

Rational use of Traditional Medicine in the Suhum Kraboa Coaltar District of Ghana

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Abstract

Traditional medicine has a long history and is the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses.

The objective of this study is to assess the extent of rational selection and use of traditional medicine in the Suhum Kraboa Coaltar district in the Eastern Region of Ghana.

This was a cross-sectional descriptive study carried out in the Suhum Kraboa Coaltar district in the Eastern Region in April/May, 2015. The questionnaire was administered by interview to respondents in their homes and workplaces.

The majority of respondents, 161 (80.5%) had used at least one form of traditional medicine, while 39 (19.5%) had never used traditional medicine. As many as 123 (76.4%) of the users most commonly used oral preparations. There was however no gender difference statistically in the use of traditional medicine, 57 (80.3%) male and 104 (80.6%) female, but more predominantly used among the elderly than the younger population. In the opinion of the majority of respondents, 118 (59.0%), inaccessibility and lack of faith, 60 (30.0%), in orthodox medical care the main barriers to the use of orthodox medicine and therefore attract them to use traditional medicine rather than cost. Conclusion: The use of traditional medicine is very predominant among the population. It is much more patronised by the elderly than the younger population, but there is no gender difference in the use of traditional medicine. The most significant barriers to the use of orthodox medicine are inaccessibility and lack of faith in health facilities rather than cost

Keywords: Traditional medicine; Suhum Kraboa Coaltar; Ghana

Introduction

Traditional medicine has a long history. It is the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental

illnesses (WHO, 2003). The terms complementary/alternative/non-conventional medicine are used interchangeably within some countries. For all the revolutionary and dramatic improvements in human healthcare in the 21st century, life in much of Africa begins with and is sustained by the support of traditional medicine. In

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many parts of Africa, the number of traditional health practitioners far outnumber that of medical doctors (WHO, 2005).

From Chatora (2003) it is also estimated that from the cradle to the grave, about 80% of Africans rely on traditional medicine for their health care needs. Thus, from the Cape to Cairo, and from Dakar to Djibouti, Africans seek traditional health care along with or even before modern medical services. Not only is traditional medicine popular and accepted in many African communities, it is the only system available in most.

It has actually been the only medical system accessible to a vast majority living in the rural areas, and that only one-third of the entire Ghanaian population has access to modern health care (MOH, 2003). This means that two-thirds of the population mostly in the rural areas depends on traditional medicine practitioners for their health needs.

Traditional and complementary/alternative medicine has demonstrated efficacy in areas such as mental health, disease prevention, treatment of non-communicable diseases, and improvement of the quality of life of persons living with chronic diseases as well as for the ageing population. Although further research, clinical trials, and evaluations are needed, traditional and complementary/alternative medicine has shown great potential to meet a broad spectrum of health care needs. Yet there is still so much unknown in terms of knowledge and practice.

The Ghana Traditional Medicine Practice Act (Act 575, 2000) was passed by the parliament of the Republic of Ghana on February 23, 2000. The act was to establish a council to regulate the practice of traditional medicine, to register practitioners and license practices, to regulate the preparation and sale of herbal medicines and to provide for related purposes.

There are still no set guidelines on diagnosis of diseases and disorders by herbal practitioners and herbal drugs are still poorly packaged sometimes, with no information about dosage, indications or contraindications.

The objective of this study is to assess the extent of rational selection and use of traditional medicine by Ghanaians in the Suhum Kraboa Coaltar district, the extent of patronage of traditional medicine and the barriers to use of orthodox medicines as first line treatment.

Subjects and Methods

This was a cross-sectional descriptive study and carried out in the Suhum Kraboa Coaltar district in the Eastern Region of Ghana over a period of six weeks in April and May, 2015.

Suhum Kraboa Coaltar District is one of the 110 District Assemblies created under the Local Government Act 462 of 1993, in line with the Government decentralization policy. It is essentially a rural district with only one (Suhum) out of the over 300 settlements qualifying to be classified as an urban town in Ghana. The district has a land area of 1,018square kilometers, a population of 180,954, based on the 2000 population census and made up of 48.1% male and 51.9% female. It is located in the southern part of the Eastern Region of Ghana with Suhum as its capital which is about 60 kilometers north- west of Accra.

The district has 1 hospital, 2 health centres, 13 clinics, 2 maternity homes, 62 licensed chemical sellers and 2 herbal centres. The Suhum Government Hospital is the first point of referral in the district. Services provided include Obstetrics/Gynaecology, general surgery, child health, Eye Care and laboratory and X-ray services, on both out and in patient basis. Onchocerciasis, Tuberculosis and Malaria Control are some of the public health programmes run in the district. The Ghana Health Service owns about 65% of the health facilities while rest is privately owned.

