International Journal of Healthcare Sciences ISSN 2348-5728 (Online)
Vol. 8, Issue 2, pp: (107-119), Month: October 2020 - March 2021, Available at: www.researchpublish.com

Religious Beliefs and its Influence on the Treatment of Non-Communicable Diseases (NCDs) in Ayawaso District, Ghana

Francisca Arboh[1], Elizabeth Yeboah[2], Emmanuel Kwateng Drokow[2], Eric Atta Quainoo[2], Adwoa Asantewaa Acquah Tyse[3], Akpene Yawa Amaglo[4], Nana Ama Anokyewaa Darko[5]

[1]School of Economics and management, Hebei University of Technology

[2]Korle-Bu Teaching Hospital, Ghana

[2]Department of Radiation Oncology, Henan Provincial People's Hospital and Zhenzhou University People's Hospital

[2]Faculty of Education, Beijing Normal University

[3]School of Economics and management, Hebei University of Technology

[4]College of Medicine, Nankai University

[5]College of Medicine, Nankai University

Corresponding author: equainoo767@yahoo.com

Abstract: **There has been a rise in the problem of Non-Communicable Diseases (NCDs) worldwide. Non-Communicable Diseases NCDs are chronic conditions and as such takes a toll on the family and the community. In Ghana, NCDs are attributed to supernatural causes, hence this study was done to assess people's knowledge and perception on NCDs, factors that influence their health seeking behaviours and how their religious beliefs affect the treatment of NCDs. The descriptive survey design through the quantitative approach was used in the study. Through stratified and random sampling procedures, a sample of 386 respondents were selected from Ayawaso District of Ghana. A questionnaire designed (in relation to literature) was used to gather data for the study. The gathered data was analysed based on the research questions, using descriptive statistics (frequency and percentage) and pearson product moment correlation. The findings of the study indicated that majority of the respondents have knowledge on NCDs, they first seek for the causes and treatment of the NCDs and there is a weak positive significant correlation between religion and seeking early intervention of NCD. Recommendations were made to contribute to optimizing the management of NCDs in the Ayawaso district of Ghana.**

Keywords: **Non-Communicable Diseases, Religious beliefs, Health, Ghana.**

1. INTRODUCTION

Communicable diseases have been the major causes of death worldwide with uncontrolled epidemics reducing life expectancy. After World War II, scientific research helped reduced the burden of communicable disease by developing antibiotics and vaccination. Non-communicable diseases started to cause major issues for the developed nations (Yawson, Abuosi, Badasu, Atobra, Adzei, & Anarfi, 2016). Diabetes, cancer and heart became a major problem in the developed countries (Bosu, 2012). Such diseases have been linked with economic growth and considered as rich people's disease. Non-communicable disease now seems to be penetrating the entire globe at the start of the third millennium with increasing pattern or incidents in developing nations (Yawson et al, 2016). Globalization has been a major cause to the increase of non-communicable diseases in developing nations and have led to the increase in technology and free trade among nations (Boutayeb & Boutayeb, 2005).

NCDs has increased globally due to causes such as risky routines of people allied with technological variations, modernization and dietary changes (Kretchy, Owusu-Daaku, & Danquah, 2014). Reported by the Global Status Report (2014), major causes of death are non-communicable diseases as compared to other causes combined, and projected that NCDs deaths are anticipated to increase from 38 million in 2012 to 52 million by the year 2030. There have been growth in the problem of non-communicable diseases in developing nations of which Ghana is no exception (Kretchy et al, 2014). There is a general conception among Ghanaian experts and lay communities that the major health problem in Ghana is infectious diseases. The reality is much more complex. In Ghana, major mortality cause has moved from primarily communicable diseases to double burden of disease (a combination of chronic NCDs and communicable disease over the past decades) (Boutayeb & Boutayeb, 2005).

Cancer, diabetes, hypertension and stroke are found in the top 10 cases of increased death. Globalization, weak health systems, changing lifestyles and urbanization are related to chronic diseases (Surjadi, Ismoyowati, Susilo, & Djarir, 2012). In Ghana, Global disease burden estimated by WHO indicates that injuries and non-communicable diseases contribute to forty percent (40%) of mortality cause and forty-six percent (46%) of morbidity cause (4). Approximately, 80% of these cases of deaths have been reported in middle-and-lower income nations, and it is estimated that the maximum rate of mortality due to NCDs will be recorded in these countries (De-Graft, Awuah, Anarfi, Agyemang & Ogedegbe, 2014). Report from Globocan, an affiliate of the WHO, indicated that NCDs accounted for over 82,000 deaths in Ghana in the year 2012. The pursuit for wellness, therefore quickly crosses into matters of religious beliefs since it represent an important role in social life (Anarfi, Badasu, Yawson, Atobra, Abuosi, & Adzei, 2016). Religion is virtually inseparable from every aspect of Ghanaian life and is important in the determination of worldview (Watkins, Quinn, Ruggiero, Quinn, & Choi, 2013). It is believed that there exist a supreme God who is a definitive wellspring of all medication and consequently, medication is seen as a blessing from the maker and it is apportioned thanks to the divinities (Landrine & Klonoff, 2016). In perceiving the way that God is the wellspring of healing, customary medical practitioners regularly tell their customers when consulted that 'if God permits you will be healed' (Kleinman, 2015). There is an assumption that western medicine can heal diseases if the correct conditions are met. Classification of disease treatment as ordinary or common is dispersed using allopathic or traditional medicine and those categorized as extraordinary or severe normally needs spiritual intervention (Boutayeb & Boutayeb, 2005). The fundamental reason is that, there is a supernatural influence in severe sickness, hence spiritual intervention is required.

