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## **The Power of Beliefs on Health Seeking Behaviour: Implication for Therapeutic Relationships for Cardiovascular Care**

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### **Abstract**

This study had as its aim, to examine health seeking behaviour among people suffering from cardiovascular disorders in the New Juaben Municipality in the Eastern Region of Ghana. Six hundred (600) participants, comprising male and female patients aged between 35-75 years and suffering from cardiovascular disorders for the past 12 months were selected used for the study. Cultural belief systems were found to significantly influence the health seeking behaviour of the people. Additionally, the perception of the aetiology of CVDs was socially constructed from a cultural point of view, which deviated from the orthodox views of disease causation. The finding of this study underscore the need for therapists and clinicians to adopt a culturally congruent approach to the provision of healthcare. This further calls for therapists to understand the cultural values and beliefs of the people in order to provide healthcare that would be acceptable to the people.

**Keywords:** cardiovascular disorders, traditional medicine, culture, belief systems, health seeking behaviour, utilisation, healthcare, biomedical, Ghanaians; diagnoses.

### **Introduction**

Culture shapes the worldview in that it interprets experiences, determines and animates over 90% of an individual's daily activities (Kraft, 2000). The term culture in the African thought is very inclusive. It takes account the religious, social, psychological, linguistic, political, economic, and many other aspects of life. Helman (1994; p 48) defines culture as set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in relation to other people, to supernatural forces or gods, and to the natural environment. Yet, very few studies have explored the cultural acceptability dimension, which, probably is as a result of difficulties in defining and measuring the concept of 'culture'.

In this study, culture is defined as 'customary beliefs and values that ethnic, religious and social groups transmit fairly unchanged from generation to generation' (Fernandez, & Fogli, 2006; Guiso et al., 2006) and is measured by a series of attitudes and beliefs held by individuals about the use of both orthodox and traditional medicine (TM). This definition is employed alongside a unique to test how cultural belief systems affect traditional medical utilisation in Ghana. Affordability, accessibility and availability have all been put forward as key reasons for utilisation

of healthcare in Ghana and elsewhere in Africa (Anyinam, 1987; World Health Organization, 2008) and accordingly quantified (for example, Hausmann-Muela, et al., 2000; Leonard & Zivin, 2005; Peltzer, 2009).

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

Rivers again (1924) illustrates differences in interpretation by depicting a person falling from a tree. Modern medicine would characterise this as an accident, perhaps owing to a loose branch or carelessness whereas traditional explanations would blame a sorcerer or spirit for loosening a branch. In these two scenarios, given that the theory of causation differs, it naturally follows that the appropriate treatment, or response, is divergent. In one causal schema, often found in folk theories of causation in Africa and elsewhere, societal ills can also manifest within an individual, at which point social responses are crucial (Hevi, 1989). Thus, legitimacy of medicinal products is attributed to local communities, institutions, and symbolic values (van der Geest, Whyte, & Hardon, 1996).

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

Barimah and Teijlingen (2008) studied attitudes toward TM of Ghanaians living in Canada and found that 73% of respondents had not changed their views about TM as a result of emigration. There were no significant differences in results between individuals who had been abroad for a long and short period of time and individuals show strong acts of agency, whereby Ghanaians import TM back to Canada from their homeland in order that supplies do not run out. Ransford et al (2010) and Senah (1988) highlight the importance of cultural alternatives for Mexican immigrants as a result of belief and structural barriers to accessing formal health care in the United States. Sometimes, cultural alternatives were shown to be a coping strategy, but similarly individuals had considerable control over their health and explicitly chose TM.

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

Since traditional medicine has been with Ghanaians and mostly rural dwellers for generations and also for the fact that orthodox medicine is often in short supply, people's approach in times of suffering from any health condition is first towards traditional medicine. It is when this fails that they resort to chemist shops or medicine vendors and then the hospital as a last resort (Katung, 2001). In traditional medicine, divination (consulting the oracles), confession, ritual sacrifices, incantations and potions made from plant and animal parts are essential components of illness management (Sallah, 2007). These are aimed at restoring the patient to a harmonious relationship with his environment and/or counteract the effect of evil forces. In every instance where an illness is diagnosed to be due to ancestor spirit anger, there is usually an antisocial act of commission or omission by the person who must usually confess the misdemeanour, followed by ritual sacrifices to appease the offended supernatural agency before he can be expected to recover (Danquah, 2008; Badru, 2001).