The respondents were members of the five communities who were interviewed in their homes and some at workplaces. Permission from chiefs and opinion leaders was sought from each town visited before the structured questionnaire was administered to the respondents in the selected houses by simple random sampling of any fifth house in the community. The starting direction was however obtained by casting a die, to select north, south, east or west. Respondents were male and female, above 20 years of age.

The questionnaire was pre-tested by administering 20 interview guides to 20 randomly selected people in the community. The necessary corrections were made before the final version which consisted of both open and closed-ended questions were developed and administered by interview. Research Ethical Clearance was sort from the District Health Management Team

Statistics and Data analysis

The data was captured in Microsoft Excel version 2007 and analyzed by SPSS version 16. Frequency distributions, group means,

confidence intervals and standard deviations were calculated with the standard descriptive statistics. Categorical data were calculated in percentages and continuous data in means and standard deviation. Analysis of Variance (ANOVA) was as well used to determine the relationship between the various socio-demographic indices and traditional drug use.

Results

A total of 200 people interviewed, 71 (35.5%) male and 129 (64.5%) female. The communities were predominantly Christian by religion, 182 (91.0%), then Islam, 14 (7.0%) and traditional, 4 (2.0%). The majority of respondents, 161 (80.5%) had used at least one form of traditional medicine, while 39 (19.5%) had never used traditional medicine. As many as 123 (76.4%) of the users most commonly used oral preparations, 8 (5.0%) used topical, 7 (4.4%) used enemata, while 23 (14.3%) used more than one preparation. There was however no gender difference statistically in the use of traditional medicine, 57 (80.3%) male and 104 (80.6%) female. All 4 (100%) those who practiced traditional religion used traditional medicine, while 13 (92.9%) Moslems and 144 (79.1%) Christians used it, but the difference was not statistically significant.

Socio-demographic characteristics and use of traditional medicine

The ages of the respondents fell predominantly into the active and productive group, 30-59, and the use of traditional medicine was statistically significant in this group, $p < 0.05$ (Table 1).

Majority of the respondents, 79 (39.5%) had only primary education or lower, while 67 (33.5%) had Junior High (JHS) or Middle School education with just 19 (9.5%) having had tertiary education (Table 2). There was however no statistically significant difference between the various levels of education and the use of traditional medicine, $p > 0.05$.

Though most of the people 125 (62.5.0%) earned very minimal income of less than thirty Ghana Cedis (GH¢30.00), there was no statistically significant difference in their use of traditional medicine, $p > 0.05$ (Table 3). This was actually consistent with their level of education, since high educational attainment usually is commensurate with high income.

AGE (YEARS)	N (%)	Use of traditional medicine	
		YES n (%)	NO n (%)
20-29	27(13.5)	18(66.7)	9(33.3)
30-39	49(24.5)	39(79.6)	10(20.4)
40-49	70(35.0)	53(75.7)	17(24.3)
50-59	41(20.5)	40(97.6)	1(2.4)
60-69	10(5.0)	9(90.0)	1(10.0)
≥70	3(1.5)	2(66.7)	1(33.3)
TOTAL	200(100)	161(80.5)	39(19.5)

Table 1: Age and use of traditional medicine.

Educational level attained	N (%)	Use of traditional medicine	
		YES n (%)	NO n (%)
Primary/lower	79(39.5)	76(96.2)	3(3.8)
JHS/middle school	67(33.5)	51(76.1)	16(23.9)
SHS	35(17.5)	20(57.1)	15(42.9)
Tertiary	19(9.5)	14(73.7)	5(26.3)
Total	200(100)	161 (80.5)	39 (19.5)

Table 2: Educational level.

Income (GH¢)	N (%)	Use of traditional medicine	
		YES n (%)	NO n (%)
<10	42(21.0)	33(78.6)	9(21.4)
10-19	31(15.5)	26(83.9)	5(16.1)
20-29	52(26.0)	38(73.1)	14(26.9)
30-39	29(14.5)	24(82.8)	5(17.2)
40-49	30(15.0)	28(93.3)	2(6.7)
≥ 50	16(8.0)	12(75.0)	4(25.0)
Total	200(100)	161 (80.5)	39 (19.5)

Table 3: Monthly income and Use of traditional medicine.

Barriers to use of orthodox medicine

In the opinion of the majority of respondents, 118 (59.0%) inaccessibility/availability of hospitals or health care facilities as well as lack of faith in orthodox medical care 60 (30.0%) were the main barriers to the use of orthodox medicine and therefore attract them to use traditional medicine (Table 4)

Barriers to use of orthodox medicine	YES n (%)
Cost of treatment	13 (6.5)
Inaccessibility of hospitals	118 (59.0)
Traditional beliefs	9 (4.5)
No faith in orthodox medicine	60 (30.0)
Total	200 (100)

Table 4: Barriers to use of orthodox medicine.

Knowledge of Traditional Medicine used

As shown in Table 5, it was quite evident from the study that most of the people who used traditional medicine had very little knowledge of either the name, expiry date, contraindications and/or side effects of the medicine they used. A relatively significant proportion of them however were conversant with the dosage they were to take.