In contrast, calamities and ill health are caused by changes with relations amongst human and his/her spiritual and societal surroundings or by armies targeted angered ancestors, evil spirit, sorcerers, wizards or witches for the violation of totemic principles (Boutayeb & Boutayeb, 2005). The common perception is that "people do not just suffer illness by chance" hence, severe illnesses such as stroke and hypertension are conceived to be originated from spiritual point of view. However, acknowledging biomedical justification centered on the presence of parasites, bacteria or viruses are viewed as secondary causes. The assumption of primary cause explains why a single person rather than others in a community is affected by these pathogens. Ghana's health sector has seen not worthy progress over the past ten years in areas such as NCD. Nonetheless, problems such as emergence of NCD like diabetes, respiratory diseases, cancers and cardiovascular diseases, substantially contribute to the nation's disease burden. These constitute a developmental and public health issues that must be of critical interest for all sectors not only for the health ministry (Boutayeb & Boutayeb, 2005). Some related problems such as insufficient awareness of non-communicable diseases in the entire populace have contributed to the late arrival of people to seek for treatment. Over 90% of chronic obstructive pulmonary and 80% of diabetes and cardiovascular deaths happen as a results of delay report to health facilities (Aikins, Anun, Agyemang, Addo, & Ogbe, 2015). NCDs have instigated major death and illness over the past years in Ghana. Nevertheless, NCDs have been ignored until lately and were not deemed a health priority (Bonsu, 2012).

Ghanaians are highly attached to their spirituality, hence most of the causes of non-communicable disease are attributed to spirituality. According to Yawson et al (2014), most parents send their children with non-communicable diseases to prayer camps first before attending the hospital when the condition becomes worse. Some of these setbacks could be attributed to low knowledge on the part of people and delay in providing treatment for people with such kind of diseases. These challenges have triggered this research to identify how religious beliefs influence the treatment of non-communicable disease. The study is therefore directed by the following research questions:

1. What is the level of knowledge of the people of Ayawaso West district with regards to NCDs?
2. What are the factors that influence the health seeking behaviours of the people in Ayawaso west district?
3. What is the influence of religious belief on the treatment of non-communicable disease?

2. LITERATURE REVIEW

Studies on religious beliefs, knowledge of non-communicable diseases, perception on treatment of non-communicable diseases, and influence of religious belief on the treatment of non-communicable diseases have been reviewed under the following headings:

Non-Communicable Diseases (NCDs)

Non-Communicable Diseases (NCDs) are disease conditions that cannot be passed or transmitted from one person to another. NCDs are having long durations and slow progression. NCDs are distinguished by their non-infectious or non-transmissible cause, that is, NCDs cannot be transferred from one person to another through a vector. The underlying socioeconomic, social, political and natural elements of NCDs are globalization, urbanization and people maturing. Based on the underlying elements, two major risk factors were posited: basic adaptable dangers (undesirable eating regimen, active work and tobacco usage) and non-adaptable dangers (aging and genetics). Identified also includes the intermediate risk factors in terms of raised blood glucose, raised blood pressure, abnormal blood lipids and overweightness or obesity. These danger factors are known to increase individual susceptibility to the major NCDs like hypertension, stroke, cancers, diabetes, and other cardiovascular diseases (WHO, 2012). Four main types of NCDs have been identified: cardiovascular diseases such as heart attack and stroke, chronic respiratory diseases (asthma and chronic obstructed pulmonary diseases), cancer and diabetes. NCDs are so far one of the foremost causes of death in the world. WHO estimated that NCDs account for 63% of all death annually, NCDs kills not less than 38million people a year and NCDs accounted for three quarters of death globally, 28million occurred in low and middle countries including Africa (WHO, 2012). Naghavi and Mohammad (2010) reported that, over 206 million deaths were due to NCDs and happened in Sub Sahara Africa a 46% (95% CI 41–59) rise from 1990.

