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SOCIOLOGY | RESEARCH ARTICLE

Do health beliefs explain traditional medical therapies utilisation? Evidence from Ghana

Razak Mohammed Gyasi^{1*}, Felix Asante², Kabila Abass², Joseph Yaw Yeboah², Samuel Adu-Gyamfi³ and Padmore Adusei Amoah¹

Abstract: Although the direct impact of health beliefs on unconventional medical therapies consumption are well documented, the previous empirical findings of the relationship have been much inconsistent and theoretically subtle in Ghana. Using social cognitive thesis, this paper examines how relative effects of personal health beliefs influence the use of traditional medicine in the Ashanti Region of Ghana. Drawing on a qualitative approach involving rural and urban peculiarities and 36 in-depth interviews, this research study adopts *a posteriori* inductive reduction model to derive broad- and sub-themes. Results suggest that health-seeking behaviour in Ghana is a socially negotiated process in which cultural beliefs play a major role in moulding the use of unconventional therapies. Perceived displeasure and pure medicalisation of western medicine push individuals into traditional medicine use. Cultural norms and health beliefs in the form of personal philosophies, desire to be part of the healing process, illness perceptions and aetiology, holistic and natural healing approaches, and perceptions on quality of care ascribe the widespread use of traditional medicine. The complexities of personal belief constructs underscore behavioural change towards traditional medicine uptake. This paper theorises that health-seeking behaviour is subject to the complex sociocultural orientation and



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Razak Mohammed Gyasi (the corresponding author) is a PhD Candidate in Social Policy, at the Department of Sociology and Social Policy, Lingnan University. His research interest is collaborative, spinning population health, social gerontology, geography of health and health services research. Razak has a time-honoured interest in traditional and complementary medicines research and has published widely in this arena in reputed international journals. He has worked on a research funded by the Council for the Development of Social Science Research in Africa (CODESRIA). His current research focuses on ageing and health behaviour in Ghana.

The authors of this paper form an eclectic team of researchers who jointly articulate the utilisation of traditional/complementary therapies in Ghana. In this paper, the authors present how personal health beliefs and the sociocultural dynamics underlie the preference for, and uptake of traditional medical therapies among the general adult population in Ghana.

PUBLIC INTEREST STATEMENT

Many people in Africa, Asia and Latin America choose traditional and complementary medicines for their primary health care needs. In Ghana, in spite of the progress made in the conventional medicine, the use of various forms of traditional medicine has become a major part of the sociocultural lives of about seven out of ten people. Using in-depth interviews, this study tries to understand the major reasons behind the increasing acceptance, and use of traditional and complementary medicine in Ghana. The study shows that use of traditional medicine is associated with strong personal beliefs and sociocultural structure of the people, viz. illness perception, holistic healing approach and being part of the healing process, which go beyond the demographic and socioeconomic conditions of the people. The findings call for a critical understanding of cultural health beliefs of people when planning, providing and developing health care in Ghana.

belief paradigm. Policies targeted at improving health services delivery at the community level should be tailored to appreciate the role of traditional structure and cultural beliefs of the people.

Subjects: Behavioral Sciences; Geography; Health and Social Care; Social Sciences

Keywords: *a posteriori*; belief paradigm; health-seeking behaviour; holistic healing; illness perception; sociocultural structure; traditional medicine

1. Background

The accumulated findings of a wide range of academic research on accessibility and utilisation of unconventional medicine in Ghana (Gyasi, Mensah, & Siaw, 2015; Kretchy, Owusu-Daaku, & Danquah, 2014) and beyond (Demirci & Altunay, 2014; Thomas, Nicholl, & Coleman, 2001) have indicated upsurge in consumption of traditional medicine (TRM) over the past decades with overt variations within and between national, regional and global levels. In their inspiring paper, Ernst et al. (1995, p. 1) describe TRM as “diagnosis, treatment, and/or prevention which complements mainstream medicine by contributing to a common whole, satisfying a demand not met by orthodoxy or diversifying the conceptual frameworks of medicine”. Other scholars agree, perceiving TRM as unconventionally and confusingly large and heterogeneous array of techniques, which exhibits both therapeutic and diagnostic approaches (Yeo et al., 2005). These diversities, approaches, practices and theories of medicine have permeated the sociocultural endeavours of people of Africa and Asia for well over hundreds of thousands of years (Johnson, 2013; WHO, 2011). TRM therefore connotes a heterogeneous spectrum of ancient to new-age approaches that purport to health promotion and disease prevention and treatment.