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

## **Method**

### ***Participants***

A representative sample of six hundred (600) male and female adults aged 35-75 years who were currently living in the New Juaben Municipal Area in the Eastern Region of Ghana. These were patients who were suffering from cardiovascular disorders and were of sound mind and had insight into their conditions, but have not suffered any complications that might have impaired their cognitive functioning. This was done to sample participants who could adequately and appropriately express their beliefs, perceptions and opinions on the subject under study.

The study sought information on cultural values, belief systems and views of cardiovascular disorders that occur within the Ghanaian context. It was the belief of the researcher that information on these cultural values and belief systems would go a long way to build a strong understanding of the socio-cultural underpinnings that influence the health seeking behaviour of the people.

Respondents for the study had diverse demographic backgrounds which contribute to the enrichment of the primary data gathered. Female participants were dominant in the sample 296 (53%) compared to their male counterparts 264 (47%). Thirty five (6%) were unemployed, self-employed 300 (54%), employed 207 (37%) and students 18 (3%). Most respondents were Akans 294 (53%). The rest comprise Ewe 127(23%), Guan 16 (3%), Ga-Adangbe 83(15%), Gruma 12(2%), Mole-Dagbani 14(3%) and Grusi 14(3%). They were also of diverse religious affiliations, with the dominant group being Christians 451 (81%), African Traditional Religion practitioners 62 (11%) and Moslems 47 (8%). Description of the localities of the participants includes Urban 289 (52%), Semi-urban 234 (42%) and rural 37 (7%).

### **Measures**

The Cultural Values and Belief Systems and Health Seeking Behaviour Questionnaire (CVBSHSB) is a 19-item scale that was used to assess participants' belief systems. This instrument was used to measure categories of beliefs involving 1) spiritual influences 2) physical influence, 3) behavioural influence and 4) perceptual influences. This questionnaire used a 7- point Likert Scale [with responses ranging from "Don't Know = 0 to Strongly Agree = 6]. The reliability statistics after piloting indicated a Cronbach's Alpha Based on Total Standardized Items is .879. Correlation Between Forms recorded a reliability of .664 while Spearman-Brown Coefficient indicated for both Equal Length and Unequal Length values of .798 and .798 respectively. Finally, Guttman Split-Half Coefficient recorded a reliability statistics of .792.

**Procedure**

Approval was obtained from the Department of Psychology, University of Ghana to carry out the study. Written consents were subsequently obtained from all participants before data collection was done. Questionnaires were then distributed to participants who were selected using a survey method of sample selection, and it took an average of one hour, fifteen minutes to complete each questionnaire. In the course of answering the questionnaires, participants were given enough time to break and get refreshed so that they could answer the questions as objectively as possible. In order to ensure the confidentiality and safety of responses obtained, completed questionnaires were scored and packed in sealed envelopes and safely paced in locked file cabinets.

**Data Analysis**

Preliminary analysis was done by testing the frequencies of demographic characteristics for the entire sample and the various study groups, analysis of the normal distribution of the variables, means, standard deviation, correlation among the key study variables and internal consistency reliability. The study tested for both normality and homogeneity.

Test for normality using skewness and kurtosis was within the acceptable range of  $\pm 2$  (Tabachnick & Fidell, 2007) for all the scales. All the scales used in this analysis also yielded acceptable results of Cronbach’s alpha coefficients ranging from 0.72 to 0.88. The Cultural Values and Belief Scale was further subjected to principal component factor analysis after the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of only four coefficients of .3 and above.

The Kaiser-Meyer-Oklin measure of sampling adequacy was 0.724, meeting the commonly recommended value of 0.6 and above. The Barlett’s Test of Sphericity reached statistical significance, ( $\chi^2 (21) = 75.481, p = 0.000$ ). Finally, the communalities were all above .3 further confirming that each item shared some common variance with other items. Given these overall indicators, factor analysis was deemed to be suitable with all the 19 items. Principal components analysis revealed the presence of one component with eigen value exceeding 1, explaining 39.12% of the variance. All the factors loaded onto one component.

