PATTERN OF HOUSEHOLD USE OF TRADITIONAL MEDICINES FOR THE MANAGEMENT OF CHILDREN'S AILMENTS IN THE NZEMA EAST DISTRICT

BY

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DECLARATION

I declare that this dissertation is the result of my efforts, based on the data collected from the field, except where specific references have been made; and that, it has never been previously published nor has it been presented anywhere else for another degree.

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DEDICATION

This is dedicated to my dear wife and children.

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

ABSTRACT

The pattern of Traditional Medicine use by households in the management of children's ailments was studied, using qualitative methods in the Nzema East district of the Western Region of Ghana.

The purpose of the study was to explore how the practice interacts with health seeking behaviour of households in the event of a child falling ill as well as circumstances that contribute to the practice.

The study was necessitated by complains from the District Health Management Team and other health personnel, that the use of traditional preparations to manage ailments in children was having adverse effects on their health.

The major tool used was a household questionnaire administered to 162 households, selected randomly, from six communities. Additional data was collected from ten herbalists by using a specially designed interview schedule. Narrative representations of illness (illness stories) were also collected from 16 households and analyzed.

One important finding was that a new pattern of health seeking behaviour is emerging among households that use traditional childcare practices as well as modern health care facilities. Findings have shown that in the event of a child falling ill, households first employ their known traditional treatment procedures. If these fail, they bypass herbalists in their communities and

send the children to a modern health care facility. However, if they are still not satisfied with the care, especially in chronic illness, then a health seeking web evolves, in which households visit the herbalists, go back to hospital and use their own known treatments. This finding seems to disagree with some earlier findings, particularly those of Melrose, which indicated that about sixty one percent of mothers take their ill children first to a herbalist before seeking care at a modern health care facility.

It was also found that communities have their own classification of which ailments of children are "hospital ailments", for which they seek hospital care. Fractures and boils among children are not considered suitable for modern medical care. Athsma and Unossified fontannele are two conditions of children that are exclusively cured satisfactorily with traditional medicines by either households or the herbalist.

Though the pharmacological aspects of herbal medicaments used in treating children's ailments was not studied, the use of substances such as goats' excreta, clay and ginger as additives to preparations for enema, were subjectively viewed, by the researcher, as potentially dangerous to the health of children. Sharing of syringes used for enema among children was another practice accompanying childcare that was seen as potentially dangerous.

Reasons for the use of traditional methods for treating children's ailments included poverty, lack of access to modern health care, due to various factors, unexplained preferences of households and the rather relatively easy access to knowledge and supply of traditional medicine. Administration of enema to children was found to be more of a habit, in most cases, than for any real therapeutic purpose.

It was recommended that any intervention to control the use of traditional medicines by households to treat children's ailments must include expansion of health care delivery, intensive health education, various forms of empowerment of households, especially mothers and addressing affordability problems of households to modern health care services. It was also recommended that the immense enthusiasm shown by mothers in caring for their ill children must be exploited by the health service to initiate community based healthcare delivery services, in which households will participate. Finally it was suggested that a long-term project in which communities will be assisted to cultivate medicinal plants could be implemented once the efficacy of such plants' medicines have been proven by community members and not necessarily, by rigorous scientific processes.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.0 INTRODUCTION

The use of the term "traditional medicine" is not very clear. As observed by Bannerman, traditional medicine is a rather vague term used to indicate ancient and culture-bound health care practices that existed before the application of science to health maters". Other terms frequently used as synonyms include "indigenous," "unorthodox," "folk" "alternative," "unofficial" or "ethno" medicine or healing".[1]

The WHO defined traditional medicine as all knowledge and practices used in diagnoses, prevention and treatment of physical mental or social imbalance, which rely mainly on practical ancestral experience and observation, handed down verbally or in writing.[2]

In this text, however, traditional medicine will be used synonymously only with herbal medicines. The term will be operationally defined as any objects, animal or plant parts and products and rituals indigenously prepared and used with the purpose of promoting health, preventing illness or restoring health during illness.

The use of Traditional medicines in the management of ill-health in man is as old as man himself. The practice has two main aspects - the professional use, which is carried out by herbalists and other traditional healers, and the rather "amateurish" use by many households.

In areas where traditional medicine usage is vigorous, households treat both ailments of adults and children alike with traditional medicines.

The choice of children's health as the focus of this study, emanates from the fact, that children are a vulnerable group, and are limited in their ability to communicate illness experience. They are a group who bears the brunt of morbidity and mortality and perhaps most likely to benefit or suffer from the use of traditional medicine when ill.

1.2 **Background to Study**

I have had several encounters with traditional medicine. I can vividly recollect how my grandfather, a traditional healer, treated various people with them when I was a child and how some were used for me on many occasions that I fell ill. When I became a health worker at the orthopaedic unit of the Korlebu teaching hospital, I had witnessed many instances where patients asked for discharge against medical advice, to continue treatment of their fractures with traditional medicine. In certain instances, patients arrived in very bad conditions with fractures, after having initially sought treatment from traditional bone setters, while some patients go to traditional bone setters immediately after discharge and fail to comply with follow up care. These encounters gave me an interest in traditional medicine usage.

In the early parts of the year 2000,during a visit to the Nzema East district for the initial field study, the use of traditional medicines for the management of ailments of children by their mothers and other relatives was raised by the District Health Management Team, as a problem to be investigated. Various instances were cited when the use of traditional medicine

for children had resulted in their conditions, presumably, getting worse or even resulting in their death. The challenge was taken up therefore, after consulting my academic supervisors to study the issue for my dissertation.

1.3 Statement of the Problem

Traditional medicines are commonly used all over Ghana, and extensively in the Nzema East district, in the management of ailments in children. This is a source of great concern for hospital management and health workers in the district, since the health of some of these children is, presumably, worsened by the practice. On the other hand, the practice persists and there is every indication that it has survived the pressures of western medicine. However, no study has been done to document which traditional medicines are being used for children; the ailments for which they are used and why they are often used.

This study seeks to explore and describe the use of traditional medicines among households in managing ailments of their children in the Nzema East district, with the view of explaining why households tend to rely on traditional remedies for the management of their children's ailments (and often resort to orthodox care only as a last resort).

CHAPTER TWO

LITERATURE REVIEW AND STUDY OBJECTIVES

2.0 LITERATURE REVIEW

The fact that traditional medicine practice is as old as man was captured in the words of Melrose when she observed that, if human history was telescoped into a day, modern medicines will put in an appearance only in the last few seconds. She went further to say that traditional medicines have withstood the rapid incursions of modernization. This assertion may be very true, but despite their late arrival, modern medicines have made the greatest impact and have become the reference for health care delivery. [3]

Twumasi similarly observed that in Ghana, before the advent of colonialism the only health care providers were traditional healers who used herbs, spiritual media or rituals or a combination of both in treating and dealing with ill health. The situation seems different today because modern health facilities exist even in very remote communities, yet some households' still practice traditional medicine. [4]

The background characteristics of people who use traditional medicines have been extensively studied. Twumasi, after studying traditional medicine use among certain communities in Ghana observed that in rural communities where there are no modern hospitals and clinics, traditional healers deal with both physical and phychosocial ills of society. [5] The question that remains to be answered is what factors still make traditional medicine usage attractive to households even when modern health facilities are available?

