were read and explained to them in the local dialect before they thumb printed to show that they would take part in the study. The discussions started with introduction and welcoming, followed by statement of the purpose of the meeting by the researcher, who was the moderator of the group discussions. Pseudonyms were assigned to each of the participants to ensure anonymity. For example those at the hospital were designated H¹, H², H³. Those at the herbal centre had the designation HC¹, HC², HC³, and those at the prayer camp were assigned PC¹, PC², PC³. The researcher, taking into consideration all the ethical considerations involved in gathering qualitative data built rapport among members and assured them of utmost confidentiality.

The ground rules for the discussion were then set after which the discussions followed. Prior to the start of each focus group discussion the researcher ensured each participant was still interested to continue with the discussion and they were made to understand that

they were free to leave at any time in case any of them experienced any discomfort in the course of the discussions. By its very nature, qualitative inquiry may produce issues that arise during the discussion that could not have been anticipated at the time of consent.

Participants in this study were therefore informed at the beginning of each group discussion that they could choose not to answer any questions or not to participate if they wished. They could also ask for the recording device to be switched-off if they so wished or they could leave the discussion or interview at any time without giving a reason. Again, before the discussions started, participants were asked whether the discussions could be audio taped and were assured that the information would be used only for the purpose of the study. With their permission, all focus group discussions were audio taped.

The researcher allowed participants to talk without too many interruptions and moderated the process by listening and probing as appropriate. Probing was used to obtain information, clarify a point, or expand on ideas (Creswell, Plano Clark, Gutmann & Hanson, 2003). The discussions were conducted based on the objectives of the study. Various themes emerged from the discussions that were used for analysis and discussion of the study. All focus group discussions were conducted in *Twi* and were fully translated and transcribed by the researcher with the assistance of an independent transcriber into English. All recordings were transcribed verbatim, and once completed were checked against the original recordings to ensure there were no errors or misquotes. Once the transcripts had been checked against the original recordings two copies were made; one was stored within a folder in Word and a hard copy was produced. All hard copies were numbered and re-checked to ensure all pseudonyms were in place.

The key informants were participants who provided healthcare services to patients. They consisted of medical officers, herbalists, diviners, and traditional priests. They were selected based on their specialized knowledge and their close contact with patients over a number of years. The aims and objectives were explained to the prospective participants after which interview appointments were scheduled with them upon them agreeing to participate in the study.

On the appointed times, the key informants were approached by the research assistants and interviewed at their own convenience and this took place individually and on different days. They were issued with informed consent forms which they read and signed before agreeing to be interviewed. As was done in the FGD, permission was sought from participants to audiotape and record the interviews. Each interview took 35 to 50 minutes. Thirteen key informants were interviewed in all. Field notes were also taken to record observations in the course of the data of the topic under review.

4.10 Data Analyses

Data analysis for the qualitative study was by the six-phase thematic analytic approach proposed by Braun and Clark (2006). Boyatzis (1998) characterises it not as a specific method but as a tool to use across different methods. One of the benefits of thematic analysis is its flexibility. Though thematic analysis does not stem from a particular theoretical or epistemological position like such as conversation analysis (CA) e.g., Hutchby & Wooffitt, 1998) and interpretative phenomenological analysis (IPA), it is essentially independent of theory and epistemology, and can be applied *across* a range of theoretical and epistemological approaches. It is compatible with both essentialist and constructionist paradigms within psychology (Braun & Clark, 2006). Through its

theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data.

The researcher initially translated the interviews and FGDs from Twi to the English language after which they were transcribed. The researcher began data analysis by initially generating codes. The researcher further listened to the audio files in order to seek further clarifications and to be abreast with the contents. The research assistants were at hand to provide further clarifications where they were needed. Discussions went on until both the researcher and research assistants agreed that there was no more new ideas required and had therefore reached theoretical saturation. After all data had been transcribed, two independent coders, both of whom were PhD students, one pursuing a course in Social and Behavioural Sciences at the school of Public Health, University of Ghana. The other was pursuing a PhD in Clinical Psychology at the Department of Psychology, University of Ghana.

Three independent coders were selected to be part of the coding in order to reduce the biases associated with familiarity on the part of the researcher. This was to further allow for differing opinions other than that of the researcher and this helped in reducing preconceptions on the part of the researcher that could potentially influence the coding system. Data was coded by the three coders who formed the coding. The team's responsibility was to transform data into codes by isolating key words that stood out in the data. All these were done through the six-phase process proposed by Braun and Clark (2006). At the end of the team's work clusters of codes that were linked to each other were formed. The researcher analysed them, which was used to conceptualise the people's view of CVDs and their health seeking behaviours.

4.10.1 Thematic Analysis

Using thematic analysis, the researcher identified, analysed, and reported patterns (themes) within data. According to Braun and Clark (2006), the process starts when the analyst begins to notice, and look for, patterns of meaning and issues of potential interest in the data, from data collection. Analysis involves a constant moving back and forward between the entire data set, the coded extracts of data that are being analysed, and the analysis of the data that being produced.

One very important component of thematic analysis is writing right from the onset where the researcher jotted down ideas and potential coding schemes through the entire coding and analytic process. Analysis of data was not a *linear* process but it was more *recursive* process, where the researcher moved back and forth as needed, throughout the phases.

First Phase Thematic Analysis

Beginning analytic process, all interviews and discussions were translated from Twi into the English language after which transcription was done. Transcription, which is seen as a key phase of data analysis within interpretative qualitative methodology (Bird, 2005: 227), helps in creating meanings within the texts. The researcher did a thorough orthographic transcription which was rigorous and “verbatim. Accounts of all verbal and nonverbal cues were noted. For example, pauses between statements and coughs were noted. By doing this, the researcher retained all the information that were needed that were true to the original information given by participants (Poland, 2002).

Data analysis began with the researcher familiarizing himself with the data by immersing himself in the data through repeated reading of the data. Reading over the notes

prevented the temptation of skipping vital information or being selective in the choice of themes. This active re-reading of data was done where the researcher searched for patterns and meanings from data collected and patterns were identified. At this point, notes were taken and ideas were marked or coding.

Second Phase Thematic Analysis

The second phase began after familiarisation and initial list of ideas and their peculiarities have been generated by the researcher. His phase mainly involved the production of initial codes from the data. The codes generated identified features of the data that appeared interesting to the researcher and could be assessed in a meaningful way regarding the phenomenon under study (Boyatzis, 1998: 63). Miles and Huberman (1994) assert that the process of coding is part of analysis, as data are organised into meaningful groups (Tuckett, 2005). Coding was data-driven and the emergent themes depended on the data so collected by the researcher.

Coding was done manually and the researcher systematically worked through the entire data set, giving full and equal attention to each data item, and identified interesting aspects in the data items that formed the basis of repeated patterns or themes across the data set. The researcher wrote notes on the texts as data was being analysed, where highlighters and coloured pens were used to indicate potential patterns by using ‘post-it’ notes to identify data segments (Braun & Clark, 2006). Here, as many potential patterns as possible were coded and data extracts were coded inclusively without losing the context (Bryman, 2001). The diagram is presented in Appendix VIII a.

Third Phase Thematic Analysis

The third phase of the analysis began with searching for themes. Here, when all data had been initially coded and collated and the researcher had a long list of different codes that were identified across the data set, the researcher then re-focused on the analysis at the broader level of themes, which involved sorting the different codes into potential themes. All relevant data extracts within identified themes were then collated. At this phase, the researcher used visual representations to help sort the different codes into themes. For example, tables and mind-maps were used. The researcher also looked the relationship between codes, between themes, and between different levels of themes, which included main and sub-themes. Some of the initial codes became the main themes, others became sub-themes while others were discarded along the process because they had been repeated under other themes. There were atypical themes which did not belong anywhere and were placed under miscellaneous themes temporarily. The diagrammatical presentation is presented in Appendix VIII b.

Fourth Phase Thematic Analysis

The fourth phase involved reviewing the themes. At this phase, the main themes had been refined, where some themes that did not have enough data to support them were no more considered as themes and other themes were also collapsed into each other because they formed one theme. Other themes were also broken down into separate themes. The researcher, at this point made sure that data within themes cohered together meaningfully, while maintaining clear and identifiable distinctions between themes. The researcher reviewed and refined the themes at two levels.

The first level involved reading all the collate extracts for each theme and considering whether they form a coherent pattern. Having satisfied this condition, the researcher moved to the second level, which involved reworking on the themes from the data extracts that did not fit by creating new themes and finding a place for those extracts that did not fit the already-existing theme, or discarding them from the analysis, and deem necessary by the researcher.

Here, the researcher considered the validity of individual themes in relation to the data set and whether the thematic map accurately reflects the meanings evident in the data set as a whole (Braun & Clark, 2006). At the end of this phase the researcher had a fairly good idea of what your different themes are, how they fit together, and the overall story they tell about the data. Having satisfied that the main themes adequately capture the contours of the coded data through a thematic map, the researcher then moved on to next phases of analysis.

Fifth Phase Thematic Analysis

The fifth phase began when the researcher became satisfied with the thematic map of the data. At this point the themes that would be presented in the final analyses were defined and refined (Braun & Clark, 2006). It was at this stage that the researcher identified the essence of each theme and what they actually stood for and also identified what was peculiar about those themes. The diagramme is presented in appendix VIII C. At this stage, themes were clearly defined as to what they are and what they are not. It is at this point that names were given to the various themes that finally emerged for the final analysis.

Sixth Phase Thematic Analysis

The final phase (phase 6) was the point at which the researcher produced the report. This was the point at which the researcher did the final analysis and had a fully-worked out themes. At this point, the researcher produced enough data extracts to demonstrate how the emergent themes had aggregated into concepts for the final write-up.

4.11 Measures to Ensure Trustworthiness

The two important criteria for assessing the quality of quantitative research are reliability and validity. However, there has been some discussion about their relevance in qualitative research. Some researchers (LeCompte & Goetz, 1982; Kirk & Miller, 1986; Mason, 2002) adapted reliability and validity for qualitative research with little change of meaning.

Others (Lincoln & Guba, 1985; Guba & Lincoln, 1994) have suggested that quite different criteria should be used to judge and evaluate qualitative research. They suggest that these criteria are ‘credibility, transferability, dependability and confirmability’ (Lincoln & Guba, 1985, pp. 289-331). Since qualitative analysis depends on the insights and the conceptual capabilities of the analyst (Patton, 2002) attempts were made to increase quality, credibility and trustworthiness of the interpretations of the analysis.

Credibility refers to the degree to which the findings and interpretations are consistent with the ideas and meanings intended by the participants. It is analogous to internal validity in quantitative research. To ensure credibility of this study, the researcher used two techniques or activities as recommended by Lincoln and Guba (1985): triangulation and peer debriefing. Triangulation typically refers to using multiple sources of data and multiple methods of data collection (Whitt, 1991). In this study, both focus group

discussion and key informant interviews were used. In social research, data is triangulated for the purpose of enhancing the validity of research findings (Yin, 2006; Onwuegbuzie, 2003). This was therefore achieved by using multiple sources and methods of data (13 interviews with healthcare providers, four focus groups with patients suffering from CVDs). In social research, data is triangulated for the purpose of enhancing the validity of research findings (Yin, 2006; Onwuegbuzie, 2003).

One other way validity issues were ensured was through internal peer review process and group interpretation. Peer debriefing is the process of using peers to ensure that the researcher acknowledges the influences of personal perspectives and perceptions on the study (Whitt, 1991). The researcher's analysis such as selecting themes, illustrating them with narrative quotes and analysing them were peer-reviewed to establish a level of consistency (Smith, Flowers & Larkin, 2009). Such exchanges for cross-validation and group-interpretation helped reduce bias, thereby increasing the credibility and trustworthiness of the findings in this study (Steinke, 2004; Whittemore, Chase, & Mandle, 2001). Frequent re-reading of transcripts was done to carefully search and select typical narrative quotes. Themes were discussed thoroughly by a team and consensus reached before analyses were continued.

In this study, continual peer debriefing was conducted with a fellow PhD student and two Master students pursuing Clinical Psychology in order to provide feedback on findings as they develop. The researcher's analysis such as selecting themes, illustrating them with narrative quotes and analysing them were peer-reviewed to establish a level of consistency (Smith, Flowers & Larkin, 2009). Such exchanges for cross-validation and group-interpretation helped reduce bias, thereby increasing the credibility and

trustworthiness of the findings in this study (Steinke, 2004; Whittemore, Chase & Mandle, 2001). Themes were discussed thoroughly by a team and consensus reached before analyses were continued.

Transferability refers to the degree that findings may be applicable or generalized to other settings or populations. It is analogous to external validity in quantitative research. However, it is not the researcher's task to decide if the findings can be generalized to other context rather the responsibility lies with the reader (Lincoln & Guba, 1985). The main technique for the purpose of transferability is 'thick description' (Lincoln & Guba, 1985). This was achieved by providing detailed descriptions of the characteristics of the study context and the methodology and research findings to allow the reader to decide if the findings are generalized to other contexts.

Dependability refers to the extent that, if the study was replicated in a similar context with similar participants, the findings would be the same. It is analogous to reliability in quantitative research. It was achieved by a description of the methods of data gathering, data analysis and interpretation. Also, it was achieved through triangulation of multiple data sources.

Finally, confirmability refers to the extent that the findings can be confirmed by another researcher. It is analogous to objectivity in quantitative research. It was achieved by providing examples of the data and findings. Also, it was achieved by maintaining an audit trail (Lincoln & Guba, 1985). In this sense, the researcher systematically collected materials and documentations that allowed an independent auditor to come to conclusions about the data (Polit & Beck, 2008).

There was also the issue of communicative validation where during focus group discussions and interviewing the researcher often summarized and checked whether the views of informants have been correctly recorded or otherwise (Kardorff, 2004).

4.12 Qualitative Results

After analysing the data using the 6-phase thematic analysis (Braun & Clark, 2006) several themes emerged from the narratives that formed the major themes, which include definition, aetiology, enemysm and sale of diseases, communality, spirituality, relational tensions and multiple health seeking.

4.12.1 Definition of Cardiovascular Disorders

In order to understand participants' views about cardiovascular disorders, they were asked about their understanding of the word cardiovascular disorders. The definition of CVDs was coded based on the results given by participants. Importantly, there was a general consensus that CVDs were conditions associated with the heart and was labelled “*akomayare*” meaning disease of the heart.

“The moment I hear about CVDs what comes to mind is that there is something wrong with the heart” (Male, 67 years old)

“Hypertension refers to a condition when the gods inflict pain on the heart of mortals when they go wrong” (Okomfo, 58 years old)

4.12.2 Aetiology of CVDs

Participants provided various reasons why individuals could contract CVDs. Comments by respondents are an indication of their strong belief in the culturally mediated patterns of disease causation and the fact that these are beliefs that have been passed on from generation to generation through oral tradition. The belief in the supernatural causes of

cardiovascular disorders, as some respondents believed was the cause of their cardiovascular disorders. Another belief is that before a person can be infected with a disease, the victim plays a role in contracting the particular disease, which can be in the form of causing harm to somebody, being involved in litigation over a family property or wronging another person unjustifiably. This is evidenced in the statements of the following participants:

“.....when I was growing up, my grandparents told me a lot of stories about how hypertension is transmitted. Evil spirits can transmit diseases like stroke to us even when we are bathing, so it is important to bath in an enclosed environment to ward off these diseases. Bathing in the open predisposes us to a lot of diseases.”
(H⁷ Male, 56 years old)

“I believe and know that witches are the causes of our heart diseases. I know I contracted this disease (hypertension) when we were litigating over a land left behind by my late father. That is when they had the chance to transmit the disease to me.” (PC⁵ Male, 66 years old)”

The mode of transmission of cardiovascular disorders were also noted that it could be from different sources, some of which are as a result of the passage of oral tradition.

“.....when I was growing up, my grandparents told me a lot of stories about how hypertension is transmitted. Evil spirits can transmit diseases like stroke to us even when we are bathing, so it is important to bath in an enclosed environment to ward off these diseases. Bathing in the open predisposes us to a lot of diseases.”
(H⁷ Male, 66 years old)

“The kind of dresses we put on can even invite hypertension (mogya mmoroso) to infect our bodies. When we were young, our parents taught us how to dress well and people lived longer. But now they wear dresses showing all parts of the body to the world. By doing this, they can contract hypertension. That is why many young people are dying of heart attack (akoma yare).” (PC⁴ Female, 43 years old)

“I believe and know that witches are the causes of our diseases. I know I contracted this disease (hypertension) when we were litigating over a land left behind by my late father. That is when they had the chance to transmit the disease to me.” (PC⁵Male, 57 years old)

“..... before they (witches and wizards) can infect us with any disorder, we play a role in giving them the chance to do so. I should have been on guard and protected myself spiritually before starting the litigation with them.” (HC³Female, 48 years old)

“I had not been to the hospital for a very long time until one day I collapsed and was sent to the hospital. How can someone who is not sick in any part of the body suddenly go through this ordeal? I suspect my auntie, who is a very well-known witch” (H⁹ Female, 52 years old)

There is a general belief in the role of the supernatural (*sunsum*) a force beyond the comprehension of the normal human senses and witchcraft (*bayie*). Mention is made of witchcraft which is among the major causes of cardiovascular disorders. The role of witches in the transmission of CVDs is very significant.

“..... before they (witches and wizards) can infect us with any disorder, we play a role in giving them the chance to do so. I should have been on guard and protected myself spiritually before starting the litigation with them.” (HC³Male, 48 years old).

“When you wrong them (witches and wizards), you give them the chance to infect you with hypertension.” (SH¹Female, 52 years old).

There was a general belief in the spirito-physical causation of CVDs, and a belief that for every physical phenomenon there is a spiritual aspect of it. For this reason the individual must be spiritually strong to avert the influence of evil spirits causing CVDs.

“Some of the diseases are spiritual and others are physical. I believe in both physical and spiritual treatments. Our forefathers, since creation have always had to pass through our ancestors to intercede

for us in the spiritual world to cure our diseases.” (SH³Female, 47 years old).

“Though I know that doctors have told us about what the causes of hypertension are, a combination of physical and spiritual forces can make us contract hypertension and stroke. If you have this in mind, it always keeps you on guard.” (PC³Female, 60 years old).

The idea of the “spirito-physical” causes of hypertension is pronounced. To every physical phenomenon, there is also a spiritual aspect of it. For this, it is relevant that one seeks both physical and spiritual help for their ailment.

“the gods and all the ancestors are with us on daily basis. Whatever goes on around us is influenced by the gods. So its always important to acknowledge their presence among us so that we don’t offend them through our actions or inactions. Don’t forget that anything that happens in the physical has its spiritual implications” (Obourtabiri Komfoɔ, 56 years).

“..... there are two sides of everything in the universe, which are both physical and spiritual. At times the spiritual influence the physical, and vice versa. So a combination of these results in us suffering from all kinds of heart diseases” (H⁷Male, 55 years old)

“Some of the diseases are spiritual and others are physical. I believe in both physical and spiritual treatments. Our forefathers, since creation have always had to pass through our ancestors to intercede for us in the spiritual world to cure our diseases.” (SH³ Male, 67 years old).

“Though I know that doctors have told us about what the causes of hypertension are, I believe that a combination of physical and spiritual forces can make us contract hypertension. It is important to know that there is a spirit behind everything we do. If you have this in mind, it always keeps you on guard.” (PC³Male, 49 years old)

The decision to consider only one aspect of disease causation is frowned upon and seen as dangerous.

“If you think that you have a heart disease and that is a result of you not eating well or not exercising, you will be deceiving yourself. We cannot suffer from these diseases because of only physical causes. You have to consider the spiritual too, because to me you don’t have to accept things on their face value” No. (PC⁹ Male, 48 years old).

”Don’t forget that the gods are the ones who control everything, including the sicknesses we have. If they don’t allow it, it will not happen. So you even have to appease them and pray to them to help you get healed. If you leave them behind, you will fail in your treatment” SH7 Male, 62 years old)

4.12.3 Enemysm and Sale of Diseases

Enemies are seen as the cause of many diseases, including cardiovascular disorders through the use of malevolent spirits. They also indicate the mode of transmission of cardiovascular disorders to victims was through the ‘sale’ of the disease. This was lucidly put by a participant

“..... and I know that they (enemies) sell the disease (CVD) as my mother has always been telling me” (PC⁹ Female, 55 years old).

“We all have enemies. They can be real or perceived, but they are always with us. These are the people who have always been the source of all our worries and misfortunes. We don’t suffer for nothing. All our sufferings are caused by these enemies. (H⁸ Male, 57 years old)

Some of these enemies constantly occur in the dreams of their victims, something that reinforce the belief that those enemies are real and there is the need to guard against them.

“I have been having consistent dreams about my auntie, who doesn’t see eye to eye with me. We have not talked for the last six years and I know she is playing a role in my sickness, but she will fail. Yes. She will” (HC⁶ Male 69 years old)

“As my brother said earlier, it is same with me. I have been having constant dreams of some people who are sworn enemies. In

fact, we fight physically and in the dream, and I always have to pray to ward off every evil spirit they use against me” (PC5 Female, 49 years old)

The sale of the diseases could result from factors like litigating over a piece of land, having constant quarrels or even sheer envy from family members and neighbours.

“My half-sister and I were litigating over a piece of land left by our late father. We were invited to the chief’s palace where the matter was settled and the land was divided into two. I was working on my part of the land one day when I felt a sharp pain in my chest. After ‘consultation’ I was told my half-sister was responsible. She had sold the disease to me so that I could die for her to take over the land. Don’t? I have children who will take over after me? (HC² Male, 68 years old)

“My disease was sold to me immediately I started teaching. This has been with me until I went on retirement. These family members don’t even care about what I was doing for them oooooo. In my family, they sell a lot of heart diseases and that is what kills a lot of family members. But I will survive it. I won’t die” (PC⁵, Female, 67 years old)

This indicates how discussants hold on to these belief systems and their desire to perpetuate it without recourse to any contrary evidence.

On the contrary, participants were of the view that completely blaming enemies for their bad health conditions has the potential to prevent them from getting healed.

“If you suffer from hypertension and you keep thinking your sickness is caused by somebody you will never get treated. Under such circumstances you will not get the right treatment and eventually you will die.” (H²Female 69 years old)

“Having suffered this condition for five years, I have realised that the more we suspect other people as being the cause of our problems, the more dangerous it is for us, and we die early through such suspicions. (HC⁷Male 54 years old)

“..... my twin sister had stroke so she accused our brother as being the cause of her sickness so the husband took her to the prayer camp. I later advised her to go to central hospital for treatment where she was diagnosed as suffering from hypertension. She is receiving treatment but is still not getting better because she believes our brother is the cause of her sickness. (H¹ Male 49 years old)

4.12.4 Communal System

There is a strong emphasis on the communal role of family members in the lives of other family members. When an individual is born, the person becomes the property of the whole community and thus could not singularly take decision regarding their health alone when they are sick.

*“I am not myself, and if I have to take any decision regarding my health my people have to be aware and approve of it. If I don’t listen to their advice and I get into trouble, who will be there to help me out?”
(H¹ Male, 45 years old)*

“I can’t just wake up and go for treatment without getting permission from my husband. If he doesn’t give me the go ahead I can’t do anything” (SH⁹ Female, 69 years)

*“I have to include the family members of my wife in the treatment because she belongs to them. If they have no idea and they hear that I have been sending her for treatment without their consent that will be a different story. It will be chaotic, something I want to avoid. (HC⁹
Husband of a Patient, 58 years old)*

Unilateral decision to seek help is frowned upon and the consequence is not palatable.

“When you are sick, it is the responsibility of the family to take care of you till you are healed. Because when you are born you belong to a family, and you don’t have to act as an individual If you don’t heed this advice and you find yourself in a difficult situation, that is where you will see where power lies. To me, at least a few people should be aware of where I am” (SH⁶ Male, 54 years old)

“I don’t just decide to go and seek help because I am sick. There is the need to decide with the family where one needs to go and seek

help. What if you don't take your time and you don't get the cue you deserve? Whom do you go to, from there (SH⁶Male, 67 years old)

A few participants held the notion that their lives were in their hands and did not have to seek anyone's approval before going to seek help when sick.

"Why must I wait for someone to tell me to go to hospital when I am sick" (H⁵), "I have received a lot of advice from many people since I became sick... .. but I finally decided on where to go. (PC¹)

"I take care of myself, so it is my own responsibility to seek help from anywhere without consulting anyone. I seek help from where I think where I can get one and not what someone tells me. I am here because I decided to come, not because someone asked me to come here. (H⁷ Male, 62 years old)

4.12.5 Spirituality

There is a high emphasis on the influence of spirituality and religiosity when explaining health seeking behaviour for cardiovascular disorders. Coding or narratives included the role of the Supreme Being (punishing and healing), demons, familial curse,

Supreme Being (Punishing and healing)

The concept of the Supreme Being that is all powerful is also regarded as the source of development of sicknesses and healing. Any act that goes contrary to the natural rules are punishable by the all-powerful Being who is referred to as "*Twereduampon Nyame*", a label given to the Supreme Being to depict His omnipotence. Furthermore any act in the right direction is rewarded by the Supreme Being through healing and general good health.

"As long as you do the right thing God will not allow any evil to befall you through sickness. He is the only one who can punish us when we go wrong. That is why we are suffering from these illnesses. As long

as we do the right thing, we will not be sick. I have a heart disease because I did not do the right thing” (HC⁶ Male, 72 years old)

“We have been asked not to go to the forest on Awukudae because that day is sacred to the gods. But nowadays we go to farm almost every day. By doing this, do you think that God will not punish us? Our heart problems is as a result of our disobedience to God’s instructions” (SH⁴ Male, 56 years old)

Participants identified various acts of omission or commission that could end people up contracting CVDs. Many acts of wrongful doing are not left unpunished.

“When you have sex with your neighbour’s wife, it is very sinful and you could end up being sick for a long time till you die, unless the person confesses and appease the husband. This happened recently until it was settled at the ‘ahemfie’ (Chief’s Palace)” (H³ Female, 66 years old)

“If you cast evil spells on your neighbour, who has not wronged you, it is very bad and ‘nananom’ (ancestors) will not forgive you for that. They seek justice and when one does this the person can become sick and even die as a result. (HC⁴ Male, 69 years old)

“Being envious of your neighbour for no reason attracts a huge punishment in the form of heart diseases and other conditions that can be costly to the individual. Also when you refuse to redeem your promise to the gods, you are liable to be punished through sicknesses like heart diseases or even madness. So we have to be careful” (SH³ Female, 56 years old)

The children and other descendants are liable to be recipients of punishment even if the perpetrators are left to go unpunished.