**Results**

Hierarchical Multiple Regression analysis showed a significant positive relationship on whether cultural values and belief systems will have a moderating effect on the relationship between the development of cardiovascular disorders and health seeking behaviour. This allowed the interaction term to be included as part of the variables used in the analysis to examine the moderating effect. The study regressed ‘health seeking behaviour’ variable scores on the cultural values and belief systems variable scores, and the cultural values and belief systems; and cardiovascular disorders interaction term scores. A summary of the analysis is shown in Table 1.

Table 1: Summary of Hierarchical Multiple Regression of Variables

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

\*\*p<.01

A significant model emerged ( $F_{(3,551)} = 91.206, p < .01$ ) when the hierarchical multiple regression analysis (enter method) was conducted, (see Table 4.2). The  $R^2$  was .332 indicating that the model as a whole explained 33.2% of the variance with the interaction term explaining additional 2.6% (Changed  $R^2 = .026$ ) of the variance when cultural values and belief systems; and cardiovascular disorders were statistically controlled.

The contribution of the cultural values and belief systems; and cardiovascular disorders interaction term though small (Changed  $R^2 = .026$ ) was statistically significant, Changed  $F_{(1,551)} = 21.390, p < .01$ . In other words, for the independent and moderator variable and their interaction term considered in the model, about 2.6% of the variances in 'health seeking behaviour' can be predicted by the cultural values and belief systems; and cardiovascular disorders interaction term.

The results also indicate that apart from the main effect of cardiovascular disorders ( $\beta = -.375, p < .01$ ); the interaction term of cultural values and belief systems; and cardiovascular disorders variables ( $\beta = -.161, p < .01$ ) was significantly and negatively related to 'health seeking behaviour'.

In addition, the significant model that emerged when the interaction term was introduced into the model ( $F_{(3,551)} = 91.206, p < .01$ ) is an indication that cultural values and belief systems do have a significant moderating effect on the relationship between the cardiovascular disorders and health seeking behaviour. although the strength of relationship is small (Cohen, 2007), the interactive term is shown by the analysis as a significant predictor of 'health seeking behaviour', an indication that cultural values and belief systems do have a significant moderating effect on the relationship between cardiovascular disorders and health seeking behaviour.

Thus, cultural values and belief systems will have a moderating effect on the relationship between cardiovascular disorders and health seeking behaviour was supported by the results

### Discussion

Cultural values and belief systems had a moderating effect on the relationship between cardiovascular disorders and health seeking behaviour. Health seeking behaviour of the people of New Juaben, thus hinges on the influences of culture comprising the social, cognitive, behavioural, material aspects of the individuals' lives. This finding showed that when a person suffers from cardiovascular disorders, cultural values and belief systems determine the kind of healthcare system her/she would prefer to use. This gives credence to the assertion by Dutta-Bergman (2004) that culture shapes health seeking behaviours and serves as the lenses for perceiving and interpreting experiences.

This finding is also consistent with a study by Pramukh and Palkumar (2006) that in the traditional system, cardiovascular disorders are attributed to certain deviant behaviours and for that matter they believe in the power of prayers and rituals that enable some herbs to heal their diseased conditions. Cultural beliefs affect the health of a people in many ways, where they use culturally specific explanatory models to think about, talk about, and direct care for health problems. The study found that the kind of health care to seek, whether self-care, home remedies, formal public health system and/or consultation with traditional healers and spiritualist are intricately linked with cultural beliefs (Nyamongo, 2002). This same belief system has led to different patterns of health-seeking and prevention, as well as mismatched provision of care (Hunt & Bhopal, 2004).

This finding could be due to the influence of the traditional system where belief systems that have been passed from generation to generation have permeated every aspect of the individuals' lives. There is a belief in a diabolical interference existent in almost all illnesses in Ghana. (Atindanbila, 2011; Onyina, 2002). This belief is deeply infused into belief systems and practices and thus, must have influenced respondents' attitude towards healthcare based on the cultural definition of the condition. Issues relating to culturally ingrained beliefs like disease causation and influences of evil spirits have not been discounted even in contemporary Ghanaian society. This lends some credence to a strong belief in a supernatural cosmology which influences people's health seeking behaviour for cardiovascular disorders.