Despite the current influx and the remarkable advances in archetypal conventional revolutionary medicine, TRM continues to play a momentous role in the health care system of nearly every culture. Besides, Priester, Kane, and Totten (2005) report that the current treatments of chronic internal diseases are not quite effective and well planned. Typically, more people turn to TRM on regular basis as the means to tackle the peril of their medical and psychospiritual problems (Adib-Hajbaghery & Hoseinian, 2014). In most parts of sub-Saharan Africa, TRM remains the primary care medium for the ethnic majority (WHO, 2013). In Ghana, traditional systems of medicine are recognised as an integral part of the sociocultural and traditional system where seven in every group of ten people access it for their primary health care needs (United Nations Development Programme [UNDP], 2007).

In the management of afflictions, individuals and families may resort to a wide range of medical practitioners and use medical modalities, often pluralising different forms of TRM and biomedical treatments (Gyasi, Asante, et al., 2015). The acute and chronic misery associated with illness has a strong effect on the health behaviour of people. TRM has long shaped the health care structure and well-being relationships of many people not only in the low-and middle-income economies but also in the advanced communities with sophisticated and well-established health systems. This intricate value-system regarding TRM use is conceptualised by the connections well beyond the socio-demographic milieus of the people. Majority of people adhere to beliefs that contest the foundations of current thinking in conventional, evidence-based medicine (Van den Bulck & Custers, 2009). The Parsonian sick role conception that embraces the biomedical model has been critiqued vehemently for its individualisation and medicalisation of ill-health. Contemporary TRM users rather choose holistic medical practices that seek to heal the whole human system. Localised community beliefs in folk remedies posed substantial culture-centric sensitivity of pre-existing tenets among rural residents (Adams et al., 2011). Bishop (2005) concludes that people might be attracted to, and consume TRM because they hold beliefs that are congruent with TRM. Gyasi and colleagues found that socio-cultural-specific health beliefs about disease aetiology and treatment trajectories are largely accountable for the upsurge use of TRM (Gyasi, Mensah, & Siaw, 2015). Studies suggest that beliefs related to control and participation, perceptions of illness, holism and natural treatments, and general philosophies of life predict TRM use (Astin, 1998).

In trying to offer a plausible reasoning for the belief concept in TRM acceptance, two arguments come up. One school of thought argues for the pull mechanism, which apparently constitutes the perceived benefits that seem to draw individuals to consume TRM. The need for, and the desire to take personal control over one's own health and holistic health beliefs are among the more often cited pull variables. Individuals may find TRM attractive because it is in agreement with people's personal values, religious backgrounds and health philosophies (Sirois, 2008). The other exponent has it that, patients may be dissatisfied with conventional treatment because it has been ineffective for most "tropical" and neglected illnesses, has produced adverse side effects partly due to chemical contamination, and/or is seen as impersonal and/or perceived to be too costly to access in terms of time and financial barriers (Sirois & Purc-Stephenson, 2008).

Documentation of a theoretically fuelled discussion on how complex personal beliefs relate to TRM use in Ghana is pertinent given the multifaceted subjectivity and perceived nature of the subject. In this way, the health policy instrument and the health professionals would be better informed and understand the health behaviour of individuals and the pattern of use of TRM. Notwithstanding, limited work has been done on the relationship between health beliefs and TRM use among populations in the Ghanaian context. Up to this point, exploring the impact of belief paradigms on TRM utilisation from the perspective of the theory of care-seeking behaviour is unleashed. This study aimed to tease out the complex personal health beliefs and the related motivation for utilisation of TRM in the Ghanaian rural and urban contexts.

2. Theoretical foundation

The belief construct and its association with health-illness perceptions, attitudes and the motivation for TRM uptake have been amply debated in the medical and health services literature. Studies have independently elucidated the impact of belief paradigm on TRM use and its relationship with the unique, holistic and philosophical orientation approach that places much emphasis on the triadic natural forces of mind, body and soul (Kuunibe & Domanban, 2012; Yekta, Zamani, Mehdizade, & Farajzadegan, 2007). To have a systematic and inclusive framework that articulates an in-depth understanding of how personal health beliefs impact on TRM use, Lauer's (1992) theory of care-seeking behaviour was adopted to guide the study.

Emanating from Triandis (1980) theory of general behaviour, the theory of care-seeking behaviour is a social cognitive perspective that has widely been applied in the field of behavioural changes regarding health care consumption among populations. According to the theory, psychosocial variables of affect, utility, norms and habits, as well as facilitating variables predominantly influence care seeking behaviour. In context, affect connotes the feelings associated with care seeking such as an anxiety about care and diagnosis procedures and their results. This affective thought of people may potentially push them from the use of certain forms of medical modality. People remain hostile to the modern sophisticated care which is entirely considered as alien to the African medical culture (Gyasi, Mensah, Adjei, & Agyemang, 2011). Utility is the expectation that explains the perceived value and overall benefits of seeking care. Studies have reported how relatively, minimal side effects of TRM pull medical consumers along into TRM use (Astin, 1998; Gyasi, Mensah, & Siaw, 2015). Norms take into account the social, personal norms and interpersonal issues to engage in health care seeking. To a larger extent, one's own paradigmatic beliefs and personal health philosophies about what is morally correct behaviour of seeking care and self-agreement to act based on beliefs by others influence the motivation to access care (Lauer, 1992). The social cohesion that binds community members together, as epitomised in Africa may influence TRM use. Social networks and recommendations through information sharing among families and friends as well as the community members determine health care decisions (Amoah & Gyasi, 2016; Gyasi, Siaw, & Mensah, 2015).