Findings from a study by Melrose in 1983 indicated that the use of traditional medicines is not limited to rural areas but also in urban areas as well despite the availability of modern health facilities where the poor are more likely to be the main users. Citing a research conducted by Oxfam, she said a group of health seekers in Ougadougou, the Burkina Faso capital, use both traditional and orthodox medicine for the cure of particular ailments such as fever, head ache and hepatitis and that in most cases visited a traditional healer first. This finding defeats the notion that traditional medicines are used only by rural dwellers and further strengthens the belief that urban dwellers equally use them. Similarly, she cited a study in the capital of Bangladesh in 1981, which revealed that over half of mothers taking their children to a clinic went to a traditional healer before seeking care from a modern facility.[6]

Lashari in a discussion on the challenges faced in attempts to integrate traditional medicines into modern health care, contended that almost all the patients in rural areas of developing countries are initially attended by traditional healers and only those who do not adequately recover make their way to the hospital.[7]

WHO, in an article on the need to integrate traditional medicines into primary health care (PHC), observed that three quarters of the population of third world countries still rely on traditional medicine. This finding may invariably apply to Ghana with the prevalence perhaps even higher in the Nzema East District, where this study was carried out.[8]

Similarly, Akerele in a study on the usefulness of traditional medicines observed that some 80% of the worlds inhabitants rely chiefly on traditional medicine for their primary health care needs.[9]

King and Funkenstein, observed that income, education and occupation are the main determinants for the use of traditional medicine but in addition religion and ethnicity also play a great role. [10] This may explain to some extent why the poor and illiterate are often believed to be over represented in the domain of traditional medicine users. Walton also observed the association of poor economic status with the patronage of traditional medicines.[11]

In describing how herbal medicines are procured, Wondergen et al found that herbal drugs in their crude form can be gathered from the bush around the house or can be obtained from trade channels in the market, from stores or from peddlers. They further observed that in rural areas there are no difficulties in finding particular herbs. [12] This view may apply in most instances for users of traditional medicines, particularly those who live in rural communities. Households' supply of herbal medicines may also come from traditional health care providers in the community such as traditional birth attendants (TBAs) and traditional healers and fetish priests as indicated by Tuwmasi.[5] In addition to this the proportion of traditional healers to patients in rural areas is relatively high (1:407) making access to them relatively easy as found by Boye and Ampofo.

Knowledge on medical herbs could also be acquired from printed texts by Abiew,[13] Irvine[14] and Ampofo. [15]

Addae-Mensah, in his book "Towards a rational basis for herbal medicines", presented results of tests and trials on the efficacy of some of the commonly used herbs in Ghana.[16] His findings indicate, that indeed some of the herbs used extensively in Ghana as traditional remedies are potent against some of the ailments for which they are used. Ayitey-Smith reported similar findings. [17]

Klouda, after studying the activities of traditional healers in Tanzania observed that their roles in society have been greatly romanticized and that there is a broad spectrum of such people from idiots, to charlatans, to people just starting, to the very experienced members of a family who happened to have dealt with an illness before. Some are generalists and some specialize in herbs or bone setting or psychiatry or social medicine or magic or witchcraft or poisoning. Some are of very great benefit especially because of their personal knowledge of families, the background causes of poor health and the individual attention to patients. Such description of herbalists can best be seen as prejudicial, as other researchers found that most of them are responsible members of their communities. Klouda went on to say that some of their practices such as applying cowdung to the umbilicus after cutting was responsible for many cases of neonatal tetanus. His final observations are very significant because it is one of the central issues of most debates surrounding the use of traditional medicine. [18]

Bibeau et al observed that the traditional healer displays genuine skills in his practice and may function variously as a botanist, pharmacist, doctor psychiatrist and social worker in treating different illnesses. They further observed that traditional medicine is a complete medical system based on holistic concepts of health covering somatic, psychological and

social aspects; and that traditional medicine is dynamic, evolving in every way to cope with today's society. [19] This observation is worth noting because unlike modern medicine, traditional medical practitioners maintain a very close relationship with their patients and seem to cater for their socio-psychological as well as their physical problems.

WHO observed that traditional healers, especially traditional birth attendants (TBA's), were very helpful in health care delivery by using traditional medicines.[20] This view has been supported by Chen, who felt that training regular health workers in traditional medicine usage would assist greatly in health care delivery.[21] The difficulty perceived here is whether modern health workers will be willing to undergo such training or whether there would be enough resources for such training in most developing countries.

Twumasi observed that the practice of traditional healers is often accompanied with magico-religious relics and that they are often accused of using non-scientific methods of managing illness, but some of their practices have been found to be scientific.[5] This apparent secrecy that surrounds medical practice is not exclusive to traditional healers alone but to orthodox medicine as well. In the view of Galverz-Tan, obscurantism of indigenous systems and the elitist mysticism of western medicine serve one common interest, that is to prevent people's participation in them in order to further their commercial interests.[22]

The psycho-therapeutic effect of traditional medicine was observed by many investigators including Twumasi [5], Opler [23] and Cannon [24]. This might explain why traditional medicine appears to be popular when illness is perceived as being caused by supernatural forces. As

observed by Herskovits, the herbal and other medications administered to people may only be a placebo but the belief that a patient is being helped through the attention of a skilled practitioner will have a positive psychosomatic effect on the patient and his family.[25]

Concerning the negative attitudes usually expressed towards traditional medicine by modern health workers, Abankwa (1987) observed that doctors by the nature of their work and training are more exposed to adverse effects of traditional medicine than their beneficial effects and that their training has given them a more negative attitude towards traditional medicines. [26]

The fact that perceptions about the cause and nature of illness play a vital role in the choice of traditional medicines was shown by Razali.[27] and again by Twumasi. Razali in a survey of psychiatry patients seeking orthodox care at a hospital in Pakistan observed that, the common view is that modern medicines are good for physical illness, but powerless against black magic and other supernatural causes of illness, while Twumasi also observed that traditional medicines have persisted in the area of psychosomatic illness, where scientific medicine has failed to produce equally good results.

In explaining why traditional medicines are often used, Carpentier et al observed that the two most important factors, which determine the choice of traditional or modern medicine, are proximity and cost which are closely related to income and educational level of the patient. [28] Equally, Chiwuzie et al found in a study in Nigeria that majority of people use traditional medicine rather than modern medicine for reasons of culture, cost and availability and that if the harmful aspects of traditional medicines could be eliminated and the two

systems were to collaborate the population would have been better serve than it had.[29] Osei in studying traditional Akan health practices observed that convulsion in children was thought to be precipitated by acute constipation, therefore, at the least suspicion of constipation children are given herbal enemas or pharmaceutical laxatives.[30]

In investigating issues such as raised by this study, Abramson, suggested the use of qualitative methods such as focus group discussions, interviews, questionnaire and observations.[31] Good, suggested the use of narrative representation of illness, [illness stories].[32] Scrimshaw and Gleason also described the usefulness of Rapid Appraisal procedures in data collection on such health issues including information from key informants.[33]

In handling data collected and its analysis Coffey and Alkinson[34] and Strauss[35], suggested the use of coding for similar categories of responses, since it is very unlikely to have all relevant data relating to one issue neatly provided under any single section of the data collection tool. Kirkwood[36] and Lemeshow et al [37] suggested a simple method of arriving at the ideal and minimum sample sizes to be used based on prior knowledge of the prevalence of the issue to be studied and the investigators preferred confidence level.

It can be seen from the literature that certain questions still remain unanswered thus creating a knowledge gap between what is actually known about traditional medicine use at household level and why it is used in managing children's ailments in particular, in the recent past and what prevails at the moment, since none of the studies cited seem to have fully addressed the issue. It is this knowledge gap that this study attempts to fill.

CHAPTER THREE

3.0 METHODS AND MATERIALS

3.1 THE STUDY AREA AND UNIT

Study Area

The study was carried out in the Nzema East district, which is one of the eleven districts in the Western Region of Ghana. The area lies in the tropical rain belt and thus experiences rainfall all year round. The vegetation is richly tropical with a variety of plant and animal species. The land is undulating with its peak around 135 metres. Provisional results from the Ghana Population and Housing Census, 2000, put the population at 131,258 of which 51.4% are female and 4% children. Twenty six percent of the people live in urban areas while the remaining live in rural areas. Illiteracy level is high in the area, particularly among females. Sanitation is also relatively poor, exposing the populace to infectious diseases. [38]

The district has two hospitals, four health centres and three community clinics. Health service delivery is made difficult by low manpower and poor transportation, especially during rainy seasons.

For the past five years, the five commonest causes of OPD attendance (morbidity) among children have been malaria, intestinal worms, anaemia, upper respiratory tract infections and diarrhoeal diseases. Other commonly reported illness among children included skin diseases, gastro-intestinal tract disorders and complications resulting from herbal enemas, such as enema colitis. Children alone account for 24% of OPD attendance while their mothers form 33% attendance in the District. Together mothers and children they form approximately 57% of all those who attend OPD in the district. [39]

Modern health service delivery in the area is uneven, with most service delivery points located in the southern sector (where this study was conducted). Two of the six study communities have modern heath facilities, one is in the process of building, while the remaining have none, and are at least five kilometers away from the nearest modern health facility. Access to modern health care is made more difficult by poor transportation system.