Religious belief

Religious belief alludes to perspectives towards fanciful, otherworldly, or profound parts of a religion. Religious belief is different from religious practice or religious behaviors with some adherents' not rehearsing religion and a few experts not having confidence in religion. Religious belief, is gotten from thoughts that are elite to religion, hence, relate to the presence, attributes and love of a god, divine mediation known to man and human existence. Religion is a lot of a piece of the Ghanaian culture. Ghanaians give a lot of concern to their separate strict convictions and practices, which is the reason the public authority set the significant strict festivals in the nation as public occasions. Individuals dispense unique time for strict occasions and customs that their gathering notices. The major religious groups are in Ghana are; Christianity, Islam and traditional religion. All these three groups believe in a supreme being but through different means of worship.

Christian Religious belief

This belief is made up of the Christian faith. They believe in the existence of a supreme being who is the creator of all things. Realizing the beliefs causes us to fill in the Christian life, to try not to do some unacceptable things, and to educate or disclose to others what we accept. A portion of their beliefs are in God, Jesus Christ, Holy Spirit and judgment day.

Islamic Religion

This group of people believes in a supreme being called Allah. They accept that Allah is one and has no accomplice. He has no equivalent, no start and no closure. Allah is almighty and nothing can overcome Him. He made everything including man and decided their lives. Nothing is stowed away from Him.

Traditional religion

This group of people accepts that there is God and that this God is a soul and is incomparable. The traditional man believes that God is the creator of all things. He is the defender of both the solid and the feeble. This conviction also is communicated in some Ghanaian colloquialisms as: "God is the helper of those who suffer" and "If God does not decree your death, you do not die". He is likewise accepted to be amazing and He is viewed as a ruler. Then again, they accept that when they sin, God will rebuff them. This may appear as dry spell, starvation, floods, disorder or passing. All these religious groups believe in the existence of a supreme being.

Religious beliefs and Health

The pursuit for health, therefore easily conceals into issues of religious beliefs since it assumes a critical part in societal life (Iyalomhe & Iyalomhe, 2012). There is the belief that western medicine can fix diseases given the correct conditions are satisfied. Treatment of illnesses noted as "common" or "ordinary" is diffused utilizing either customary or allopathic

prescriptions while those named as "severe" or "extraordinary" for the most part require unique (spiritual) consideration (Olujimi,2006; Ewhrudjakpor, 2007; Omotosho, 2010). The fundamental explanation is that, in genuine illness there is a supporting of an extraordinary, hence spiritual intervention is required. Then again, infirmity and different hardships can result from an aggravation in the connection among man and his social and otherworldly climate, or from powers coordinated by witches, wizards, magicians, abhorrent spirits or maddened progenitors due to infraction of tribal standards (Mbiti, 1987). The well-known idea is that "people do not just suffer illness by chance" consequently, genuine illnesses like stroke and hypertension are accepted to have their starting point in an essential extraordinary reason. There is no trouble, nonetheless, in tolerating biomedical clarifications dependent on the presence of infections, microorganisms, parasites, disease or hypertension; these are just observed as optional causes. The possibility of essential causation gives a clarification concerning why a specific individual, and not others in the gathering, is beset by these irresistible specialists (Kroeger, 1983; Twumasi, 1988). There is some evidence indicating that religious beliefs among people is high for people with health problems and also those who have no health problems (Plakas, Boudiono, Fouka, & Taket, 2011). In a study by Plakas et al (2011), religiosity was found to be the main source of strength, courage and hope for relatives. It was expressed in church attendance, belief in God, praying and performing ritual. Again, in a study conducted by Kretchy et al (2013), poor adherence to anti-hypertensive medication was high occurring in 93.27% of the respondent. Spirituality influence medication non- adherence. Hypertensive patients related more to the attachment of a supreme being which makes them place much emphasis on spiritual healing than orthodox medication. The patients tend their beliefs in spiritual healing thinking that hypertension is incurable. Also, the study revealed that some patients neglect orthodox medication while anticipating for divine healing outcomes.