Habits denote the usual way patients act, whether or not to seek care promptly. It relates well to the care behaviours of previous experiences, particularly when similar situation suffices. Experiences of effectiveness, less side effects of TRM and positive affective behaviour of traditional healers may

pull people along to utilise TRM. These mechanisms could be influenced by facilitating conditions such as having health insurance, less medical cost conditions and family history of medical conditions. The relationships among the theoretically identified variables propose that psychosocial variables could influence behaviour either directly or in interaction. The tendency for cognitive behaviours to plinth certain influences on the direction and magnitude of health care cannot be underestimated. Care-seeking behaviour thesis has been supported empirically in various studies (Backonja, Royer, & Lauver, 2014; Heit, Blackwell, & Kelly, 2008). Despite its content validity, no study has been guided by the care-seeking behaviour theory in explaining why wholesale utilisation of TRM continues to upsurge, particularly in the African landscape.

3. Methods

3.1. Research design

This paper emerged from a larger study that was carried out to examine the factors influencing traditional medicines utilisation in the Ghanaian health care delivery system. Other substantive issues examined in the larger study have been reported elsewhere (see Gyasi, 2015; Gyasi, Asante, et al., 2015; Gyasi, Mensah, & Siaw, 2015; Gyasi, Mensah, Yeboah, & Siaw, 2015; Gyasi, Siaw, & Mensah, 2015; Gyasi et al., 2016). The larger study espoused a retrospective household cross-sectional and mixed-method survey involving rural and urban peculiarities. Data for this paper draw on reports and findings from a part of the qualitative section of the larger study, exploring how personal health beliefs influence the tendency to utilise TRM among the adult population in the Ashanti Region, Ghana. This study adopted the interpretivist paradigm and subjectivist epistemology (Angen, 2000) where the original experiences and belief systems of respondents are granted the prominence. These perspectives ensure an adequate discourse between the researchers and the interviewees to generate the desired collaborative meaningful reality (Guba & Lincoln, 1994).

3.2. Ethics and participant selection

The study protocol was approved by the Committee on Human Research Publication and Ethics (CHRPE), School of Medical Sciences at Kwame Nkrumah University of Science and Technology (KNUST) and Komfo Anokye Teaching Hospital (KATH), Kumasi (CHRPE/AP/260/14). Secondly, the study participants were approached and systematically briefed on the main research objectives. Their personal consent were sought as detailed by the principles of the Declaration of Helsinki. The issues of confidentiality were highly taken into consideration with emphasis. Participation was therefore voluntary.

The study participants were purposively selected, followed by theoretical sampling to focus on the developing concepts and categories as the study advanced, based on a laid down criteria. Individual community members who had used any form of TRM and/or had accessed the services of traditional healers in the last 12 months preceding the interview and also had attained the statutory age of 18 year or more were recruited for the study. To bring the real situation into being regarding TRM use and to curb incidence of research bias, rural-urban character and gendered dimensions were taken into consideration during the sampling processes. Overall, 36 participants were conveniently recruited for this study based on the defined inclusion criteria. Nineteen respondents from rural Sekyere South District and 17 from Kumasi Metropolis (urban community) were enlisted for this study. We aimed to obtain information-rich evidences about complex normativity in TRM use. This selection procedure was therefore an arbitrary one, regardless of any parameters such as the size of the target and the accessible population of the study, following Barbour (2001). A relatively larger number of respondents were selected from the rural setting. The reason being that rural residents in most of the selected rural study communities lack access to modern conventional medical care and therefore depend much on traditional systems of medicine. Most of the rural people are strongly bonded culturally which could express certain belief paradigms in relation to health behaviours.

3.3. Research instrument and data production

The instrument for this study was divided into two major sections. Thematic, open, loose-ended and flexible items were generated and used as an interview guide for the study to solicit in-depth data from the study participants. The other section was composed of multi-item demographic and socio-economic issues. The research instrument was reckoned as appropriate for this study given the complexities of belief dimension and its motivation for health behaviours particularly in rural and remote settings. Interviews were conducted in the *Asante Twi*—the predominant local dialect of the study communities—and in English Language, thus serving the needs of the respondent with diverse socio-economic backgrounds. Respondents were interviewed in their homes or apartments. Each interview lasted one hour on average. All interviews were tape-recorded and transcribed verbatim in order to capture the responses of the participants in their own words. This allowed for the examination of what was discussed. A range of techniques such as a third party review of the transcript, were used to check the consistency of information obtained and also provided detailed understanding of the health-seeking behaviour pattern of the respondents.