The main language spoken by the people is Nzema (a brand of Akan language). Chiefs and elders handle traditional authority, while the district assembly controls civil authority.

Some health programmes being run in the district by the Ministry of Health include Polio Eradication, AIDS/STD, TB, Leprosy, Accelerated Malaria Programme, Filariasis, Onchocerciasis, Yaws, Schistomiasis and School Health and School Treatment of Malaria Project.

3.2 Study population and units

The study population comprised of all households and herbalists in the study area, the Nzema East District. The households that formed the study units were those that were eligible as earlier defined and sited in the sampled communities. The study units were those identified anywhere in the study area. A respondent for the household study unit was an adult member selected by the household head.

3.3 **Study design**

The study is a cross-sectional explorative and descriptive study of the use of Herbal/Traditional medicines in the management of ailments in children for the purpose of understanding the factors that interplay in the process of using herbal/traditional medicines as cure for children when they are ill.

3.4.0 Sampling

3.4.1 Sampling procedure

A multi-stage sampling procedure was adopted. Mixtures of random and purposive, as well as opportunistic sampling methods were employed. Firstly, the six sub-districts that made up the study area (district) listed. Two of these were randomly selected. These formed the first stage sample. Since it was planned to interview study units in two urban communities, the only two urban communities in this sample automatically qualified to participate in the study.

Secondly, due to accessibility problems, only nine easily accessible communities in the first stage sample were listed, out of which four were randomly selected. These formed the second stage sample. The households in theses communities then formed the third stage sample. From these the eligible households were identified and interviewed. The selection of herbalists in this study was purely opportunistic, in that, any person identified in the study area as such qualified to be studied, one he/she was interested. The only limit was the number per community and the total number to be studied (10).

The communities were classified into urban and rural. Two urban communities were thereafter selected at random while four rural communities were also randomly selected.

Approximately (42) 26% of households (respondents) were randomly selected and interviewed from the urban community and the remaining 74% (120) selected from the rural communities. (The proportionate representation was in accordance with the demographic characteristics of the district. 26% of communities live in urban areas while, 74% live in rural areas).

3.4.2 Sample Size

The sample size for this study was 162. This was arrived at based on certain realities, such as budget, logistics, time and other resources at the disposal of the research team. A more appropriate sample size should have been 288 based on Kirkwood's methods of adequate sample size determination, whereby the prevalence of traditional medicine use was assumed to be 75% (WHO) and the researcher's preferred confidence level for the study was 95%. (i.e. standard error of 2.5%). Refer to appendix E.

The number of respondents to be interviewed in each sampled community was predetermined. In the two urban communities 21 households each were interviewed (42). In the rural communities, 25 households each were interviewed in two, 30 in another and 40 in the other (120). (This was based on their relative sizes). The composition of the sample was in conformity with the residential structure of the study area, 26% (42) of the people live in urban areas, while 74% (120) live in rural areas.

Ten herbalists were interviewed, two each from the two sampled urban and the larger rural communities and one each from the remaining sampled rural communities. One herbalist outside the sample area, but within the study area, was also interviewed.

Illness stories were collected from 16 households within the sampled areas who were randomly selected, two each from the urban communities and three each from the rural communities.

3.5.0 Data collection

3.5.1 Tools

The main data collection tool used was a questionnaire administered to an adult member selected by each eligible household. The questionnaire had both open and close-ended questions and was in six sections, with each section dealing with a specific research question or objective.

Two supplementary tools, an in-depth interview guide for herbalists and an illness story collection guide were also used.

A planned focus group discussion with health workers and selected groups from three non-sampled communities could not come off due to organizational problems beyond the control of the researcher.

Unstructured interviews with community key informants and some health workers provided valuable baseline information in the development of the data collection tools.

3.5.2 Tool for Economic status assessment

In quest for a suitable working definition and classification of households as poor, average or rich, a six-point measure of economic status was selected from a long list of issues, based on the community's perception of wealth and poverty. The final six issues selected and used as measures of wealth or poverty were:

1. Household's source of energy for cooking.
2. Household's means of transport.
3. Household's source of light.
4. Household's source of place of convenience.

5. Household's possessions and
6. Type of shelter in which household lives.

The first items on each of the six selected issues were given equal weights of three points and third items had one point. All middle items had two points. (That is to say having a car was given equal weight as having light supply from electricity source. Similarly, living in a mud- house had equal weight as using a public toilet or easing oneself in the bush).

It was assumed that using the six- point scale would greatly reduce biases in favour of any single issue. The scores on each issue were added and households, who scored between 6 and 9 classified as poor, those from 10 to 12 classified as average and those from 13 and above classified as rich. (Refer to appendix B, section six)

(The pretest showed that this was a suitable tool, at least for the purpose of this study, though some of the households classified as rich by the standards and seen as such by community members, did not see themselves as rich. On the other hand those classified as poor admitted they were poor).

3.5.3 **Pretesting of Tools**

One tool, the household questionnaire, was tested. It was administered to five randomly selected households each in the rural and urban non-sampled communities in the study area. Findings from the pretest indicated that certain questions were repetitive while some were not clear to respondents. The questionnaire was also found to be too long. In the end the

length was reduced, some questions restructured and others deleted. The interpreter was found to be competent.

3.5.3.1 **Data collection techniques**

All six sampled communities were notified about the study through their chiefs with the assistance of either an assemble member or a nurse who was familiar with the community. In most cases the chiefs ordered gong-gong to be beaten to inform the people about the study.

Data was collected within a six- week period. In the two urban areas the direction to start data collection from was determined by throwing sand in the air and following the direction of wind flow to the first house, after alighting at the main lorry park. (This was possible because the houses were in line). In the rural communities no specific pattern was followed, we just went into any house.

Once a home was entered the house hold head was looked for. When identified, the purpose of the study was communicated to him or her (the introductory letter from the District Administration was shown if asked for). With his / her assistance a respondent was selected. The questionnaire was then administered. In homes where the respondent could not speak Fante or English, communication was through an interpreter, who served as assistant to the resident or a member of the household who volunteered.

In houses where there was more than one eligible household, only one was interviewed. In others where the respondent was too busy to be interviewed, interview was postponed to another day.

Illness stories were collected by interviewing an adult member, who was directly responsible for the upbringing of the child whose illness story was being told at the time he/she was ill in the sampled communities only. The household questionnaire was not administered to such households. Data from herbalists was collected by first identifying them and arranging for their interview. Interview was then carried with them in their homes. Certain aspects of household economic status were observed for around the home and appropriately marked on the questionnaire without asking further questions.

3.6 Data Analysis

Data was analyzed manually. Codes were provided for each category of data

Relevant data were separated into categories under each code. Simple frequencies of responses were found (expressed in percentages). Decoding was then done and meaning attached to the entire data.

This process was limited to information generated from household questionnaire and in-depth interviews with herbalists only. Illness stories were analyzed differently because their trends were more easily predictable.

3.7 Limitations of Study and Problems

The fact that this researcher cannot speak Nzema, the language spoken by the people in the study area, might have in some ways affected the quality of data. This is because though an interpreter was used it was found that in households where either English or Fante was spoken, data collection was much faster and smooth.

The method used to assess economic status of the study unit might not have fully reflected their true economic stations in life, since culturally some households may prefer to be seen as poor rather than rich, as observed from the pretest. (Attempts to widen the search for true economic status would have reduced this work to a socio-economic status study).

CHAPTER FIVE

STUDY FINDINGS

4.1 Survey Findings

Table 1 represents the background characteristics of respondents in the study. Majority of respondents (97%) were females. Their ages were fifteen years and above, with majority between the ages of 20 and 29 years (46.3%). Eighty percent were in marital union while the remaining were either single, divorced or widowed. Most respondents were related to children in the households as mothers (77%) or grandmothers (18.5%). The remaining were either aunts, fathers or grandfathers.