Knowledge and Perception of NCDs

Within the last three decades there have been growing rate of health challenges across the globe. WHO, (2012) emphasized that non-communicable diseases such as cardiovascular diseases, cancers, diabetes and chronic respiratory diseases are the most prevalent of health threats globally. A study by Mbuya, Fredrick and Kundi (2014) on information of diabetes and hypertension among teaching staff of higher learning institutions in Dar es Salaam, Tanzania, revealed that majority of the participants had knowledge on NCDs and elements identified with cause, signs and manifestations, dangers or difficulty of the diabetes and hypertension. Out of the 164 participants, (65.5%) accurately perceived that diabetes and hypertension are preventable conditions. In a comparable report in India, just 42.6% of the informed and expert respondents perceived that diabetes could be prevented (Mohan, Suresh, Deepa, Pradeepa & Rema, 2005). About three quarters of university students in United Arab Emirates answered to know that diabetes could be prevented (Khan et al., 2012). The study uncovered that larger part of respondents had right information on cardiovascular breakdown and stroke and loss of vision as inconveniences of hypertension yet short of what 33% perceived kidney disappointment as one of intricacies. Then again, information on intricacies of diabetes was low especially as for cardiovascular breakdown, stroke and hypertension which were effectively recognized by not exactly 50% of the members. Helpless information with respect to the intricacies of diabetes has additionally been accounted for among diabetic patients in India, all the more so among women (Gulabaniet, John & Isaac, 2008). Also, the study of Al Shafaee, Al-Shukaili and Rizvi (2008) on information and view of diabetes in a semi-urban Omani population confirms that knowledge on NCD is low. The study was done with two semi-urban populations with a total sample of 563 grown-up occupants with the point of finding the information on individuals on diabetes including the definition, causes, signs and manifestations and its danger factor. The study revealed that, 320(56.8%) of the participants had knowledge of diabetes, anyway just 262 had the option to characterize it. Awareness of diabetes, its causes, signs and symptoms and its risk factor according to the study is minimal. Just 55% of the respondents realized that diabetes is a condition if not controlled can deliver long lasting ramifications. Also, the study indicated that one's level of education has a direct influence on one's level of knowledge regarding to definitions, symptoms and risk factor. The study concluded that knowledge is associated with health education. In the Ghanaian context, the study by Aikins et al (2015) indicated that participants are aware of the existence of chronic diseases. They defined chronic diseases as incurable conditions thus, doctors cannot cure. Almost all the participant mentioned hypertension and diabetes as chronic diseases which infer that, most people are aware of the existence of NCD conditions in Ghana. Several causes were mentioned which includes, diets, poor lifestyle living, hereditary, physical factors, environmental factors, psychological factors and spiritual factors. This study inferred that most people have knowledge of the existence of NCD in Ghana. However, Yawson et al (2016) studies on NCD among kids in Ghana concluded that NCD are caused by spiritual forces. The study revealed that almost half of the participant of parents/caretakers believed that, it isn't typical for kids to experience the ill effects of persistent illnesses. Out of the 225 participants, 169 parents believed that children suffer from NCD as results of sins from parents. NCDs are subsequently seen as difficulties by extraordinary forces in conventional Ghanaian culture.

Health Seeking Behaviour

Truly, sicknesses whose etiology couldn't be promptly clarified, an example being convulsion, have been given powerful clarifications among the different ethnic gatherings in Ghana (Awusabo- Asare & Anarfi, 1997). Such a clarification of sickness causation impacts individual's disposition towards the illness as well as toward tainted people, and this impacts the wellbeing looking conduct of contaminated people. In a number of societies, the occurrences of diseases such as cardiovascular disorders with no known fix or beginning might be ascribed to the commission of an offense against one's spirits, the predecessors or the divine beings, or an exclusion of obligation with respect to a contaminated individual. It could likewise be ascribed to a revile from an envious neighbour, co-spouse and even a relative or someone who has been violated (Danquah, 2008). At various occasions in Ghana, the event of illnesses, for example, hypertension, stroke, tuberculosis, measles and guinea worm has been ascribed to extraordinary sources (Amoah, 2003). The mainstay of the African philosophy of health and illness is the reverence and respect for the ancestors (Oladipo, 1998). Ancestral spirits, God and witches and sorcerers were and still are believed to influence health and illness. There is a conviction that western medication can give neither a clarification nor a remedy for specific sicknesses. Such orthodox medicinal practices teach for instance that once an individual is hypertensive, the condition is for life and one may have to be on medication until death (Dokosi, 1998). Such an explanation has not been embraced by all, for which reason people seek explanation from other sources. Therefore, people suffering from cardiovascular diseases the origin of which has been attributed to supernatural causes, may look for clarification and conceivable solution for the sickness at obsession hallowed places, soothsayers or mystics. A study by Shehu and Ogunsola (2014) showed that religion and marital status of the respondents decide the health-seeking behaviour of the people, while gender does not necessary influence the health behaviours of the people. The investigation concludes that strict connection had huge relationship with wellbeing looking for conduct of the individuals. The suggestion is that diverse religion affiliations of Islam, Christianity and Traditional religions direct the wellbeing conduct of their adherents. The study is supported by a study conducted by Kiawi, Richard, Shu, Unwin, Kamadjeu and Mbanya (2006) where all participants (parents/caregivers) consented to utilize customary clinical test in medical clinics for their children with NCD. Yet, 73 participants (32.66) of caregivers agreed to have previously used other means such as traditional medicine or spiritual healing. Again, in a study by Anarfi et al. (2016) which pointed toward taking a gander at the connection between grown-ups' strict affiliation and their mentalities and insights to children's NCDs and how guardians of children with NCDs look for care for infected children, out of all the background characteristics, out of all the foundation attributes, just age and gender of guardians had significant relationship with looking for treatment from supplication camps. Guardians who have a place with Christian groups which transparently buy in to otherworldliness, for example, Charismatic/Pentecostal Churches, known as profound temples in Ghana, were bound to disparage supplication camps than those in different sections just as different religions. For the most part, more Christians look for treatment for their kids from petition camps than Muslims. The way that guardians from all strict affiliations, including Muslims and conservatives, look for treatment for their youngsters with NCDs from supplication camps, confirms Atiemo's affirmation that in crisis circumstances, numerous Ghanaians look for help from any source including those external their typical scope of strict exercises. Among the Christians, Catholics were almost certain than guardians from other Christian groups to look for natural treatment for their youngsters' NCD condition, along with Muslims and Traditionalists/Spiritualists. In Ghana, there is the propensity for individuals to connect natural treatment with fetishism and this could clarify the wary disposition of guardians from the other Christian divisions towards home grown treatment. Complex cycle is associated with settling on medical care choice. Blend of powers meeting up to create individual and individual decisions of healthcare treatment is high. The forces of traditional, cultural and religious all shape healthcare choices. The perception of people about the causes of NCDs, beliefs attached to it determines when to seek treatment, where to seek treatment and which kind of treatment is the best for NCD conditions (Tabi, Powell, & Hodnicki, 2006).