3.4. Analytical procedure

From the perspectives of the various categories of respondents, data were analysed in relation to personal health beliefs and perceptions regarding motivation for TRM use. The study applied *a posteriori* inductive reduction methodology to develop broad and consistent themes (Glaser & Strauss, 1967). The thematic techniques were adopted by comparing the responses in order to identify common trends, similarities and contrasts through the application of Grounded Theorising Approach (Guba & Lincoln, 1994). Braun and Clarke (2006) and Bryman (2004) noted independently that thematic data analysis is one of the best methods for identifying, analysing, and reporting patterns within data, while also organising and describing the data in rich detail. This method has therefore been used to analyse data from qualitative interviews because of its usefulness in exploring contexts and meanings guided by specific themes. Any explanations or theories that emerged were derived from the data-set itself rather than from the researchers' prior theoretical perspective. Specific normative and subjective views from the perspectives of study participants have been presented as direct quotes.

4. Results

The findings of the study report the analysis of TRM users' accounts based on the belief paradigm and its impact on TRM utilisation. The findings generally focus on the constructed category of pull and push dimensions of TRM use as informed by belief systems. Other issues that encouraged TRM use were related to the general dissatisfaction with the use of modern conventional medicine. These categories presented major subcategories: control and participation, illness perceptions, holistic approach and natural treatment, personal health philosophy, coping mechanism and experiences with orthodox medicine use.

4.1. Holistic and natural healing approach

Various reasons were reported to show that respondents' decisions to use indigenous therapies were directly related to the holistic healing that TRM provides. Respondents repeatedly testified that TRM was inclusive to healing and was applied not only for preventive care, but for curative and rehabilitative reasons. Respondents expressed that part of their reasons for the use of TRM was due to it being more natural, involving no or little chemicals and therefore, has minimal side effects. The principle of "natural being neutral" was echoed. Participants explained that most aspects of TRM appear natural and therefore considered free from chemical infestations. A respondent described how they perceived TRM to be holistic healing and safe to use:

TRM does not target a particular health challenge but it takes absolute cure of the entire human system. It is capable of treating as many as diseases at the same time. [Meddle aged man]

Natural plants are mostly free from health-threatening chemicals unlike manufactured drugs from hospital or chemical shops. They (herbal medicines) are safe because they are natural. [Middle aged woman]

The interviewees discussed the excellent affective behaviour of traditional medical practitioners towards their clientele. The argument was wholly based on the belief that the indigenous practitioners were experienced, knew their clients as community members, understand the language of their patients and also provided technically, client-centred healing approaches. Most participants described the good attitude and outstanding human relations of the traditional healers towards their clients in the illness episode:

When I visited the traditional birth attendant in the next community for medicine when I was pregnant, I found that she has patience. To some point, I couldn't follow accurately, the prescriptions and instructions. She never insulted me but she took her time and explained everything to me again. She's not like some nurses at the clinic who always embarrass me [Young woman]

Again, some respondents shifted the emphasis to the benefits one gains from consuming leafy vegetables and fruits and other plant products. They explained the dual effect of plants' products. Respondents reported not only the dietary/nutritional value of plants, but also their medicinal effects. The plants' potential to provide humans with roughages that aid in digestion processes which in turn reduces the chances of one getting constipation were equally described by the participants. These standpoints were notable among both rural and urban participants and across gender facet though, many of the instances were provided from the respondents in the rural communities.

I hope you know that vegetables and plant leaves are herbal medicines. Then, tell me why you can take any quantity of them at any time but will cause no problem for you? Look at "kontomire" [leaves of the cocoyam or taro plant], "kwawunsusaa" [solanum toivum], onions, cabbage, carrots, lettuce, pawpaw leaves ... they're all herbal medicines for certain diseases but harmless. Leaves and fruits may help easy digestion too. [Middle age woman]

The respondents explained that TRM treatments and therapies were effective, particularly in managing "tropical" and neglected diseases. Respondents reported specific cases of malaria and typhoid fever. Other problems mentioned were sexually transmitted infections, infertility, menstrual problems, sexual weakness, piles, cold, influenza, cough, hernia, intestinal problems, bone fracture and illness of psychic origin.