“Even if a person does wrong and dies without being punished, the children and their children could suffer punishment. I know a ‘wicked’ man who did not have any heart diseases but his daughter and the daughter’s son have hypertension” (H⁶ Male, 73 years old)

There was an emphasis on the need for prayers and other spiritual rites to be performed in addition to the use of drugs, whether traditional or orthodox. A combination of these, to participants will go a long way in speeding up the healing process. The relevance of this is that God, or the Supreme Being is seen as the source of all illnesses and healing and having a relationship in the spiritual realm to be able to get cure for their heart diseases.

“Akomfo, Adunsifo, and Doctors can all cure, but the real healing comes from above. So, depending on one’s belief it is very important to pray so that we can be healed. Don’t forget that whatever faith you have has the potential to heal you. People from different means of communicating spiritually. Some pray, others chant and speak through oracle consultation and for other, consulting the gods help them solve their problems. (SH1 Male, 59 years old)

“Prayer is the best medicine you can have. We come here (prayer camp) every Tuesday to pray for healing and we even bring the medicines here to pray over them before I take it. So without prayers, don’t waste your time going for treatment. It is God who allows the sickness to befall us, and the condition is spiritual, so when we pray He will cure us. What we have to do is to rely on Him for healing.” (PC⁷ Male, 54 years old)

Demons

Demons are wicked spirits whose only duty is to inflict pains and diseases on people and this has nothing to do with whether the person has committed any wrongful act or not. These demons take human form to cause harm and misfortune to people. These include witches and wizards.

“Witches and wizards are found everywhere and they are always with us. They are the ones who serve as the major cause of your heart diseases. It is even worse when the person is your family member. (HC⁴ Male, 69 years old)

“To talk of witches and wizards, they are the cause of all or problems. They give us a lot of troubles by inflicting us with all the

conditions we are suffering from now. This is how these spirits want to worry us and at the least opportunity, they will even kill you. At first witches who were blood related had the power to harm you, but nowadays even those that are not related to you can even do worse things to you. Hmmmmm” (PC² Female, 59 years old)

4.12.6 Relational Tensions

Relationship between caregivers and patients plays a major role in influencing people's health seeking behaviour.

“The nurse at the OPD tied my hand and I asked her about it. She looked at me from my head straight down to my toes and then looked away. I then decided not to go there again until I had hypertension (mogya mmoroso).” (H¹¹ Female, 9 years old)

“When you go to the hospital, they don't even look at you when talking to you. They don't care about us. By the time you get home you even become sicker. But when I come here (herbal centre) they enquire about even my family and show that they care about me. This is what we call healing” (SH⁶ Female, 70 years)

“I like this place because they treat me like their own. I feel at home here and that alone makes me feel better.” (PC⁴ Male, 57 years old)

Scanty caregiver information dissemination is an area of concern that affect where to seek help. Access to information on caregiver practices is vital in the overall treatment process.

“I went to the hospital at 6:30 am. We sat at the OPD for over three hours and there was no doctor and no one told us anything. They become angry when we go there to ask why we are not being attended to. That is not right.

“At this place (shrine) the people talk to us nicely and I feel at home. The last time I went to ‘central’ (Regional Hospital), they made my situation even worse. It took a long time to get even a folder but when you dare go and ask why it is taking that long, the rain insults at you and embarrass you. They don't care about the plight of

patients and have no respect for us in any way. I have vowed never to go there again (SH¹ Male, 54 years old)

The presence of open communication, which plays an integral part in the healing process makes the traditional health system the most preferred choice compared to the orthodox.

“In fact the nature of ‘treatment’ at the hospital is that it appears only the doctors and nurses at the hospital are supposed to know what is wrong with a patient. Patients do not seem to have the right to know what is wrong with them. But when I come here (herbal centre) they take their time to explain to me my condition and make me understand everything before I go home” (HC¹² Male, 60 years old)

“Nana (Okomfo) asked me about how my family is doing and asked later told me a lot about my family and even made me aware of certain things that I didn’t know. He later promised to protect me and my family, something I am very grateful for” (SH Female, 55 years old)

4.12.7 Multiple Healthcare Seeking

Concurrently seeking help from various sources, including shrines, herbalists, hospitals and going through the healing processes simultaneously to alleviate the condition is part of the help seeking process.

“When I realized that I had hypertension, I first went to an herbal centre for some time and I realized I wasn’t getting better so I had to seek treatment at the hospital too. Now I feel better using medication from both place” (H² Male, 70 years old)

“I have had this condition for four years and the hospital alone was not helping me. So I am combining both hospital and traditional medicines. I feel strong now. (H¹ Female, 55 years old)

Western oriented messages about cause and control of cardiovascular disorders have not been embraced because it lacks culturally relevant contents. Spiritual cause of CVDs is still the most preferred explanation, though there is the reluctant desire to seek help from the orthodox system because they have been asked to do so by some significant others.

Some diseases are for the orthodox health practitioners and others for the traditional health practitioners. The following narrations attest to their assertions:

“Though I know that doctors have told us about the causes of hypertension, I still believe that there are forces that can make us get hypertension and stroke. You can’t treat some diseases at the hospital.....others cannot also be cured at the herbal centre.” (PC⁷)

“I went to the hospital and they told me I have to take medicine for the rest of my life. This is not a “hospital sickness” because they have no cure for it. I have to come here (spiritualist) to get medication and “powers” that can help me control the disease” (SH⁶ Male, 52 years old)

“This treatment is beyond what the doctors can do because they see nothing.” (KII, Traditional Priest)

As gathered from the coded narratives, the more one is able to create awareness about their plight, the greater their chances of receiving cure. For this reason many treatment options are explored in order to get an antidote to people’s condition.

“Our elders say that if you don’t ‘sell’ your disease, you will not get an antidote. When you keep your condition from awareness, you suffer alone. So it is important to go to many places and at least test them. If one treatment option is not able to help you, another will do” (H⁵ Male, 49 years old)

“Se wote faako a wote w’adee so’. (Literally means one will not get a cure for his or her ailment when they don’t make the effort to get treatment from many sources). To me, it is only when I engage in many treatments that I will get cured. If I hadn’t come here, I will still be suffering” (SH⁴ Female, 68 years old)

Consequences of single Source Help Seeking

Seeking help from a single source was seen as detrimental to the health of the individual. The view is that there are many sources. The popular notion is that “Se wote faako a wote w’adee so” meaning if you stay at one place, you sit on your own success (health). It is

therefore rife for many people to seek help for their ailment either simultaneously or sequentially. The following narratives attest to the fact:

“Our elders have a saying that ‘Sɛ kuro dɔɔso a y’ɛntena faako nnye animguaseɛ’. If there are many towns we don’t stay at one place and get disgraced. Since there are many places that I can go and seek help, why should I stay with one healer? It is only when I go on a healer shopping that I will be able to identify the one who can help me. (H⁹ Male, 54 years old)

“‘Sɛ w’antɔn wo yaree a wonnya ano aduro’. If you don’t sell your sickness there is no way you will be healed.

Few others have contrary views about the dire consequences of multiple health seeking, as it the potential to do more harm than good to the patient. To them, simultaneous ingestion of both traditional and orthodox medicines could be dangerous to the health of the person.

“I am aware that at times it is good to get help from different places but one thing I have realised is that the practice is very dangerous and can kill the person, especially when you combine the hospital and traditional (abibiduro) medicines. I think we don’t have to combine them (HC⁷ Female, 49 years old)

There are idiosyncratic reasons why people seek multiple help. It is therefore wrong to judge the person just on the face value that he or she is seeking help from a particular place. There was a unanimous conviction among participants that no one should be quick to judge or condemn anybody for seeking help from whatever source of treatment they so wished because people have various reasons for seeking help from different health care providers. Participants had this to say:

“We do not have to condemn anybody for visiting a particular treatment centre but we just have to find out the reason behind the person visiting any treatment centre at any point in a time.” (H⁹Male, 47 years old)

“My wife does not agree with me coming to this place (shrine) because she thinks it is unchristian, but I have my own reasons for patronizing this place, which she doesn’t know. As long as I get what I want from this place, why should I not come here? So it’s important to understand a person, but not to condemn him/her for doing something” (SH¹ Male, 56 years old)

“You don’t have an idea what it means to be sick and not receive cure. When you are sick and want to be healed, you can do anything you haven’t even imagined before. For all you know a particular place of treatment did not help the person and as a result had to fall on other places.” (HC¹Female, 48 years old)

4.13 Discussion of Qualitative Findings

The qualitative study sought to examine help seeking behaviour for cardiovascular disorders with the following aims and objectives: to examine the effects of cultural values and belief systems on health seeking behaviour for CVDs, seek participants’ views on orthodox and traditional health systems, the influence of socioeconomic factors on health seeking behaviour and finally to examine the relationship between multidimensional health locus of control and health seeking behaviour for CVDs.

Focus group discussions and key informant interviews were conducted as means of data collection. The six phase thematic analysis proposed by Braun and Clark (2006) was used to analyse the data.

Data analysis revealed several themes that emerged and coded. These include definition, aetiology, enemysm and sale of diseases, communality, spirituality, relational tensions and multiple health seeking. The study showed that participants hold a view of CVDs by

definitions that met the criteria set by cultural norms of the people. Within the Akan context, the heart must be functioning well without any hindrance and therefore anything untoward that happens to the heart and affects its functioning calls for concern, and generally referred to as “*akomayaree*” (disease of the heart) and this cuts across the broad spectrum of conditions that affect the heart. Such traditional knowledge and definition of diseases is disseminated through generations by family members (Appiah-Kubi, 1981).

What really constitute CVD is an issue for consideration for researchers and clinicians since there is a qualitative distinction between the lay construction of the condition and that identified by clinicians, though the basic consensus is that CVDs constitutes conditions related to the heart. This socially constructed conceptualisation of cardiovascular disorders reflects the socio-cultural context within which the people interpret the condition and this conception supports the Leventhal and colleagues’ (1984) common sense model of illness that disease conditions are interpreted based on their presentation and the individual’s response to it.

The biopsychosocial(s) relationship between cultural belief systems and health interact to shape the belief in aetiology of CVDs as found in this study. These belief systems influence the type of treatment sought, based on the interpretation of the source of the condition, which forms part of the African worldview of holism, that focuses on the whole living organism (Sow, 1980). CVDs are believed to arise when there is a departure from the natural equilibrium of total harmony between the individual and the natural environment. These may take the form of bewitchment, a curse from the gods or a neighbour, a belief that is consistent with the findings of Agyapong (2000) and

Owoahene- Acheampong (1998) who stated that there is a triad of sunsum (spirit), okra (divine) and mogya (blood), which forms the basis for holistic health and healing. A disharmonious relationship therefore, has the potential to cause CVDs in the individual involved. This belief, probably could explain the desire to seek help from spiritualists such as the akomfo and diviners, since they have the potential to cure such ailments as opposed to seeking help from the western oriented facilities who are perceived as not having a good understanding of the individual's situation.

The concept of sale of disease (*ntonyare*) and enemysm influenced health seeking behaviour for CVDs as found in this study. These concepts form the basis of the worldview of participants who believe in the capacity of their enemies using malevolent spirits to 'sell' diseases to them. This worldview, influences the help seeking behaviour of the people. The notion among participants of this study is that one cannot contract a disease without any cause. There is both spiritual and physical cause to every sickness (Appiah-Kubi, 1981; Twumasi, 1988) and that one's enemies, family and non-family members inflict diseases upon them, especially when one is not spiritually strong. This is a sharp contrast to western-oriented explanation of disease causation where the germ theory serves as the only explanation.

Important aspects of the socially constructed meaning of CVDs as a consequence of diabolical interference featured prominently in the study under the concepts of 'enemyship' and the '*sale of diseases*'¹ The diabolical explanatory model for CVDs in this study generally reflects the social construction of diseases. That is, people assign

¹ The sale of diseases in the Akan conceptualisation is not based on the general notion of buying and selling, but rather on the belief that an enemy has the ability to transfer a disease or evil spirit to a victim through a malevolent force.

meanings to particular diseases and that subsequently determine where to seek help. Patronage of prayer camps, herbal centres therefore could be understood from such socially constructed viewpoints of CVDs. Respondents who believed in the malevolent cause of cardiovascular disorders felt that the disease had been ‘sold’ to them by their enemies including witches. This belief presupposes that people’s perception about diseases is not viewed as just simple biomedical disruptions, but rather due to an external diabolical agent. Despite the major inroads of education and urbanization, some participants (n=26 of 33) strongly held on to the belief that they had been bewitched by envious relatives who didn’t want to see them prosper.

Others held the belief that they had develop cardiovascular disorders through bewitchment as a result of litigation over a piece of land or some other properties left behind by a dead relative. However, it was noted that a reasonable number of participants (n=29 of 33) currently suffering from hypertension and on antihypertensive therapy from orthodox health systems still hold on to the belief that they had been bewitched. Some of them were on antihypertensive medication because they claimed they have been advised by their Prophets, Prophetesses and relatives to combine prayers with medication and that would give them a complete cure. This could be a direct result of enculturation based on the beliefs of the people (Wiredu & Nyame, 2001). This current finding enjoins researchers and clinicians to consider that of Rivers (1924) and (Winkelman, 2009) that we must first start with an understanding of how an individual perceives disease before we can understand observed actions: all health-seeking behaviour is the result of a process involving identification of causation, followed by aetiology, diagnosis then prognosis.

Understanding diseases and illnesses from the anthropological viewpoint would deem illness to involve more than simply a biomedical explanation, placing the individual within a societal context. Other respondents who believed that their CVDs were caused by witchcraft were of the view that Western medicine could not cure them, and therefore sought healing from the traditional spiritualists, herbalists and prayer camps. Findings on such beliefs systems are consistent with the findings of Awah, Unwin and Phillimore (2009).

Related to this is the perception that diseases sold to victims by enemies can be transmitted from one generation to another as long as the causative agent of the disorder has not been dealt with through prayers and other rites in order to cure the victim, and that one cannot be completely cured without confronting the source of the disorder. For this reason, many collective rites like fasting and prayers, application of concoctions for ritual bathing, ingestion of herbal preparations and other practices such as getting the causative agent to confess and perform rituals to overturn the spell they cast on the victim. The aim of such practices is to stop the transmission of some diseases from generation to generation. This practice is in line with the assertion by Tsala Tsala (2005), that the belief systems that disease is systematically acknowledged as having a supernatural or malevolent origin, the practice of sorcery and various spells are employed to cure the victim of the disorder. This portrayal of sale of CVDs to victims by enemies is in line with the general belief regarding the causes of illness (Odejide, Oyewumi & Ohaeri, 2006; Makinde, 2005; Field, 2003).

This fact might be partly responsible for the relatively high uptake for traditional care compared with orthodox health treatment. This explains why in Africa traditional healers

and spiritualists still enjoy large patronage for health care (Odejide, Oyewumi & Ohaeri, 2006; Prince, 2002; Ebigbo & Tyodza, 2007), probably borne out of the perceived causative factors mentioned previously. On the other hand, with this perceived cause of CVDs orthodox hospital care has been shown to be largely ineffective, and is a factor that discourages people from seeking early orthodox care. In general, the belief in aetiology of CVDs was a major determining factor of the health seeking behaviour of respondents.

Subjective beliefs about cardiovascular disorders was deduced to have influenced many patients to search for different kinds of healers. These practices resulted in different health seeking behaviours, with patients going in search of what is responsible for their dilemmas (Jain & Agrawal, 2005). These behaviours stemmed from different beliefs about the aetiology of cardiovascular disorders. While some believed in witchcraft as a cause, others believed too much blood in the body and genetics as a cause of cardiovascular disorders and that the occurrence of the disorder cannot be controlled.

The belief in the cause of cardiovascular disorders was a major factor that influenced the health seeking behaviour of respondents as explained by Boyle (2007). Findings of this study showed that respondents patronised either orthodox or traditional health care system based on their belief in the aetiology of the condition. This belief, as defined by cultural norms of supernatural causation could explain why some respondents were of the opinion that the orthodox health system was no place for them; and that seeking help from the traditional healer was the most probable option. In the same vein, those who believed in the biomedical explanation of the causes of their illnesses sought help mainly from orthodox health systems and saw these as the best places to receive treatment. Some

patients indicated titrating orthodox medications with traditional remedies concurrently or alternately according to their perceived symptoms.

With the perception of efficacy of treatment of particular health systems and the eventual health seeking behaviour notwithstanding, cases of multiple health care was not ruled out by respondents (Addo, Smeeth & Leon, 2007). Multiple healthcare seeking was also influenced by the length of illness. FGD analysis showed that the longer the illness took, the higher the possibility of seeking multiple healthcare (Conco, 2001). This attitude of respondents presupposes that health seeking for orthodox and traditional systems are not strictly dichotomous and that there are some nuances like the length of the illness and the desire to get complete cure, which override allegiance to a particular health system. This further reveals that perception of health systems change in relation to the success or failure of health care delivered by a particular system (MacKian, 2005).

The role of traditional spiritual and herbal healers in the provision of health care in Ghana cannot be overestimated. Herbalists, *Akomfoɔ* and diviners were found to continually providing immense help to people suffering from various ailments, including CVDs. The *akomfoɔ* and the diviners serve as spiritual backbones of people suffering from CVDs, who believe that their conditions have been spiritually caused. They therefore provide both physical and spiritual support for people and provide psychological support for people suffering from chronic conditions.

Findings of this study showed that family members were available to provide support in terms of information and generally shied away from giving financial support. Such information include the best places to get help for their ailment, and this is mostly advice

to seek help from the traditional system. The informational support given by the extended family members in support of the traditional health system could be due to their compelling presence and their ability to provide services that are appealing to the people. It could also be due to the increasing advertisements on the mass media by the traditional healers who make claims to have a completely curable antidote to every sickness, ranging from infectious diseases to non-communicable diseases such as cardiovascular disorders. The advertisements also go with the promises that patrons do not need to hold a lot of money before seeking treatment since payment for services is very meagre or could be deferred or paid in kind (Jonas et al., 1997).

These advertisements are defended on daily basis with many of the traditional practitioners consistently buying airtime for this exercise, while at the same time these traditional healers try to explain the negative side effects of medication prescribed by the orthodox health system (Haddad & Fournier, 2006). These assertions by some traditional healers have reinforced participants' beliefs that the drugs administered by the hospitals are poisonous, and it is not proper to spend huge sums of money on drugs that may eventually kill the individual. This attitude and belief toward the orthodox health reflects a mutual misunderstanding orthodox healthcare provision and the preferences of health seekers. Participants have preference for particular sources of treatment due to a combination of factors like level of literacy, length of illness in addition to other socio-cultural factors mentioned in earlier pages. Based on these considerations, CVD patients were willing to devote as much money as possible to seek treatment from any source, provided they would be cured of their cardiovascular disorders.

However noble the intentions of the traditional medicine practice (TMP), defined by the World Health Organisation as "health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being" there were indications from the study about the potential adverse effects of seeking healthcare from these areas. These effects included: over reliance on fasting, monotonous treatment modes, high level of suspicion among religious adherents, problem with efficacy of treatment, unhygienic preparation of herbs and lack of doxology.

First, fasting is a practice that may pose a big challenge to patients. Fasting is one major tool used in the healing and curing process by the churches. Some respondents were made to do 'dry' fasting for three days to one week, a type of fasting in which the individual does not eat anything apart from drinking water. The continual use of fasting has resulted in further complications among participants. The body requires energy for normal functioning, such as growth and healing, so prescribing fasting for hypertensive and stroke patients who are already psychologically stressed from the effects of the disorders may not only worsen their condition but also affect their energy level (Taylor, 2011). The dry or special fasting that deprives the person of both liquids and solids for three days or more would lead to serious dehydration that could later lead to other medical complications especially with drug interactions (Sackey, 1999a; Sackey, 1999b).

Secondly, there is the question of efficacy of treatment offered by traditional healers and complications that arise as a result of solely relying on prayers to treat cardiovascular disorders. This mode of treatment could be based on the presupposition by the healers

that all ailments can be alleviated through spiritual means. This has resulted in faith-based treatments preventing the use of other medications that could help alleviate the suffering of patients. Such practice could divert attention from objectively seeking the needed help for the treatment of their ailment. The person is thus unable to spend enough time and energy to take active control over the situation but rather makes efforts of something that is beyond his or her capacity. As a result, disappointment over self-focused attention, worry and rumination could induce painful emotions that could aggravate the already bad state of health (Osafo et al., 2011; van den Boom, Nsowah-Nuamah & Overbosch, 2008).

Much as some respondents reported being cured as a result of prayers, others have suffered further complications due to over reliance on the use of only prayers to cure their cardiovascular disorders. Since religious treatment is faith based, failure by religious leaders to allow patients take medications in addition to prayers could be explained as a sign of lack of faith. This practice may explain why faith is regarded as the most important panacea in the healing process and anyone who uses medication could incur the wrath of God for mistrusting Him. This practice has since time immemorial been detrimental to the health of most faith-based patients but the interesting aspect of the practice is that there seems to be no end in sight despite the precarious conditions some patients suffer (Takyi, 2003; Powell, Shahabi & Thoresen, 2003). As a result of such practices, much time is spent on incessant prayers and patients don't act promptly on their condition, which lead to further complications (Turner, 2008). This explains why some deaths and very serious complications occur in camps because the healers and

caregivers of the sick spend a lot of time in prayer instead of sending them to hospitals for early treatment.

Sometimes patients are sent to the hospital at a point of death because the hospital is regarded as the most appropriate place to die. One other danger is that there are instances where the healers clandestinely mix some of the anti hypertensives and other medications with the holy water they offer their clients, creating the impression that it is only prayers that have healed them. This practice could have a more complicated effect on patients since the healer might not have the required knowledge and understanding of the patients' condition and might not have given the right medication or dosage. Further, the amount of dosage that goes into each preparation administered to patients and the possibility that some properties of the drugs may not auger well for the health of patients (Azikiwe et al., 2009; Schnall, Wassertheil-Smoller, Swencionis, et al., 2010). This may exacerbate adverse effects due to (unknown) contents of decoctions and the combination of allopathic and traditional medicines, which may hamper adequate assessment and intervention when complications occur (van den Boom, Nsowah-Nuamah & Overbosch, 2008).

Thirdly, the nebulous nature of spirituality makes it quite difficult to measure the level at which a person can be said to be spiritual. While some studies have associated the high level of spirituality with a sense of peace, tranquility and coping (Scharlach, Kellam, Ong, Baskin, Goldstein & Fox, 2006; Utsey, Adams & Bolden, 2000), findings among some respondents in this study suggest otherwise. Participants in this study who claimed to be highly spiritual were rather living in a state of fear, suspicion and delusion.

According to this study, participants who deemed spiritual rather appeared to believe that other people are responsible for their misfortunes. It may therefore be deduced from cultural sense of enemy spirits negatively influencing the everyday lives of individuals. This cultural belief system has been fused with the Christian religion and that, the wrong use of religion has not helped to bring peace and tranquility to faithfuls, but rather tension and suspicion, a situation that arises due to the superficial interpretation of the Bible. This finding contrasts those of Farrow (2004) and Mattis and Jagers, (2001) who observed that commitment to religious and spiritual beliefs, or religiosity and spirituality assisted and ensured a sense of equanimity among study participants and this attitude promoted healing and prosocial behaviours, and supports the study of Sloan and Bagiella (2002), who found weak empirical support to a positive relationship between religious involvement and health.

Generally, participants of the current study showed that religion played important role among CVD patients because as people become ill, they experience stress over the changes in life that the illness has caused. Many who claimed were not religious previously turned to religion for comfort. Turning to religion could thus be regarded to serve as a method of coping as people suffered terminal diseases like cerebrovascular accident (Gall et al., 2005; Graham, Furr, Flowers & Burke, 2001). Findings in this study showed that those who sought comfort in religion approached it in many ways. These ways often involved belief in a loving and caring God, belief in the Okomfo who served as the mediator between the individual, the gods and the Supreme Being, private religious activities (such as prayer and meditation), reading religious scriptures for direction and encouragement, or looking for support from a pastor or members of a faith community.

Patients in this study commonly reported that religious beliefs and practices are strong sources of comfort, hope, and meaning, particularly in coping with a medical illness. This is particularly true for patients with disorders like CVDs that are characterized by their chronic nature, extent of disability, or poor prognosis. Relating this to the proposed conceptual framework of the study, religion as part of culture has been found to play a significant role in influencing health seeking behaviour for cardiovascular disorders.

Furthermore, patronage to churches could be explained in terms of the role the church has played over the years as more humane as compared to the other healthcare delivery system. Respondents asserted that the Prophet (*Odiyifo*) and the Akomfoɔ (traditional spiritualists), after healing patients would allow them to stay and be catered for spiritually until they are better prepared psychologically to go home (Sackey, 1999a). This practice by traditional healers, in a way provided a sense of protection and care for patients. The different types of interaction with patients could be a relevant factor contributing to the patronage of these traditional healers. This atmosphere where human touch to treatment is regarded as an integral part of care for patients is almost non-existent in the orthodox medical institutions (Niklaus, Sabine, Engelbert, Jozien & Wolf, 2010). The belief is that the healers and patients together actively participate in healing in the church and there is direct rapport between patient and healer while the patient is seen as a passive recipient of health care in the hospitals and clinics.

Most respondents (n = 29 of 33) mentioned prayer as a coping mechanism. Participants, who were not necessarily religious but generally sought treatment from prayer camps and other spiritual churches, believed that enemy-spirits are persistently up in arms against them. These reasons could have influenced participants' beliefs that when they are

afflicted by cardiovascular disorders they would first go to God in prayer to find out what was actually happening to them. Prayer creates a level of relationship between the person and God from whom the person receives help during a crisis situation. The significance of prayer as the first point of call in a crisis situation for participants, gives them the chance to reappraise the situation with the understanding that the crisis is not a dead end because God was there to help them in times of their greatest need (Osafo et al., 2011; Ai, Peterson, Bolling & Koenig, 2002). Through this process, they could conceptualise God as a significant form of social support and such a perception served as a relief for any distress they might suffer (Kuwahara, Nishino, Ohkubo & Tsuji, 2004).

Prayer and spirituality have been associated with high levels of optimism among participants of this study, a major characteristic that helped them endure major crises associated with the CVDs. The belief in the efficacy of prayers gave respondents and participants a positive outlook on their conditions (Yohannes, Koenig, Baldwin & Connolly, 2008). The effective use of prayer serves as a healing mechanism to cope with the pains and discomfort associated with CVDs, and this finding is consistent with the findings of other studies (Eckstein, 2000; Philips & Henderson, 2006). In contemporary Ghana, prayer groups constitute one of the prevalent forms of religious expression for solving problems (Asamoah-Gyadu, 2005), and perhaps, such a phenomenon emphasizes the value and reality of the practical use of prayer in the lives of the respondents.