In this study, belief in the aetiology of cardiovascular disorders had a direct relationship with the health seeking behaviour of respondents. Respondents who believed that their condition was caused by evil spirits and other supernatural powers sought treatment from traditional healers, prayer camps and other unorthodox sources for treatment consistent with the finding of other

studies (Walker, 2006). For those who held unto a biomedical cause of cardiovascular disorders, they sought healthcare from orthodox health care providers and pharmacies. In explaining these health seeking behaviours, a cue can be taken from the assertion by Yawney (2005) that there must be a proper understanding of the culture of a people. On the basis of that assertion, it is plausible that people believe that allopathic medicine can only explain cardiovascular disease conditions within the confines of the medical model at the expense of local cultural explanatory models.

Thus though medical science can describe illness clinically without recourse to cultural factors, it cannot explain or treat all illnesses successfully. Against the backdrop of such belief systems, it could be explained that people rely on culturally relevant explanatory models of their CVDs than from the orthodox. The condition is therefore seen from a cultural point of view than medical.

Important aspects of the socially constructed meaning of CVDs as a consequence of diabolical interference featured prominently in the study under the concepts of 'enemyship' and the '*sale of diseases*' which is referred to in the local Ghanaian parlance as "*nton yare*", which means a disease that has been literally sold to the victim by perceived enemies. The diabolical explanatory model for CVDs as found in this study generally reflects the social construction of the aetiology of diseases.

That is, people assign meanings to particular diseases and that subsequently determine where to seek help. Patronage of prayer camps, herbal centres therefore could be understood from such socially constructed viewpoint of CVDs. Respondents believed in the malevolent cause of cardiovascular disorders, and felt that the disease had been sold to them by their enemies, including witches. This belief presupposes that people's perception about diseases is not viewed as just simple biomedical disruptions, but rather due to an external diabolical agent. Despite the major inroads of education and urbanization, there is a strong belief that people can be bewitched by envious relatives who didn't want to see them prosper.

There are further beliefs held by participants that one could be bewitched to develop cardiovascular disorders as a result of litigation over a piece of land or some other properties left behind by a dead relative. The study found that a reasonable number of participants currently suffering from hypertension and on antihypertensive therapy from orthodox health systems still hold on to the belief that they had been bewitched and therefore sought help from the prayer camps and the *akomfo*. Those who were on antihypertensive medication claimed they have been advised by their Prophets, Prophetesses and relatives to combine prayers with medication and that would give them a complete cure. Other respondents who believed that their CVDs were caused by witchcraft were of the view that Western medicine could not cure them, and therefore sought healing from herbalists and prayer camps.

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

This portrayal of sale of CVDs to victims by enemies is in line with the general belief regarding the causes of illness (Odejide, Oyewumi & Ohaeri, 2006; Makinde, 2005; Field, 2003). This fact might be partly responsible for the relatively high uptake for far less effective traditional care compared with orthodox health treatment. This is in line with the situation in Africa, where traditional healers and spiritualists still enjoy large patronage for health care (Odejide, Oyewumi & Ohaeri, 2006; Prince, 2002, Ebigbo and Tyodza, 2007), probably borne out of the perceived causative factors mentioned previously. On the other hand, with this perceived cause of CVDs orthodox hospital care has been erroneously, shown to be largely ineffective. Hence this could be a factor that discourages people from seeking early orthodox care. In general, the belief in aetiology

of CVDs as found in the study was a major determining factor of the health seeking behaviour of respondents.

Subjective beliefs about cardiovascular disorders was deduced to have influenced many patients to search for different kinds of healers. This was without regard to whether or not the practices of these healers were beneficial to them. These practices resulted in different health seeking behaviours, with patients going on a wild goose chase in search of what is responsible for their dilemmas (Jain, & Agrawal, 2005).