I have a testimony myself. My own son fell and broke his leg at school. I took him immediately to a nearby hospital ... [I don't want to mention it] ... for several occasions. The POP [means Plaster of Paris] was on but the leg kept on swelling and the child was suffering. When the boy eventually was sent to a bone setter the child was able to walk after one week. Most aspects of TRM to me, are very potent and effective. [Middle age man]

I never trusted the healing power of traditional medicines until when my sister was mentally ill and she was taken to a mental healing centre. After moving from one psychiatric hospital to the other for eight years, the Faith Healer intervened and she became well ... no more stigma, no more pain ... [Young man]

4.2. Personal philosophies and illness perceptions

Respondents' accounts suggest that personal philosophies are directly linked to the unique cultural values and belief system of the people. It was noticed that the cultural values and traditions of people invariably determine their psyche, which in turn influences their health care-seeking behaviours. Some of the study participants maintained that TRM harmonises with their religious, cultural and spiritual beliefs. An old male respondent explained how traditional beliefs have influenced him to use TRM:

I have a strong belief in the potency of TRM. I know that TRM is part of my culture and total upbringing. I was born into TRM and have grown in it. It always yields quite satisfactory results when I use it to treat any disease I may suffer from. Some people may say no to it but I will always use it, yea ... [Old man]

It was again observed that some respondents perceived spiritual illness as a reason to seek traditional medical care. There is the belief that certain diseases have spiritual connections. Our respondents went on and on to describe that diseases that have spiritual underpinnings can only be treated and reversed through spiritual means. To them, Newton's second law of motion—action and reaction are equal and opposite—can conveniently be applied to some spiritual health problems and their solution thereof. This quotation by a middle-aged woman explains further, that:

Master, spiritual diseases must be tackled spiritually; they should go through the exact ways they came. My sister was sick and we could not find any proper healing for her. When it was getting worse, we took her to a woman that could see spiritually. It then came out that my sister was cursed by someone she fought with sometime ago. Certain things were done and in just two weeks she became well again. [Young man]

We found that the traditional healers not only exhibited rich experiences in healing many health problems but they also possess a unique theoretical system which cannot be explained by modern sciences and that one has to believe in it.

4.3. Control and participation

Respondents presented the idea of the desire to participate in the treatment decisions. This was found to have a connection to the doctor–patient relationships and the move towards a patient-centred model of care. We noted that TRM and the traditional practitioners provided their clients/patients more participatory role in treatment decisions and this pulled most people into TRM use. That is to say that the TRM users play an active/collaborative part in treatment decisions. It was reported that:

Well, I'm always able to ask about all that I should know. I have good relationship with the healers in this village so I try to understand why certain things are done to maintain my own health. They have time for you and always happy to discuss at length with me whenever I want to know how and why certain medicines are taken. I am afraid if this could happen in a hospital environments. [Middle aged woman]

The use of TRM in the restoration of health and well-being was a hallmark of the individual respondents. These findings were validated by the urban respondents interviewed. A tertiary student explained that using TRM enabled him take a more active part in maintaining his own health. He did not really appreciate why accessing medical treatment and use of his medications should be a rigid process to go through. He held the belief that it is good, easy and refreshing to be able to sort things out for himself in terms of treatment-seeking routine. He passionately asked back that:

How can I be cured with a treatment regimen that I do not even understand? Someone sits somewhere and controls my own health and also tells me what I should do with no explanation as if he owns my life [Young man]

4.4. Coping mechanism

Many of the respondents turned to the use of TRM for reasons of easy access and cost-effectiveness. The study participants said they were motivated to use TRM because it was readily available and easily accessible; that most aspects of TRM, especially the herbal-based modalities could be found at any time without much stress. Issues about cost of TRM were reflected in many instances. Respondents provided examples that TRM could be obtained from their backyards or could be purchased at a lower cost. A university student explained that:

I think some of the TRMs are not expensive [as compared with hospital]; sometimes I am required to pay only a few Ghana Cedis to the healer for treatment or to buy the medicine. Here too, I do not travel far to warrant spending so much on lorry fares. Virtually, I spend nothing on transport. They [traditional practitioners] are here with us. So, to me, herbal medicines are cool [Young Woman]

I use TRM because I don't have money to go to hospital. You see, sometimes I cannot afford hospital bills so I go to the herbalists for help. Hospital drugs are always very expensive and they [hospitals] are far away too. The sad aspect is that the national health insurance scheme is no longer working ... people are always ask to pay for the drugs they're given, or they're ask to buy the drugs themselves from outside. [Middle aged man]

4.5. Unpleasant experiences of using conventional medicine

The study generally found that previous bad experiences and dissatisfaction of the orthodox medicine influences the health behaviour of many people and hence push them into TRM use. Majority of the respondents attributed increased use of TRM to several problems they have faced with conventional health care practitioners or aspects of the modern health care system. Some respondents expressed concerns about dissatisfaction with orthodox medicines in terms of ineffectiveness for most of their medical problems such as malaria, excruciating boils, broken bones, mental disorders and other psychological or spiritual problems, and hence having alternative treatment was prioritised. The following excerpt confirms this claim:

You see ... doctors do not have the eye to see any “sunsum-mu-yadee” [spiritual illness]. They just do trial and error and before you realise your casket is close to you. Isn't it better I rather go to see a medicine man to solve my problem for me? [Old woman]

Safety of conventional therapies was a repetitive subject and a major concern to the study participants. Most respondents mentioned that prescribed drugs contain chemicals that may have both momentary and long-term side effects. One respondent noted that:

I will always use herbal mixtures. The fact is that “white man's drugs” have side effects—when I take more of them. I am always afraid of it. I am not comfortable taking them because they are not safe” For example, I daze anytime I take Artesunate Amodiaquine for malaria, but Time Herbal Mixture and Taabea Herbal Mixture are good for me without any side effects. [Old man]

One important issue discussed was the attitude of some health professionals towards their patients, principally as regards emotional issues. The doctor–patient or nurse–patient relationship is an important one as the doctor and/or nurse interacts with the patient. Past negative experiences with health care professionals—doctors, nurses, midwives—had led to the reluctance to consult providers and therefore heavy reliance on TRM. Again, these attitudes paint biomedicine as distinctly foreign. People consider biomedical practice as a “distant health care system”, which does not belong to the local people.

For me, orthodox medical system is alien, I see it that it's not part of my culture and upbringing. In fact, I am not comfortable with those prescribe drugs at all and so, I don't take them when I'm not well. [Old man]

4.6. Problems with TRM

Interesting evidences were provided particularly with the herbal-based therapies regarding the challenges of TRM use. One major concern was related to the quality control and regulatory mechanisms for herbal medicines. One participant explained that he was not certain about the efficacy and safety of some aspects of TRM because they lack clinical tests and therefore could be dangerous to use.

Although herbal medicines are good, they can cause harm and even death. Most of them are not tested and tried. We buy them from peddlers mostly in the open markets and at bus terminals with no idea of how safe they are and the extent to which they can work. We just hope that our problems will be solved but it's only God that cares for us. [Middle aged man]

Other participants made mention of the poor packaging and labelling of the herbal medicines. The participants spoke of the herbal preparations having no expiry and dosage indications. This, they

concluded could torment the quality of life of individuals and exacerbate the health problems of people. A respondent lamented that although aspects of TRM are good, if proper quality control measures are not enforced to monitor strictly the preparation, distribution through to the use of herbal medicines; safety of the unsuspecting public is likely to be compromised.

Most of the medicines are not well presented to appeal to us. I think the authority in charge should do well to see to improve on the standards and quality of the medicine so that we can be safe. [Young woman]

Anyway, my only problem here is that most of the herbal products do not have expiry dates on them. In this case we cannot tell whether or not the drugs are good to use ... [Middle aged man]

5. Discussion

The recent interest in the acceptance and uptake of TRM has burgeoned worldwide. Studies have been carried out in the search for why these interests continue to upsurge (see Astin, 1998; Gyasi, Mensah, & Siaw, 2015). To contribute to this debate, the current study has detailed the spectrum of personal health beliefs as the dominant antecedents for motivating TRM consumption. The participants' description of the potential role of health beliefs of patients to influence TRM use concurs with the theoretical arena of the health care-seeking behaviour. On the one hand, and to a larger degree, people behave rationally towards the perceived benefits that traditional healers and their medical practices provide clients who present a wide range of medical and spiritual and or psychological problems for assistance. On the other hand, the generally perceived dissatisfaction felt by the health care consumers invariably pushes far a lot more into TRM use. These ideas are not different from the findings of other studies elsewhere in, both, economically developed (Williams, Kitchen, & Eby, 2011) and developing nations (McLaughlin, Lui, & Adams, 2012).

The utilisation of TRM reflects in what has been constructed as disease and health in the traditional and cultural purview. Among many psychosocial variables, findings revealed the holistic and inclusive nature of TRM as well as the natural treatment approaches employed by the practitioners as unique. Respondents' positive attitudes to TRM are associated with the beliefs in holism and natural remedies. The ability of TRM to treat not just an aspect of the being and or disease-specifics but a whole being, taking into account the importance of body, mind and spirit in health is critical. Unlike the scientific medicine, TRM conveniently deals with physical and spiritual and or emotional problems towards a "whole health" restoration. The cultural milieu of the local people therefore subsumes TRM use. In line with the report of Gyasi et al. (2016) our findings suggest that holism remains one major concept that separates traditional system of medicine and the conventional counterpart. In his national survey, Astin (1998) found that having a holistic philosophy of health was predictive of TRM use. This potentially repels many people, but rather into TRM use as defined by the utility variable in the care-seeking thesis.