Essentially, social support in terms of being a member of a religious group appeared to provide a buffer against stressors and their sequelae, including anxiety and depression, and decrease the risk of cardiovascular disease and even mortality (Abe-Kim, Gong, & Takeuchi, 2004; Brown, Smikes, Patel & Hargreaves, 2008; Dunn & Horgas, 2000). In

this study, the congregational benefit aspect of religious support appears to have similar characteristics. In particular, religious social support may include an expectation within the religious community that members of the congregation are there to help one another, in times of need. The community may encourage healthful behaviors and instill a sense of integration and belonging, which is comforting and reassuring to the individual. These aspects of religious support would in turn work against hopelessness and fear, depression and anxiety associated with devastating cardiovascular disorders (Sulmasy, 2002; Fortin & Barnett, 2004).

Participants (n= 27 of 33) engaged in private religious practices more often and also had greater religious commitment. Private religious practices are the non-organizational religious activities in which people engage, such as private prayer, meditation, saying blessings or grace at meals, and use of religious media (e.g., television, radio, reading scripture or other religious texts) (Koenig, 2004; Astrow, Pulchalski & Sulmasy, 2007).

Religious commitment among respondents focused on one aspect of what can be considered intrinsic religiousness, which involves an individual possessing a deeply held religion that permeates throughout his or her experience and that is continuous, in that its goal is spiritual in nature and involves ideas of a better world (Pargament, 2002b). The study found that though majority of FGD participants patronised the services of prayer camps (n= 28 of 33), and the use of such private prayer sessions otherwise known as prayer camps in the study was a great source of comfort to them. They claimed that having a man of God praying for them and giving them directions (*akwankyerε*) on how they could be healed gave them the hope that they would be cured one day, no matter how long the healing process would take.

Based on comments from participants, one could deduce reasons for the use of such prayer camps and the search for help from other spiritualists from three angles, namely psychological, social and economic support. Psychologically, religious and spiritual beliefs can be understood as being a part of a person's cognitive schema and how he or she views the world. Thus, how people form ideas and impressions of the world, how they appraise and interpret the world, are often informed and influenced by many factors, including religious beliefs (Taylor, Lamdan & Siegel, 2004). Prayer camps have therefore served as a source of mental relief to patients who believed that in the face of their ongoing bad health conditions, there is a powerful and unseen Being who still cares for them and would appropriately heal them, in good time. This psychological sense of protection could have served as a source of comfort and relief in the face of discomfort associated with their conditions and, helped them better cope well. This belief has therefore contributed to their externalizing their conditions in order to obtain and maintain some relief to be able to cope well with the condition they suffer.

Socially, the use of prayer camps also served as a form of social support where patients have a sense of belonging to a group that cared for them in their times of need even in times when their family members had neglected them. FGD participants (n= 28 of 33) believed that the current psychosocial situations have made it impossible to seek refuge in one's children in times of need or when they are sick (Brooks & Easterbrooks, 2011; Thoburn, Wilding & Watson, 2000). Their resignation from trusting that their children would be available when they were sick could be explained by the change in family ties system where matters pertaining to caring for parents have been relegated to the background, with people concentrating mainly on their immediate families comprising

their spouses and children. It is due to the cultural breakdown where the communal system of family ties has given way to the individualistic lifestyles, and children no more feel responsible towards their parents (Radford & Hester, 2006). This could be attributed to the change of social structure which has made people suffering from CVDs seek refuge at prayer camps where they establish close relationships with the caregivers and other patients suffering from similar conditions.

Commitment to prayers for healing is theoretically linked with other forms of intrinsic religiousness like religious service attendance (Ransford, Carrillo & Rivera, 2010). Taken as a whole, the findings of this study point to beneficial congregational support being particularly important in attenuating psychological distress associated with cardiovascular disorders (Ai, Peterson, Tice, Bolling & Koenig, 2004). Additionally, organizational religiousness in terms of being a member of religious group was significant in relation to how it influenced the people's health seeking behaviour. The current findings signal that even in the deconstruction of religion and spirituality concepts within the context of cardiovascular disease, religious attendance and social support remain key factors that to a large extent influenced the perception of CVDs and health seeking.

The inextricable nature of religiosity, spirituality and health seeking behaviour can be summed in the words of Robert Gerber that "A system of medicine which denies or ignores the spirit will be incomplete, because it leaves out the most fundamental quality of human existence – the spiritual dimension" (Gerber, 2001, p. 124). The results of this study therefore indicate a robust connection between religious support, spirituality, sociocultural and the psychological factors that influence health seeking behaviour for cardiovascular disease. Pattern of belief system among participants with regards to

religion provides an indication that, traditional healers are regarded, in part, as intermediaries between the visible and invisible worlds; between the living and the dead or ancestors, sometimes to determine which spirits are at work and how to bring the sick person back into harmony with the ancestors (Habtom & Ruys, 2007; Heinzerling, 2005).

Traditional spiritualists and diviners played very significant roles in the provision of health care to participants. The current study showed that the Akomfoɔ and the diviners played significant roles in providing both physical and spiritual support to people who patronised their services, and thus provided protection for their patrons. The reliance and trust for the traditional spiritualist could stem from the kind of professional services they render to their patrons due to their rigorous and disciplined training (Busia, 1954). Such traditional practitioners have, since time immemorial played very indispensable roles in the lives of individuals and have earned the trust and respect such that they are not in any danger of abandonment despite the inroads made by western medicine and the influence of Christianity (Pramukh & Palkumar, 2006; Coffie, 1998). The preference for the traditional system could be explained in terms of their ability to offer holistic healthcare (physical, emotional, economic and spiritual) for their patrons.

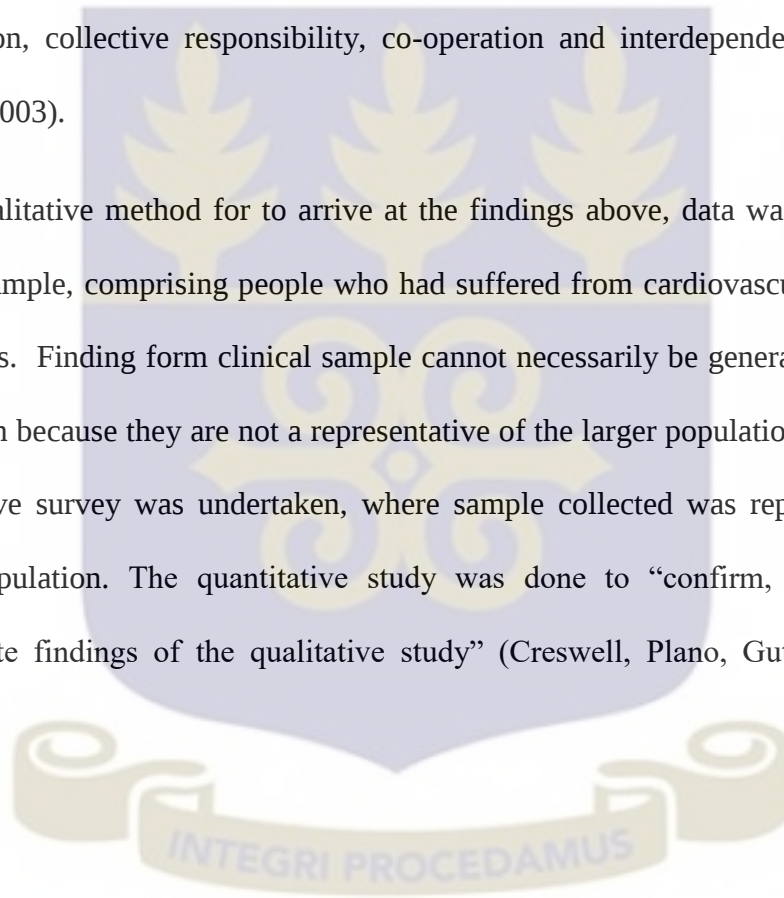
Participants of the current study were of the view that such one stop services provided them makes traditional healthcare more attractive and appealing to the people. Furthermore, they have continually served as a link between the people, the ancestors, the gods and the Supreme Being. This linkage is so important that without the spiritualists, it is believed that it is impossible to communicate with the spirit world. The traditional spiritualists are there to play this important role in addition to the provision of material support and this assistance given to clients by traditional practitioners transcend the

individual level and covers the welfare of the person involved. Such help include waiver of consultation fees or deferred payments, spiritual protection for family members and assurances of further help should the need arise. This method of treatment cut across almost all traditional health care providers, but a sharp contrast is seen in the western dominated hospitals who provide only symptom relief and leave their patients at that level. For these reasons, traditional spiritualist are held in very high esteem and continue to maintain the trust of the people (Anyinam, 1987; Busia, 1954; Ekem, 2008). Traditional health care providers have the tendency to understand diseases from the cultural and the patients' point of view and thus provide culturally relevant services to their clientele. Healthcare seeking therefore involve identification of causation, followed by aetiology, diagnosis then prognosis from the cultural point of view (Rivers, 1924).

Another concept is relational matter involving practitioners and patients who patronise the services. Generally, most practitioners in the orthodox health settings operate from the western point of view where a paternal ideology is the order of the day. The practitioner assumes a position of authority. An air of secrecy and fear, which was explained as being for the patients' own good to prevent knowing the bitter truth of their condition (Minkus, 1980). Secrecy and fear could be explained to protect the privileged status of the practitioner and to further maintain patient compliance. A sharp contrast is with the traditional health system where patients had the liberty to explain their condition and had the chance to talk about their families, a situation that endeared traditional healer to their patients. These attitudes could explain why there is a strong presence of traditional health system despite the vehement questioning of the efficacy of traditional medicine in recent times.

In the current study, participants indicated the strong attachment of the individual to the family system, and that help seeking is not an individual affair but a responsibility of the whole community. The conception of communality finds support from the findings of Wiredu (1983). In explaining the concept of communality in terms of help seeking, participants showed that the individual is part of the family system and therefore is not an independent entity from the family and that Values and customs are reinforced by cooperation, collective responsibility, co-operation and interdependence (Mbiti, 1969; Viljoen, 2003).

Using qualitative method for to arrive at the findings above, data was collected from a clinical sample, comprising people who had suffered from cardiovascular disorders, key informants. Finding from clinical sample cannot necessarily be generalized to the larger population because they are not a representative of the larger population. To this effect, a quantitative survey was undertaken, where sample collected was representative of the larger population. The quantitative study was done to “confirm, cross-validate, or corroborate findings of the qualitative study” (Creswell, Plano, Gutmann & Hanson, 2003).



CHAPTER FIVE

STUDY 2 – QUANTITATIVE

Introduction

This part is the quantitative aspect of the study that sought to explore health seeking behaviour among people suffering from cardiovascular disorders through the use of survey from the general population. This part is the second aspect of the study that employed quantitative methods of data collection and analysis.

A quantitative approach is defined as ‘an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analysed with statistical procedures, in order to determine whether the predictive generalizations of the theory hold true’ (Creswell, 1994, p.2). Its main aims are to objectively measure the social world, to test hypotheses and to predict and control human behaviour. Creswell (2003) points out that a quantitative approach is useful when attempting to test a theory or explain or identify factors that influence results. It is concerned with questions about How much? How many? How often? To what extent? (Yin, 2006). The most common quantitative approach methods include experiments, quasi-experiments and surveys.

The strengths of a quantitative approach are that it can produce factual, reliable outcome data that is usually generalizable to some larger population (Denzin & Lincoln, 2005; Patton, 2002). Its main limitation is that the results provide less detail on human behaviour, attitudes and motivation (Gorard, 2003).

5.1 Aims of the Study

The aims of the qualitative study were as follows:

- i. To identify the effect effects of culture on help seeking or CVDs.

- ii. To assess participants' views on health seeking for orthodox and traditional health systems.
- iii. To examine socioeconomic factors and their effect on health seeking behaviour for CVDs.
- iv. To examine the relationship between multidimensional health locus of control (MHLC) locus of control orientations and health seeking behaviour for cardiovascular disorders.

5.2 The Study Setting

The study was conducted in the New Juaben Municipality in the Eastern Region of Ghana. The New Juaben Municipality covers a land area of 110 square kilometres. It shares boundaries to the north-east with East Akim Municipality, to the south-east with Akuapem North District, Yilo Krobo District to the east and Suhum Kraboa Coaltar District to the west. Details of the setting have been presented on page 89 and 90.

5.3 Population and Sample Size Determination

This involved a sample selected from a cross section of the population who fell within the age range from ages 35 to 75 years. The purpose of this sampling decision was to gather unbiased views of the general populace with respect to their health seeking behaviour. Participants selected were people who were part of the general public and might have had varying perceptions, opinions, attitudes, knowledge and beliefs about cardiovascular disorders. The research sought information on cultural values, belief systems and perception about cardiovascular disorders that occur within a cultural context. It was the belief of the researcher that information on these cultural values and belief systems would go a long way to build a strong understanding of the socio-cultural underpinnings that

influence the health seeking behaviour of the people. This component was used for purposes of corroboration, complementarity and/or otherwise of the findings of the qualitative aspect. A structured questionnaire mainly close ended questionnaire cover the thematic areas under consideration in the study was the tool for data collection.

The sample size for the general population was determined by taking and calculating a percentage of the number of people residing in the New Juaben Municipality between the ages of 35 and 75 years, the age group required for the purpose of this study. The Municipality has a population of 147, 528 residents who qualified for this purpose (2010 Population and Housing Census). The Epi Info version 3.5.1 StatCalc was used for the computation. The sample size for the study was calculated as follows:

Population Size	147,528
Expected Frequency	15%
Worst Acceptable Value	10%
Confidence Level	<u>99%</u>
Estimated Representative Sample	550

Based on this calculation, six hundred and five (605) copies of questionnaires were given out to respondents in order to cater for attrition. Five hundred and eighty 580 questionnaires, representing 95.9% were finally retrieved. Of the 580 questionnaires retrieved, 560 (96.55%) were used for the final analysis. Responses to 20 copies of the retrieved questionnaires were not completely answered, and were therefore taken out. In all, out of 605 questionnaires administered, 560 representing 92.56% were used for the analysis.

5.4 Quantitative Study Participants

Participants for the study involved a sample selected from a cross section of the population who fell within the age range from ages 35 to 75 years. The purpose of this component was to gather unbiased views of the general populace with respect to their health seeking behaviour. Participants selected were people who were part of the general public and might have had varying opinions, attitudes, knowledge and beliefs about cardiovascular disorders. The research sought information on cultural values, belief systems and views of cardiovascular disorders that occur within a cultural context. It was the belief of the researcher that information on these cultural values and belief systems would go a long way to build a strong understanding of the socio-cultural underpinnings that influence the health seeking behaviour of the people. This component was used for purposes of corroboration, complementarity and/or otherwise of the findings of the qualitative aspect. A structured questionnaire mainly close ended questionnaire cover the thematic areas under consideration in the study was the tool for data collection.

Respondents for the study had diverse demographic backgrounds which contribute to the enrichment of the primary data gathered. Information on the demographic background of the participants is presented on Table 5.3. Female participants were dominant in the sample 296 (53%) compared to their male counterparts 264 (47%). Thirty five (6%) were unemployed, self-employed 300 (54%), employed 207 (37%) and students 18 (3%). Majority of the participants, 453(81%) reported their monthly income as between GH¢100 and GH¢550 Ghana cedis (low socio-economic status). The rest 107 (19%) indicated their monthly income was either GH¢550 or above (high socio-economic status). Most respondents were Akans 294 (53%). The rest comprise Ewe 127(23%),

Guan 16 (3%), Ga-Adangbe 83(15%), Gruma 12(2%), Mole-Dagbani 14(3%) and Grusi 14(3%). They were also of diverse religious affiliations, with the dominant group being Christians 451 (81%), African Traditional Religion practitioners 62 (11%) and Moslems 47 (8%). Description of the localities of the participants includes Urban 289 (52%), Semi-urban 234 (42%) and rural 37 (7%).

Table 5. 2 Demographic Characteristics of Respondents

Cardiovascular Disorder Patients (n=560)		
Demography	Freq	Percent
<u>Sex</u>		
Male	264	47
Female	296	53
<u>Age</u>		
30-39	164	29
40-49	198	35
50-59	127	23
60andabove	71	13
<u>Education</u>		
No Education	63	12
Primary	46	8
JHS/Middle School	146	26
SHS/Secondary	80	14
Voc/Comm./Tech	52	9
Diploma	89	16
Degree	61	11
Postgraduate	17	4
Other	6	

5.5 Instruments for Data Collection

This study was survey method that utilised structured questionnaires, made up mainly of close-ended questions, which were administered to the general population to explore patterns and trends which helped to describe what is happening in context and provide a measure of respondent's opinion, attitudes, feelings, and perceptions about particular

concerns to the researcher (Creswell, 2003). Structured questionnaires, made up of close-ended questions were administered to respondents to explore patterns and trends which helped the researcher to describe the people's belief systems regarding CVDs within a context and provide a measure of respondent's opinion, attitudes, feelings about cardiovascular disorders in the Municipality (Creswell, 2003).

There were five sections in the questionnaire, which included those relating to biographical data, cultural values and belief systems, health locus of control section and the fifth section dealing with socioeconomic status, and the use of orthodox and the traditional healthcare systems.

Data were collected using two types of measures. The first was made up of 7-point Likert scale questionnaires that were designed for the purpose of this study by the researcher to measure different variables and their relationship with health seeking behaviour. The first measured cultural values and belief systems and health seeking behaviour. This was a 19-item measurement scale designed to assess participants' belief systems. This instrument measures categories of beliefs involving 1) spiritual influences 2) physical influence, 3) behavioural influence and 6) perceptual influences. The responses on the scale ranged from "Don't Know – 0 to Strongly Agree – 6. (Appendix I)

The second measure involved a scale that measured orthodox and traditional health systems. This was a 20-item scale with categories that measure preference involving 1) orthodox health system, 2) traditional health system, 3) spiritual preference and 4) multiple health seeking.

The 21- item scale that measured socioeconomic factors and health seeking behaviour. The categories such as i. cost of treatment, ii. income levels, iii. proximate determinants –

affordability, accessibility and acceptability (See Appendix 1). Finally, the 19-item adapted multi-dimensional health locus of control scale measured how a person's health locus of control influenced health seeking behaviour (Appendix I Section 4).

5.6 Description of Quantitative Data Collection Tools

Multidimensional Health Locus of Control Form C (MHLC – C)

The Multidimensional Health Locus of Control Form C (MHLC – C) is an 18 item scale developed by Wallston, Stein and Smith (1994). It measures five main domains; Internal Health Locus of Control, Powerful Others Health Locus of Control, and Chance Health Locus of Control, Other People Health Locus of Control, Doctor's Health Locus of Control. Original responses were measured on 1 to 6 point Likert response-scale. After adoption and adaption, the scores on the MHLC – C were calculated by adding respective items for a total scale score (i.e., where 1 = “strongly disagree” and 6 = “strongly agree”), where higher total scores reveal stronger endorsement of MHLC domains. One question (*cardiovascular disorders are hereditary and nothing can be done to prevent its occurrence*) was added to make them 19 items before piloting. The Cronbach alpha of this scale is 0.78.

Other Scales Developed for Study

The subsequent scales were developed by the researcher after review of literature and piloted for reliability. See section 5.10 for reliability of scales. Prior to the extraction of factors by using Principal Component Analysis Based on Eigenvalue greater than 1, the Bartlett test of Sphericity [Appox: Chi-square= 16005.54, $p = 0.000$] and the Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) [Value of .840] were tested. This

established that there was a significant correlation among the variables to permit the application of exploratory factor analysis. Following Hair et al.'s (2010) and Costello and Osborne's (2005) assertions, considerations for item inclusion or exclusion were done with respect to magnitude of the loadings.

Cultural Values and Belief Systems and Health Seeking Behaviour (CVBSHSB)

Questionnaire

Cultural Values and Belief Systems and Health Seeking Behaviour Questionnaire is a 19-item scale designed to assess participants' belief systems. This instrument measures categories of beliefs involving 1) spiritual influences 2) physical influence, 3) behavioural influence and 4) perceptual influences. This questionnaire used a 7- point Likert Scale [with responses ranging from "Don't Know = 0 to Strongly Agree = 6]. The reliability statistics after piloting indicated a Cronbach's Alpha Based on Total Standardized Items is .879. Correlation Between Forms recorded a reliability of 0.664 while Spearman-Brown Coefficient indicated for both Equal Length and Unequal Length values of .798 and .798 respectively. Finally, Guttman Split-Half Coefficient recorded a reliability statistics of .792.

Orthodox and Traditional Health Systems (OTHS) Questionnaire

The second measure involved a scale that measured orthodox and traditional health systems. This was a 20-item scale with categories that measure preference involving 1) orthodox health system, 2) traditional health system, 3) spiritual preference and 4) multiple health seeking. This questionnaire also used a 7- point Likert Scale with responses ranging from "Don't Know = 0 to Strongly Agree = 6. The reliability statistics after piloting indicated a Cronbach's Alpha Based on Total Standardized Items is .821.

Correlation Between Forms noted a reliability of .659 while Spearman-Brown Coefficient indicated for both Equal Length and Unequal Length values of .795 and .795 respectively. Finally, Guttman Split-Half Coefficient recorded a reliability statistics of .791.

Socioeconomic Factors and Health Seeking Behaviour (SFHSB) Questionnaire

This is a 21- item scale that measured socioeconomic factors and health seeking behaviour. The categories such as i. cost of treatment, ii. Income levels, iii. Proximate determinants (affordability, accessibility and acceptability). The scores on the SFHSB were calculated by adding respective items a 7- point Likert Scale for a total scale score (i.e., where 0 = “Don’t Know” and 6 = “strongly agree”). The reliability statistics after piloting recorded a Cronbach's Alpha Based on Total Standardized Items is .799. Correlation Between Forms indicated a reliability of .577 while Spearman-Brown Coefficient indicated for both Equal Length and Unequal Length values of .732 and .732 respectively. Lastly, Guttman Split-Half Coefficient recorded a reliability statistics of .731.

5.7 Procedure for Data Collection

The researcher employed a survey method to select participants for the study. There were 20 research assistants. Eight (8) first degree psychology graduates and 8 Higher National Diploma (HND) graduates and 4 professional translators who were doing their National Service and had knowledge in research methodology and data collection activities were recruited as Research Assistants.

The purpose and the thematic areas of the study were explained to them. Recruited research assistants given an orientation and the details of the study were explained to

them. The research assistants were trained on the contents of the questionnaires, rapport building, listening and probing, as well as how to collect data on all the variables using the needed instruments and tools. The research assistants were divided into four groups. Each group had one translator whose was part of the data collection team, but primarily responsible for translating the questionnaires to respondent who had difficulty reading as a result of problem with literacy or in situations where the respondent was physically challenged. One limitation with the data collection process was that people who were deaf and dumb could not be included in the study because there was no research assistant who had been trained in sign language. In all, twenty research assistants who were involved in the survey within the New Juaben Municipality to administer the questionnaires. In addition to the questionnaires there were the following:

1. An introductory letter of researcher and research assistants.
2. Informed consent form
3. Authorisation letter from the Head of Department of Psychology, University of Ghana.

At the beginning of each session, the participant was informed that the study consisted of two 20-35 minute answering questionnaires.

Each group of research assistants were assigned to an area that had been previously agreed upon by the team where they would collect their data. The New Juaben has 52 communities, out of which 13 communities were selected. Selection was done using the lottery method where all the names of those communities were written down and then participants picked then randomly.

In this survey, systematic sampling, using the equal-probability method was used. This involved a random selection of houses where every k th house was chosen. In this sense, $k = (\text{population size} / \text{sample size})$. By using this procedure each element in the population has a known and equal probability of selection. From the sampling frame, the research assistants chose a starting point randomly, and thereafter select houses at regular intervals. For example, there were 120 houses in a community and the research assistants sampled 8 houses. It was calculated $120/8=15$, so every 15th house was chosen after a random starting point between 1 and 15. This pattern of house selection was done for all the communities. Respondents for the study who met the criteria for selection were randomly selected. This method of sampling was done in order to allow each participant an equal chance to be selected to be part of the study.

Six hundred and five (605) questionnaires were administered and 580, representing 96% were retrieved. Of this number, 560 questionnaires were finally used for the analysis which further represents 92.6% of the total questionnaires administered. In the course of the administration respondents who could read and understand filled the questionnaires themselves and those who had difficulty reading had the research assistants who were professional translators to help them translate the questions into the local language (which was mainly Akan), before they could answer the questions. Some respondents answered the questionnaires and gave them back the same day while others asked research assistants to come on an appointed date to collect them. It took seven months to complete the data collection process.

5.8 Data Quality Assurance Measures

Quality assurance measures were system of procedures, checks, audits and corrective actions that were put in place to ensure that the activities carried out in undertaking the study are of the highest achievable quality (Patton, 2002). Measures put in place included the following:

5.8.1 Pilot Study

A pilot study involving 20 respondents, made up of health workers, patients/clients, traditional healers, churches, and prayer camps was conducted at Nankese, a town that is about ten kilometres from Koforidua. Pretesting was done to prepare for the major study (Greene & Caracelli, 2003). This procedure aided in determining feasibility of the administration procedure, the clarity of concepts, and the amount of time required in questionnaire administration. Pre-testing the appropriateness of the instruments gave the researcher the opportunity to identify shortcomings of the questions and had them corrected. For example, ambiguous and double barrelled questions were clarified. Inappropriate questions were either taken off or modified. The coding scheme and data entry process were also tested and inconsistencies discovered in the coding system were rectified.

5.8.2 Monitoring and Supervision of Fieldwork

There was daily monitoring and supervision of all field activities of the research assistants by the researcher. As part of the monitoring process, the researcher ensured that there was ongoing editing and cleaning of data. The researcher kept a journal in which all interactions with research assistants were recorded.

5.9 Ethical Considerations

To ensure the protection of the rights of respondents, permission was sought from the management of the hospital and traditional healers before the research was carried out. Furthermore, an informed consent (see appendix 6) was sought from the various participants and respondents before the study was carried out. Finally because this study was to be conducted in a healthcare setting, an introductory letter was written by the researcher and submitted to the hospital management for the study to be undertaken (See appendix 5). Approval was therefore given by management upon assurance by the researcher to produce worthwhile findings and ensuring that patients were not inconvenienced or harmed. In order not to invade the rights and privacy of respondents, time for data collection was mutually agreed upon with participants with the assurance that all responses would be treated with utmost confidentiality.

5.10 Preliminary Analysis

5.10.1 Descriptive Scales and Reliability

These included frequencies of demographic characteristics for the entire sample and the various study groups, analysis of the normal distribution of the variables, means, standard deviation, correlation among the key study variables and internal consistency reliability. The present study tested for both normality and homogeneity. Test for normality using skewness and kurtosis was within the acceptable range of ± 2 (Tabachnick & Fidell, 2007) for all the scales. All the scales used in this analysis also yielded acceptable results of Cronbach's alpha coefficients ranging from 0.72 to 0.83 (see Table 5.3).