The occupations of the respondents included fish mongering, farming, trading, oil milling, food selling, teaching and others. The rest were unemployed. The educational status of respondents was found to be generally low with almost half of respondents (46.3%) having no formal education. Another 45.7% had either primary or middle school/JSS education. Eight percent had secondary education and above.

Majority of respondents were Christians, while the rest were either Moslems, Traditionalists, belonged to unspecified religious groups or did not practice any religion at all.

Table1 describes the background characteristics of respondents.

Table 1: Background Characteristics of Respondents

Characteristics	Number of Respondents	Percentage
Sex	157	
Female	5	97
Male		3
Age		
15-19	6	3.7
20-29	75	46.3
30-39	42	25.9
40-49	15	9.3
50 and above	24	14.8
Relationship to children		
Mother	125	77.0
Grandmother	30	18.5
Others	7	4.5
Number of children per household		
1	41	25.4
2	47	29.0
3	48	29.6
4	21	13.0
5 or more	5	3.0
Occupation		
Trading	36	22.2
Fishmongering	34	21.0
Farming	31	19.0
Food selling	24	14.8
Others	28	17.4
Unemployed	9	5.7
Education Level		
None	75	46.3
Primary	22	13.6
Middle/JSS	52	32.1
Secondary	10	6.1
Tertiary	3	1.9

Most of the respondents were Nzemas by ethnicity (76.5%). Fantes formed 14.2%, while other ethnic groups consisting of Wassa, Ewe, Ahanta, Wangara and Hausa made up the remaining 9.3%. Majority of households in the study were found to be poor (61.1%). Those considered average were 27.2% while the rich made up 11.7%.

Knowledge and Perception of Illness

Respondents' knowledge about ailments affecting children in their communities was found to be quite high. At least each household was able to mention three ailments affecting children in the community. Fever was the commonly mentioned ailment followed by Measles, diarrhoea and colds and coughs.

Table 2 shows the percentage of households that mentioned corresponding ailments of children in their communities.

Table 2: **Children's ailments in community mentioned by households**

Ailment	Number of households	Percentage of Households
Fever	142	87.7
Measles	99	61.1
Diarrhoea	97	59.9
Coughs and colds	52	32.1
Stomach ache	38	23.5
Asthma	18	11.1
Convulsion	18	11.1
Skin rashes	14	8.6
Hernia	9	5.6
Anaemia	8	4.9
Boils	6	3.7
Intestinal worms	5	3.0
Mucoid stools	12	7.4
"Unossified fontanelle"(Mpaemu)	4	2.5
Hydrocephally	1	0.62
Vaginal discharge	1	0.62

Ninety seven percent of households said at least one child in the hosuehold had suffered from one of the ailments they mentioned within the previous two years. Of the 97%,(149,95.6%) had used traditional medicines in treating at least one of such ailments of their children. The rest used traditional medicines for treating ailments that they did not see as commonly affecting children and so did not mention them. Ninety six percent of those who used traditional medicines for the ailments that affected their children reported improvements in their children's conditions; 1.3% did not notice any improvements while 2% reported of their children's conditions getting worse. Majority of households 123(75.9%) felt that poor nutrition predisposes children to ill-health while, 96 (59.3%) also felt poor environmental sanitation was a predisposing factor. Poor parenting, hostile climatic conditions, stress and evil spirits were other factors mentioned.

Health seeking behaviour of households

Most households will self treat their ill children at home with herbal medicines when they perceive the child's ailment as mild 81(50%). Another 23(14.2%) and 17(10.5%) would do so when they do not have money to take ill child to hospital and when illness has just started, respectively. About eleven percent would self-treat their children at home when hospital treatments fail to cure their children. A further 8.6% would self treat their children at home when suitable herbs for the particular ailment is available. The rest would self treat when they perceive illness as "non-hospital" illness or when child is at a suitable age to tolerate the particular herbal medicines appropriate for his ailment.

One hundred and two (62.9%) households said they would never under any circumstance seek the services of herbalists in the event of their children being ill, while 60 (37.1%) said they would require the services of a herbalist at a point in time of illness of their children. Thirty two (53%) of those who would seek herbalist services said they would require the services of a herbalist when both self treatment of their children with herbs and treatment from a modern health care facility fail to help their children recover. Twelve (20%) also said they would require the services of herbalists in emergency situations such as convulsion or sudden illness at night, of their children. A further 10(16.6%) said they would visit a herbalist for care of their children only with specific ailments such as fractures or "Mpaemu" (unossified fontanelle). The remaining respondents would see a herbalist if they perceive their childrens ailment as being caused by evil spirits.

One hundred and four (86.4%) households said they would seek treatment for their ill children at a modern health care facility when they perceive illness as serious. Nine percent said they would do so during emergency illness, while only 4.3% said they would do same when they have money. (*Serious illness was defined as illness that does not respond to treatments within two to seven days with appropriate herbal medicines or illness in which child shows progressive weakness, refuses food, continues to spike temperature, shows progressive signs of restlessness or in the case of diarrhoeal illness, shows an increase in the frequency of passing watery stools).*

Majority of respondents (56.8%) would make up their minds to seek care for their ill children at a modern health facility after three days of self -care. Nine and a half percent would take the decision after 2 days of self-treatment, while 17.9% would do same after 4 days. The remaining 43.2% would seek care at a modern facility after 7 or more days of self- care. One hundred and twenty one (74.7%) households felt that certain ailments were more susceptible to treatment with traditional medicine than orthodox medicines while 41(25.3%) differ on this view. On the other hand, 158(97.5%) respondents felt there were certain ailments of children for which hospital treatments are more effective.

Table 3 compares the views of households on the issue.

Table 3. Comparison of respondents' views on susceptibility of various children's ailments to orthodox and traditional medicines.

	Percentage of Households	
Ailment	**Orthodox treatment**	**Herbal medicine**
Fever	49.4	5.6
Measles	17.3	23.5
Diarrhoea	25.9	5.6
Convulsion	23.5	11.1
Stomach ache	13.0	5.6
Hernia	0.6	2.5
Early stages of injury	3.7	-
Colds and coughs	4.9	
Constipation	-	5.6
"Mpaemu"		6.2
Boils		13.0
Fractures	-	6.8
Asthma		8.6

Before taking an ill child to a modern health facility for treatment, 18.5% of respondents said they needed to seek permission from their spouses, mothers or the priests of their religious organizations. Almost all the respondents (99.4%) said once they had money and were convinced that the ailment of their child was serious enough to warrant care at a

modern health facility, there is nothing about the hospital system that would discourage them from sending their children there.

Households' main source of knowledge on use of traditional medicines was immediate older family members and community elders (77.8%). Peddlers and herbalists also provided some information to households. About ninety one percent of households had their supply of herbs used in treating ailments of children from the bush (around home or farm), while the remaining had theirs from peddlers (7%), and herbalists (1.6%). Ninety six percent said it was relatively easy to come by their herbs, while the remaining said it was relatively difficult.

For treating ailments in children, households use five main types of herbal preparations. These include herbal enemas (58.2%), herbal drinks (24.3%), skin preparations (6.3%) and herbal baths (5.3%) and nasal instillations (5.8%). Various preparations exist for the same ailment of children. All five preparations were available for the cure of fever, while certain ailments such as boils had only one preparation.

Table 4 shows the ailments or conditions and the proportion of corresponding preparations available for their treatment.

Table 4 Percentage form of traditional medical preparations used to treat children's ailments.

	Percentage form of particular preparations for treating corresponding ailments				
	Nasal Instillation	Enema	Drinks	Skin prep.	Baths
Measles	-	73.1	19.2	7.3	-
Fever	1.9	37.7	43.4	7.3	9.4
Constipaiton	-	90.0	10.0	-	-
Asthma	-	-	100.0	-	
"Mpaemu"	14.2	28.6	28.6	28.6	-
Convulsion	46.2	7.7	15.4	-	30.8
Diarrhoea	-	90.9	9.1	-	-
Mucoid stools	-	100.0	-	-	
Stomach ache		90.0	10.0	-	-
Hernia	-	83.3	16.7		
Skin rashes	-	25.0	-	50.0	25.0
Anemia	-	-	100.0	-	-
Coughs and colds	75.0		25.0		-
Delayed toddling		100.0		-	-
Boils	-	-	-	100.0	-
Chicken pox	-	-	100.0		-

Additives to herbs for preparation of enema included pepper (61.0%), ginger (24.4%), both pepper and ginger (11.0%), clay (2.4%) and goats' excreta (1.2%).