Natural treatment that characterises TRM was found to be a recipe for its wholesale utilisation in all spheres of endeavour. Consistent with Seidl and Stewart (1998), the current study suggests that various aspects of TRM are natural and therefore perceived as safe. Most of our respondents believed that TRM is not only effective in dealing with a plethora of medical problems beyond the walls of the orthodox care, but also safe to use since TRM is "natural" with less side effects. Whilst this finding is consistent to some previous studies (Gyasi, Mensah, Yeboah, & Siaw, 2015), it is inconsistent with other research outputs which reported that TRM is less safe than modern therapies (Addo, 2007). This disparity arguably stems from the diversity of individual perceptions and the variety of medications people access in dealing with specific and/or differences in ill-health. People use the educational standards of traditional healers and the general processes of medicine preparation to question the safety of TRM utilisation. As variously cited in both developing and developed countries (Amoah & Gyasi, 2016; Mensah & Gyasi, 2012; Sen, Chakraborty, & De, 2011), this study buttresses the

effectiveness of TRM particularly in dealing with tropical and neglected health problems based on the respondents' self report.

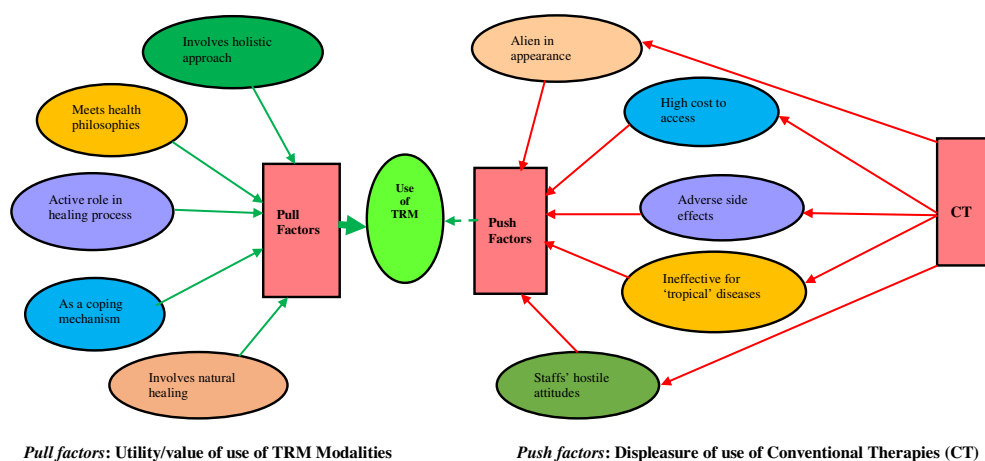
The autonomy and personal control have been cited as strong predictors of TRM uptake. It was reported that TRM consumers preferred to play active role in their health care trajectories. It was interesting to find that some participants aligned their preference for traditional treatments and medicines to personal control. Control over illness is the idea that people vary in the extent to which they desire participation in treatment decision (Bishop, 2005). Indeed, the desire to take responsibility for one's own health and well-being and to make their own health care choices is paramount among the study participants. TRM use allows individuals and families the opportunity and the freedom to choose to shape up one's health. The study found that most respondents from rural areas noted that TRM better serves them in terms of flexibility of access and use as reported by previous studies (Chang, Wallis, Tiralongo, & Wang, 2012). Traditional healers and their practices offer clients more participatory role in treatment decisions and therefore pulled community members along.

In the evaluation of health care behaviours, values and sociocultural factors—spirituality, customs, religious and personal beliefs and philosophies—are critical agents that pull people into TRM use. Spirituality and religion have been introduced into the medical circle, implying a growing interest in the possible perceived health benefits connected with having a spiritual belief and/or following a religious belief. People might be attracted to TRM use because they hold beliefs that are congruent with TRM practice. The utilisation of TRM is based on historical circumstance, cultural acceptability and perceptions of illness and disease. In addition, respondents reported the essence to treat “certain” forms of diseases solely with one modality of TRM or the other. This assertion was heightened based on the people's perception that diseases must be treated through the exact ways by which they emerged. This principle is fully entrenched in TRM practices. This finding corroborates the discoveries of Osamor and Owumi (2010) in urban Nigeria that belief in supernatural causes of illness strongly predicts TRM utilisation. This finding presents a strong linkage with the habit construct within the framework of care-seeking behaviour theory. The experiences people have acquired may lead them into the varied treatment options in their quest to fine good health.

The study found an evidence to suggest that the use of TRM could be explained in the context of the economy. Health care cost in terms of treatment and medication bills as well as the waiting time and transport costs in many cases push patients from accessing conventional care but causes a great deal of pulling effects towards medical alternatives. Many scenarios were expressed in our interview where the study participants reported that a few amount of the Ghanaian Cedis in most times is needed to obtain for oneself the needed dosages of TRM to cure an ailment, if not in kind. This is consistent with the corpus of previous research findings. Gyasi et al. (2011) for example argue that certain aspects of traditional medicine are less expensive and more readily available to the people than the orthodox care. In the rural settings, people may not be able to afford the bills of the conventional medical care, and therefore turn or return to TRM as a coping strategy of staying healthy.