Influence of Religious beliefs on Health Treatment

Knowledge and perception on NCD, religious beliefs on NCD and health seeking behaviours have an influence on the treatment of NCDs. A study by Basu-Zharku (2011) agreed that religious beliefs can influence health treatment in four most prominent pathways: well-being behaviours (through recommending a specific eating routine and additionally debilitating the maltreatment of mixed refreshments, smoking, and so forth, religion can secure and advance a sound way of life), social help (individuals can encounter social contact with co-religionists and have a trap of social relations that can help and ensure at whatever point the case individuals can encounter a superior emotional well-being, more certain mental states, more hopefulness and confidence, which thusly can prompt a superior actual state because of less pressure) and 'psi' impacts (extraordinary laws that administer 'energies' not presently appreciated by science yet perhaps justifiable eventually by science). The primary understanding thinks about that religion can impact wellbeing through any of the four pathways noted above (wellbeing practices, social help, mental states and psi impacts). The subsequent understanding, the 'psychobiological' one, thinks about that otherworldliness/religion impact wellbeing through psychoneuroimmunology or psych neuroendocrinological pathways past the advantages that religion

has through wellbeing practices and social help. The third understanding, the 'too exact' or 'psi' translation, thinks about that otherworldliness/religion impact wellbeing through super-experimental pathways, past wellbeing practices and mental states. At long last, the 'psycho-conduct' understanding, focuses on that religion can impact wellbeing through different mental conditions, for example, character, resolve, centered consideration or expanded inspiration past pathways, for example, social help (Oman and Thorensen, 2002). Another study conducted by Yawson et al (2016) confirms that religious beliefs serve as a hindrance to the treatment of NCDs. NCD conditions are presented late at health facilities and thereby cause much death in Ghana. Most parents attached religious believes to the cause of NCDs on their children, as a result of their sins. They believed that it is not normal for children to acquire NCD, hence as a result of sins of their parents to a supernatural force. This serves as a major determinant of health seeking for treatment. Most of the participants were aware of medical treatment, yet the beliefs attached to the condition encourage them to seek treatment from spiritual source. Participant sought treatment from medical facilities only at the worst stage. The study reviewed that, children are taken to health facilities only at the advanced stage, after seeking help from prayer camps and traditional healers. This delays treatment and most children die from NCD conditions due to late presentation of the diseases at medical health facilities. However, the study conducted by Kiawi et al (2006) agreed to the fact that religious beliefs have negative effect on the treatment of NCD, yet other factors account to where and when to seek treatment. Most of the participants had low knowledge on the existence of NCDs. Also, most people believed that medical healthcare facility is the best place to seek treatment, yet money served as a hindrance in seeking treatment from these places. As a result, most people with diabetes report late and most of them die at the hospital. Prevention measures such as changing lifestyle, physical activity and changing diet was not known to the people as a result of lack of information of NCDs and its roots. Lay beliefs about causation and treatment of diabetes were managed at home, traditional healers and prayer camps which delays the presentation of the diseases at the health facilities. This problem has tended to increase the prevalence of NCD in Africa.

Health Belief Model (HBM)