Practices associated with the use of traditional medicine in managing children's ailments

The minimum age at which a child is exposed to herbal medicines varies greatly among households but lies between two days old and 12 months of life. Sixteen percent of households said they could introduce herbal medicines to their ill children at any age depending on the specific ailments. The same proportion would introduce their children to traditional medicines when child is between zero and two weeks old. Twelve percent would start herbal treatments when child is between 3 and 4weeks old. Forty percent would introduce herbal treatment when child is between 2 and 6 months. The remaining (16.1%) would begin using herbal medicines for child when he is more than 7 months old.

About eighty five percent of households had separate syringes for giving enema to each child in the household, while the remaining either shared one syringe among all children or had one for babies and another for older children.

Seventy nine percent of households would not borrow syringes from their neighbours to use on their children, but 21% would. On the other hand, 71% would lend their children's syringes to neighbours to use for their children. Most of these indicated that they would only have to wash the syringes with hot water when they were returned before using them on their children again. Some also said it was culturally deviant to refuse neighbours use of one's items especially when the health of children is at stake.

Another finding of interest was that most households had replaced the rectal pieces of their enema syringes with pen tubes to increase their effectiveness. Also children had to be

immobilized by other household members during the process of administering enemas. (They invariably cry and struggle during the process).

Almost eighty eight percent of households said they would withhold herbal medicines if child was taking hospital medicines, while 19(12.3%) would not. For enema, in particular, the group said they could give if child is on oral hospital medications. Some indicated that even if the child is on oral hospital treatment and their herbal medicines are also oral they would give herbal medicines very early in the mornings and give hospital medicines later. Others also said they would give the medications on alternate days.

Households' perceptions regarding the practice of using traditional medicines in managing ailments of children

About seventy eight and half percent(127) of households said they did not perceive any risks associated with the use of traditional medicines to manage ailments of children. Those who thought otherwise believed issues surrounding hygienic preparation of herbal medicines, determination of dosages and lack of knowledge of appropriate herbs by households were potential risk factors in using herbal medicines to treat ill children.

One hundred and fifty three (94.4%) respondents believe that the use of traditional medicines in managing children's ailments is beneficial. The most common benefits mentioned was financial, (77%). Other benefits mentioned included easy accessibility to traditional medicine, preservation of traditional knowledge in childcare, source of cure for illnesses that have defied orthodox treatments and the only available health care for people who do not have access to modern health care facilities. Those who do not think herbal

medicines were beneficial claimed they used them because they could not afford hospital bills.

For the immediate management of a convulsing child, (90)55.6% of respondents said they would rush their children to the nearest modern health facility. Thirty six percent said they would self-treat their children at home, either with appropriate herbal medicines, or simply sponge the child. The remaining said they would rush child to community elders or a herbalist's home for care. It was also found that only men rush convulsing children to herbalists' homes, while the child's mother and other community members follow and that women are not allowed to do so.

Proposed measures to control the practice of using traditional medicines to manage ailments of children

Increase of geographic accessibility of households to modern health care was the main issue dealt with. One hundred and fifty seven (96.9%) households would welcome the idea of a modern health facility being built in their community and manned by a nurse who could attend to their children's health needs.

Of the 157, 151 (95.7%) said the arrangement would greatly affect their dependence on traditional medicines for managing ailments of their children. Sixty two percent of these respondents (94) said they would stop the use of traditional medicines for children outright. The remaining said they would reduce their dependence on herbal medicines if certain conditions were met.

Of the later group,(7) 11.9% said their perceptions of the ailment either, as "hospital or non-hospital" illness would still play a role in their utilization of the modern facility. Fifteen respondents also said their reduced dependence on herbal medicines would be closely linked to the cost for treatments at the new facility (when it is free more of them would reduce their dependence but do otherwise when cost is high), while eighteen (18) also linked their reduction of traditional medicine use on children to their perceived efficacy and quality of care at the modern facility. The respondents also noted that, health workers, especially nurses, did not frequently visit them at home.

4.2 **Findings from interview with Herbalists**

It was found that herbalists' services in the study area are provided mainly by the priests of a "Christo-tradtionalist" group referred to by the indigens as "Nakaba" and by other Akan groups as "Awoyo", but who refer to themselves in Christian circles as "The Twelve Apostles' Church". These priests undergo special training from older priests / herbalists, after which they are ordained and accepted as leaders of "churches" in their communities, where they also double as herbalists. They combine magico-religious acts and herbs in the management of children's ailments. They also combine other economic activities with their functions. The female priests also function as Traditional Birth Attendants (TBAs) and provide neonatal care for babies. (No other categories of traditional healers were accessed for interview).

The herbalists vary in their views on which ailments of children they would treat and the ones they would advise "mothers" to take to hospital. But generally they attempt to treat

most common ailments of children in the community ranging from fever, convulsion, "Mpaemu" and Mealses to fractures. They were however unanimous that they would invariably advise mothers to send their children to a modern health facility if they perceive that the child is seriously ill.

In addition to the usual preparations used by households (drinks, baths, enema, skin preparations and nasal instillations,) herbalists also use protective charms or Talisman, scarifications and prayers (religious rituals).

Payments for herbalists' services were flexible, in that households are required, by tradition, only to give thanks offerings after their children have been successfully treated. Care-seekers were not required to pay anything before treatments are instituted for emergency illness. Consultation procedures were cordial and no consultation fees were required.

Dosages of herbal medicines to be given to a child are determined by the severity of illness and age of a child, based on prior experience with other children with similar ailments or by community standards (using tea spoons or "children's enema syringes" etc). Diagnoses were made by physical examination, inspection and at times, by divination.

Herbalists' practices were advertised far and near by satisfied clients and they are held in high esteem in society. Some of them play certain key roles such as community opinion leaders by virtue of the fact that they are herbalists.

Using convulsion as a reference, it was observed that the herbalists' knowledge of the pathophysiology of disease and its aetiology was grossly inadequate. For example, majority of those interviewed claimed convulsion in children, was caused by accumulation of mucus or phlegm in their abdomen. Only one added that increased temperature was a factor.

A classical treatment procedure was witnessed. *A middle-aged man, followed by a few other people rushed a convulsing child of about two years, to the home of a herbalist, whom I was interviewing. The herbalist sprang up, rushed to the bush behind the house, and came back with some herbs; then collected the child from the man and squeezed some of the herb into the child's nostrils. He lowered the child onto a mat on the ground, rushed to the "shrine", picked an egg, murmured some words onto it and placed it on the child's abdomen.* (I wondered why the egg did not roll off, while the child was twitching, but could not ask why?)*At this moment the young man was mashing some of the herbs in a bucket of water, which they kept pouring on the child. The child sneezed and suddenly got up, crying.* Thereafter, the herbalist advised that the child be taken to hospital for treatment.

4.3 Findings from Illness Stories

All but one illness story were found to follow a peculiar pattern – a pattern that attempts to show the efficacy of herbal medicines for illnesses that have defied orthodox medicine. They show a trend whereby an ill child was taken to hospital several times without success but was later cured when traditional medicines were used.

The only odd story was from an elderly woman, the grandmother of a child who supposedly died through the use of herbal medicine. The woman said *"Not long ago, I gave a herbal concoction to one of my grandsons (six months old), for the cure of hernia. This was a preparation we always use to treat hernia; which I had used for several babies. Not long after the enema, which he retained, he became restless with the abdomen very shiny. Later the eyes started rolling. I called for his mother and we took him to the hospital. He died later with a distended abdomen and foaming month. The Nurses said he died from the enema I gave, which I had to admit"*. Her gestures clearly indicated that she did not believe the child died from the effects of the enema.