Table 5. 3 Summary of Descriptive Statistics, Reliability Analysis, Skewness and Kurtosis of the Variables in the Study (N = 560)

Variable	Mea n	SD	Skewness	Kurtosis	Cronbach α
Cultural values and Belief	14.58	6.37	.059	-1.28	0.77
Orthodox & Non-Orthodox Med Practices	14.84	3.02	-.473	-.209	0.88
Socio-economic Status	51.62	4.50	-.622	.092	0.72
Health Locus of Control	62.49	7.06	-.463	-.224	0.83

5.11 Factor Analysis of Scales

To further check the robustness of the scales factor analysis was conducted to determine if the items are part of a single construct (MacCallum & Browne, 2004; Field 2005). To accomplish this Principal Component factor analysis was conducted on all the scales. The influence of factors on each construct is measured by means of factor loadings. The numerical value of a factor loading indicates the strength of the influence of the factor on the manifest variable. Factor loadings are considered to make significant contributions to the manifest variable when they are greater than .30. All the items on the scales used in the present study have factor loadings of .427 and above and is deemed satisfactory.

Cultural Values and Belief Scale

Table 5.4 Factor loadings based on a principal components analysis for 19 Cultural Values and Belief Scale (N = 560)

ITEMS	
It a belief in my culture that cardiovascular disorders are caused by supernatural forces.	.573
I believe that witches have an influence in any disease I have.	.556
It is a belief in my culture that evil spirits have the potential to infect me with CVDs.	.490
When I don't fulfil my vows to the church or the gods, they can send misfortune in the form of cardiovascular disorders.	.622
If I am faithful, I can get supernatural protection from all cardiovascular disorders.	.651
Evil spirits can enter houses through doors, cracks and walls and spread cardiovascular disorders.	.419
When the family fails to observe traditional rites, misfortune in the form of cardiovascular disorders will befall us.	.692
It is important to wear lucky charms to protect us from contracting cardiovascular disorders.	.664
A deceased family member becomes a spirit, who influences the health of other members of the family.	.654
It is a cultural belief that there are certain diseases that are not treatable by western medicine.	.614
It is important to consult the oracles before seeking treatment for cardiovascular disorders.	.615
When I have no explanation to the cause of my condition, I will consult the spiritualist /shrine for explanation.	.518
It is a belief that treatment offered by non-orthodox health practitioners (herbalists, spiritualists, prayer camps, etc) are more potent than those offered by the orthodox system.	.505
My cultural values and practices perceive orthodox medicinal practice as not having enough answers to illnesses.	.489
From my culture, it is believed that there is a complete cure for every disease condition.	.485
When cardiovascular disorders persist for a longer period than acceptable, it is believed that the disease was caused by an envious family member or witches.	.461
It is a cultural belief that all diseases have supernatural causes for which western medicine has no explanation or antidote.	.438
My traditional system does not accept the view that certain diseases cannot be completely cured but can only be managed.	.687
The best source of treatment for cardiovascular disorders is the orthodox health system.	.682

Extraction Method: Principal Component Analysis

The Cultural Values and Belief Scale was subjected principal component factor analysis after the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of only four coefficients of .3 and above. The Kaiser-Meyer-Olkin measure of sampling adequacy was 0.724, meeting the commonly

recommended value of 0.6 and above. The Barlett's Test of Sphericity reached statistical significance, (χ^2 (21) = 75.481, p = 0.000). Finally, the communalities were all above .3 further confirming that each item shared some common variance with other items. Given these overall indicators, factor analysis was deemed to be suitable with all the 19 items. Principal components analysis revealed the presence of one component with eigenvalue exceeding 1, explaining 39.12% of the variance. All the factors loaded onto one component.

Orthodox and Non-Orthodox Medicinal Practices

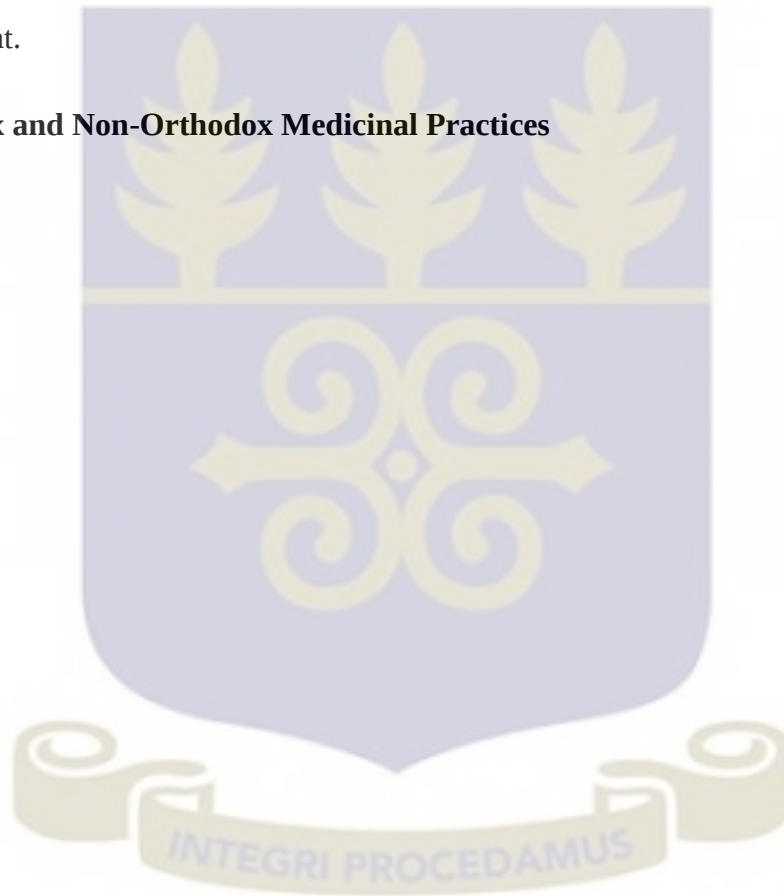


Table 5. 5 Factor loadings based on a principal components analysis for 20 item Orthodox and Non-Orthodox Medicinal Practices Scale (N = 560)

ITEMS	
Whenever anything goes wrong in my life, I consult a traditional health practitioner first.	.770
I consult a herbalist when western doctor cannot heal me.	.746
I believe that orthodox medicine has answers to all my health problems.	.640
I prefer the orthodox health system because I have faith in their treatment more than the non-orthodox health system.	.640
It is more time consuming to seek treatment from the traditional health system	.484
Orthodox health practitioners do not have the patience to give me thorough treatment as compared to the traditional system.	.428
In order to be completely cured from cardiovascular disorders, it is important to seek help from both orthodox and non-orthodox health practitioners.	.406
I only go to the hospital when my condition is very serious.	.664
I prefer the hospitals, because they are better resourced to take care of me when have a cardiovascular disorder.	.654
I prefer orthodox medicine because traditional healers lack the skills needed to proffer correct diagnosis on very serious disorders like cardiovascular disorders.	.614
I believe that prayer is the best solution to my cardiovascular disorders conditions.	.675
The traditional medicine practitioners are more accessible to the people than the cosmopolitan modern doctors.	.619
Orthodox health systems don not have antidote to my cardiovascular conditions.	.515
The use of traditional medicine only provides a temporary relief to cardiovascular related conditions as compared to orthodox medicine.	.496
I prefer the orthodox health delivery system, because the traditional medicine lacks standard dosage and has not been subjected to "scientific" verifications.	.492
I believe that the combination of orthodox and traditional medicines provide the best solution to my cardiovascular related conditions.	.490
The traditional healer's skills in treatment techniques enable them to achieve a high success rate in the management of cardiovascular disorders	.579
I believe that treatment from traditional healers is more long lasting.	.731
The healers in the traditional system lack the equipment needed to conduct physical examination on patients.	.490
I spend a lot of time whenever I go to the hospital.	.449

Extraction Method: Principal Component Analysis

The 20 item Orthodox and Non-Orthodox Medicinal Practices scale was also subjected principal component factor analysis after the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of only four coefficients of .3 and above. The Kaiser-Meyer-Okin measure of sampling adequacy was .709, meeting the commonly recommended value of .6 and above. The Barlett's Test of

Sphericity reached statistical significance, (χ^2 (6) = 70.739, p =.000). Finally, the communalities were all above .3 further confirming that each item shared some common variance with other items. Given these overall indicators, factor analysis was deemed to be suitable with all 20 items. Principal components analysis was used because the primary purpose was to identify the factors underlying the turnover intention scale. Principal components analysis revealed the presence of one component with eigenvalue exceeding 1, explaining 68.544% of the variance. All the factors loaded onto one component (this is presented in table 5.5).

Socioeconomic Status and Health Seeking Behaviour for CVDs

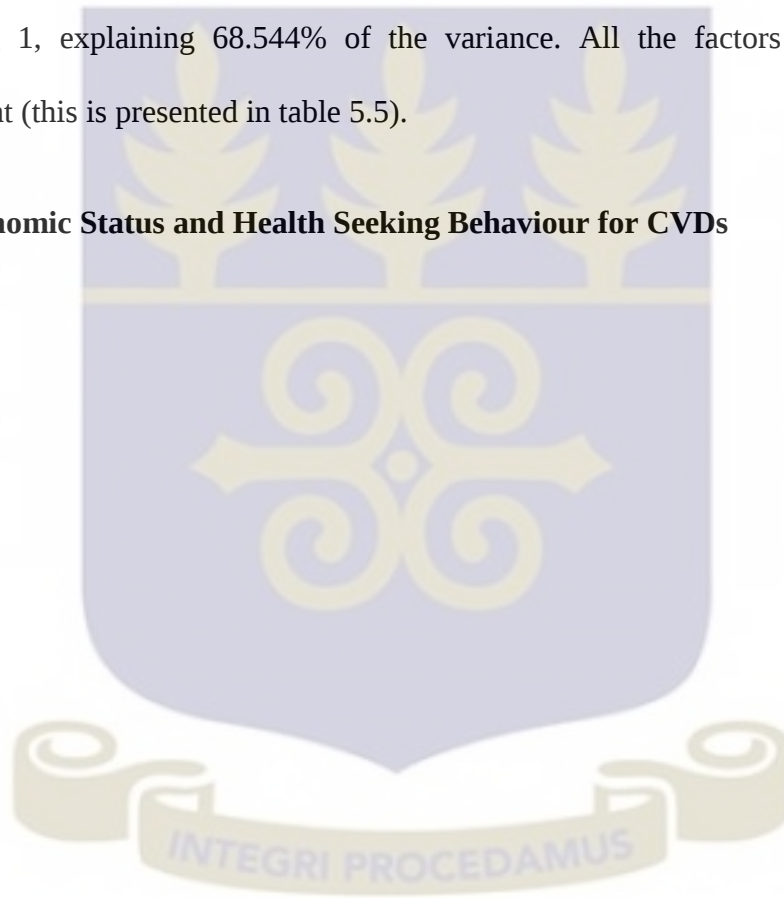


Table 5. 6 Factor loadings based on a principal components analysis for 21 Socio-economic Status Scale (N = 560)

ITEMS	
I consider the cost of orthodox healthcare as very high.	.873
It is difficult to get proper healthcare from the hospitals because of low level of income.	.625
The distance from my home to the hospital prevents me from seeking help from there.	.75 4
I seek help from multiple sources without considering the cost.	.677
I prefer to get treatment from the pharmacy shop/drug store to going to the hospital.	.588
Health seeking from traditional providers is too expensive as compared to those received from orthodox health settings.	.648
The level of my income to a greater extent influences my health seeking behaviour.	.783
I only seek help from a particular system mainly based on availability of the facility.	.731
I prefer to go to the hospital because the National Health Insurance Scheme (NHIS) will cater for my bills.	.394
I will only go to the hospital, when I am very sick.	.425
Herbalists and prayer camp operators do not have antidote to my ailment.	.551
I consider seeking treatment at the hospital as too luxurious.	.872
Services of prayer camps and herbalist only aggravate my condition.	.573
Going to the hospital is too much time-consuming	.693
I consult friends and relatives for treatment because both traditional and orthodox health systems are expensive and time consuming.	.554
Among all the healthcare delivery systems, orthodox health systems provide the best solutions to our health problems	.495
I prefer to go to herbalists because their services are very cheap.	.624
Treatment at the non-orthodox health system takes too long.	.527
Treatment at the non-orthodox health system is too expensive.	.555
My health seeking behaviour is mainly based on the accessibility of the facility.	.504
The cost of treatment has nothing to do with my health seeking behaviour.	.827

Extraction Method: Principal Component Analysis

The 21 item Socioeconomic Status scale was also subjected principal component factor analysis after the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of only four coefficients of .3 and above. The Kaiser-Meyer-Olkin measure of sampling adequacy was .624, meeting the commonly

recommended value of .6 and above. The Barlett's Test of Sphericity reached statistical significance, (χ^2 (21) = 75.481, p =.000). Finally, the communalities were all above .3 further confirming that each item shared some common variance with other items. Given these overall indicators, factor analysis was deemed to be suitable with all 21 items. Principal components analysis was used because the primary purpose was to identify the factors underlying the power distance scale. Principal components analysis revealed the presence of one component with eigenvalue exceeding 1, explaining 39.114% of the variance. All the factors loaded onto one component (this is presented in table 5.6).

Health Locus of Control Scale

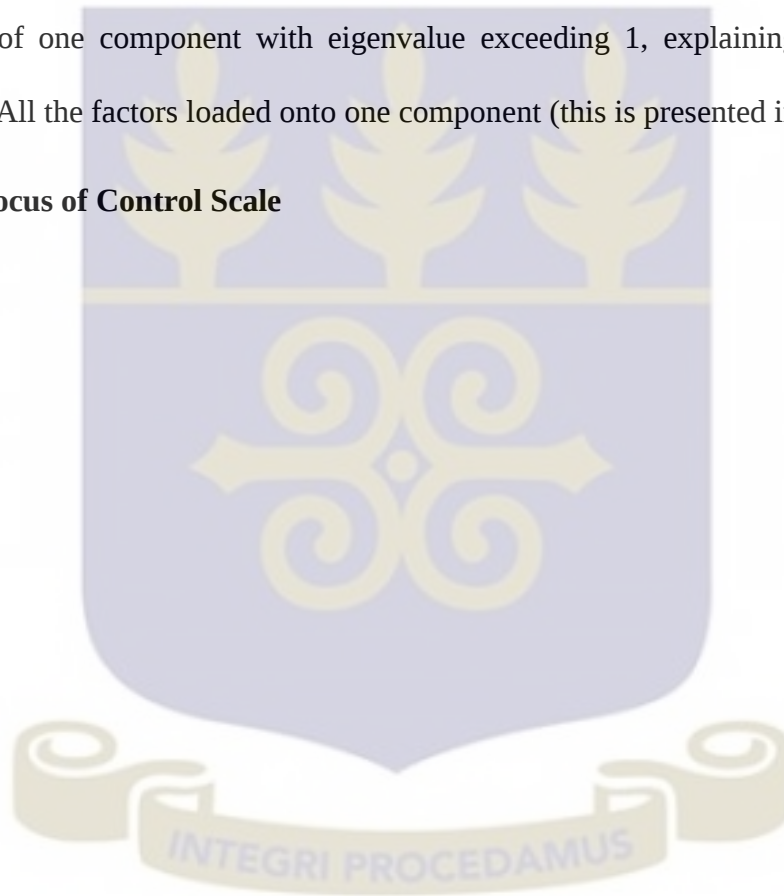


Table 5. 7 Factor loadings based on a principal components analysis for revised 19 item Health Locus of Control Scale (N = 560)

ITEMS	
If I get sick, it is my own behaviour, which determines how soon I get well again.	.416
No matter the situation, if I will be sick, certainly I will.	.619
Having regular contact with my physician is the best way for me to avoid illness.	.678
Most things that affect my health happen to me by accident.	.575
Whenever I don't feel well, I often consult health professional.	.589
I take care of my health my health problems.	.554
My family has a lot to do with my staying healthy.	.505
When I get sick, I am to blame.	.413
Luck plays a big role in my recovery from an illness.	.692
Health professionals have control over my health.	.538
My good health is largely a matter of good fortune.	.672
The main thing, which affects my health, is my habits.	.698
If I take care of myself, I will avoid illness.	.727
Whenever I recover from an illness, it's usually because other people (for example, doctors, nurses, family, and friends) have been taking good care of me.	.496
No matter what I do, I 'm likely to get sick.	.624
If it is meant to be, I will stay healthy.	.394
If I take the right health procedures, I will stay healthy.	.425
Regarding my health, I can only do what my health professionals tell me to do.	.824
Cardiovascular disorders are hereditary and nothing can be done to prevent its occurrence.	.463

Extraction Method: Principal Component Analysis

The revised 21 item scale was subjected principal component factor analysis after the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of only four coefficients of .3 and above. The Kaiser-Meyer-Oklín measure of sampling adequacy was .731, meeting the commonly recommended value of .6 and above. The Barlett's Test of Sphericity reached statistical significance, (χ^2 (15) = 100.675, p = .000). Finally, the communalities were all above .3 further confirming that

each item shared some common variance with other items. Given these overall indicators, factor analysis was deemed to be suitable with all 19 items. Principal components analysis was used because the primary purpose was to identify the factors underlying the Availability of alternative jobs scale. Principal components analysis revealed the presence of one component with eigenvalue exceeding 1, explaining 65.836% of the variance. All the factors loaded onto one component and are consistent with the original scale. This makes the interpretation of the health locus of control scale consistent with previous research (Wallston, Stein & Smith, 1994; Wallston, Wallston & DeVellis, 1978; Schnoll, Rothman, Newman, Lerman, Miller & Movsas, 2004).

5.12 Testing of Hypotheses

Four hypotheses based on variables discussed under 4.1 were tested employing inferential statistical tools:

- H1: Cultural values and belief systems will have a moderating effect on the relationship between the development of cardiovascular disorders and health seeking behaviour.
- H2: There will be a positive relationship between efficacy of treatment and health seeking behaviour for the orthodox and the traditional healthcare systems.
- H3: People with high socioeconomic status are more likely to seek help from orthodox health system for the treatment of cardiovascular disorders as compared to those with low socioeconomic status.
- H4: Health locus of control orientation will have a mediating effect on the relationship between cardiovascular disorders and health seeking behaviour for cardiovascular disorders.

5.13 Data Analysis and Interpretation

After careful cleaning of data, the completed questionnaires were coded and entered into SPSS for data analyses. Quantitative data were analysed using SPSS for Windows version 16.0. Both descriptive and inferential statistics were used. Descriptive statistics focused only on the demographic characteristics of the respondents. Four hypotheses were tested. Hierarchical multiple regression analysis, which sought to analyse the moderating effects of cultural values on health systems was used to analyse hypotheses 1 and 2. To determine whether socioeconomic status influences health seeking behaviour for orthodox health system, the independent t-test was used to analyse hypothesis three. Categorical multiple regression was used to analyse hypothesis 4. Inferential analyses focused on comparison of factors that influenced behavioural health seeking behaviour for cardiovascular disorders or research participants.

Data analyses revealed that all four hypotheses were supported by the quantitative analyses. Findings indicated that cultural values and belief systems had a moderating effect on the relationship between cardiovascular disorders and health seeking behaviour. Findings further indicated that efficacy of treatment was correlated with health seeking behaviour for both traditional and orthodox health systems. Furthermore there was no significant relationship between socioeconomic status and health seeking behaviour. That is, the socioeconomic status of participants had no influence on their health seeking behaviour for cardiovascular disorders. Finally multidimensional health locus of control did not mediate the relationship between health seeking behaviour and cardiovascular disorders.

5.14 Results of Quantitative Study

The study explored the influence of belief in cultural norms and values, orthodox/non-orthodox treatment efficacy and socioeconomic factors on health seeking behaviour of cardiovascular disorder patients. Four hypotheses were tested; i. the effect of cultural values and belief systems on the relationship between the development of cardiovascular disorders and the behaviour of health seeking, ii. the relationship between the efficacy of treatment and health seeking behaviour for the orthodox and the traditional healthcare systems, iii. the relationship between socioeconomic status and health seeking behaviour for the treatment of cardiovascular disorders, and iv. the effect of multidimensional health locus of control and health seeking behaviour for cardiovascular disorders.

5.14.2 Effect of Cultural Values and Belief Systems on Health Seeking Behaviour

To test the first hypothesis, that is: Cultural values and belief systems will have a moderating effect on the relationship between the development of cardiovascular disorders and health seeking behaviour, the Cultural values and belief systems; and cardiovascular disorders interaction term were first computed. This allowed the interaction term to be included as part of the variables used in the analysis to examine the moderating effect. The study regressed 'Health Seeking Behaviour' variable scores on the Cultural values and belief systems variable scores, and the Cultural values and belief systems; and cardiovascular disorders interaction term scores. The results are presented in Table 5.8.

Table 5. 8Hierarchical Multiple Regression of ‘Health Seeking Behaviour’ variable scores on the Cultural Values and Belief Systems scores, Perception of Cardiovascular Disorders scores and the Cultural Values and Belief Systems; and Perception of Cardiovascular Disorders interaction term scores

Variables	R-square	Changed R-square	Standardised Beta (β)	<i>F</i>
Independent Variables	.306**	.306**		121.621**
Cultural Values and Belief Systems			.213**	
All Variables	.332**	.026**		91.206**
Cultural Values and Belief Systems			.228**	
Cultural Values and Belief Systems of Cardiovascular Disorders interaction term			-.161**	

** $p < .01$

A significant model emerged ($F_{(3,551)} = 91.206$, $p < .01$) when the hierarchical multiple regression analysis (enter method) was conducted, (see Table 4.2). The R^2 was .332 indicating that the model as a whole explained 33.2% of the variance with the interaction term explaining additional 2.6% (Changed $R^2 = .026$) of the variance when Cultural Values and Belief Systems; and Cardiovascular Disorders were statistically controlled. The contribution of the Cultural Values and Belief Systems; and Cardiovascular Disorders interaction term though small (Changed $R^2 = .026$) was statistically significant, Changed $F_{(1,551)} = 21.390$, $p < .01$. In other words, for the independent and moderator variable and their interaction term considered in the model, about 2.6% of the variances in ‘Health Seeking Behaviour’ can be predicted by the Cultural Values and Belief Systems; and Cardiovascular Disorders interaction term.

The results also indicate that apart from the main effect of Cardiovascular Disorders ($\beta = -.375$, $p < .01$); the interaction term of Cultural Values and Belief Systems; and

Cardiovascular Disorders variables ($\beta = -.161$, $p < .01$) was significantly and negatively related to 'Health Seeking Behaviour'. In addition, the significant model that emerged when the interaction term was introduced into the model ($F_{(3,551)} = 91.206$, $p < .01$) is an indication that Cultural Values and Belief Systems do have a significant moderating effect on the relationship between the cardiovascular disorders and health seeking behaviour. Although the strength of relationship is small (Cohen, 1988), the interactive term is shown by the analysis as a significant predictor of 'Health Seeking Behaviour', an indication that Cultural Values and Belief Systems do have a significant moderating effect on the relationship between cardiovascular disorders and health seeking behaviour. Thus H1: Cultural values and belief systems will have a moderating effect on the relationship between cardiovascular disorders and health seeking behaviour was supported by the results as shown in Table 5.8.

5.14.3 Efficacy of Orthodox and Traditional Health System treatments; and Health Seeking Behaviour

To test the second hypothesis, that is: There will be a positive relationship between efficacy of treatment and health seeking behaviour for the orthodox and the traditional healthcare systems. The study regressed 'Health Seeking Behaviour' variable scores on efficacy of Traditional Health System treatment scores and efficacy of Orthodox Health System treatment scores. The results are shown in Table 5.9.

Table 5.9 Hierarchical Multiple Regression of ‘Health Seeking Behaviour’ variable scores on efficacy of Traditional Health System treatment scores and efficacy of Orthodox Health System treatment scores.

Variables	R-square	Standardised Beta (β)	F
Independent Variables	.247 **		90.319**
Efficacy of Orthodox Health System treatment scores		.383**	
Efficacy of Traditional Health System treatment		.196**	

**p<.01

A significant model emerged ($F_{(2,552)} = 90.319$, $p < .01$) when the hierarchical multiple regression analysis (enter method) was conducted, (see Table 4.3). The R^2 was .247 indicating that the model as a whole explained 24.7% of the variance in Health Seeking Behaviour of respondents. In other words, about 24.7% of the variances in ‘Health Seeking Behaviour’ can be predicted by Traditional Health System treatment efficacy and Orthodox Health System treatment efficacy; where Orthodox Health System treatment efficacy ($\beta = .383$, $p < .01$) and Traditional Health System treatment efficacy ($\beta = .196$, $p < .01$) were significantly and positively related to ‘Health Seeking Behaviour’ respectively. The results presented in Table 4.3 above, did show that both Traditional Health System treatment efficacy and Orthodox Health System treatment efficacy were significant predictors of ‘Health Seeking Behaviour’, an indication of the data set lending support to the second hypothesis, H2: that there will be a positive relationship between efficacy of treatment and health seeking behaviour for the orthodox and the traditional healthcare systems.

5.14.4 Socioeconomic Status and Orthodox Health Seeking Behaviour

The third hypothesis (H3), which stated that people with high socioeconomic status are more likely to seek help from orthodox health system for the treatment of cardiovascular disorders as compared to those with low socioeconomic status, was examined employing the independent t-test. The test results on this hypothesis are presented in Table 5.10.

Table 5. 10 Results of Independent t-test of Orthodox Health Seeking Behaviour among Patients with Low and High Socio-economic Status

Socioeconomic Status	N	Mean	SD	<i>t</i>	<i>df</i>	<i>p</i>
Low Socioeconomic Status	453	70.543	14.465	2.800	556	.005
High Socioeconomic Status	105	65.962	17.636			

Results presented in Table 4.4 revealed that the likelihood of seeking help from orthodox system by participants with low socio-economic status ($M=70.543$, $SD=14.465$) was significantly higher than their counterparts with high socio-economic status ($M=65.962$, $SD=17.636$), $t(556) = 2.800$, $p < .01$. The higher the mean, the more likely is the patient will seek health from the orthodox health system, implying that patients with low socio-economic status likewise sought treatment at the orthodox system as shown in Table 5.10. In essence, hypothesis four was not confirmed by this analysis.