Some patients indicated titrating orthodox medications with traditional remedies concurrently or alternately according to their perceived symptoms. These behaviours stemmed from different beliefs about the aetiology of hypertension and stroke. While some believed in witchcraft as a cause, others believed too much blood in the body and genetics as a cause of cardiovascular disorders and that the occurrence of the disorder cannot be controlled. These findings are in consonance with recommendations by Benson (2006), whose conclusions to their study findings were that patients' perception of illness may be influenced by their subjective beliefs but that further studies were required to identify such contributory factors.

This study has found that belief in the cause of cardiovascular disorders as one of such contributory factors. The study found, further that the multiple use of medications for the same condition created more complications for patients, and a sizeable number of them ended up at hospitals, for further management. In this study, there was a belief in spiritual causation of cardiovascular disorders that resulted in the use of traditional medicine by study participants. This provides direct evidence for previously described notions (Amira & O kubadejo, 2007; Chuma, Thiede & Molyneux, 2006; Shafiq, Gupta, Kumari & Pandhi, 2003) that non-orthodox medicinal use are perceived to work in ways that orthodox medication may not.

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

It is important to explore the reasons for which participants sought help from such quarters. Some of the reasons gleaned from the results included: perception of aetiology and efficacy of treatment, relational issues between healthcare providers and patients, proximity and acceptability of healthcare services, and availability of health services and involvement of family members.

The belief in the cause of cardiovascular disorders was a major factor that influenced the health seeking behaviour of respondents as explained by Boyle (2007). Findings of this study showed that respondents patronised either orthodox or traditional health care system based on their belief in the aetiology of the condition. This belief, as defined by cultural norms of supernatural causation could explain why some respondents were of the opinion that the orthodox health system was no place for them; and that seeking help from the traditional healer was the most probable option. In the same vein, those who believed in the biomedical explanation of the causes of their illnesses sought help mainly from orthodox health systems and saw these as the best places to receive treatment. With the perception of efficacy of treatment of particular health systems and the eventual health seeking behaviour notwithstanding, cases of multiple health care was not ruled out by respondents (Addo, Smeeth & Leon, 2007). This attitude of respondents presupposes that health seeking for orthodox and traditional systems are not strictly dichotomous and that there are some nuances like the length of the illness and the desire to get complete cure, which over ride allegiance to a particular health system and that. This further reveals that perception of health systems change in relation to the success or failure of health care delivered by a particular system.

Relational issues between health care providers and patients that influence the preference of healthcare systems among patients. For therapeutic success and eventual confidence in the health system, a good health care giver-patient relationship is of essence. These relational issues are in the form of patient abuses and communication systems (Ademuwagun, 1998; Iyalomhe, 2009). Some of the abuses, as gathered were in the form of insults, scornful looks, refusal to respond to patients' enquiries and humiliating patients in public through shouting at them. These attitudes of health staff and other instances of perceived neglect of patients and lack of proper care and concern for their welfare were perceived as factors that moved patients from these facilities. These attitudes were mainly found in the orthodox health facilities as opposed to the traditional systems that were very receptive and welcome patients with warm attitudes. These negative behaviours could stem from a variety of factors. The orthodox health facilities are more often than not inundated with hundreds of patients thus putting the health staff under a lot of pressure making them easily irritated. This is in sharp contrast to the non-orthodox health system where their source of income is hugely dependent on the patronage of their services.

For this reason they are more likely to put up attitudes that would attract a lot of customers (Atindanbila, & Thompson, 2011). A converse factor was the perception of health staff that patients are ungrateful and that no amount of sacrifices made by hospital staff for them, will please them. Attitude towards healthcare providers is also an important factor that determines the level of patronage (Atindanbila, 2011). The perceived ungrateful attitude of patients has paradoxically turned hospital staff against the very patients they are supposed to care for (Omotosho, 2010). Adequate explanation of the situation may resolve these dilemmas of cyclical misunderstandings between healthcare providers and patients (Ademuwagun, 1998; Iyalomhe, 2009).