An illustration of stories showing the efficacy of herbal medicine is as follows: *"When my daughter was three months old she was so small that I even felt shy carrying her at my back outside home. I took her to hospital several times, where she was given different medicines, but she remained the same. When I took her another time she was admitted. I put her at my back and asked permission from the nurses to come home and prepare and also inform my mother and husband. When I was waiting for a car at the entrance to the hospital, an elderly woman passing by noticed the child. She came closer and asked to see the child. I did not know her. She used her hands to press on the child's head as if she was searching for something in his head. Then she smiled and asked me what was wrong with the child. I told her I did not know and that we were being admitted to the hospital. She then told me that the child had "mpaemu" (unossified fontanelle) and that hospital medicines could not cure it. She later directed me to a medicine man at Aborah. When I reached home, I went to the man who took the child from me and started examining the head the way the elderly woman had. He also said that the child had "mpaemu" but he did not have the medicine ready. The next*

day he sent one of his assistants to Tarkwa who brought the medicines. He directed me on how to use them. I gave some as enema, instilled some into her nostrils and added shea butter to some, which I was smearing on the scalp. I started noticing improvements in the child within a week. By three weeks my baby became normal. She is now 3 years old and very healthy". (This was from a 26-year old mother about her first and only child). The story was substantiated by her mother, and younger sisters who teased her about the size of Pomaa, the small girl, before her recovery.

One factor which is also evident from the illness stories was that, they were told with a sense of pride and fulfillment, to stress a point that traditional medicines work miracle where orthodox medicines fail.

CHAPTER FIVE

DISCUSSION OF FINDINGS AND CONCLUSIONS

The findings of this study, that most of the households who use traditional medicines to treat their childrens ailments are poor (61.1%); have little or no formal education (59.9%) and live in deprived communities (74%), agree with most earlier findings, particularly of Melrose, Twumasi, King and the Funkenstein, and most of WHO and World Bank findings. Yangni-Angate, and Waltson, also had similar findings.

In addition, findings of this study suggest that the poor in society are five times more likely to resort to the use of traditional remedies for their children's illnesses than the rich, while those with no formal education and little education, together, are about twelve times more likely than the educated to use traditional medicines in treating their children's illnesses.

Findings also suggest that for virtually every ailment that affects children in the community, there is a corresponding traditional treatment and that communicable diseases related to poor environmental conditions, poor nutrition, ignorance and abject poverty abound in the area. (Perhaps the most disturbing issue is the high incidence of reports of measles, despite immunization).

The general health seeking behaviour of households in the event of children's illness includes self-medication with traditional medicines at home, taking child to a herbalist or to a modern health care facility.

Findings here do not agree fully with some earlier findings. It was found that most households (62.9%) bypass herbalists in their communities and take their ill children to the hospital when their own traditional treatments fail. This seems to be in contrast to Melrose's finding that majority of mothers seeking care at health centres visited traditional healers first. In fact, if this had been the case in the recent past then presently the trend seems to be changing. This may be partly due to religious influences that may not make the herbalists practice appealing to Christians, who form majority of the sample. It may also be due to the fact that over the years, knowledge of suitable traditional medicines and access to them by households have improved so much that, at least for children's illnesses, most households choose not to utilize the services of herbalists. It may also be due to the fact that, "mothers" are beginning to realize that care from modern health facilities are efficacious against most of their children's ailments that do not respond to their traditional treatments. If their own treatments fail the likelihood that those of the herbalists would also fail is high. The cultural differences between sample for this study and that of Melrose is also worth noting; her study was conducted in Bangladesh.

The fact that a very high proportion of households were aware that insanitary conditions and malnutrition are the most common factors which predispose children to illness also, suggests that they equally believe that if such factors were removed most children would be healthier. This is in agreement with earlier findings of Bannor (1962), who is of the view that most ailments that affect children were due to poor environmental conditions ignorance and others, and would not have occurred in a good and well-planned public health system.[40]

Findings on the practices of households with respect to traditional preparations used for treating various aliments of children, suggest the possibility of adverse effects on their children despite their perception that no risks are associated with the use of traditional medicine. The uses of pepper, ginger and to a lesser extent, clay and goats' excreta as additives to enema preparations are a potential source of problem. At least pepper and ginger are known gastro-intestinal tract irritants. Moreover the hygienic status of the equipment used to prepare these medicines cannot be guaranteed. The sharing of enema syringes among children of the same household and with neighbours' children seems potentially dangerous. This agrees with the views of Klouda (1981). Since the contents of the main herbs used were not studied, much could not be said in that respect.

Another point worthy of note is the finding that some households combine traditional medicines with hospital drugs in treating their children's ailments. This is worrying since it can lead to problems for the child. Apart from the possibility of adverse effects resulting directly from the combination, the possibility of non-compliance with directives on hospital medications exists, particularly among those who indicated they would give the drugs on alternate days.

That the use of traditional medicines is beneficial to households is reflected in most of the findings of this study. Apart from the fact that ill children are cured at little cost, preservation of traditional knowledge in medicines for children and the fact that there is a hope for the cure of ailments that have defied the "magic of western medicines" is rewarding to households. This issue was much reflected in the illness stories analyzed. In fact, the use

of traditional medicines seems to be an integral part of the people's culture, particularly giving of enemas to children, without which their culture of proper maintenance of children's health will be incomplete.

The finding that households seek treatment at modern health facility usually when they perceive their children's ailments as serious raises several questions. What is serious illness? Their definition for serious illness was simple – illnesses of children which fail to respond to traditional medicine within a specified period and perceptions of behaviour changes of their children – refusal of food, restlessness, high temperature, crying and so on. The question is, does this define serious illness from the point of view of health workers? If not then there would definitely be a problem. But one fact is clear, that is, anytime a mother appears with her ill child at the outpatients department (OPD), the assumption is that her child is seriously ill and needs prompt attention. Perhaps this explains the anxieties on the faces of "mothers" when hospital bureaucracies tend to delay their access to the doctor for prompt care of their children.

A point is also made clear here that, the proximate determinant for seeking orthodox care, for an ill child from a household where traditional medicine is used for the cure of children's illness, is the perception that child's ailment is serious. Financial considerations are contributory, as well as distance from health facility, but are irrelevant in the face of severe illness of the child.

Another point to note from findings, is the number of days spent in self-treating children at home (average of 3 days). In the event of failure of traditional medicines to cure child, ample time might have been wasted, not only 3 days of illness time, but assuming mother did not notice symptoms in time, more than one week might have been spent at home, making the child's condition worse by the time of arrival at the hospital.

Findings also indicate that any meaningful intervention to control the use of traditional medicines in the management of children's ailments by households must first start with expansion of modern health service delivery. Firstly, health workers must visit the homes of community members and secondly, geographic access to modern health facilities must be improved.

The finding that magico-religions relics still accompany traditional medicine as exemplified in the treatment of the convulsing child, supports Twumasi's, and Herskovits' findings about the art of traditional medical practice. This phenomenon was not evident at household level. The fact that cold water was also poured on the child suggests that part of the herbalist practice have indeed scientific basis. This observation indicates that some of the practice of traditional medicine could indeed be encouraged when they are found to be beneficial and harmless.

As was found from most of the illness stories, there is a strong sense of pride in the reporting of comparatively dramatic effects of traditional medicines. This issue often leads to

polarization of views of people about the claims of traditional medicine and perhaps its antagonism by modern health workers.

CONCLUSION

After exploring and describing the use of traditional medicine at household level for managing children's ailments, various reasons for the practice become apparent, though no single reason fully explains it. Interplay of factors tend to determine households reliance on traditional remedies for managing ailments of their children.

In answering the question of why households resort to the use of traditional medicines in the management of their children's ailments therefore, it is clear that foremost they perceive traditional medicines as efficacious and safe, not only against ailments that they perceive as mild, but also "serious" ones for which they have sought prior treatment from a modern health facility and failed. Their feeling that modern medicines are powerless against certain ailments evidently gives them the impetus to use traditional remedies for such ailments.

The fact that access to knowledge about suitable traditional medicines and their procurement is relatively easy is another factor that encourages households to use traditional medicines. Households are not required to part with their small incomes that will be needed for other purposes. They do not have to pass through any rigorous training to know what appropriate remedies exist for particular ailments. In so doing they preserve their most valued treasure, their tradition.

The non-availability of modern health facilities and the cost of treating an ill child at such a facility are other factors that compel households to use traditional remedies. The time and money and sometimes transportation to the nearest modern facility may be unbearable. The distribution of health facilities/ services is not equitable, particularly in relation to remote

areas. Health workers do not visit households at home, so that children's health issues could be discussed. No health workers are stationed in most of these communities to promptly attend to health needs of children.