	Name	Dosage	Expiry date	Contra-indications	Side Effects
	n (%)	n (%)	n (%)	n (%)	n (%)
YES	71 (44.1)	101 (62.7)	35 (21.7)	16 (9.9)	19 (11.8)
NO	90 (55.9)	60 (37.3)	126 (78.3)	145 (90.1)	142 (88.2)
Total	161 (100)	161 (100)	161 (100)	161 (100)	161 (100)

Table 5: Knowledge about Herbal medicine used.

Discussions

The study was done to assess the rational selection and use of traditional medicine of Ghanaians in the Suhum Kraboa Coaltar district. The study sought to find out the extent of patronage of traditional medicine and the factors affecting and influencing usage. It also sought to find out how much the population knew about any of the herbal preparations they were using or had used.

The study found a wide patronage among Ghanaians, since 81% of the population used traditional medicine in one form or the other. This is in agreement with the Ministry of Health Report that plant medicine caters for the health care needs of a large sector of the population (MOH, 2001). It is also in line with the findings of Bagozzi (2003) that traditional medicine has maintained its popularity in all the regions of the developing world. There is however no gender difference in the use of traditional medicine, since both men and women patronise traditional medicine at the rate.

The study could not substantiate the observation made by Gedif et al, (2003) that females were found to use herbal medicine in self-care than males.

As found in Gedif et al, (2003) and in this study, the use of traditional medicine is more in the elderly than younger population. It is possible that the available healthcare to people before orthodox medicine was introduced to their communities was traditional medicine and continues to be so.

Socioeconomic characteristics such as level of education, and income had no bearing on the use of traditional medicine in the population. The people general had low level of education with low income. This was in contrast to the WHO Traditional Medicine Strategy 2002-2005, that herbal medicines are considerably cheaper and may sometimes even be paid for in kind and/or according to the 'wealth' of the client and the finding of Gedif et al, (2003) in Butajira area in Ethiopia that economic inaccessibility to modern healthcare is a reason for choosing herbal medicine as first line of care. Religion had no effect on the use of traditional medicine by the population. This could be attributable to the fact that Ghanaians generally live and stay together in harmony with exhibiting any religious barriers.

WHO (2005) found that broad use of traditional medicine in developing countries, is often attributable to its accessibility and affordability while belief on efficacy and geographical inaccessibility of modern healthcare are mentioned as reasons for choosing herbal medicine as first line of care option in Butajira area in Ethiopia by Gedif et al, (2003). Inaccessibility and lack of faith were the major barriers to orthodox medical care found by this study. Taking cognizance of the population of Suhum Kraboa Coaltar district and its population, the available health facilities are woefully inadequate since most people would have to travel longer distances to access health care.

Why wouldn't people lose faith in our health facilities when due to numbers and attitude of our healthcare workers patients have to wait for hours on end before being attended to. The needed attention is never given to the patient. Our hospitals are simply 'not hospitable'. One-on-one attention is more available at the traditional healer's where believe to get their money's worth. Cost of treatment and traditional belief though have effect on people's use of traditional medicine they are rather low in the Ghanaian population.

It was quite significant to note that most of the users of traditional medicine did not know either the expiry date, contraindications and/or side effects of the medicines they used. The Ministry Of Health, Ghana has stated that in spite of its wide patronage and immense contribution to health care delivery, herbal medicines have a number of limitations, which make their official acceptance into the national health care delivery system difficult. These concerns are related to their unregulated use (both in frequency and quantity), self-medication, and issues associated with their dosage, efficacy, safety and quality, (MOH, 2001).

According to the WHO, recognizing the widespread use of traditional and complementary/alternative medicine and the tremendous expansion of international markets for herbal products, it is all the more important to ensure that the health care provided by traditional and complementary/alternative medicine is safe and reliable; that standards for the safety, efficacy, and quality control of herbal products and traditional and complementary/alternative therapies are established and upheld; that practitioners have the qualifications they profess; and that the claims made for products and practices are valid (WHO, 2001).

The above concerns expressed by the WHO and MOH were confirmed in the study are doubtful whether or not they are applicable only to traditional medicine. Taking in consideration the level of education of the population it would have been surprising how many of them would have known the expiry date, contraindications and/or side effects of any of the orthodox medicines they took. WHO and MOH should check and control the quacks in the medical profession as well as the fake and adulterated drugs in orthodox medical practice.

Conclusion and Recommendations

Most people in the district have used or continue to use herbal or traditional medicine. The elderly patronise traditional medicine more than the younger population, but there is no gender difference in the use of traditional medicine. The most significant barriers to the use orthodox medicine are inaccessibility and lack of faith in health facilities rather than cost

Since the patronage of traditional medicine is high Ghana, strategic and timely measures need to be taken to make the production, sale and use of traditional medicine safe and acceptable at community, district and national levels.

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