Health seeking behaviour is therefore not dependent only on affordability, accessibility or availability, but on other factors not captured by earlier researchers (Good, 1987; Omotosho, 2010). On the contrary, traditional healers interacted differently with their patients than providers who have been trained in Western medicine. They were significantly more patient-centred in several aspects: They focused more on psychosocial topics and on issues of daily life than on purely medical questions and in particular, they more often asked for the patient's opinion and frequently discussed their concept of illness (Niklaus, Sabine, Engelbert, Jozien & Wolf, 2010).

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

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

This attitude to health reflects a contextualised understanding among the people that seeking help from the orthodox system directly involves paying huge sums of money for drugs that only harm that have the potential to further harm the body. This perception and financial constraints could, in a way explain the perpetuation of the use of traditional medicine. For this reason, extended family members without strong financial backing are likely to shy away from discussing health seeking with a sick relative in areas that involve financial commitments. The informational support given by the extended family members in support of the traditional health system could be due to the increasing advertisements on the mass media by the traditional healers who make very “wild” claims to have a completely curable antidote to every sickness, ranging from infectious diseases to non-communicable diseases such as cardiovascular disorders. The advertisements also go with the promises that patrons do not need to hold a lot of money to go there since payment for services is very meagre or could be deferred or paid in kind (Jonas, Franks, & Ingram, 1997).

These advertisements are tenaciously defended on daily basis with many of the traditional practitioners consistently buying airtime for this exercise, while at the same time these traditional healers try to run down the efficacy and the long term negative effects of medication prescribed by the orthodox health system (Haddad, 2005). These could be reasons why people are swayed by these actions due to a combination of factors like level of literacy, length of illness in addition to other socio-cultural factors mentioned in earlier pages. Based on these considerations, CVD patients were willing to devote as much money as possible to seek treatment from any source, provided they would be cured of their cardiovascular disorders.

### **Limitations**

This study has some limitations that must be taken into consideration. First, the study was conducted in the New Juaben Municipal area, which though comprises people of diverse ethnic groups is highly dominated by Akans who make up more than fifty percent of participants for the study. Their views may not necessarily reflect that of other ethnic groups. Therefore, the findings of this study may not necessarily be generalizable to other ethnic groups who may have different cultural backgrounds that influence their health seeking behaviour.

Secondly, the scope of the study was limited to people suffering from cardiovascular disorders and excluded people with other conditions for which patients seek treatment. This is because cardiovascular disorders comprising hypertension, stroke and chronic cardiac failure as defined in this study are constantly among the first ten diseases in Ghana just like malaria, TB, HIV/AIDS. For which people seek health care (de Graft Aikins, 2006; Sarfo, Cudjoe, Fosu, & Schlatter, 2015). Unfortunately, CVDs are among the least studied disorders in Ghana. The researcher therefore decided to limit the scope of the research to cardiovascular disorders.

Furthermore, extending the scope to other categories of disorders could have compromised the effectiveness of the study since having many variables in a study that is being undertaken within a limited time could potentially lead to shoddy work done.

### **Conclusions**

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

Secondly, religiosity and spirituality were identified as major factors that influenced health seeking behaviour among participants. Religious affiliation and a sense of reliance on a Supreme Being who cared for the suffering of people was a source of encouragement that provided emotional and psychological healing to patients though some of them might be suffering from debilitating conditions. The concept of religious healing was a force that participants reckoned kept

them going even in very trying moments of their suffering from cardiovascular disorders. Both traditional Spiritual heads and Christian spiritual heal heads play very significant roles that should not be downplayed. They have constantly served as hope for those that need it.

Health professionals need to develop and inculcate into their practice the concept of cultural competence where healthcare providers would understand the culture of the patients' they take care of. Healthcare providers are encouraged to be sensitive to patients' concerns and to understand the conditions from the patients' point of view and incorporate these in their professional practice. There is the dire need for healthcare givers to pay close attention to the traditional aspect of healthcare provision, since patients seeking help interpret the condition from a cultural point of view. Currently this aspect of healthcare delivery is missing in the health system, due to the western oriented training given to health professional where patients are viewed from the clinical point of view without enough regard for the cultural values of the patients. Closely related to this is the barrier of communication channels between health care providers and their patients which prevent patients from adequately expressing themselves. There is therefore the need for the health facilities to provide cultural-congruent services where they would take the cultural backgrounds of their patients into consideration when they are treating them.

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