In certain instances, however, the use of traditional medicines for children seems to be only out of habit, particularly the prophylactic use of herbal enema for children. In such cases the level of education of the particular household becomes the dominant factor in their use of traditional medicines. Their ignorance about the hazards posed by the practice to their children's health sustains the habit.

The concerns raised by management and health workers about the adverse effects of traditional medicines on children's health seem genuine, as could be found from some of the practices that accompany traditional medicine usage. Issues about sharing of syringes among children; the arbitrary determination of dosages of traditional medicines; their levels of efficacy and harmlessness and the fact that failed attempts to treat children with traditional medicine may lead to illness-time wasting and its attendant effects on the child, are indeed genuine. But equally genuine are the reasons for which households use traditional medicine. If modern health care for children is not accessible to households for various reasons, and they have alternate care, then they are right in using it until they feel that their methods are not working. On the other hand, if after taking a child to a modern facility the child does not seem better, they are compelled to use other available methods, which of course, include traditional medicines. But all said, traditional medicines have been found in this study to be a great source of health care for children in households, without which, as put by some respondents, they could not know what would have become of their children.

CHAPTER SIX

RECOMMENDATIONS

With regards to the findings of this study and the forgoing discussions, the following recommendations are put forward.

Firstly, there is the need to create awareness among health workers that traditional medicine is not as despicable as some of them might perceive it to be. There is the need to gather evidence on the efficacy and harmlessness of some the commonly used traditional medicines in order to convince some of the more scientifically minded modern health personnel. But whatever the challenges, a totally new approach to the perception of traditional medicine is needed in order to move the quest of integration forward. The need to harness the benefits of traditional and modern medicines must supersede protectionist interests.

Secondly, there is the need to control the use of traditional medicines in managing illness in children particularly communicable diseases for which western medicines have shown that they have no parallel. In the first place, circumstances that lead to the children's illnesses need to be controlled. Poverty, malnutrition, unsanitary environment, ignorance etc need to be tackled more vigorously. Community participation needs to be encouraged. Service delivery must be brought much closer to the doorsteps of households. There must be more frequent home visits by health workers.

Thirdly, there is the need to investigate and possibly stop certain aspects of the practice of traditional medicine at household level. For example giving enema to three-day old babies;

over-administration of enema with adulteration of the syringes, sharing of syringes, possible unhygienic preparation of medicines and contents of the preparations, must be studied.

The reported high incidence of measles despite vaccination also needs to be followed up particularly with children vaccinated in 1997.

If within the means of the District Assembly, a scheme must be put in place to assist needy households procure care for their seriously ill children at modern health care facilities.

Communities must be encouraged to cultivate herbs that they find to be efficacious against children's illnesses and must share knowledge and experiences on child health issues and practices.

Since there is a strong indication that households are prepared to take time off to treat their children, this is a basis for stepping up home-based management of some common ailments such as malaria and URTI.

Future studies into the use of Traditional Medicine, as a Public Health Issue, must concentrate more on the household as the unit of study, as against the traditional studies, which focus more on herbalists' practices, particularly if the study has something to do with child health. My short encounter with households during this study has convinced me that there is no where else better to learn about the child's health than the home.

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APPENDIX A: FOCUS GROUP DISCUSSION-GUIDE

Introduction

Herbal medicines and cures have been with us for long. They often complement the orthodox medicine. Each of us at one time might have used them.
This discussion or meeting is to enable us deliberate on the role of traditional medicine in the health of our children.

Anonymity

Contributions during this discussion are confidential. Contributors' names will not accompany their contributions.

- Brief Introduction of Issues to be Discussed

We will be discussing general issues regarding the use of herbal medicines in the management of children's ailments in this area.

- Introduction of Members

Let's begin by introducing ourselves. Please mention your name and nickname, (if you have one) your place of work and number of children. Each participant will mention the names of two preceding participants before introducing himself.

QUESTIONS GUIDE

1. What are people's general beliefs about what causes illness, especially in children in this area?.....
2. What are the general health problems of children in this district/area?
   .....
3. What are some of the local vocabularies used to describe these ailments?.....
4. When children are ill how or where do you take them for treatment?
   .....
5. Where do community members get their supply of herbal medicines from?.....
6. How do you pay for herbal treatment of children?.....
7. Do you prefer herbal treatment to hospital care, why?.....
8. By what routes are herbal medicines generally applied to children in this area?.....
9. Which route is the commonest?
10. For which ailments of children do people normally use herbal medicine?.....
11. Can any one tell us of a case in which herbal medicine was used to treat a child recently? (By describing the ailment, how medicines were used and the final outcome of the illness).....
12. Has anyone anything more to share with us regarding the use of herbal medicines in curing children apart from what we have been discussing so far?.....

Thank you!

APPENDIX B: HOUSEHOLDS' QUESTIONAIRE

This study seeks to examine the use of Traditional Medicine in the management of ailments in children in the Nzema East district. You have been selected as a participant in the study. You are assured that whatever you say will be handled confidentially. As such you are not required to give your name. We count on your faithfulness and co-operation for the success of this exercise.

SECTION ONE

CHARACTERISTICS OF RESPONDENTS.

1. Sex [1] male - [2] female
2. Age of caretaker - 15-19 [1] - 20-24 [2] 25-29 [3]
   - 30-34 [4] - 35-39 [5] 40-44 [6]
   - 45-49 [7] 50 and above [8]
3. Marital Status: Married [1] single [2] divorced [3] widowed
4. Relationship to children:.....
5. Number of children from birth to 10 years alive:.....
6. Occupation:.....
7. Level of education: None [1] Primary [2] Middle School/JSS [3] Secondary/SS [4] Tertiary, state [5] .....
8. Religion: Christian [1] Moslem [2] Traditionalist [3] Any Other [4]
9. Ethnicity (state).....
10. What are some of the ailments that affect children in the community? Including your children.....
    - i. .....
    - ii. .....
    - iii. .....
    - iv. .....
    - v. .....
    - vi. .....
    - vii. .....

11. Have any of your children suffered form any of these ailments in the past two years? Yes [1] No [2]

11b.If yes which?.....

12. Did you use herbal medicine to treat any of these ailments for your child? Yes [1] No [2]

13. What was the outcome if your response to 12 is yes.
    a. The child improved
    b. Condition remained same
    c. Condition worsened
    d. Child died.

14. What do you think makes children become ill? (Tick as mentioned).
    a. Evil spirits
    b. Poor care from parents
    c. Poor environmental sanitation
    d. Poor nutrition
    e. Any other.

15. If you wish to use particular herbs for your child's ailment where do you get them? Are they easy to find?.....

16. Under what circumstance will you use your own selected herbs to treat your child when she/he is ill?.....
    .....

17. Under what circumstances will you take her/him to the herbalist?.....
    .....

18. Under what circumstances will you take her/him to the hospital.....
    .....

19. How do you determine that your child is seriously ill?.....
    .....

20. Do you think there are some particular ailments of children for which herbal medicines are better? Yes. [1] No [2]

21. If your response is "yes" can you please mention some?
    1 .....
    2 .....

3 .....

.....

22. Do you also think there are some ailments of children for which hospital treatment/medicines are better? Yes [1] No [2]

23. Can you mention some if your response to 22 is 'yes'

1. .....
2. .....
3. .....

24. How did you acquire your knowledge in the use of herbs in curing children?

.....

25. If your child is taking hospital medicine will you give her herbal medicine alongside? Yes [1] No [2]

26. Give reasons for your answer.....

.....

.....

27. Before you take your ill child to the hospital will you have to seek permission from anyone? Yes [1] No [2]

28.If yes from whom.....

29 Even if you have money, are there any aspects of the hospital which discourage you from taking your child there when he/she is ill? Yes [1]No [2]

30 Give reasons

1. .....
2. .....
3. .....
4. .....

SECTION THREE

(Briefly describe how you prepare a particular herbal medicine for the treatment of a named ailment of your child)

31. Mention or describe ailment .....

31b. List ingredients for preparing medicine:

1. ..... 2. .....