Health belief model was used to support this study. In spite of the fact that there are various models identified with behaviour and behaviour modification, one of the up-to-date and generally utilized models of health-related behaviours is the health belief model (Champion & Skinner, 2008). The HBM ascended from the studies of a few social clinicians during the 1950s, which tried to clarify why a few people declined interest in preventive medical care projects, for example, inoculation and tuberculosis screening that could help with early analysis and avoidance of infections (Janz & Becker, 1984). Likewise, similarly as with different speculations investigating conduct alteration or change, the HBM incorporates a conviction segment, a demeanor segment and a conduct segment. The conviction segment identifies with what the individual surveys as the genuine circumstance, while the mentality segment relates to how the individual feels about the circumstance. Together, these two parts functions as the driver for the person to carry on in a particular way. The model has been explored and stretched out throughout the years to incorporate a self-adequacy segment, in light of the exploration of Albert Bandura, and a signal to activity or boost part, and has been generally utilized by sociology scientists to portray and conjecture wellbeing related practices (Shillitoe & Christie, 1989). The principal thought of the first HBM is that wellbeing conduct is dictated by close to home convictions or insights about an infection and the techniques accessible to diminish its event (Hochbaum, 1958). Individual discernment is impacted by the entire scope of intrapersonal factors influencing wellbeing conduct. The Health Belief Model (HBM) is to comprehend wellbeing conduct and potential purposes behind rebelliousness with suggested wellbeing activity. It can give rules to program improvement permitting organizers to comprehend and address purposes behind resistance. The HBM tends to four significant parts for consistence with suggested wellbeing activity: saw boundaries of suggested wellbeing activity, seen advantages of suggested wellbeing activity, seen helplessness of the infection, and saw seriousness of the illness. Furthermore, there are altering factors that can influence conduct consistence. Changing variables would incorporate media, wellbeing experts, individual connections, motivations, and self-adequacy of suggested wellbeing activity. The Health Belief Model by Hochbaum (1958) which expresses that health conduct is controlled by close to home convictions or discernments about a sickness with the procedures accessible to diminish its event will help comprehend the investigation. The model further announces that singular insight is impacted by the whole extent of intrapersonal factors influencing wellbeing practices.

3. METHODOLOGY

This study employed the quantitative research approach using specifically the descriptive survey research design. This was based on Creswell (2014) assertion that descriptive survey tends to document situations as they naturally occur and uses the quantitative research approach to test a theory by specifying narrow hypothesis, collect quantitative data to support or refute the hypotheses, and analyse the information using statistical procedures. The study area was the Ayawaso District of the Greater Accra Region and in particular University of Ghana Hospital. The study area mirrors the entire situation in Ghana in that the University of Ghana Hospital is the major hospital in the district that records NCD cases. Population of the study included men

and women with NCDs living in the district of which 386 were sampled through stratified and random sampling procedure based on the Krejcie and Morgan (1970) sampling formulae. The tool used for data collection was a questionnaire designed in relation to literature reviewed. To ensure validity and reliability of instrument, the questionnaire was subjected to expert judgement and pilot testing. In particular, the instrument was piloted using 30 participants in the GA East District of Greater Accra Region and the Cronbach alpha obtained was 0.75. According to Pallant and Manual (2010), an instrument's reliability coefficient of .70 and above is effective for data collection. To ensure, ethical and moral issues, respondents' anonymity, confidentiality, voluntary participation, right to leave the study, among others, were duly adhered to. The gathered data were analysed by means of descriptive statistics (frequency and percentage) and pearson product moment correlation.

4. RESULTS AND DISCUSSION

Results of the study is presented based on the research questions.

Research Question One:

What is the level of knowledge of the people of Ayawaso West district with regards to NCDs?

This research question sought to determine the level of knowledge of the participants with regards to NCDs. Respondents were asked to respond to items on their knowledge of NCDs, experience of NCDs, type of NCDs, causes of NCDs and whether NCDs are curable and transmitted. Participants' responses were analysed with frequencies and percentages. The responses of participants are shown in Table 1 – 6.

Table 1- Knowledge of NCDs

Heard about NCD	Frequency	Percentage (%)
Yes	365	94.3
No	11	2.8
Maybe	11	2.8
Total	386	100.0

Table 1 presents the responses of participants by knowledge NCDs. From the table, participants who have heard about NCDs (n=365, 94.3%) were the majority and participants who have not heard about NCD (n=11, 2.8%) were the least.

Table 2- Experience of NCDs

Family experience	Frequency	Percentage (%)
Yes	358	92.7
No	28	7.3
Total	386	100.0

Table 2 presents the responses of participants by experience NCDs. From the table, participants who had experienced NCDs (n=365, 94.3%) were the majority and participants who had not experienced NCDs (n=11, 2.8%) were the least.

Table 3- Type of NCDs experienced

Disease	Frequency	Percentage (%)
Cancer	263	73.5
Hypertension	51	14.2
Diabetes	44	12.3
Total	358	100.0

Table 3 presents the responses of type of NCDs experienced by participants. From the table, participants who sufferred cancer (n=263, 73.5%) were the majority, participants who sufferred hypertension (n=51, 14.2%) followed and participants who sufferred diabetes (n=44, 12.3%) were the least.

Table 4- Causes of NCDs

Causes	Frequency	Percentage (%)
Personal lifestyle	93	24.1
Spiritual causes	293	75.9
Total	386	100.0

Table 4 represents the causes of NCDs. Out of the 386 respondents, 293 participants representing 75.9% indicated that their condition is caused by spiritual causes whiles 93 participants representing 24.1% also indicated that their conditions are caused by personal lifestyle. It can be explained from the results that, spiritual cause is perceived to be the major cause of NCDs.

Table 5- Whether NCDs is curable or not

Curable	Frequency	Percentage (%)
No	360	93.3
Yes	15	3.9
Maybe	11	2.8
Total	386	100.0

Table 5 represents knowledge of participants on whether NCDs can be cured or not. From the table, 360 participants representing 93.3% indicated that NCDs cannot be cured whiles 15 participants representing 3.9% indicated it can be cured. 11 participants representing 2.8% indicated maybe.