5.14.5 Health Locus of Control Orientation and HSB

The fourth hypothesis stated that health locus of control will have a mediating effect on the relationship between cardiovascular disorders and health seeking behaviour. To test if health locus of control orientation will have a mediating effect on relationship between cardiovascular disorders and health seeking behaviour, the study used three regression equations to examine the statistical significance of the mediator effect in line with the

method specified by Baron and Kenny (1986) of health locus of control orientation. The categorical multiple regression analysis (optimal scaling method) was conducted (see Tables 5.11 and 5.12).

In the first set of regression equations, the mediator - health locus of control orientations – was regressed on the independent variable which is cardiovascular disorders. The results are shown in Table 5.12.

Table 5. 11 Categorical Multiple Regression of ‘Health Locus of Control Orientations’ variable scores on Cardiovascular Disorders z-scores

Mediating Categorical Variables	Cardiovascular Disorders z-scores			
	R-square	Standardised Beta (β)	$F_{(1,554)}$	Sig.
Internal Health locus of control orientation	.004	-.060 ^{ns}	1.975	.160
Chance Health locus of control orientation	.005	-.072 ^{ns}	2.924	.088
Powerful others Health locus of control orientation	.001	.028 ^{ns}	.428	.153

ns = not significant

From Table 4.5 cardiovascular disorder was not a significant predictor of Internal Health locus of control orientation ($\beta = -.060$, $p=ns$), Chance Health locus of control orientation ($\beta = -.072$, $p=ns$) and Powerful others Health locus of control orientation ($\beta = .028$, $p=ns$); that is, there is no significant relationship between cardiovascular disorder and any of the health locus of control orientations.

Health seeking behaviour – the study’s dependent variable – was regressed on cardiovascular disorders in the second regression equation. This was followed by a third regression equation where health seeking behaviour was regressed on both cardiovascular

disorders and health locus of control orientation simultaneously. The results are shown in Table 5.12.

Table 5.12 Categorical Multiple Regression of ‘Health Seeking Behaviour’ variable scores on Cardiovascular Disorders z-scores and Health Locus of Control Orientations variable scores

Variables	R-square	Changed R-square	Standardised Beta (β)	F
Independent Variables	.282**	.282**		216.583**
All Variables	.284**	.003 ^{ns}		54.530**
Internal Health locus of control orientation			-.051 ^{ns}	
Chance Health locus of control orientation			-.014 ^{ns}	
Powerful others Health locus of control orientation			.001 ^{ns}	

**p<.01; ns=not significant

When Health Seeking Behaviour was regressed on Cardiovascular Disorders a significant model emerged ($F_{(1,553)} = 216.583$, $p < .01$) where R^2 is .282, that is, Cardiovascular Disorders accounted for 28.2% variance in health seeking behaviour. Cardiovascular disorders and Health Locus of Control Orientations were simultaneously introduced into the model with a significant model emerging ($F_{(4,549)} = 54.530$, $p < .01$). The R^2 was .284 indicating that the model as a whole explained 28.4% of the variance in Health Seeking Behaviour, however the Health Locus of Control Orientations just explained additional 0.3% (Changed $R^2 = .003$) of the variance in Health Seeking Behaviour. The contribution of the Health Locus of Control Orientations (Changed $R^2 = .003$) was statistically insignificant, Changed $F_{(3,549)} = .650$, $p = .589$.

In line with two conditions proposed by Baron and Kenny (1986) that must be met for a mediator effect to be present: (a) the mediator is a significant predictor of the outcome variable and (b) the direct relationship of the independent variable to the outcome variable is less significant than it was in the second equation, the present study's analysis

showed that Internal Health locus of control orientation ($\beta = -.051$, $p=ns$), Chance Health locus of control orientation ($\beta = -.014$, $p=ns$) and Powerful others Health locus of control orientation ($\beta = .001$, $p=ns$) did not have significant mediating effects on relationship between cardiovascular disorders and health seeking behaviour. Thus H₄: Health locus of control orientation will have a mediating effect on relationship between cardiovascular disorders and health seeking behaviour was not supported by the results as shown in Table 5.11 and Table 5.12.

5.15 Discussion of Quantitative Findings

In the New Juaben Municipal Area, health seeking behaviour for people suffering from cardiovascular disorders is more varied, consisting the use of the orthodox system, traditional healers, spiritual churches and pharmacies and a combination of different sources of treatment among others. The quantitative study was used to “confirm, cross-validate, or corroborate findings within the study” (Creswell, Plano, Gutmann & Hanson, 2003). This study therefore sought to cross validate the qualitative findings and to provide explanation for the varied health seeking behaviours among people suffering from cardiovascular disorders. Based on the extensive literature reviewed and the aims of the study, four hypotheses were stated.

It was stated in the first hypothesis that cultural values and belief systems will have a moderating effect on the relationship between the cardiovascular disorders and health seeking behaviour. The second stated that there will be a positive relationship between the efficacy of treatment and health seeking behaviour for orthodox and traditional healthcare systems. The third hypothesis stated that people with high socioeconomic status are more likely to seek help from the orthodox health system for the treatment of

cardiovascular disorders as compared to those with low socioeconomic status. Finally, the fourth hypothesis stated that health locus of control will have a mediating effect on the relationship between perceived cardiovascular disorders and health seeking behaviour. Hierarchical and categorical multiple regression and t-test methods were used to analyse the data. Findings are discussed in detail in the following subsections, i) cultural values, belief systems and health seeking behaviour, ii) multidimensional health locus of control and health seeking behaviour. The researcher proposed two and iii) the decision making process of health seeking behaviour.

5.16 Cultural values, belief systems and Health Seeking Behaviour

The hypothesis that cultural values and belief systems will have a moderating effect on the relationship between the cardiovascular disorders and health seeking behaviour was supported. Health seeking behaviour of the people of New Juaben, hinges on the influences of culture comprising the social, cognitive, behavioural, material aspects of the individuals' lives as derived from the based on the proposed model of healthcare utilisation. This finding showed that when a person suffers from cardiovascular disorders, cultural values and belief systems determine the kind of healthcare system her/she would prefer to use. This gives credence to the assertion by Dutta-Bergman (2004) that culture shapes health seeking behaviours and serves as the lenses for perceiving and interpreting experiences. This finding is also consistent with a study by Pramukh and Palkumar (2006) that in the traditional system, cardiovascular disorders are attributed to certain deviant behaviours and for that matter they believe in the power of prayers and rituals that enable some herbs to heal their diseased conditions.

The current study has shown that cultural beliefs affect the health of a people in many ways where they use culturally specific explanatory models to think about, talk about, and direct care for health problems. In this study, the kind of health care to seek, whether self-care, home remedies, formal public health system and/or consultation with traditional healers and spiritualist are intricately linked with cultural beliefs (Nyamongo, 2002). This same belief system has led to different patterns of health-seeking and prevention, as well as mismatched provision of care (Hunt & Bhopal, 2004). This finding could be due to the influence of the traditional system where belief systems that have been passed from generation to generation have permeated every aspect of the individuals' lives. There is a belief in a diabolical interference existent in almost all illnesses in Ghana. (Atindanbila & Thompson, 2011; Onyina, 2002). This belief is deeply infused into belief systems and practices and thus, must have influenced respondents' attitude towards healthcare based on the cultural definition of the condition. Issues relating to culturally ingrained beliefs like disease causation and influences of evil spirits have not been discounted even in contemporary Ghanaian society. This lends some credence to a strong belief in a supernatural cosmology which influences people's health seeking behaviour for cardiovascular disorders.

Belief in the aetiology of cardiovascular disorders had a direct relationship with the health seeking behaviour of respondents. People who believed that their condition was caused by evil spirits and other supernatural powers sought treatment from traditional healers, prayer camps and other unorthodox sources for treatment consistent with the finding of other studies (Walker, 2006; Toliver-Weddington, 2000). For those who held

unto a biomedical cause of cardiovascular disorders, they sought healthcare from orthodox health care providers and pharmacies.

When explaining these health seeking behaviours, a cue can be taken from the assertion by Yawney (2005) that there must be a proper understanding of the culture of a people (as presented in the adapted conceptual framework of this work) in order to design treatment strategies. On the basis of that assertion, it is plausible that people believe that allopathic medicine can only explain cardiovascular disease conditions within the confines of the medical model at the expense of local cultural explanatory models. Thus though medical science can describe illness clinically without recourse to cultural factors, it cannot explain or treat all illnesses successfully. Against the backdrop of such belief systems, it could be explained that people rely on culturally relevant explanatory models of their CVDs than from the orthodox. The condition is therefore seen from a cultural point of view than medical.

These findings are in consonance with recommendations by Benson (2006), who concluded from a study that patients' perception of illness may be influenced by their subjective beliefs but that further studies were required to identify such contributory factors. This study has found that belief in the cause of cardiovascular disorders as one of such contributory factors. The study found, further that the multiple use of medications for the same condition created more complications for patients, and a sizeable number of them ended up at hospitals, for further management. In this study, there was a belief in spiritual causation of cardiovascular disorders that resulted in the use of traditional medicine by study participants. This provides direct evidence for previously described notions (Amira & Okubadejo, 2007; Chuma, Thiede & Molyneux, 2006; Shafiq, Gupta,

Kumari & Pandhi, 2003) that non-orthodox medicinal use are perceived to work in ways that orthodox medication may not.

This belief could be explained in terms of the view that non-orthodox medicine can work on supernatural causes (unlike orthodox medication) and may more likely lead to a complete cure. These traditional beliefs have continually increased the popularity of traditional medicine among the people who attributed the cause of hypertension and diabetes to a curse or witchcraft. Also, majority of the hypertensives were unaware of the symptomless nature of the disease (hypertension), which is also called the silent killer Olivera et al. (2005) and Babaei et al. (2008). These attributes of the disease and lack of in-depth understanding of cardiovascular disorders may be responsible for individual's negative attitude to treatment, high non-adherence and inadequate lifestyle adjustments, including over reliance on concoctions prescribed and given by traditional healers which have long term negative implications on their health. Consistent with Pearce (2007) and Obeng (2002) finding, these African belief systems are based on cultural and social values, philosophies and expressions.

It is important to explore the reasons for which participants sought help from such quarters. Some of the reasons gleaned from the results included: definition, belief of aetiology, enemysm and sale of diseases, relational issues between healthcare providers and patients, communality, spirituality, relational tensions and multiple health seeking theta influenced help seeking behaviour.

Another reason for the patronage of the various health systems was the proximity and acceptability of the various facilities. In terms of proximity, traditional healers were more evenly distributed than 'formal' health institutions within the Municipality. The average

distance to reach a traditional healer was no different from the distance to a hospital or a clinic for which reason patients preferred either health systems. Proximity and testimonies were partly some of the reasons why people patronise faith healers. Respondents stated that they patronized the services because they were close to them but more importantly this patronage was based on testimonies of how spiritually potent the prophet was. A greater number of FGD participants (n=29 out of 36) reported that their patronage of churches and other spiritual healing centres was based on testimonies by previous users (Lee, 2002). This evidence points to the fact that the passage of oral information features prominently in the health seeking behaviour of the people under study. Apart from the fact that most Spiritual Churches and herbalists are in close proximity to the patients, especially in the rural areas, more importantly, they engage in constant re-branding of their programmes that appear enticing to patients (Lincoln & Mamiya, 2006; Matlock-Hetzel, 2005).

On the other hand, one cannot clearly conclude that proximity and accessibility alone were factors that egregiously influenced people's choice of health care options. Other factors that influenced acceptability of health systems apart from availability the issue of conservation of time, that is, time spent at private clinics and traditional healers were comparatively shorter and hustle-free. There was a general belief among patients that time is of a great essence and would rather patronize the services of private practitioners and other healthcare providers in order to save time (Russell, 2008). Another reason for acceptability was the quality of care offered. The quality of care, in terms of attention, emotional and psychological support given by healthcare providers to patients among others, as opined by respondents were the major reasons for attending a particular health

system, and that the traditional health system and private orthodox health systems had the best practices in this direction. By this treatment, it could be reasoned that patients felt better when they healthcare practitioners (Rosenthal & Wilson, 2008; Stewart et al., 1999).

Affordability of the treatment is another component of accessibility: financial accessibility that influenced patients' health seeking behaviours. There were respondents who found hospital services to be cheaper than treatment from a traditional healer. Their reasons were that at the hospital, payment for services was one stop, but at the traditional centres, one had to pay in bits both in cash and kind. The cumulative effect of this is that one ends up paying more at the traditional centres than at the orthodox hospitals. Habtom and Ruys (2007) and Heinzerling, (2005) found similar explanations. The cumulative cost of health care was that traditional treatments were much more expensive, took longer, and more often included inpatient treatment. These findings are different from previous reports of other authors, who had argued that in Africa mainly poor and less educated people seek care from traditional healers because they offer treatment at lower cost and are easier to reach (Cook & Zumla 2008). However, it seems that people in the New Juaben know exactly where to seek help, their choice is not a chance decision (Leonard, 2000).

Related to the above are relational issues between health care providers and patients that influence the preference of healthcare systems among patients. For therapeutic success and eventual confidence in the health system, a good health care giver-patient relationship is of essence. These relational issues are in the form of patient abuses and communication systems (Kreuter et al., 2003; Iyalomhe, 2009b). Some of the abuses, as

gathered from the FGDs were in the form of insults, scornful looks, refusal to respond to patients' enquiries and humiliating patients in public through shouting at them. These attitudes of health staff and other instances of perceived neglect of patients and lack of proper care and concern for their welfare were perceived as factors that moved patients from these facilities, a situation that was mainly found in the orthodox health facilities as opposed to the traditional systems. The traditional systems were very receptive and welcome patients with warm attitudes.

These negative behaviours could stem from a variety of factors. The orthodox health facilities are more often than not inundated with hundreds of patients thus putting the health staff under a lot of pressure making them easily irritated. This is in sharp contrast to the non-orthodox health system where their source of income is hugely dependent on the patronage of their services. For this reason they are more likely to put up attitudes that would attract a lot of customers (Astrow et al., 2007). A converse factor was the perception of health staff that patients are ungrateful and that no amount of sacrifices made by hospital staff for them, will please them. Attitude towards healthcare providers is also an important factor that determines the level of patronage (Ashford, 2004). The perceived ungrateful attitude of patients has paradoxically turned hospital staff against the very patients they are supposed to care for (Omotosho, 2010). Adequate explanation of the situation may resolve these dilemmas of cyclical misunderstandings between healthcare providers and patients (Ademuwagun, 1998; Iyalomhe, 2009b).

Health seeking behaviour is therefore not dependent only on affordability, accessibility or availability but on other factors not captured by earlier researchers (Good, 1987; Omotosho, 2010). On the contrary, traditional healers interacted differently with their

patients than providers who have been trained in Western medicine. They were significantly more patient-centred in several aspects: They focused more on psychosocial topics and on issues of daily life than on purely medical questions and in particular, they more often asked for the patient's opinion and frequently discussed their concept of illness (Niklaus, Sabine, Engelbert, Jozien & Wolf, 2010).

One might summarise these findings as stating that traditional healers followed a more 'biopsychosocial approach' in the sense that they actively sought common ground with patients. Patients do not appear intimidated but feel invited to ask more questions themselves. In short, one might say traditional healers try to approach their patients by talking about issues that matter in real life and by thoroughly exploring their beliefs. This attitude is reflected by patients' responses, who ask more questions themselves and provide less information in response to routine medical questions. Instead of a provider interrogating the patient about his/her symptoms, it is the patient, who uses his or her share in the consultation to interview the healer about the meaning of his/her symptoms, where they come from, and what can be done. These contrasting health care giver – patient relationships could stem from different working cultures where the orthodox system appears depersonalized and far removed from patients while the traditional system has more accepting attitude and encourages to air their problems, situation that is regarded as part of the therapeutic process.

There is also the issue of availability of services as respondents put it. According to them orthodox or allopathic practitioners are located primarily in cities or other urban areas. This confirms the situation where the Ministry of Health in Ghana (MOH Report, 2010) has bemoaned the growing number of doctors in the two major cities of Ghana (Accra

and Kumasi) to the detriment of rural areas where doctors have refused postings. So for many rural populations TM is the only available source of health care to treat their cardiovascular disorders. In effect, one of the key reasons cited for the popularity and continual use of traditional medicine was the ready accessibility of herbal medicines in rural areas.

Traditional healers, indeed seem to have a compelling presence in the lives of people. Current changes in lifestyle and the increase in the development of the twin problems of cardiovascular and cerebrovascular disorders have pulled traditional healers further into the limelight (Twumasi, 1988; Hillenbrand, 2006). Traditional healers are actively involved in the management of these conditions; patients are increasingly turning to indigenous medication in their attempt to come to terms with the disease. Thus traditional healers have a potentially important role to play in the delivery of health care, particularly in resource poor areas (Labhardt, Schiess, Manga & Langewitz, 2009; Nuwaha, 2006).

These findings contrast with the assertion that visits to traditional healers and unofficial medical channels should be prevented, thus encouraging people to opt first for the official channels (Ahmed, et al, 2001; Wootton, 2006). Although the desired health care seeking behaviour is for an individual to respond to an illness episode by seeking first and foremost help from a trained allopathic doctor, in a formally recognised health care setting, a consistent finding in many studies is that, for some illnesses, people will choose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or government health. The ideal situation is that efforts should be made to raise community awareness regarding the importance of seeking care from trained personnel and the availability of services”.

Finally, the role of extended family members significantly influenced the health seeking behaviours of patients. Notably, this study found that typically family members lend support in areas of emotional and psychological care and “informational support” in terms of directions to the “best” places to seek treatment but support in terms of financial backing is not encouraged. At best family members discuss health maintenance and health enhancing behaviours and in a subtle manner avoid discussing issues that involve financial commitments with sick relatives. The involvement of extended family on where to seek help was more positively skewed towards the search for traditional medicine than orthodox medicine. For example, there was a general belief among some participants that hospitals do not have cure for such terminal conditions like CVDs and that if sufferers needed a complete cure, they could seek help from the traditional health system.

5.17 Multidimensional Health Locus of Control (MHLC) Orientation and Health

Seeking Behaviour

Although there were no significant results showing whether participants’ health seeking behaviours were influenced by their LC, qualitative analysis revealed that people social network did influence them. Focus group discussions and interviews showed that among participants of the study, illness and consequent treatment is not always an individual or familial affair. At times the whole village or the community may be perceived as affected by such diseases and healing must be done at community level. In this case various suggestions are put up by family and community members as to when to start treatment outside the usual home remedies, where to get the best form of treatment and how to go about the treatment regime.

The study showed that it is the cultural values that dictate how a patient's cardiovascular disorders must be treated (Saudia, Kinney, Brown & Young-Ward, 2001). This involvement of family and the community is likened to powerful others orientation but has more to do with ingrained cultural orientation and belief systems that influence the health seeking behaviours of respondents. In this case the power of the sick person is devolved to other people, which make them dependent on others for health enhancing behaviours. This finding suggests that in order to increase risk awareness and proper education for cardiovascular disorders in individuals who are generally influenced by cultural practices there is the need to explore interventions that involve the family and other community members (Helman, 1990; Nagda, 2004).

A major reason why the health locus of control did not significantly influence health seeking behaviour for cardiovascular disorders could be due to the reciprocal attitudes of health professionals toward their patients and the perception of patients of health professionals. This study found that, there is a subculture in the health system in Ghana, whether orthodox or traditional, where healthcare professionals have generally built a kind of "informational flow wall" and a "barrier of disclosure" between themselves and patients and their caregivers and that makes it difficult for patients and clients to ask questions about their own state of health, despite their awareness of the patient charter that requires that a patient has the right to know their true state of health.

These health professionals, as found in this study have over the years tried to keep the true state of health conditions of their patients as professional secrets and diagnoses of patients as sacred which must be concealed from everybody, including the patients and their caregivers. For instance, some health professionals in the study maintain that it is in

the best interest of a patient not to know what they suffer from. They further maintain that even if patients are aware of their diagnoses, they would not understand, and for that reason there is no need to tell them anything. This attitude of healthcare givers have gradually turned patients into passive receivers of healthcare who may be erroneously construed as having powerful others locus of control but are rather constrained by societal, cultural and systemic barriers which prevent them from acting out their true behaviours (Graham, 2006; AbuSabha & Achterberg, 2007).

Another reason why the health locus of control did not significantly influence health seeking behaviour for cardiovascular disorders could be due to perceptual differences between healthcare givers on one hand and patients on the other hand (Howat, Veitch & Cairns, 2006). This study found that, there is a subculture in the Ghanaian health system, whether orthodox or traditional, where healthcare professionals have generally built a kind of “informational flow wall” and a “barrier of disclosure” between themselves and patients and their caregivers and that makes it difficult for patients and clients to ask questions about their own state of health, despite their awareness of the patient charter that requires that a patient has the right to know their true state of health. Health professionals, as found in this study have over the years kept diagnoses and the true state of health conditions of their patients as professional secrets.

This attitude of healthcare givers have gradually turned patients into passive receivers of healthcare who may be erroneously construed as having powerful others locus of control but are rather constrained by societal, cultural and systemic barriers which prevent them from being their true selves. Patients, on the other hand have regarded health professionals as people to be feared and therefore found it difficult to ask questions even

if they did not understand instructions given to them. This could explain why patients who insist on their rights in order to get a better understanding of their state of health at the health facilities are regarded as rebellious and are therefore treated with contempt and in some situations not given the necessary care they deserve. In this instance, even those who hold internal orientation could not have exhibited these characteristics for fear of being verbally abused or neglected by health professionals.

This is in direct contrast to the situation in the Western world where respondents with internal locus of control orientation would know more about their own condition, would question healthcare providers more and would express more or less satisfaction with the amount of feedback or information they were given about their state of health (Norman, *et al.*, 1998.). These attitudes of health professionals found in this study may have turned patients who would otherwise have fit into any of the locus of control orientations, into docile receivers of healthcare. This reception by healthcare providers towards people for being assertive could be a direct result of sociocultural practices where assertiveness is frowned upon as a sign of arrogance. Some researchers, e.g. AbuSabha and Acterberg, (2007); Carlson and Petti, (2004); Wurtele, Britcher and Saslawsky, (2007) have reported that there are inconsistencies in the impact of health locus of control and its ability to distinguish participation in health behaviors due to the factors explained above.

CHAPTER SIX

GENERAL DISCUSSION

Introduction

The purpose of this study was to explore the health seeking behaviour of people suffering from cardiovascular disorders. Cardiovascular disorders have risen to alarming levels in terms of prevalence in Ghana, which always ranked among the first ten diseases in Ghana (GHS Annual Report, 2011). Health seeking behaviours have generally been varied based on many factors and is especially worse for asymptomatic illnesses like hypertension. A feature of contemporary health care is the diverse sources of help available which appears in tandem with the pluralistic medical systems of Ghana (Atindanbila & Thompson, 2011, Twumasi, 1979). For example, an individual who feels unwell may consider contacting the hospital (formal or private), over-the-counter consultation (pharmacies and chemical/drug stores), prayer camps and traditional healers. Many symptoms of CVDs are ignored, tolerated, self-treated or sent for treatment from either the orthodox or traditional healers.

In the New Juaben Municipal Area, health seeking behaviour for people suffering from cardiovascular disorders varied, consisting the use of the orthodox system, traditional spiritualists, spiritual churches (mainly prayer camps) and pharmacies and a combination of different sources of treatment among others. This study therefore sought to provide explanation for the varied health seeking behaviours among people suffering from cardiovascular disorders. Based on the extensive literature reviewed and the aims of the study, four hypotheses were stated. The first hypothesis stated that cultural values and belief systems will have a moderating effect on the relationship between the

cardiovascular disorders and health seeking behaviour. The second stated that there will be a positive relationship between the efficacy of treatment and health seeking behaviour for orthodox and traditional healthcare systems. The third hypothesis stated that people with high socioeconomic status are more likely to seek help from the orthodox health system for the treatment of cardiovascular disorders as compared to those with low socioeconomic status. Finally, the fourth hypothesis stated that health locus of control will have a mediating effect on the relationship between perceived cardiovascular disorders and health seeking behaviour.

Two concurrent studies were conducted. Study 1 involved a qualitative method which used focus group discussions using a sample participants suffering from cardiovascular disorders and key informant interview of health care providers as methods of data collection. Study 2 used a quantitative survey where questionnaires were used to collect data from the general population in the New Juaben Municipality. Data for the qualitative study was analysed using thematic analysis proposed by Braun and Clark (2006). For the quantitative data, hierarchical and categorical multiple regression and t-test methods of analyses were used. A concurrent mixed method technique was then used to triangulate both data sets. Findings were discussed in detail in the following thematic areas i) cultural values, belief systems and health seeking behaviour, ii) multidimensional health locus of control and health seeking behaviour. This session presents the general discussion and models of health seeking and decision making process proposed by the researcher.

6.1 Integrating Traditional Medicine into Orthodox Medicine

There are so many people who live in areas where there are no health facilities and so the first point of call for these people is to see the herbal practitioner (VOA News, 2006). In many rural-based populations, traditional healers are the only source of health services for majority of the people and in most cases they are the preferred source of health care. 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 (Rukangira, 2001).

This is not peculiar to Ghana. The records suggest that countries like India, China and a number of other Southeast Asian states have developed their traditional medical practice better and have used this in supplementing and complementing the modern health care system. Thus it is logical that the burden on public healthcare delivery system in Ghana will be made lighter if traditional medicine is further integrated into the healthcare system.

At the centre of Ghana's modern healthcare system is a serious shortage of health workers. Ghana's case feeds into the fact that despite the unprecedented advances in health care, the world is immensely confronted with severe shortages of health workers especially in the poor countries.

WHO (2008) explain that in African region, traditional medicine is better integrated in Ghana's healthcare system compared with other African countries, where there is mutual distrust between traditional healers and conventional medicine. In Ghana, one of the seven directorates of the Ministry of Health is Traditional Medicine. One of the key vehicles to integrating traditional medicine into Ghana's healthcare system is the mechanism of decentralization. The records however suggest that in Ghana as in other

African States, the decentralization of the healthcare system is a response to poor economic conditions, poor logistics, and reduced public finance for health services (ACF, 2007). It is important to note that although PNDC Law 207 (1988) provided the framework for decentralization of Ghana's healthcare system, it failed to formally integrate traditional medicine into the system, especially at the local level.

6.2 The Decision Making Process of health seeking Behaviour

One major finding that the researcher identified after analysis of the triangulated data was a decision making process engaged in by participants before seeking help for cardiovascular disorders (Woods & Graves, 2002; Young, 2001). Based on analysis of results a four broad dimensional linear decision making process derived from the study was proposed by the researcher. These stages include:

- 1) **Causal attributions dimension:** this type of remedial action is based on a consequence of the perceived cause of the disorder. It has three components, which are: Perception of cause, what type of remedy and perceived efficacy.
 - i) Perception of cause: Based on the cultural background of the individual, a conjecture is made as to who or what was responsible for the cause of the disorder. The question as to *who* was responsible deals with a perceived diabolical intervention; whilst the question of *what* caused CVD addresses potential physical aetiology.
 - ii) what type of remedy. Here a decision is made whether the nature of the condition requires home remedies. This is based on the previous knowledge of the symptoms of the condition and what they have successfully treated before. Another option is considered whether to seek treatment from an outside source.