In addition, perceived dissatisfaction of conventional medicine was built upon the unpleasant experiences that respondents had suffered by choosing conventional medicines. As reported severally in other studies, the current study revealed that first, conventional medicines are not much effective in dealing with the identified “tropical” medical episodes. Second, the respondents bemoaned the fact that upon the use of these medicines, the advent reactions in the form of side effects are numerous which threatens the safety of the patients. Respondents again re-counted poor provider-patient/client relationships. The truth is that most health care professionals treat their clients with scorn and sheer disrespect. These fearful circumstances psychologically may exacerbate the medical conditions of these patients. These experiences and embarrassments, as explained by the affect variable in the care-seeking behaviour perspective, may put the unsuspecting patient in much anxieties and worries and resultantly push them into the TRM utilisation. Despite these clear-cut enumerations, weak influences were generally observed by the negative and unpleasant aspects of

Figure 1. Heuristic framework for understanding effects of belief (psychosocial) paradigms on TRM utilisation.



orthodox health services regarding TRM utilisation by the adult population. This was consistent with the other studies elsewhere which have reported independently that aspects of modern medicine that push people into TRM use are only an ancillary to the various pull mechanisms (Astin, 1998; McLaughlin et al., 2012) (see Figure 1).

Our findings draw attention to the various challenges pertaining to TRM use with particular emphasis on the herbal-based therapies. The quality control and standards of TRM, which rest on the regulatory conditions, were not prioritised and sometimes neglected. The participants explained that the efficacy and safety of some aspects of TRM are not assured as most aspects of TRM lack the necessary clinical tests to confirm the effectiveness as well as the safety. This finding is similar to the observation of other studies in Ghana (see Addo, 2007; Gyasi, Mensah, Yeboah, & Siaw, 2015) and elsewhere (Sirois, 2008), which noted similar challenges with TRM use. Respondents associated these bottlenecks with the poor educational background of and training packages for most of the indigenous healers. Consequently, the effectiveness, professionalism and credibility of TRM healers and their practices are compromised. This has implications for the well-being and the welfare of the innocent patient.

6. Conclusion

This paper highlights the complex relationship between health beliefs and decision to use TRM. The study found an empirical evidence to suggest that cultural attitudes and personal health beliefs and traditions of people have strong and complex relationships with motivation for TRM acceptance which go beyond socio-demographic traits of people. Lending support to Laver's theory of care-seeking behaviour, the evidence-based findings of this study propose that health beliefs and psychosocial conditions are crucial in determining health seeking behaviours.

This research provides an insight into the understanding of the mechanisms that motivate individuals to make informed choices and actions in the context of TRM use in the Ashanti Region, Ghana. The findings show that the use of TRM is an integral part of a set of cultural beliefs, which embrace a holistic and spiritual orientation to life. Illness perceptions, natural healing approaches, health philosophies, freedom of control and to participate in the healing processes on the one hand, and the perceived unpleasant experiences of using conventional therapies on the other, are the basis for burgeoning TRM utilisation. Thus, the decision-making towards TRM use is potentially influenced by these interwoven and inseparable constructs. Health policy efforts should well acknowledge the complex beliefs of people in relation to TRM utilisation. However, efforts are required to deal with the pertinent bottlenecks in TRM and other natural treatment options through clinical trials in order to warrant the safety and well-being of TRM users and to maximise the utility of TRM utilisation.

7. Implications for policy and practice

This study has implications for policy, practice and theory. The findings are relevance to the health policy directions particularly towards the move to improve health care use. As policymakers and health professionals debate health reforms, the understanding of why wholesale use of TRM would be an excellent contribution towards the best way forward. An idea of the health beliefs and health care use interface will guide health care professionals in medical history taking, diagnosis and treatment of their clients. This is the first theoretically fuelled qualitative study to enrich understanding on complex mechanisms that stimulate the decision-making regarding TRM use among the adult population in the Ashanti Region of Ghana. The findings are woven well with the variables of the theory of care-seeking behaviour and may generate further discussions towards a better understanding of why people of various socio-economic, cultural and politico-religious backgrounds continue to consume traditional medical services despite headways of orthodox medical practices. This is nested in the emerged heuristic model which may contribute to further investigations on TRM utilisation and its associated motivations. Despite the outlined strengths of this study, one should bear in mind some possible limitations when considering the findings. First, the study covered a limited area and sample size of 36 in-depth interviews. However, this approach provided the opportunity to obtain detailed evidence and specific accounts related to the role of personal health beliefs and TRM use. The study participants were recruited through purposive and then theoretical sampling techniques, which may have the tendency of leaving out some potential respondents with rich experiences regarding the subject of inquiry.

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