Table 6- Whether NCDs is transmittable or not

Transmission	Frequency	Percentage (%)
No	281	72.8
Yes	61	15.8
Maybe	44	11.4
Total	386	100.0

Table 6 represents knowledge of participants on whether NCDs can be transmitted or not. From the table, 281 participants representing 72.8% indicated that NCDs cannot be cured whiles 61 participants representing 15.8% indicated it can be cured. 44 participants representing 11.4% indicated maybe.

Overall, the findings indicated that majority of the respondents have knowledge on NCDs. The good knowledge of the NCDs may be from relatives who's experiencing the illnesses combined with a decent information on eating routine, and active work would be because of the elevated level of exposure given to them to advance these. The general knowledge of NCDs is very adequate because these respondents are inhabitants of the district who have vowed to battle the plague of NCDs, and should be proficient enough of the infections and their anticipation. The findings of the study is in relation to Mbuya et al, 2014 whose studies concluded that majority of the participants had knowledge on NCDs and factors identified with cause, signs and side effects, dangers or difficulty of NCDs. This study concludes that knowledge and awareness of NCD is high therefore it shed lights on the significance of education in encouraging way of life changes to forestall these conditions.

Research Question Two:

What factors influence the health seeking behaviours of the people in Ayawaso west district?

This research question sought to determine factors that influence health seeking behaviours of participants with regards to NCDs. Respondents were asked to respond to items on their first reaction when they discover they have the condition, need to visit the hospital, alternative intervention if they do not see the need to visit the hospital, factors that influenced the alternative intervention and need for combined therapy. Participants' responses were analysed with frequencies and percentages. The responses of respondents are shown in Table 7 – 11.

Table 7- Reactions when participants discover they have the condition

First reaction	Frequency	Percentage (%)
Seek for the causes	299	77.5
No reaction	55	14.2
Visit my spiritual leader	32	8.3
Total	386	100

Table 7 shows reactions of participants when they discovered they have NCDs. Out of 386 respondents, 299 representing 77.5% indicated that they first sort for the cases, 55 participants representing 14.2% had no reactions and 32 participants representing 8.3% indicated that, they visited their spiritual leader. This shows that, the causes of diseases are really important to most of the respondent.

Table 8- Need to visit the hospital

Need to visit hospital	Frequency	Percentage (%)
Yes	348	90.0
No	11	2.8
Maybe	27	7.0
Total	386	100

Table 8 shows the responses from participants on the need to visit the hospital when discovered with NCDs. 348 participants representing 90% indicated the need to visit the hospital immediately they discovered their condition, 11 participants representing 2.8% indicated that is not necessary to visit the hospital and 27 participants representing 7.0% indicated maybe. This shows that most people are aware of the need to visit the hospital and also seek medical intervention.

Table 9- Alternative intervention if they do not visit the hospital

Alternative intervention	Frequency	Percentage (%)
Visit herbal healers	11	2.8
Visit prayer camps	26	6.7
Others	349	90.4
Total	386	100

Table 9 represents responses of participants seeking alternative intervention other than visiting the hospital immediately a condition is discovered. Out of the total response, 26 respondents representing 6.7% indicated that visiting prayer camps (spiritual intervention) is the best intervention to seek for and 11 respondents representing 2.8% indicated the need to visit the herbal facility than the hospital. However, 349 respondents representing 90.4% will seek for other interventions.

Table 10- Factors that influence alternative interventions

Factors	Frequency	Percentage (%)
Financial problem	97	25.1
The disease is spiritual cause	132	34.2
Advice from friends and families	157	40.7
Total	386	100

Table 10 represents the factors that influenced participants to seek alternative intervention. From the table, 157 respondents representing 40.7% indicated that they receive advice from friends and families to seek alternative

intervention, 132 respondents representing 34.2% indicated that the disease is spiritual, therefore the need for alternative intervention and 97 respondents representing 25.1% indicated that financial constraints hindered them from visiting the hospital, hence seeking alternative intervention.

Table 11- The need for combined intervention

Combined therapy	Frequency	Percentage (%)
Yes	375	97.2
No	11	2.8
Total	386	100

Table 11 represents the responses of participants with regards to whether medical and spiritual intervention should be combined. 375 respondents representing 97.2% of the respondents indicated that it is necessary to combine both therapies, while 11 respondents representing 2.8% did not see the need to combine both therapies.