- 2) **Social persuasion dimension:** This relates to the various testimonies and recommendations of what can be done to address the illness that come from close family members and friends to sick person for considerations. Here, health seeking decision is not an individual affair. Contributions on where to seek help are volunteered by family and friends who provide various options as to which treatment is efficacious.
- 3) **Spatial dimension:** This relates to the time and space aspects of the decision making process. This dimension has two components. i)) when to start treatment. Here, the decision taken is when a patient decides to start treatment, whether immediately or at a later date, based on previous experiences. This is based on the practice that treatment for different diseases have peculiar characteristics, which need to be examined carefully before initiating treatment. Secondly, ii) where to seek treatment first. Here, the decision taken concerns whether to utilise orthodox or traditional health system first. This decision is mainly based on the perception of aetiology of the disorder which influence the perceived efficacy of treatment.
- 4) **Final health seeking:** An individual finally decides to seek help after going through this linear dimension. It must be emphasised though, that some intricacies and dynamics like past experiences of similar conditions, which would influence the individual's decision making process which may not necessarily follow this linear pattern, generally, people do not just end up opting for a traditional healer over the allopathic medicine without serious consideration to the perceived cause of the illness for instance and thus the consequent follow-up.

This process outlined above is consistent with the adapted conceptual used for the study which took in to consideration the various components of culture as well as the predisposing, enabling and need factors, which are influenced by culture. At each stage, the process involved a combination of all the three health loci of control orientations, and that made it very difficult to identify whether an individual is high or low on a particular scale. Health seeking behaviour appears more communal or familial at the least than individual. This significant finding therefore brings to the fore the fact that decision on healthcare seeking is not necessarily a simple one that is taken by only an individual but cultural context in terms of the communal way of life and other relevant factors are critical determinants. This process is diagrammatically presented in Figure 6.1.

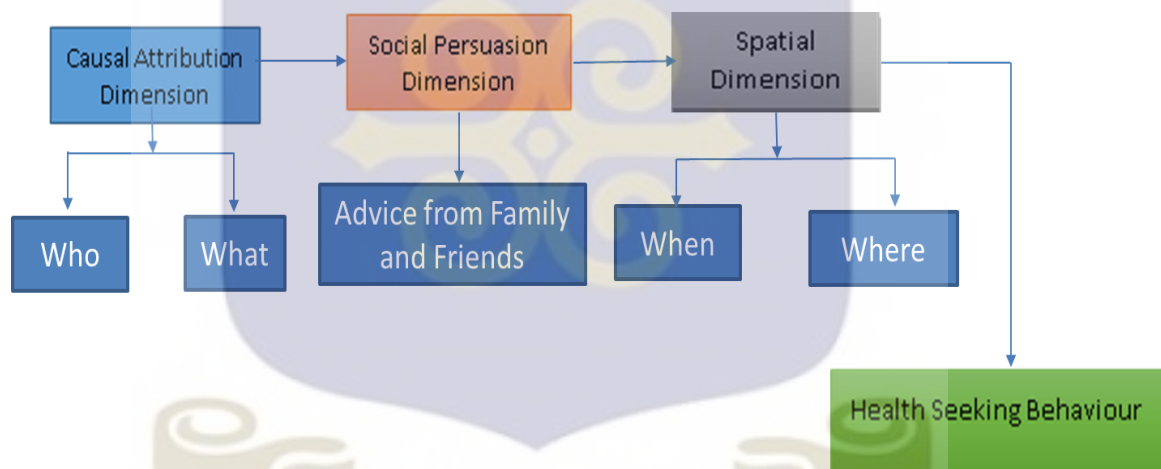


Figure 6.1 Three Dimensional Decision Making Model

6.3 Proposed Model of Health Seeking

The inability of western medicine to adequately explain disease conditions due to the fact that there is very little or no mention of cultural considerations have led to the search for alternative explanations and this has led to diverse culture based belief systems about the causes of illnesses, which in turn determine the health-seeking behaviour among the

people. If people believe that spirit possession is the problem, they would consult an exorcist. Thus, to enhance a more realist understanding of health seeking behaviour of Ghanaians the following concept has been proposed. If one is able to redefine what constitutes illness and the cultural context of health-seeking, one would understand better the decision-making processes individuals engage in when choosing healthcare system, giving little or no consideration to proximity or cost. The adapted healthcare utilisation model which took into consideration the influences of culture (Fig.6.2) was therefore proposed as a better fit for this study.

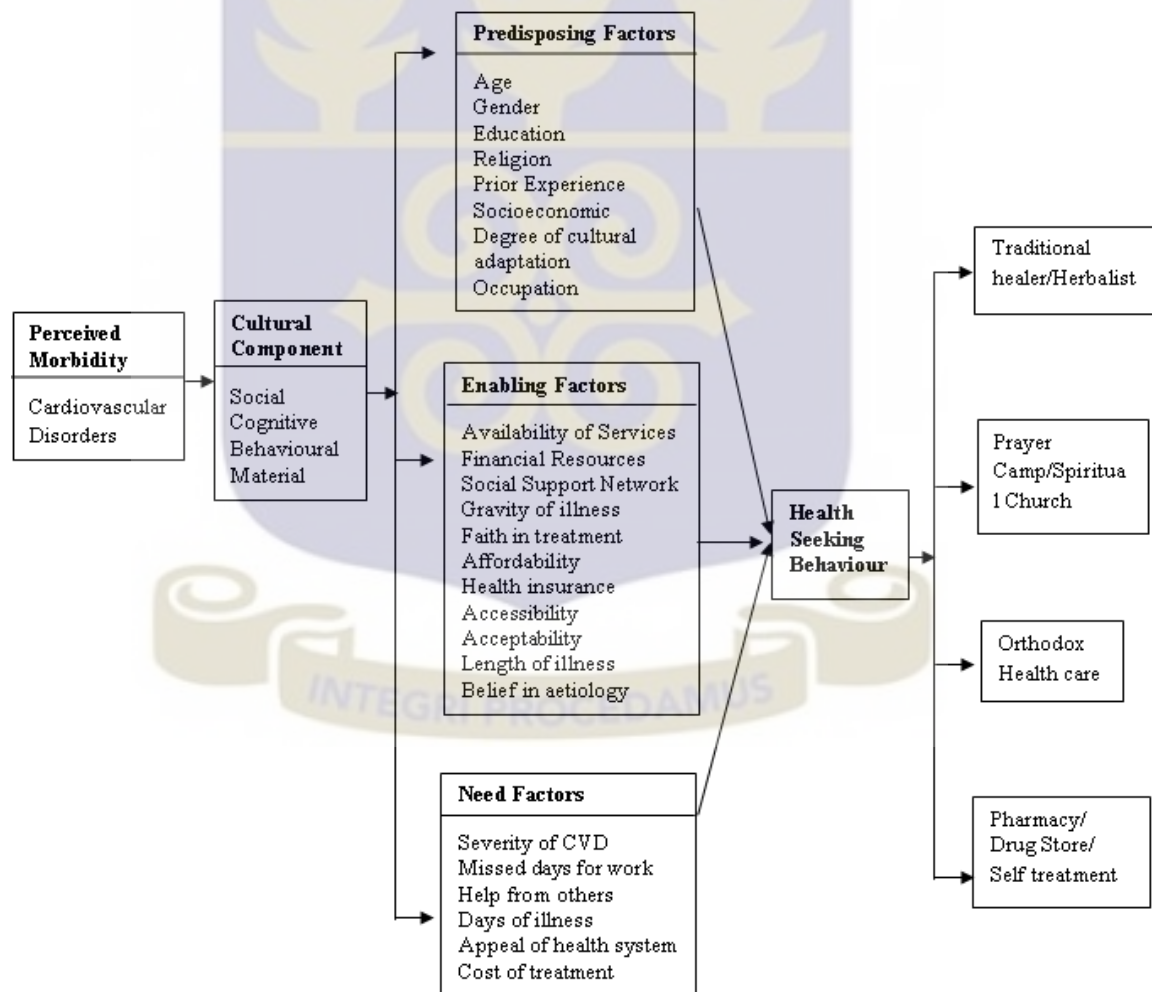


Figure 6.2 Proposed Model for Health Seeking for Cardiovascular disorders

The researcher, based on the consideration of the relevance of the influence of culture and other factors on health seeking behaviour, proposed a model for help seeking (adapted from Anderson & Neuman's 1973 Model), which is more applicable within the Ghanaian socio-cultural context. In this conceptual model, health seeking behaviour is postulated to be determined by a set of cultural components (social, cognitive, behavioural and material) that influence the following factors: 1) predisposing factors (such as age, gender, ethnicity, religion, socioeconomic background and education); 2) enabling factors (availability of services, financial resources, social support network, affordability, health insurance accessibility and acceptability); 3) need factors (severity of illness, total number of sick days, help from others) and 4) health system response (services of traditional healers/herbalists, prayer camps/spiritualists, orthodox healthcare system and self-treatment/pharmacy/drug store. These factors influence how the people perceive illness which leads to specific health seeking behaviours.

The proposed model centres specifically on the influence of culture system and beliefs of people to explain health seeking behaviours. This is based on the assumption that without taking cognizance of the cultural practices of a group of people, it would be difficult to fully understand their health seeking behaviour. It has also laid emphasis on the belief system that plays a major role in the health seeking behaviour of Ghanaians. It has also sought to recognise the roles played by both the church and traditional healers including the shrines beside the well-known orthodox health facilities. The model recognises the complex interrelatedness of the factors which influence health seeking behaviour of the people of the New Juaben Municipality, and explains why or how individuals seek help

from more than one source of care (traditional, faith healing or orthodox medicine). And or simultaneously use all the available sources of healthcare.

In conclusion, the adapted healthcare utilisation model tries to explain health seeking behaviour from the cultural point of view. The role of culture in the Ghanaian setting is believed to influence all other factors, when an individual decides to seek help for cardiovascular conditions, be it predisposing factors, enabling factors or locus of control. This framework was therefore used as the theoretical framework underlying health seeking behaviour to explain the factors that people take into consideration and their expectations before they seek help from a healthcare provider/facility with special relevance to the Ghanaian culture.

6.4 Summary of Discussions

This study set out to investigate the cultural influence on health seeking behaviour for cardiovascular disorders. In this study, culture, which is defined as "that complex whole which includes knowledge, belief, art, morals, law, customs, and many other capabilities and habits acquired by members of society" Taylor (1871), cited in Sardar and van Loon, (1997) was found to significantly influence health seeking behaviour for cardiovascular disorders. In this study, the use of traditional medicine was significantly associated with belief in supernatural aetiology of CVDs.

Religiosity and spirituality, as part of culture were found to influence health seeking behaviour. Religious practices like the use of prayer, church attendance and the use of such paraphernalia like 'florida water', incense, holy water were major treatment regimen for coping with CVDs. This in a way provided a feeling of spiritual healing and coping

even in the presence of physical disability (Utsey et al., 2007). Furthermore, being a member of a group that showed love and care under the tutelage of a prophet or prophetess gave a psychological sense of belongingness and protection. However, the unbridled reliance on religion as a coping strategy, as found in the current study was found to be associated with a high level of suspicion among adherents of the faith. This concept could be due to the syncretic nature of some Ghanaian religious practices where certain belief systems which border on suspicion of diabolical intervention from some neighbours and family members as the cause of their woes are fused with the Christian religion.

Closely linked to religious and spiritual factors influencing health seeking behaviour for CVDs was the cultural conceptualization of enemyship and ‘selling of diseases’, (where enemies were perceived as selling diseases to their victims through malevolent spirits such as witchcraft) the use of the traditional health care providers such as the traditional spiritualists, diviners, herbalists becomes imperative because it is the belief that their treatment work in ways that the orthodox medicine may not. The issue of the influence of personal enemies was reflective of the ontology of study participants who were mainly Akans (Adams, 2005). The Akans believe that man’s current relationship with his environment and this relationship could be disrupted by the activities of such enemies who could inflict diseased conditions on them. Such enemies could be family members, neighbours, friends, colleagues at the workplace or anyone who is jealous of the victim’s accomplishments.

Another determinant of health seeking behaviour for CVDs in this study was major relational issues relating to caregiver – patient interaction. Patient abuse and

communication systems were found to be the major factors that influenced health seeking behaviours. There was found a cyclical communication barrier where health care giver do not open up to patients and thus do not give them the needed information on their health; and another situation where patients, for fear of rebuke do not gather enough courage to interact with healthcare givers, a situation that is likely to be the source of disaffection for healthcare giver, especially the orthodox health system. Preference for the traditional health care system was found to be due to the care and support the healers gave to their clients, (WHO, 2008)

Multidimensional locus of control did not have any significant effect on health seeking behaviour. This lack of effect could be explained in the peculiar sociocultural environment in the Ghanaian system where interpersonal interactions do not lend individuals to be categorised as being internal, external or powerful others orientation. The paternalistic style of healthcare provision in the orthodox health settings makes patients passive recipients of healthcare and this makes it to find a locus to categorise participants into the western dominated orientations as being internal, external or powerful others.

In conclusion, the study found that participants' health seeking decisions were in three dimensions with five sub components. These dimensions include the causal attributions, social persuasion and spatial dimensions. After considering these factors the individual then decides to seek help for CVD. On the whole, decision making for health seeking was seen to be more communal than an individual affair. This is based on the notion that the individual is part of the family system and thus belong to the family. Health seeking

behaviour for CVDs in Ghana can plausibly be a product of culture and the dynamics of caregiver-patient relationship.

6.5. Implications, Recommendations and Conclusions

6.5.1 Implications of the Study

The findings of this study have certain implications which are geared toward effective healthcare delivery in Ghana. The implications are organised under the following subheadings: sociocultural, clinical, policy and religio-spiritual implications.

6.5.1.1 Socio-cultural implications

This study highlights a number of elements that are useful for healthcare professionals as well as social service providers. First, findings from this research illustrate a unique cultural definition and perception about the cause of CVDs, which are variously in the form of casting spells on the victim by a relative or the disease being ‘sold’ to the victim by envious co-tenants and enemies. This study therefore provides an insight into knowledge for healthcare providers with regards to the strong influence of cultural values and belief systems on health seeking behaviour and realisation that, the lack of appreciation for these cultural values and belief systems would not auger well for the effective delivery of health care to the people.

This has implications for healthcare providers to learn, understand and appreciate the cultural environment within which they operate in order to provide relevant care to the people. Hitherto this area had been left unattended to by other researchers and most of those studies were done in clinical settings that left out a lot of information about the people’s attitudes, beliefs and perceptions that were required to thoroughly understand them in order to make informed decisions in relation to providing culturally relevant

health care services to them. Based on the study findings, the researcher has formulated a three-dimensional decision making process based on the cultural interpretation of the disease that has so far not been found in the literature reviewed. These stages include i) causal attribution dimension, ii) social persuasion dimension, and iii) spatial dimension

This finding is critical for physicians, nurses, and other healthcare workers like the traditional medical practitioners and other social services providers like non-governmental organisations (NGOs) and the National Council for Civic Education (NCCE) to pay particular attention to people's sociocultural backgrounds, beliefs, perceptions and preferences during their interactions in order to provide culturally congruent services that address the peculiar needs of such people. This will help provide care and services that are within the ambit of acceptable social norms and expectations.

6.5.1.2 Health Practice Implications

Findings of this study have clinical implications for the field of clinical psychology, medicine, social work and general healthcare. It is the cultural interpretation of the disease that informs the decision of patients to seek help from a particular health system. The belief in aetiology of cardiovascular disorders significantly influenced people's decision to seek help and that when they believed the condition was spiritually caused, they would seek help from a spiritualist. This is therefore expected to guide clinicians and other healthcare providers to understand the cultural influences on definition of diseases and subsequent health seeking behaviours. It is imperative therefore for clinicians to develop the concept of cultural competence where healthcare providers would have a clear understanding of cultural values, beliefs and practices of the people and incorporate

the people's own understanding of CVDs into their professional practice (Omizo, Kim & Abel, 2008).

Healthcare providers have the responsibility to understand patients from the patients' point of view and be mindful of these cultural values in a non-judgemental manner. In doing this, patients will build and sustain confidence in the healthcare delivery system. This finding emphasizes the need for clinicians to take cognizance of cultural belief systems and synchronize them with the western understanding of illness in order to provide culturally relevant explanation of disease causation and treatment strategies that would be appreciated by patients within the cultural context. The fact that patients consistently have belief in and patronise the services of traditional medical system gives the impression that there is something attractive there that literally pull patients to them and that western-trained clinicians can learn from the traditional system and not always the other way round.

This study helps to expand on the notion of cultural competency by illustrating a number of core Ghanaian cultural values, an element that is currently missing from the healthcare delivery system. These characteristics are not only beneficial for physicians in a clinical setting, but also for instructors and planners like the Ghana Health Service, Ministry of Health, Medical and Dental Council, Nurses and Midwives Council, Traditional Medical Practitioners Council and other stakeholders as they develop outreach health programmes for Ghanaians.

Furthermore, the clinical implications extend to preventive healthcare in that finding ways to connect cardiovascular disorders with health promotion interventions may yield further health benefits. Working within the structures of established networks of health

delivery, the concept of cardiovascular living can be supported and reinforced within the patient's socio-cultural network. Such programmes, if strategically implemented will bring home a more sustainable understanding of cardiovascular disorders, their causes and treatment actions.

6.5.1.3 Religio-Spiritual Implications

Implications of the findings of this study which support the idea that religion and spirituality are important factors that influence people's health seeking behaviour, adds to the knowledge of how individuals with cardiovascular disease can benefit from spiritual and religious attributes in their lives, which, hitherto were not found in literature related to health seeking behaviour in Ghana. The search for healing using religion was identified to have been with the people since time immemorial though not much seems to have been documented regarding the relevance of religion and spirituality in the treatment process among the people. This study has therefore created the awareness regarding the relevance of religion in the healing process among people suffering from cardiovascular disorders. The results echo the fact that religion and spirituality do relate positively to health and well-being, and suggest that these factors are worthy of increased attention by the healthcare system at-large. This is not to advocate that religion and spirituality become forced or compulsory ingredients in healthcare. Undoubtedly, there is the real concern that the implications of spirituality and religion in health may lead to their blanket introduction into healthcare services and potentially lead to abuses by healthcare professionals (e.g., persuasion and discrimination based on religious/spiritual beliefs).

Increased consideration by the healthcare system hopefully would incorporate optional rather than forced elements of religion and spirituality, if these elements are found to be mentally and physically helpful for patients. For example, some hospitals have already begun to view prayer and meditation practices as emergent forms of complementary and alternative therapy which are recognized as being helpful to cardiovascular-related patients and other patients and for this reason there are resident chaplains to take care of these factors (Hodge, 2005a; Koenig, 2004, Hodge, 2003; Sackey, 1999). Likewise, consideration by healthcare professionals of patients' religious/spiritual beliefs and practices could lead to better orchestration of continuity of spiritual care (i.e., referral to clergypersons and chaplains) for medical patients (Koenig, 2002).

Given the positive association found between cardiovascular disorders and religious support and organized religiousness, continuity of spiritual care appears highly relevant. For example, health professionals' awareness of patients' access to chapels and meditation rooms in hospitals, as well as to religious services and events, can be emphasized.

In another vein, findings from previous studies showed that a high level of religiosity was associated with a sense of relaxation and equanimity. However, in this current study, religiosity is predominantly associated with high levels of suspicion, especially among people who patronise prayer camps and other spiritual churches. This attitude suggests the systemic suspicious beliefs associated with the aetiology of diseases among respondents.

This study has brought to fore the negative effects of religious indoctrination on families; where relatives are accused as being the cause of patients' diseases, a situation that could potentially wreak havoc among patients and their relatives. The association between religiosity and suspicion is therefore supported by the findings of this research that religious beliefs, as part of culture influence health seeking behaviour, both positively and negatively. This finding therefore has implications for religious leaders to be mindful of the type of religious indoctrination of their clients during the healing process and to make sure that harmonious family relationships are kept intact. This, therefore has wider implications for researchers to delve into the phenomenon in order to come out with scientific explanations that are also culturally relevant to the people.

This current information has implications for designing health promotion interventions and programming. Determining spirituality's level of impact on positive health behaviors when designing and implementing health promotion endeavors is of importance. There has been a revival of interest and empirical research on the impact of spirituality and health and wellness (Benson, 2006; Levin, 2001).

6.5.1.4 Policy Implications

This study has broader implications for policy planners and implementers who take decisions that have direct bearing on the health and wellbeing of the people. The importance of why people seek medical care is undoubtedly critical in health policy planning. This study has brought to the fore that health seeking behaviour is not a simple realisation of symptoms and people taking remedial actions of just going to any nearby health centre, hospital or herbalist. It rather involves going through a decision making processes as proposed by the researcher (refer to page 212). The implication for policy

makers is that there is the need for them to understand that provision of healthcare does not necessarily mean the availability of physical structures and equipment. Healthcare provision should be tailor-made where it would suit the needs of the potential consumers, based on their expectations.

The mechanistic ways through which healthcare services and amenities are provided to communities without proper needs assessment should be reconsidered. Failure on the part of policy makers and implementers like the Ministry of Health and Ghana Health Service respectively to understand the culture and culturally-related health needs of the populations has contributed to the failure of health care interventions like the case of buruli ulcer in some parts of the northern regions of Ghana (Stephens, Timaeus, & Ackerman, et al., 2007). This study should therefore encourage policy makers and implementers to understand the health needs of the people based on their culturally-mediated understanding of the condition before providing for those needs.

Another implication of this study to policy makers is the need to better integrate traditional and orthodox medicines in order to provide healthcare that would be acceptable to recipients. As postulated by the WHO (2008) over 80% of Africans, Ghana not being an exception, rely on traditional medicine for healing and cure. This study has confirmed the heavy reliance of the people on traditional medicine. Policy makers are therefore encouraged by findings of this study which supports the notion that there is a heavy reliance on traditional medicine to better integrate both orthodox and traditional medicines as enshrined in the 5-year Plan of the Ghana National Health Policy (2007). By doing this, traditional medical practitioners may be trained to have a better appreciation of the causes of cardiovascular disorders which would help them to better

explain the condition to their patients in order to take away the traditional myths surrounding cardiovascular disorders.

6.6 Directions for Future Research

Findings of this study have revealed that there is a unique interpretation of CVDs by participants based on their cultural beliefs. Cultural explanations of diseases have therefore been identified as paramount in understanding the causes and effects of diseases, with the resultant health seeking behaviour. In order to provide more culturally relevant literature for contemporary Ghanaian society, researchers are encouraged to undertake studies that take cognizance of the Ghanaian culture and strive to develop conceptualisations that portray the true Ghanaian attitude and reduce the heavy reliance on Western-dominated concepts that were developed without recourse to our local norms. This will help bring home the proper understanding of the Ghanaian concerning his/her health seeking behaviour. There should also be more researchers who are interested in undertaking studies in areas that directly relate to the Ghanaian culture.

The exploration undertaken in the present study points to the need for continued research into the interface of religious beliefs and practices and health seeking behaviour in the context of cardiovascular disease. Religion has been identified as playing a major role in influencing the health seeking behaviour of people. The role played by religion in the lives of the population and its effect on health seeking behaviour cannot therefore be underestimated by researchers. The ability to study religion/spirituality and cardiovascular health dynamically across time would be helpful to better understand the relationship between the two. Further studies are thus required to unearth the

understanding of this phenomenon. This also would aid in building and supporting theoretical causal avenues between the relationships.

Though several studies have been undertaken with regard to locus of control (LOC) and their effect on health seeking behaviours, the role of multidimensional health locus of control (MHLC) in health seeking behaviour still remains a virgin area in the Ghanaian literature and that needs further exploration by researchers. This is a pioneer study that specifically used multidimensional health locus of control to understand health seeking behaviour of the people, which didn't find a strong association between MHLC and health seeking behaviour of the people. Researchers are therefore encouraged to do more studies in this area using Ghanaian norms. The concept of spiritual locus of control, as was identified by the researcher in this study needs further exploration. Multidimensional locus of control and its relationship with religiosity needs further research, using culturally relevant concepts, as it is a virgin area among social science researchers in Ghana. This will help us understand the role of health locus of control in influencing health seeking behaviour.

More exploratory studies are required to provide a better understanding of people in terms of their belief systems, attitudes, perceptions and feelings all of which influence their health seeking behaviours. The heavy reliance on quantitative studies alone misses out on a lot of variables that significantly impact on people's health and their health behaviours. Researchers are encouraged to use more qualitative studies to explore such attributes that influence people's health seeking behaviours. The use of qualitative data in this study brought out the views, feelings, perceptions, beliefs, fears and practices of participants that helped the researcher develop concepts that truly reflected the views of

the people. The richness of such information is not readily available in quantitative studies that aggregate respondents' responses and lump them together in search of significance.

Further, discussions of quantitative studies are usually based on the researchers' own understanding of the phenomenon but not necessarily from the viewpoint of respondents.

The use of qualitative data in this study has helped to understand health seeking behaviour from participants' own point of view that cultural beliefs and values in totality have influence on their views of cardiovascular disorders. The use of qualitative studies by researchers is in effect, very imperative in this direction.

There is the need for future researchers to show keen interest in the traditional system in terms of the provision of healthcare. Their role in healthcare delivery is indispensable that it is better for researchers to have a proper understanding of how the system works and this will help influence policy decision that will take into consideration the needs of the traditional healers who are generally alienated in favour of western-oriented system that does not have a proper understanding of the cultural orientation of the people. More researchers are needed in this area.

The next section presents some recommendations and conclusions based on the key findings of the study.

6.7 Recommendations from the Study

Based on the findings of this current study and the associated literature review, the following recommendations are proposed:

1. Based on the findings on the influence of culture on health seeking behaviour, which was supported by the study, attempts need to be made to understand patients from their local socio-cultural point of view. This is because understanding patients from the views based on western concepts would prevent healthcare providers from properly understanding their patients. For example using the MHLC, the concept of internal, powerful other and external loci of control did not neatly fit respondents of this study as has been the usual finding using locus of control scale. There is therefore the need to take cognizance of the several socio-cultural factors that influence health seeking behaviour in order to develop culturally relevant concepts to suit the Ghanaian context. Researchers of universities, psychology students and other social science researchers could promote research interest in this direction to create awareness among healthcare providers in order to provide care that suitably fits the health needs of the people.
2. Health education and promotion programmes could be incorporated into the academic curricula by the universities and other health training institutions in order to create awareness among would-be health professionals and social service providers. This could help intensify education in the area of cultural belief systems where cardiovascular disorders are perceived as being caused by supernatural forces and enemies. This is due to the popularity of traditional health systems and the messages regarding the cause of CVDs, a practice which tends to divide and create confusion in families. It is therefore recommended that public and community health practitioners intensify health promotion campaigns in the

various hospitals, communities and other health institutions to provide relevant information that would help people make informed choices.