3. ..... 4. .....

32. How is it prepared?

.....

.....

.....

33. How is it applied?.....

.....

.....

34. How long? .....

35. Which other ways could herbal medicines be applied?.....

.....

.....

36. At what age can a child be given enema or other herbal medicine?.....

37. If you wish to give enema to your children, does each of them use a separate syringe? Yes. [1] No [2]

38. For what ailments do you give your children enema?

1. .....
2. .....
3. .....
4. .....

39. Do you sometimes have to borrow syringe from your neighbour to use for your child? Yes. [1] No. [2]

40. Do your neighours sometimes borrow your syringe to use for their children? Yes. [1] No. [2]

41. Why? .....

SECTION FOUR

42. Which of the following steps will you take immediately if your child starts convulsing?
    a. Quickly prepare herbal medicine and give her
    b. Quickly bathe her with cold water (sponging)
    c. Rash her to the herbalist home
    d. Any other.
    e. Don't know
43. Do you think there are any risks associated with the use of herbal medicines for children? Yes [1] No [2]
44. If 'Yes' mention some.....
    .....
45. What are some of the benefits of using herbal medicines for managing children's ailments?
    1. .....
    2. .....
    3. .....
46. Are there some advantages of taking ill children to hospital? Yes [1] No [2]
47. Kindly mention some if your answer is 'Yes'
    .....
    .....
    .....

SECTION FIVE

48. How far is your residence form the next modern health facility?.....
49. How often do you have health workers (Nurses) visiting your home?.....
50. Would you wish a health worker stationed in your community who can take care of your children? Yes. [1] No [2]

51. Will the arrangement in 51 affect the use of herbal medicine on your child if she is ill? Yes [1] No [2]
52. Why?.....
.....
.....
.....
53. Are you aware of free treatment of children below five years in government health facilities? Yes[1] No [2]
54. What are your comments on this issue?
.....
.....
.....
.....

SECTION SIX
(ECONOMIC STATUS)

55. What do you use to cook in your home?
    a. Gas or Electric stove
    b. Kerosene stove or charcoal
    c. Firewood, coconut shell
    d. Any other
56. Do you have any of the following?
    a. Car or Motor bike
    b. Bicycle, horse or donkey
    c. None of the above
57. What source of light do you use in the home?
    a. Electric light or solar panel
    b. Gas light or kerosene lamp
    c. Any other specify
58. What type of toilet do you have in the home?

a. Water closet or KVIP
b. Household pit or vault latrine
c. Use public toilet, bush etc.

59. Do you have a television set?
    a. Is it colour
    b. Is it black and white
    c. None
60. What materials are used in building house?
    a. Blocks Modern Building with evidence of affluence, well painted etc.
    b. Bricks with 'moderate' aluminum sheet roofing 'medium standard'
    c. Mud house, tatch roofing or other low class building.
61. What final comments would you like to make concerning the use of Traditional Medicine in the management of ailments in children.

.....

.....

.....

.....

.....

Thank you.

APPENDIX D: INTERVIEW GUIDE FOR HERBALISTS

We are exploring the use of Traditional Medicines in the management of ailments in children in this area. We understand you treat ill people in this community and we wish you to share some of your experiences with us. You are assured that whatever you say will be treated as confidential. We count on your openness for the success of this exercise.

1. For how long have you been treating the sick? .....

2. How did you acquire your skills? .....

   .....

3. What are some of the ailments of children that you normally treat?

   .....

   .....

   .....

4. What are some of children's ailments that you would advise relatives to take to hospital?

   .....

   .....

5. How do you treat children? .....

   Herbal drinks

   Enemas

   - Scarification

   - Skin preparations

   Talisman etc.

   Any other

6. How do you charge for your services? .....

7. What procedures do you use to know the particular ailment of a child? ……..

……

8. How do you determine the amount of medication to be given to a child for his particular ailment? ……

9. Apart from being a "medicine man" do you do any other work? ……

10. How do you think this community sees your work? ……

11. Who do you think people come to you for medical help? ……..

12. In case a mother rushes to you with a convulsing child, would you demand a fee before attending to the child? ……

13. What is convulsion?

What causes it?

How do you treat it?

14. Do you have any special roles in this community? ……..

15. Why were you assigned this role? ……

……

16. Do you think there are any problems associated with the use of herbal medicines for children? ……..

17. Do you recommend mothers giving herbal medicines to their children without consulting herbal medicine experts like you? Why? ……

18. What role do you think herbal medicines can play in the whole health care delivery of children in this area? ……...

……

19. Is there any age limit of children treated by you? Why .....

20. What is your level of formal education? .....

21. Are there some ailments for which you use herbs alone to cure? (State) .....

.....

22. Are there some for which you combine herbs and other means? (Explain) .....

.....

23. Kindly make your final comments regarding the role of traditional medicine in the management of ailments in children. .....

.....

Thank you.

APPENDIX D: ILLNESS STORIES GUIDE

1. Age and sex of child at start of illness.
2. How did the illness start?
3. What were its features?
4. How was the decision to seek treatment taken?
5. How was treatment given and where?
   - A. Nature of treatments, how long
   - B. Medications
   - C. Issues concerning treatment
   - D. Subjective perception of treatment procedure
6. Outcome of treatment.
7. Other issues relating to illness, its treatment, outcome and aftermath.
8. Age, sex and relationship of narrator to child.

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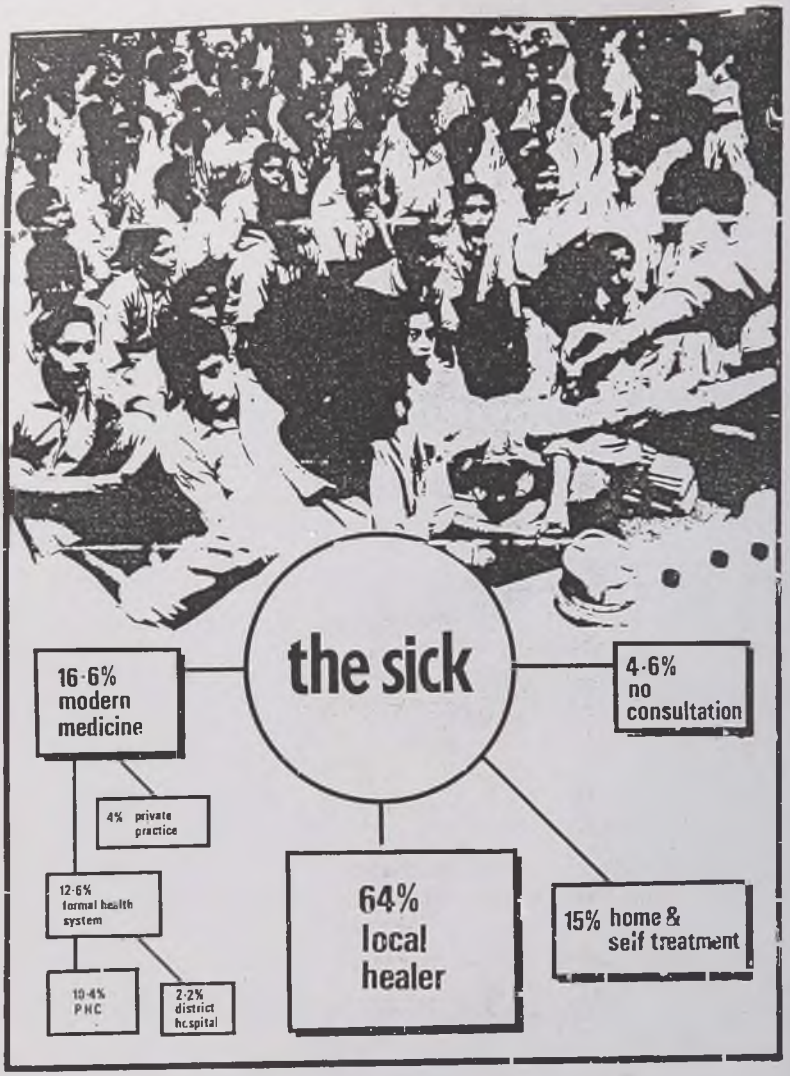

Where the sick turn for treatment in India.