3. Health professionals need to develop and inculcate into their practice the concept of cultural competence where healthcare providers would understand the culture of the patients' they take care of. Healthcare providers are encouraged to be sensitive to patients' concerns and to understand the conditions from the patients' point of view and incorporate these in their professional practice. There is the dire need for healthcare givers to pay close attention to the traditional aspect of healthcare provision, since patients seeking help interpret the condition from a cultural point of view. Currently this aspect of healthcare delivery is missing in the health system, due to the western oriented training given to health professional where patients are viewed from the clinical point of view without enough regard for the cultural values of the patients. Closely related to this is the barrier of communication channels between health care providers and their patients which prevent patients from adequately expressing themselves. There is therefore the need for the health facilities to provide cultural-congruent services where they would take the cultural backgrounds of their patients into consideration when they are treating them. It is also very important for the Ghana Health Service to encourage health professional to provide congenial atmospheres for patients to properly express themselves and by doing this it will create much confidence in the healthcare system.
4. In order to eliminate or reduce the level of suspicion and mistrust between traditional and orthodox health systems, it is recommended that there should be

more collaboration between orthodox and non-orthodox healthcare providers. This collaboration will pave the way for exchange of ideas and to reduce the myths surrounding the practice of traditional medicine. It will also open the way for orthodox practitioners to understand the work of traditional practitioners that have often been shrouded with secrecy. This collaboration could be done through the Ghana Health Service, GAFTRAM, Association of Traditional Birth Attendants, Pharmaceutical Society of Ghana and all those who matter in the healthcare delivery system. The reduction or complete elimination of prejudices could go a long to build mutual trust and respect for one another, which will help in better provision of health care. For example, some prayer camps will see the need to encourage their clients to take medication for their CVDs to avoid further complications as was found in this study.

5. Due to the level of suspicion of traditional medical practice by the orthodox practitioners, measures should be taken by the Ministry of Health, Ghana Health Service and Council for Traditional Medical Practitioners to properly regulate the activities of traditional medical practitioners in order to raise their activities to standards that would help build confidence between the two systems. Traditional healthcare provision has been part of people since time immemorial and this cannot in any way be reduced by westernisation of society. There is therefore to give the practice the official recognition it deserves, so that they could better play their role in providing assistance to those that need it. This will help build a complementary healthcare system where holistic healthcare would be provided to the people. This recommendation is based on the finding of the study where

orthodox medical practitioners have questioned the efficacy of traditional treatment of CVDs. This notion is supported by the finding of the study that there is a mutual mistrust between orthodox and traditional healthcare delivery systems though they seek to achieve the same goal of finding cure for CVDs.

6. Findings of the study supported the fact that the role of the traditional system in the treatment of CVDs was indispensable but the system has no formal recognition by the healthcare delivery system. The decisions they take for patients under their care have enormous impact on the health and wellbeing of those patients. It is therefore recommended the Ghana Federation of Traditional Medical Practitioners (GAFTRAM) which is a body created to control the activities of traditional medical practitioners should be empowered to regulate and organise training programmes for such practitioners in order to help them build their capacity and acquire more insight into the diseases and their treatment. This measure must not aim at turning them into orthodox health practitioners but rather to ensure best practices in the course of their service delivery. This will help prevent the practice of surrounding the causes of diseases with myths that eventually create problems for patients and their relatives. In another vein, the fact that there is a high patronage of traditional health system means that there is something attractive that orthodox medical practitioners are not aware of. The Ghana Health Service is as a result, encouraged to collaborate with the traditional medical practitioners' council to be able to understand the operations and practices of traditional healers.

7. This study needs to be replicated, especially the area of multidimensional health locus of control and its effect on health seeking behaviour. Researchers have used general locus of control scales extensively but the use of multidimensional health locus of control to study health seeking behaviour is largely unexplored in Ghana. The influence of MHLC on health seeking behaviour has been generally inconsistent among researchers (AbuSabha & Acterberg, 2007; Carlson & Petti, 2002; Wurtele et al., 2000). The study did not find a significant relationship between health locus of control and health seeking behaviour and was due to many factors that have been discussed in earlier sections. It is therefore recommended that further studies could be carried out in this direction social science researchers, psychologists, graduate and undergraduate research students.

6.8 Limitations of the Study

This study has some limitations that must be taken into consideration. First, the study was conducted in the New Juaben Municipal area, which though comprises people of diverse ethnic groups is highly dominated by Akans who make up more than fifty percent of participants for the study. Their views may not necessarily reflect that of other ethnic groups. Therefore, the findings of this study may not necessarily be generalizable to other ethnic groups who may have different cultural backgrounds that influence their health seeking behaviour. Secondly, the scope of the study was limited to people suffering from cardiovascular disorders and excluded people with other conditions for which patients seek treatment. This is because cardiovascular disorders comprising hypertension, stroke and chronic cardiac failure as defined in this study are constantly among the first ten diseases in Ghana just like malaria, TB, HIV/AIDS. For which people seek health care

(de Graft Aikins, 2006). Unfortunately, CVDs are among the least studied disorders in Ghana. The researcher therefore decided to limit the scope of the research to cardiovascular disorders. Furthermore, extending the scope to other categories of disorders could have compromised the effectiveness of the study since having many variables in a study that is being undertaken within a limited time could potentially lead to shoddy work done.

Another limitation was the issue of cross cultural validity of the instruments used for data collection. Questionnaires were specifically designed to and administered based on the peculiar characteristic of the population under review. They were therefore not tested on other populations to determine its applicability to other populations.

6.9 Conclusions

This exploratory study sought to find out the health seeking behaviour among people suffering from cardiovascular disorders, with reference to the people of the New Juaben as the study area. On the basis of the results of this study the key conclusions reached are presented in the subsequent paragraphs:

First, in line with the proposed theoretical model, the findings of the current study found that cultural beliefs and values played a major role in influencing health seeking behaviour for cardiovascular disorders among the people of New Juaben. This means that, the decision to seek help for the treatment of CVDs hinges on the various components of culture, which include the social, cognitive, behavioural, material aspects. The study findings also indicate that a belief in the cause of cardiovascular disorders determined where an individual decides to seek treatment that is the approach to

treatment options is determined by how the individual culturally defined the condition and the sociocultural definition of cardiovascular disorders. There was also a strong belief in the supernatural cause of cardiovascular disorders. These beliefs were based on the notion that evil spirits and envious relatives and co-tenants were capable of transmitting cardiovascular disorders to other people. The belief in the supernatural transmission of CVDs significantly influenced patronage of traditional medicine, a notion based on the perception of some diseases classified as “not-for-hospital” diseases and that orthodox medicine has no antidote to these ailments. These findings therefore supported the key objective of the study that cultural values and beliefs do influence health seeking behaviour for cardiovascular disorders.

Secondly, religiosity and spirituality were identified as major factors that influenced health seeking behaviour among participants. Religious affiliation and a sense of reliance on a Supreme Being who cared for the suffering of people was a source of encouragement that provided emotional and psychological healing to patients though some of them might be suffering from debilitating conditions. The concept of religious healing was a force that participants reckoned kept them going even in very trying moments of their suffering from cardiovascular disorders. Both traditional Spiritual heads and Christian spiritual healers play very significant roles that should not be downplayed. They have constantly served as hope for those that need it.

However, other negative influences of culture and religiosity were identified which could negatively affect the health of the already suffering patients. The use of concoctions and ritual baths that were meant to ward off evil spirits that cause cardiovascular disorders,

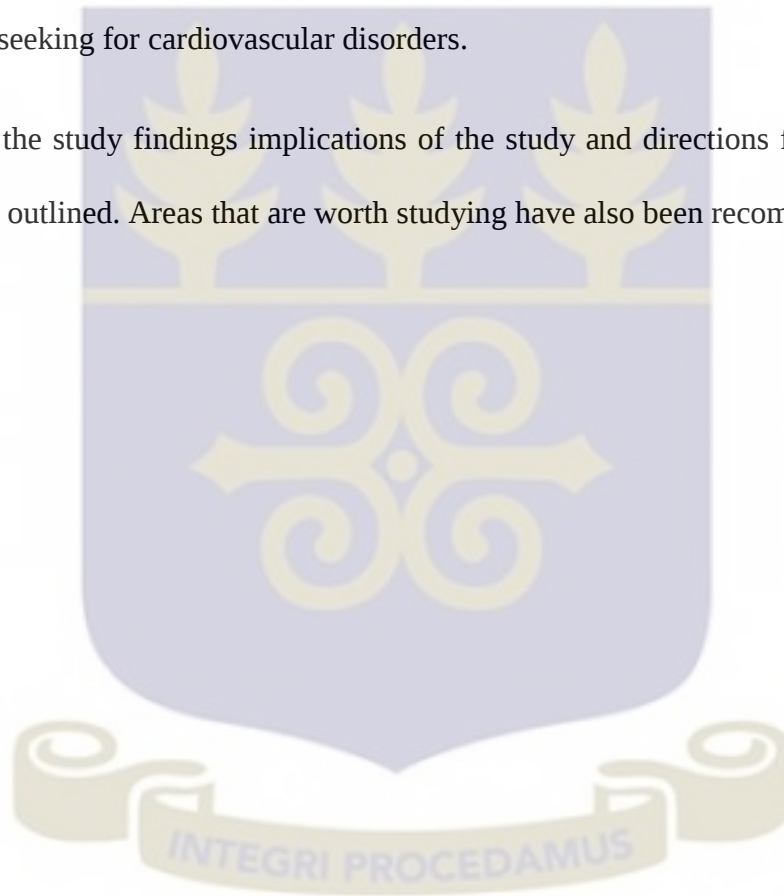
and the exclusive use of prayers to cure cardiovascular diseases ended up worsening the patients' conditions.

Thirdly, patients' attendance at a particular health facility was mainly based on their assessment of the efficacy of the particular health system. Despite the strong presence of orthodox health system manned by trained personnel and the availability of the state-of-the-art equipment, there was still a strong presence of traditional medical practitioners who treat all manner of cardiovascular disorders their influence is strongly felt among participants of the study. Most patients were found to be as engaging in multiple health seeking behaviour, concurrently or sequentially patronising the services of both orthodox and non-orthodox medical practitioners. This practice mostly resulted in further complications in the condition of patients. This finding, which was in line with the theoretical model of health seeking behaviour for CVDs supported the objective that perception of efficacy of treatment would influence health seeking behaviour for CVDs.

Fourthly, it was found that there was no difference between people of both high and low socioeconomic status in terms of their health seeking behaviour for cardiovascular disorders. Most people regardless of their socioeconomic status used both the orthodox and non-orthodox health care systems. However, most with high socioeconomic status utilised the services of private clinics more than the general hospitals. Though location of health facility was not an important factor that determined participants' health seeking behaviour, there were factors like literacy, age, poverty and personal characteristics of the person suffering from the disorder that influenced their help seeking for cardiovascular disorders.

Finally, multidimensional health locus of control, with its subscales comprising internal, external, and powerful others did not appear to play any significant mediating role in the health seeking behaviours of participants of the study. This was due to the peculiar socio-cultural practices of the people that did not seem to fit neatly in the dimensions prescribed by the western –oriented health locus of control scale. It was identified in the study that patients pass through a three-stage decision making process before embarking on health seeking for cardiovascular disorders.

Based on the study findings implications of the study and directions for future research have been outlined. Areas that are worth studying have also been recommended.



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APPENDIX I**HEALTH SEEKING BEHAVIOUR AMONG PEOPLE SUFFERING FROM
CARDIOVASCULAR DISORDERS**

Instructions: Each item below is a belief statement about your health seeking behaviour in relation to cardiovascular disorders with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher will be the number you circle. The more you disagree with a statement; the lower will be the number you circle. Please make sure that you answer EVERY ITEM by circling ONLY ONE number per item.

This is a measure of your personal beliefs, and there are no right or wrong answers.

Name of Location:

--

Time Interview Started:

--

Time Interview Ended:

--

Interviewer's Name:

--



SECTION 1

Please provide the answer by circling the appropriate numerical codes adjacent to the responses.

SECTION ONE: SOCIODEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

QUES. NO.	QUESTIONS	RESPONSES	CODES
1.1	What is your sex?	Male 01 Female 02	SDC1
1.2	What is your marital status?	Single 01 Married 02 Separated 03 Divorced 04 Widowed 05	SDC2
1.3	How many children do you have?	0 1 2 3 4 5 6 7 8 9 10 Other, specify.....	SDC3
1.4	Which of these age range do you belong	35 – 39 40 – 44 45 – 49 50 – 54 55 – 59 60 – 64 65 - 69 If don't know, code 88	SDC4
1.5	What is your highest level of education attained?	01 No education 02 Primary 03 JHS/ Middle School 04 SHS/Secondary 05 Voc/Comm./ Tech 06 Diploma 07 Degree 08 Postgraduate Other, specify	SDC5
1.6	What is your main occupation?	01 Unemployed 02 Trading /Business Teaching	SDC6

		03 Civil Servant 04 Public Servant 05 Professional 06 Student 07 Farming 08 Other, specify	
1.7	Which range does your monthly income fall?	<100.00 01 100.00 – 250.00 02 250.00 – 400.00 03 400.00 – 550.00 04 550.00 – 700.00 05 700.00 – 950.00 06 >950.00 07	SDC7
1.8	What ethnic group do you belong to?	Akan 01 Ewe 02 Guan 03 Ga-Adangbe 04 Gruma 05 Mole Dagbani 06 Grusi 07 Other, specify..... 98	SDC8
1.9	What is your religious affiliation? After ethnic	Catholic 01 Protestant 02 Pentecostal/Charismatic 03 SDA/Jehovah Witness/Deeper Life 04 Spiritual Church 05 Moslem 06 Traditional Religion 07	SDC9

		No Religion 08 Other, specify	
1.10	How would you describe the locality within which you stay?	01 Urban 02 Semi-urban 03 Rural	SDC10

SECTION 2**CULTURAL VALUES AND BELIEF SYSTEMS AND HEALTHSEEKING BEHAVIOUR**

0=DON'T KNOW 1=STRONGLY DISAGREE (SD) 2=MODERATELY DISAGREE (MD) 3=DISAGREE (D)		4=AGREE (A) 5=MODERATELY AGREE (MA) 6=STRONGLY AGREE (SA)								COD E
Question		Codes								
		N	SD	MD	D	A	MA	SA		
1	It is a belief in my culture that cardiovascular disorders are caused by supernatural forces.	0	1	2	3	4	5	6		CB1
2	I believe that witches have an influence in any disease I have.	0	1	2	3	4	5	6		CB2
3	It is a belief in my culture that evil spirits have the potential to infect me with CVDs.	0	1	2	3	4	5	6		CB3
4	When I don't fulfil my vows to the church or the gods, they can send misfortune in the form of cardiovascular disorders.	0	1	2	3	4	5	6		CB4
5	If I am faithful, I can get supernatural protection from all cardiovascular disorders.	0	1	2	3	4	5	6		CB5
6	Evil spirits can enter houses through doors, cracks and walls and spread cardiovascular disorders.	0	1	2	3		5	6		CB6
7	When the family fails to observe traditional rites, misfortune in the form of cardiovascular disorders will befall us.	0	1	2	3	4	5	6		CB7
8	It is important to wear lucky charms to protect us from contracting cardiovascular disorders.	0	1	2	3	4	5	6		CB8
9	A deceased family member becomes a spirit, who influences the health of other members of the family.	0	1	2	3	4	5	6		CB9
10	It is a cultural belief that there are certain diseases that are not treatable by western medicine.	0	1	2	3	4	5	6		CB10
11	It is important to consult the oracles before seeking treatment for cardiovascular disorders.	0	1	2	3	4	5	6		CB11

12	When I have no explanation to the cause of my condition, I will consult the spiritualist /shrine for explanation.	0	1	2	3	4	5	6	CB12
13	It is a belief that treatment offered by non-orthodox health practitioners (herbalists, spiritualists, prayer camps) are more potent than those offered by the orthodox system.	0	1	2	3	4	5	6	CB13
14	My cultural values and practices perceive orthodox medicinal practice as not having enough answers to illnesses.	0	1	2	3	4	5	6	CB14
15	From my culture, it is believed that there is a complete cure for every disease condition.	0	1	2	3	4	5	6	CB15
16	When cardiovascular disorders persist for a longer period than acceptable, it is believed that the disease was caused by an envious family member or witches.	0	1	2	3	4	5	6	CB16
17	It is a cultural belief that all diseases have supernatural causes for which western medicine has no explanation or antidote.	0	1	2	3	4	5	6	CB17
18	My traditional system does not accept the view that certain diseases cannot be completely cured but can only be managed.	0	1	2	3	4	5	6	CB18
19	The best source of treatment for cardiovascular disorders is the orthodox health system.	0	1	2	3	4	5	6	CB19

SECTION 3

ORTHODOX AND NON-ORTHODOX MEDICINAL PRACTICES

0=DON'T KNOW 1=STRONGLY DISAGREE (SD) 2=MODERATELY DISAGREE (MD) 3=DISAGREE (D)		4=AGREE (A) 5=MODERATELY AGREE (MA) 6=STRONGLY AGREE (SA)							CODE
		N	SD	MD	D	A	MA	SA	
1	Whenever anything goes wrong in my life, I consult a traditional health practitioner first.	0	1	2	3	4	5	6	ON1
2	I consult a herbalist when western doctor cannot heal me.	0	1	2	3	4	5	6	ON2
3	I believe that orthodox medicine has answers to all my health problems.	0	1	2	3	4	5	6	ON3
4	I prefer the orthodox health system because I have faith in their treatment more than the non-orthodox health system.	0	1	2	3	4	5	6	ON4
5	It is more time consuming to seek treatment from the traditional health system	0	1	2	3	4	5	6	ON5
6	Orthodox health practitioners do not have the patience to give me thorough treatment as compared to the traditional system.	0	1	2	3	4	5	6	ON6
7	In order to be completely cured from cardiovascular disorders, it is important to seek help from both orthodox and non-	0	1	2	3	4	5	6	ON7

	orthodox health practitioners.								
8	I only go to the hospital when my condition is very serious.	0	1	2	3	4	5	6	ON8
9	I prefer the hospitals, because they are better resourced to take care of me when have a cardiovascular disorder.	0	1	2	3	4	5	6	ON9
10	I prefer orthodox medicine because traditional healers lack the skills needed to proffer correct diagnosis on very serious disorders like cardiovascular disorders.	0	1	2	3	4	5	6	ON10
11	I believe that prayer is the best solution to my cardiovascular disorders conditions.	0	1	2	3	4	5	6	ON11
12	The traditional medicine practitioners are more accessible to the people than the cosmopolitan modern doctors.	0	1	2	3	4	5	6	ON12
13	Orthodox health systems don not have antidote to my cardiovascular conditions.	0	1	2	3	4	5	6	ON13
14	The use of traditional medicine only provides a temporary relief to cardiovascular related conditions as compared to orthodox medicine.	0	1	2	3	4	5	6	ON14
15	I prefer the orthodox health delivery system, because the traditional medicine lacks standard dosage and has not been subjected to “scientific” verifications.	0	1	2	3	4	5	6	ON15
16	I believe that the combination of orthodox and traditional medicines provide the best solution to my cardiovascular related conditions.	0	1	2	3	4	5	6	ON16
17	The traditional healer’s skills in treatment techniques enable them to achieve a high success rate in the management of cardiovascular disorders	0	1	2	3	4	5	6	ON17
18	I believe that treatment from traditional healers is more long lasting.	0	1	2	3	4	5	6	ON18
19	The healers in the traditional system lack the equipment needed to conduct physical examination on patients.	0	1	2	3	4	5	6	ON19
20	I spend a lot of time whenever I go to the hospital.	0	1	2	3	4	5	6	ON20

SECTION 4**SOCIOECONOMIC STATUS AND HEALTH SEEKING BEHAVIOUR**

0=DON'T KNOW 1=STRONGLY DISAGREE (SD) 2=MODERATELY DISAGREE (MD) 3=DISAGREE (D)		4=AGREE (A) 5=MODERATELY AGREE (MA) 6=STRONGLY AGREE (SA)							CODE
		N	SD	MD	D	A	MA	SA	
1	I consider the cost of orthodox healthcare as very high.	0	1	2	3	4	5	6	SES1

2	It is difficult to get proper healthcare from the hospitals because of low level of income.	0	1	2	3	4	5	6	SES2
3	The distance from my home to the hospital prevents me from seeking help from there.	0	1	2	3	4	5	6	SES3
4	I seek help from multiple sources without considering the cost.	0	1	2	3	4	5	6	SES4
5	I prefer to get treatment from the pharmacy shop/drug store to going to the hospital.	0	1	2	3	4	5	6	SES5
6	Health seeking from traditional providers is too expensive as compared to those received from orthodox health settings.	0	1	2	3	4	5	6	SES6
7	The level of my income to a greater extent influences my health seeking behaviour.	0	1	2	3	4	5	6	SES7
8	I only seek help from a particular system mainly based on availability of the facility.	0	1	2	3	4	5	6	SES8
9	I prefer to go to the hospital because the National Health Insurance Scheme (NHIS) will cater for my bills.	0	1	2	3	4	5	6	SES9
10	I will only go to the hospital, when I am very sick.	0	1	2	3	4	5	6	SES10
11	Herbalists and prayer camp operators do not have antidote to my ailment.	0	1	2	3	4	5	6	SES11
12	I consider seeking treatment at the hospital as too luxurious.	0	1	2	3	4	5	6	SES12
13	Services of prayer camps and herbalist only aggravate my condition.	0	1	2	3	4	5	6	SES13
14	Going to the hospital is too much time-consuming	0	1	2	3	4	5	6	SES14
15	I consult friends and relatives for treatment because both traditional and orthodox health systems are expensive and time consuming.	0	1	2	3	4	5	6	SES15
16	Among all the healthcare delivery systems, orthodox health systems provide the best solutions to our health problems	0	1	2	3	4	5	6	SES16
17	I prefer to go to herbalists because their services are very cheap.	0	1	2	3	4	5	6	SES17
18	Treatment at the non-orthodox health system takes too long.	0	1	2	3	4	5	6	SES18
19	Treatment at the non-orthodox health system is too expensive.	0	1	2	3	4	5	6	SES19
20	My health seeking behaviour is mainly based on the accessibility of the facility.	0	1	2	3	4	5	6	SES20
21	The cost of treatment has nothing to do with my health seeking behaviour.	0	1	2	3	4	5	6	SES21

SECTION 5

HEALTH LOCUS OF CONTROL AND HEALTH SEEKING BEHAVIOUR

0=DON'T KNOW 1=STRONGLY DISAGREE (SD) 2=MODERATELY DISAGREE (MD) 3=DISAGREE (D)		4=AGREE (A) 5=MODERATELY AGREE (MA) 6=STRONGLY AGREE (SA)							CODE
		N	SD	MD	D	A	MA	SA	
1	If I get sick, it is my own behaviour, which determines how soon I get well again.	0	1	2	3	4	5	6	LOC1
2	No matter the situation, if I will be sick, certainly I will.	0	1	2	3	4	5	6	LOC2
3	Having regular contact with my physician is the best way for me to avoid illness.	0	1	2	3	4	5	6	LOC3
4	Most things that affect my health happen to me by accident.	0	1	2	3	4	5	6	LOC4
5	Whenever I don't feel well, I often consult health professional.	0	1	2	3	4	5	6	LOC5
6	I take care of my health my health problems.	0	1	2	3	4	5	6	LOC6
7	My family has a lot to do with my staying healthy.	0	1	2	3	4	5	6	LOC7
8	When I get sick, I am to blame.	0	1	2	3	4	5	6	LOC8
9	Luck plays a big role in my recovery from an illness.	0	1	2	3	4	5	6	LOC9
10	Health professionals have control over my health.	0	1	2	3	4	5	6	LOC10
11	My good health is largely a matter of good fortune.	0	1	2	3	4	5	6	LOC11
12	The main thing, which affects my health, is my habits.	0	1	2	3	4	5	6	LOC12
13	If I take care of myself, I will avoid illness.	0	1	2	3	4	5	6	LOC13
14	Whenever I recover from an illness, it's usually because other people (for example, doctors, nurses, family, friends) have been taking good care of me.	0	1	2	3	4	5	6	LOC14
15	No matter what I do, I'm likely to get sick.	0	1	2	3	4	5	6	LOC15
16	If it is meant to be, I will stay healthy.	0	1	2	3	4	5	6	LOC16
17	If I take the right health procedures, I will stay healthy.	0	1	2	3	4	5	6	LOC17
18	Regarding my health, I can only do what my health professionals tell me to do.	0	1	2	3	4	5	6	LOC18
19	Cardiovascular disorders are hereditary and nothing can be done to prevent its occurrence.	0	1	2	3	4	5	6	LOC19

APPENDIX II

FOCUS GROUP GUIDE: CLIENTS/ PATIENTS

Focus group schedule for individuals who have suffered symptoms attributable to cardiovascular disorders.

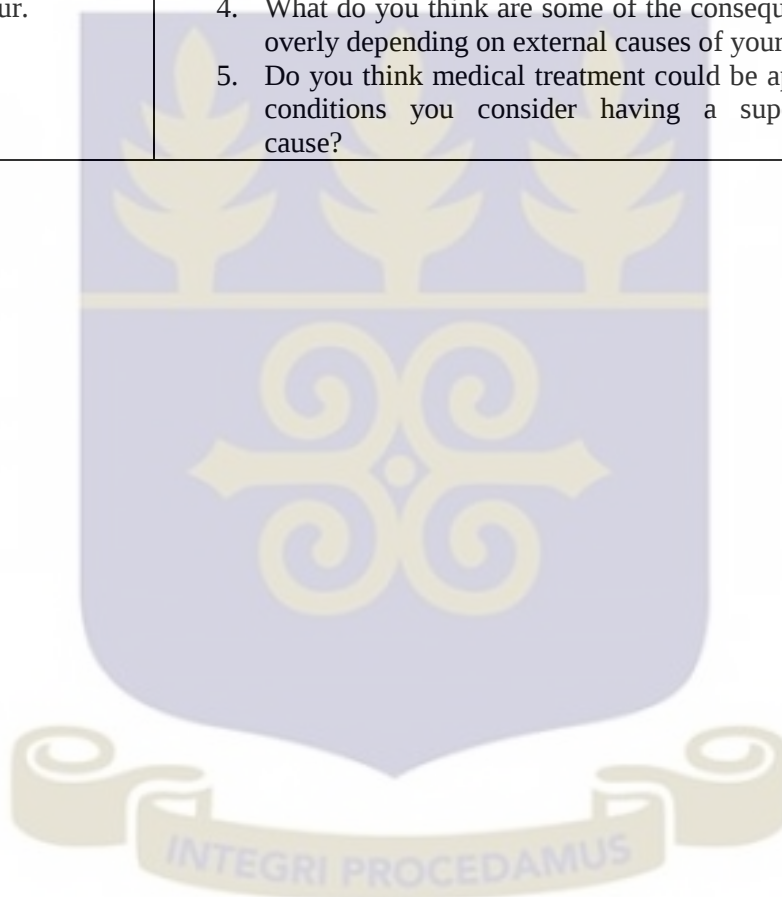
Focus Group Script

Welcome, thank you for taking the time to be a part of this discussion about health seeking behaviour among people suffering from cardiovascular disorders. My name is Isaac Acheampong Sarfo. You have been asked to participate because you have ever suffered from stroke or hypertension. The purpose of the discussion today is to talk about your views and beliefs about cardiovascular disorders, factors that you take into consideration before seeking help from health care givers in terms of your cultural beliefs, locus of control, and socioeconomic factors.

I would like to stress that there are no right or wrong answers. If your view is different from what someone else says or you want to add to what someone else has said, feel free to disagree or give an example of what you mean. You do not have to respond to all the questions, but your opinions are very important and I am here to ask questions and listen to what you have to say. If you have a lot to say and are talking a lot, I may ask you to let someone else share their thoughts so that everyone has a chance to talk. Everything that is said here today is important, so I'll be taking notes and taping the session. I may ask you to clarify something you have said, but all of this information is confidential, no names will be included in any reports. There is refreshment available, feel free to get something any time.

Research Aim		
	Welcome & Thank you/ Meda m'oase Review study purpose, confidentiality, format for discussion, rules of engagement, audio taping, and introductions.	
	Questions	Prompts
Aim 1: Explore the effects of cultural values and belief systems on health seeking behaviour for cardiovascular disorders.	1. When we mention culture, how do you understand it? 2. To what extent does your culture have anything to do with your health? 3. What are your beliefs about cardiovascular disorders as far as your culture is concerned? 4. Do you think there is a supernatural cause of CVDs? 5. What are some of the practices that can predispose someone to develop cardiovascular disorders? 6. Tell me a little bit more about your belief and feelings about your personal view of CVDs. 7. Is there anything else you would like to say about your beliefs?	Explain in detail your choice of answer
Aim 2: Examine socio-economic factors that influence health-seeking behaviour.	1. Why do you prefer to seek help from this particular health system? Why? 2. Does access to a health facility have anything to do with your health seeking behaviour? 3. Do you think your financial situation contributed to you accessing help from this particular facility? 4. Would you agree to the assertion that seeking help from a particular health system depends on individual's financial standing? Why?	Does the cost of healthcare have any role to play? Give reasons for your answer.
Aim 3: Assess the effect of perception of efficacy of orthodox and traditional health systems on health seeking behaviour.	1. Why do you prefer to seek help from this particular health system? Why? 2. What are some reasons why you prefer a particular healthcare delivery system than the other? 3. Where do you think is the best place for the treatment of cardiovascular disorders? 4. Why would someone who has already decided to use a particular healthcare system change their mind? 5. What do you think account for the use of multiple healthcare systems?	This refers to orthodox or traditional health systems Give reasons for the choice of answer.

	6. Do you think treatment in a particular health system is more potent?	Give reasons for your answer.
Aim 4: Examine the relationship between health locus of control and health seeking behaviour.	1. When you suffer from CVDs who determines where you should seek treatment? 2. Do you believe that there is some supernatural force behind your condition? 3. Do you think you have control over your illness? 4. What do you think are some of the consequences of overly depending on external causes of your illness? 5. Do you think medical treatment could be applied to conditions you consider having a supernatural cause?	Why? Give reasons for your answer?



APPENDIX III

INTERVIEW GUIDE FOR KEY INFORMANTS ON HEALTH SEEKING BEHAVIOUR AMONG PEOPLE SUFFERING FROM CARDIOVASCULAR DISORDERS

1. DEMOGRAPHIC CHARACTERISTICS

1.1 What is your designation in this facility?

1.2 How long have you been working in this position?

1.3 How long have you been working as a health care provider?

2.1 Do you think culture and belief systems have any influence on your patients' health seeking behaviour?

2.2 What do you think are some of the cultural values that influence the health seeking behaviour of people?

2.3 What are some of the belief systems that influence the health seeking behaviour of people?

2.4 At what point in the course of contracting CVDs do patients use your facility?

2.5 Could you explain why some patients use your facility as a first point of call when they have CVDs?

2.6 Explain why some patients prefer to use your facility as a secondary source for the treatment of cardiovascular disorders.

2.7 Can you explain why some patients prefer combining the treatment from your facility with other treatment regimen?

2.8 What do you think are the main causes of delay in seeking for treatment in your facility?

2.9 What problems do you encounter when people suffering from CVDs are brought to your facility for treatment?

2.10 At what stage do people suffering from CVDs report at your facility.

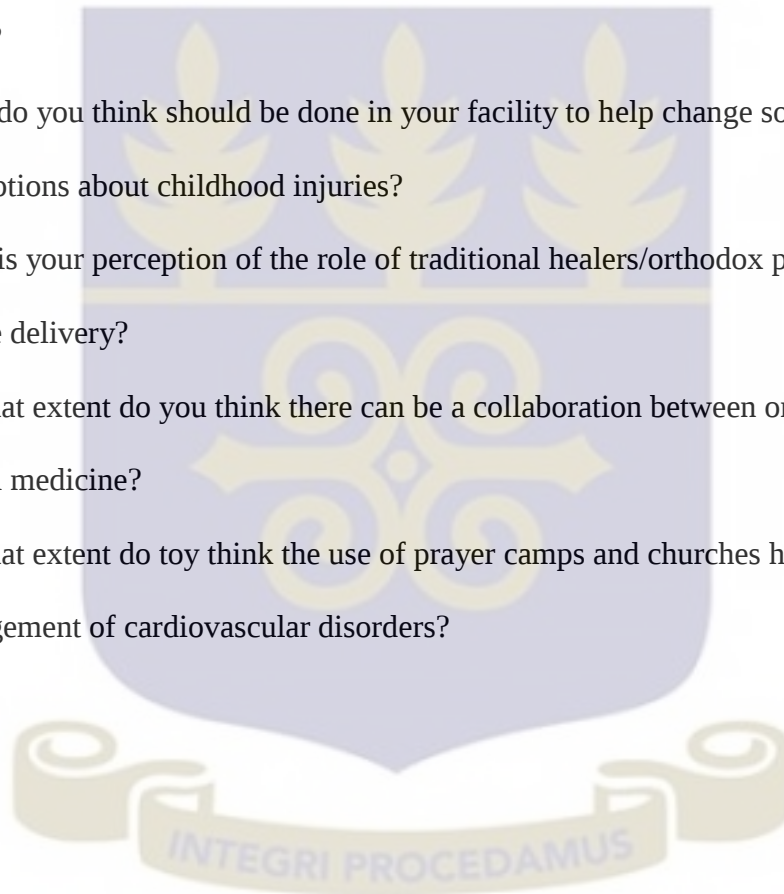
3.1 What do you think are the local perceptions and the causes of cardiovascular disorders?

3.3 What do you think should be done in your facility to help change some of these misconceptions about childhood injuries?

3.4 What is your perception of the role of traditional healers/orthodox practitioners in healthcare delivery?

3.5 To what extent do you think there can be a collaboration between orthodox and traditional medicine?

3.6 To what extent do you think the use of prayer camps and churches have contributed to the management of cardiovascular disorders?



APPENDIX IV

University of Ghana
Department of Psychology
P. O. Box LG 84
Legon
2nd November, 2011

Dear Sir/Madam

LETTER OF INTRODUCTION

I am a PhD student at the Department of Psychology, University of Ghana and I am conducting a study into the “Health Seeking Behaviour among People Suffering from Cardiovascular Disorders”. You happened to be one of the sampled respondents for this survey.

I would be grateful if you could use about 45 minutes of your time and at your convenience to answer the questions in the survey. This study aims at exploring the cultural determinants of health seeking behaviour and to examine the effect of these cultural practices on the overall health of Ghanaians.

This survey is part of an important academic research project and your participation will enhance our knowledge on the socio-cultural factors that influence the choice of treatment when faced with cardiovascular disorders.

However, participation in this research is voluntary and you may choose to withdraw at any time. Your response to this questionnaire will be kept confidential. No identifying information will be used and all individual data will be put together for analysis.

I will be most grateful if this questionnaire could be filled within one week of receipt so that I can collect after a later date.

Thank you for your assistance.
Yours sincerely,

Isaac Acheampong Sarfo
Researcher

APPENDIX V

University of Ghana
Department of Psychology
P. O. Box LG 84
Legon
2nd November, 2011

THE HOSPITAL DIRECTOR
REGIONAL HOSPITAL
P. O. BOX KF 201
KOFORIDUA

Dear Sir,

PERMISSION TO USE YOUR FACILITY FOR DATA COLLECTION

I am a PhD student at the Department of Psychology, University of Ghana and I am conducting a research into the “Health Seeking Behaviour among People Suffering from Cardiovascular Disorders”.

I am organizing Focus Group Discussions among People who are suffering from cardiovascular disorders as defined operationally in the study being undertaken. I would also organise Key Informant Interviews among selected health personnel.

I would therefore appreciate it if you could give me the permission to undertake the study in your establishment.

All information gathered would be used purely for academic purposes and would also be treated with utmost confidentiality.

Thank you and I hope to receive a favourable response from your outfit.

Yours faithfully,

Isaac Acheampong Sarfo
Researcher

APPENDIX VI

University of Ghana
Department of Psychology
P. O. Box LG 84
Legon
2nd November, 2011

NANA OBUORTABIRI KOMFOO
OBUORTABIRI SHRINE
KOFORIDUA

Dear Sir,

PERMISSION TO USE YOUR FACILITY FOR DATA COLLECTION

I am a PhD student at the Department of Psychology, University of Ghana and I am conducting a research into the “Health Seeking Behaviour among People Suffering from Cardiovascular Disorders”.

I am organizing Focus Group Discussions among People who are suffering from cardiovascular disorders as defined operationally in the study being undertaken. I would also organise Key Informant Interviews among selected health personnel.

I would therefore appreciate it if you could give me the permission to undertake the study in your establishment.

All information gathered would be used purely for academic purposes and would also be treated with utmost confidentiality.

Thank you and I hope to receive a favourable response from your outfit.

Yours faithfully,

Isaac Acheampong Sarfo
Researcher

APPENDIX VII

Informed Consent Form

University of Ghana
Department of Psychology (2011)
Informed Consent for Participants

Please read this document carefully. Sign your name below only if you agree to participate and you fully understand your rights. Your signature is required for participation. You must be 18 years of age to give your consent to participate in research. If you desire a copy of this consent form, you may request one and we will provide it.

The policy of the Department of Psychology is that all research participation in the Department is voluntary, and you have the right to withdraw at any time, without prejudice, should you object to the nature of the research. You are entitled to ask questions and to receive an explanation after your participation.

Description of the Study:

This is a cross-sectional study that seeks to understand the health seeking behaviour in Ghana. To do this, we will ask you to do the following: answer the close-ended questionnaire with reference to cultural and belief systems, socioeconomic factors and attitudes towards particular health systems by ticking the appropriate answer that you deem fit.

Nature of Participation:

You will participate in two sessions. In the first session you will be asked to provide answers to questionnaires. In the second session, you will be engaged in an interview on health seeking behaviour.

Purpose of the Study:

To evaluate the influence of culture and belief systems on health seeking behaviour. This means we want to find out some general information about the usefulness of (your variable inserted here) and how people react and behave.

Possible Risks:

There are no risks associated with the filling of the questionnaires or engaging in an interview. There are no right or wrong answers to the questions and you are therefore not to worry about how you perform on answering questions.

Possible Benefits:

- a) When your participation is complete, you will be given an opportunity to learn about this research, which may be useful to you in your understanding of the myriad of factors that influence health seeking behaviour.
- b) You will have an opportunity to contribute to psychological science by participating in this research.

Confidentiality:

Your name will not be mentioned. You will be assigned a code number which will protect your identity. All data will be kept in secured files. All identifying information will be removed from questionnaires as soon as your participation is complete. No one will be able to know which your questionnaire responses are.

Opportunities to Question:

Any technical questions about this research may be directed to:

Principal Investigator: Isaac Acheampong Sarfo Phone: 0268 707068

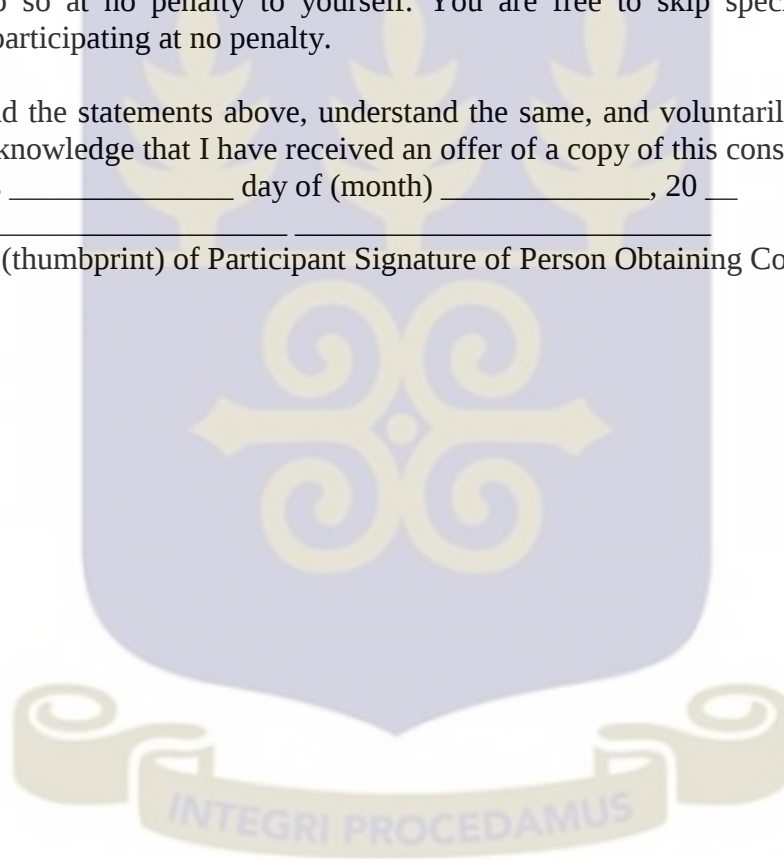
Opportunities to Withdraw at will:

If you decide now or at any point to withdraw this consent or stop participating, you are free to do so at no penalty to yourself. You are free to skip specific questions and continue participating at no penalty.

I have read the statements above, understand the same, and voluntarily sign this form. I further acknowledge that I have received an offer of a copy of this consent form.

Dated this _____ day of (month) _____, 20 ____

Signature (thumbprint) of Participant Signature of Person Obtaining Consent



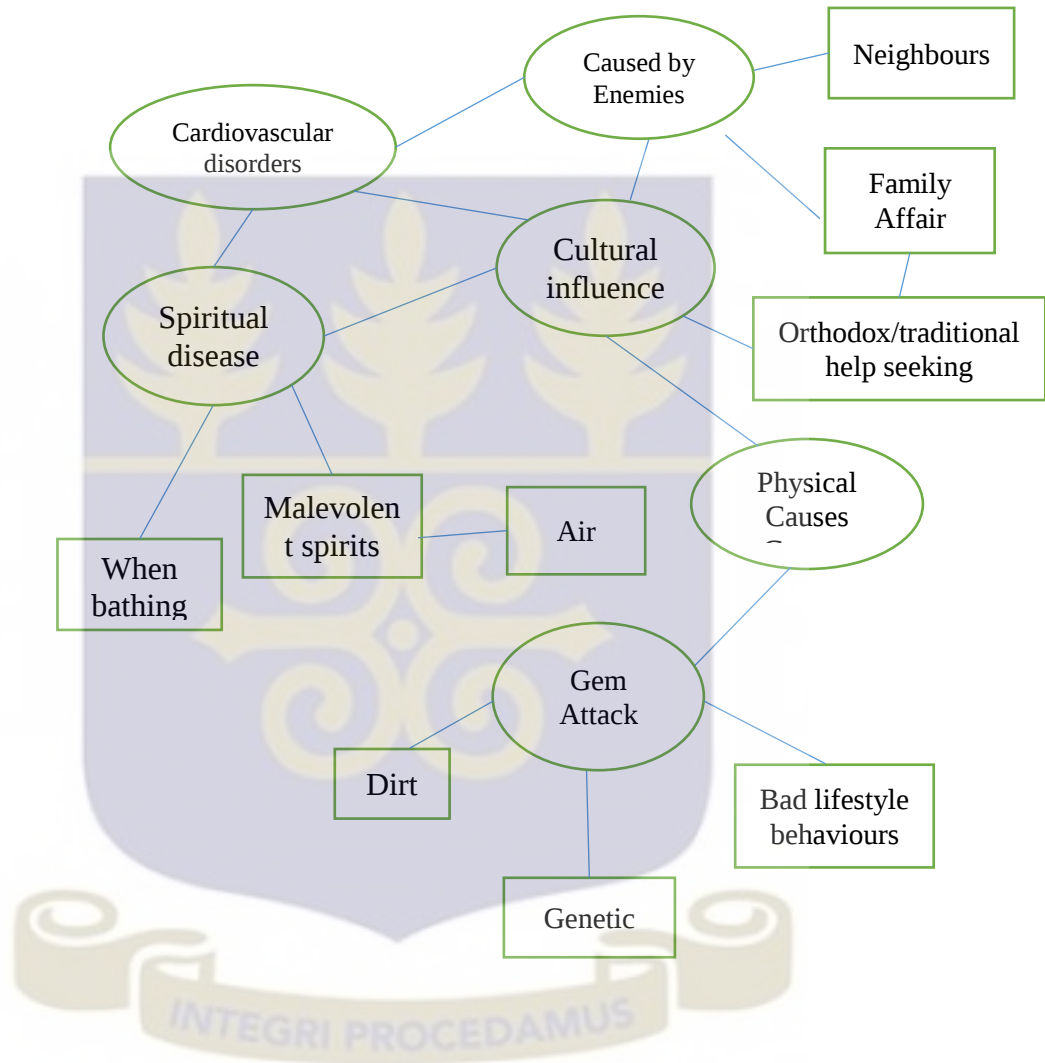
APPENDIX VIII

APPENDIX VIII

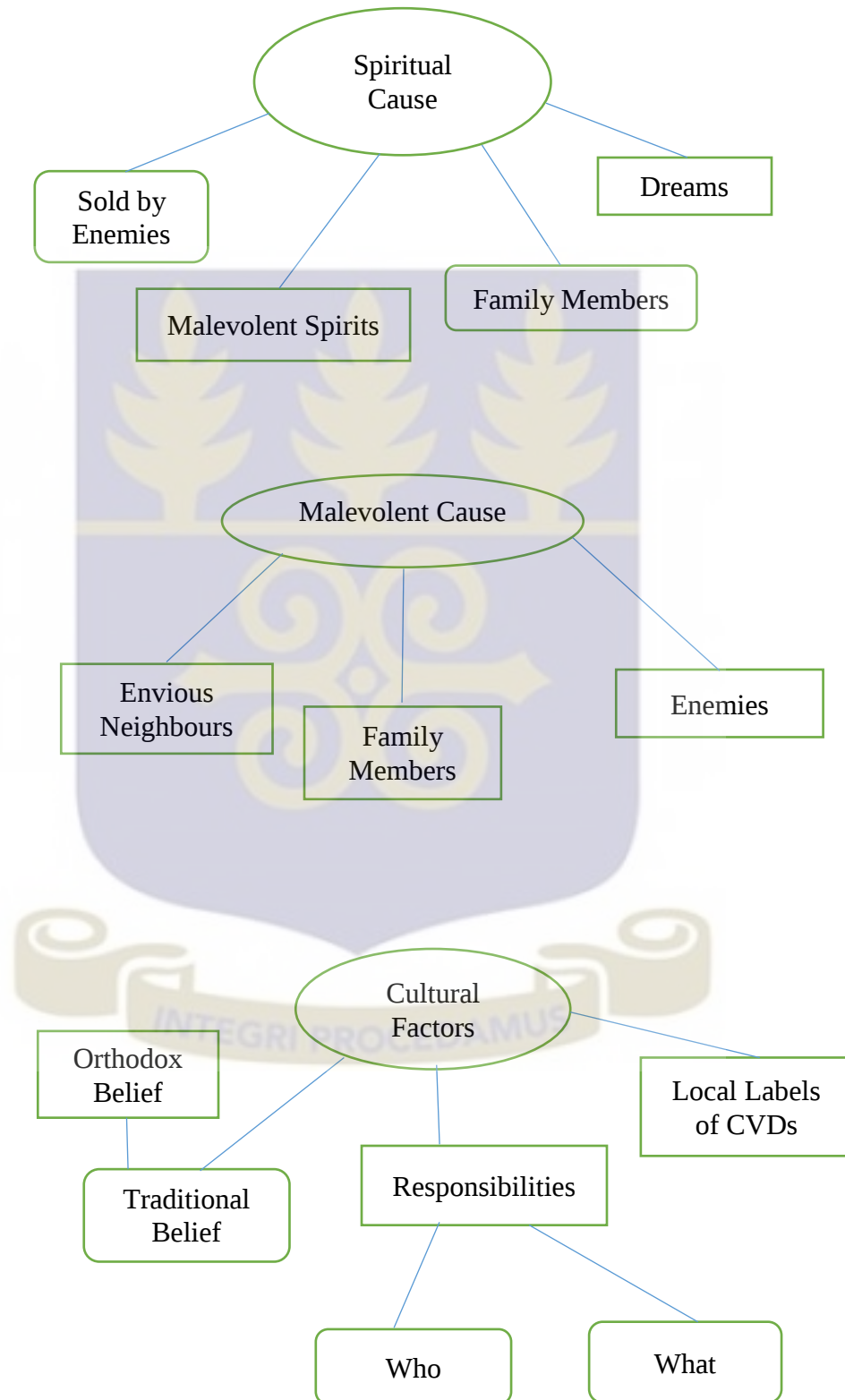
Phases of thematic Analysis	
Phase	Description of the Process
1. Data familiarisation:	Data transcription, reading and rereading the data, noting down initial ideas.
2. Generation of initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collation of data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Review of themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic map of the analysis.
5. Definition and naming of themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

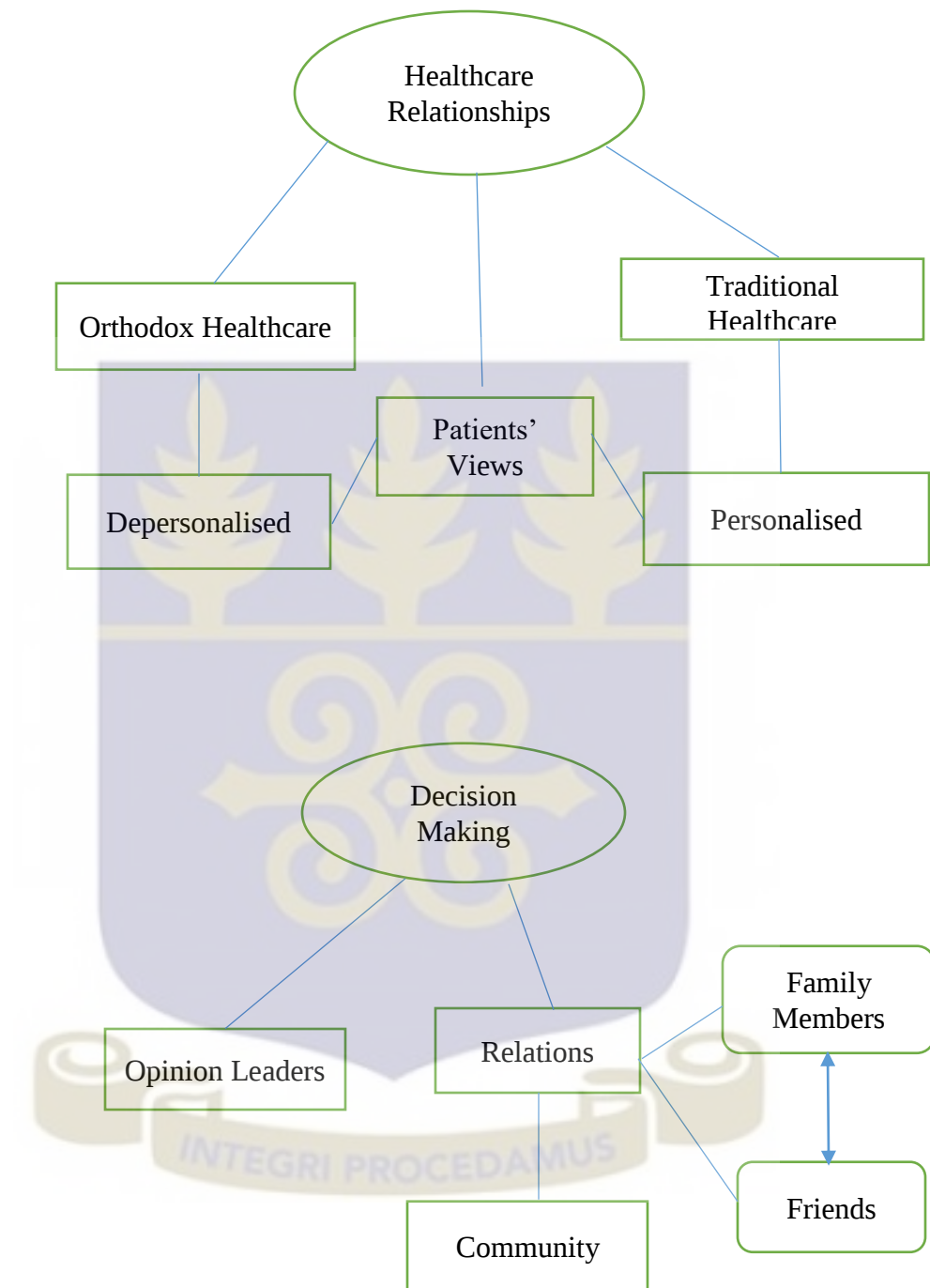
Adapted from Braun & Clark (2006)

APPENDIX VIIIa



APPENDIX VIII b





APPENDIC VIIIc