Overall, the results of the study indicated that majority of the respondents first seek for the causes of the disease. In seeking for the sources of the disease, majority of the respondents visit the hospital. However, majority of the respondents advocated for combined therapy where they seek for medication from the hospital and spiritual healing. The study therefore concludes that mind boggling process is associated with making healthcare seeking decision. Mix of powers meeting up to create individual and individual decisions of healthcare seeking behaviour is high. According to Tabi et al (2006), the forces of traditional, cultural and religious all shape healthcare seeking behaviours and choices. On the other hand, the perception of people about the causes of NCDs, beliefs attached to it determines when to seek treatment, where to seek treatment and which kind of treatment is the best for NCD conditions. Although, the ideal place to seek health treatment is the modern healthcare facility, other alternatives are used when there is lack of money. As seen in this study, participants also seek for spiritual and herbal treatment, and this confirms studies by Kiawi et al (2006) who concluded that participants seek regular medical check-ups in hospital for their children with NCD. However, they likewise use other means such as traditional medicine or spiritual healing.

Research Question Three:

What is the influence of religious belief on the treatment of non-communicable disease?

This research question sought to find out the influence of religious belief on the treatment of NCDs. Pearson Product Moment Correlation Coefficient was used to find out the influence of religious belief on the treatment of NCDs. The finding is presented in table 12 below.

Table 12: Influence of religious belief on the treatment of non-communicable disease

		Religion	First-intervention
Religion	Pearson Correlation	1	.140**
	Sig. (2-tailed)		.006
	N	386	386
First-intervention	Pearson Correlation	.140**	1
	Sig. (2-tailed)	.006	
	N	386	386

**. Correlation is significant at the 0.01 level (2-tailed).

It can be indicated from the results that there is a weak positive significant correlation between religious beliefs and early intervention of NCDs. Though religious beliefs influence participants' intervention of NCDs, the influence is very weak. The finding is in congruence with the study of Yawson et al (2016) which confirms that religious beliefs serve as a hindrance to the treatment of NCD, therefore NCD conditions are presented late at health facilities and thereby cause much death in the Ayawaso district.

5. CONCLUSION

This study sought to investigate how religious beliefs influence the treatment of non-communicable disease. Specifically, the study investigated the knowledge and awareness on non-communicable disease of people in the Ayawaso west district, found the main issues that influences health seeking behaviours of the people of Ayawaso west district, and determined the influence of religious beliefs on seeking early intervention of non-communicable diseases. It was found out from the study that, with the knowledge and awareness of NCDs, majority of the respondents have knowledge on NCDs. With the health seeking behaviours of respondents, the study concludes that mind boggling process is associated with healthcare seeking decisions. Mix of powers meeting up to create individual and individual decisions of healthcare seeking behaviour is high. Thus, the forces of traditional, cultural and religious all shape health seeking behaviours and choices. There is a weak positive significant correlation between religion and seeking early intervention of NCDs. Though religion influence people's intervention of NCDs, the influence is very weak. Overall, as the inhabitant of the Ayawaso west district have knowledge and awareness of NCDS, they believe that medical healthcare facility is the best place to seek treatment. However, money served as a hindrance in seeking treatment from these places. Thereby they seek herbal and spiritual healing. Financial capabilities influence them as to when and where to seek treatment. This means the financial capability of patients is a contributor to health seeking behavior. There is the requirement for educators and religious leaders to get effectively associated with the mission against undesirable ways of life of NCDs. This mission would assist with tending to strict restrictions, convictions and odd notions related with nourishment and other health practices in the district.

6. RECOMMENDATION

The study made the following recommendations which are intended to contribute to optimizing the management of NCDs in the Ayawaso district, Ghana:

1. Health care professional should teach NCD patients about their condition explicitly underlining on the constant idea of the condition, seriousness of the infection, how their drugs work and the outcomes of non-adherence with treatment.

2. Health education on NCDs should be done through banners, flyers and durbars at health facilities in addition to health talks given. Health facilities can embark on regular screening programs in the district to allow people to have regular checkups.

3. The government should ensure that NHIS covers medications that are used in the management of NCDs as this will reduce the out-of-pocket payment burden for medications.

REFERENCES

[1] Aikins, G., Anun, A., Agyemang, C., Addo, J., & Ogbe, O. (2015). lay representation of chronic diseases in Ghana. *Ghana medical journal, 46*(2).

[2] Al Shafaee, M. A., Al-Shukaili, S., Rizvi, S. G. A. (2008). Knowledge and perceptions of diabetes in a semi-urban Omani population. *BMC Public Health 8,* 249-260. https://doi.org/10.1186/1471-2458-8-249.

[3] Amoah, A. G. (2003). Hypertension in Ghana: a cross-sectional community prevalence study in greater Accra. *Ethn Dis. Summer, 13*(3), 310-5. PMID: 12894954.

[4] Anarfi, J. K., Badasu, D. M., Yawson, A., Atobra, D., Abuosi, A. A., & Adzei, F. A. (2016). Religious affiliation and health seeking behavior among children in Ghana. *International journal of healthcare, 2*(2), 45-55.

[5] Awusabo-Asare, K., & Anarfi, J. (1997). Health-seeking behaviour of persons with HIV/AIDS in Ghana. Health transition review: the cultural, social, and behavioural determinants of health. *Suppl., 7,* 243-56. 10.2307/40652305.

[6] Bosu, W. K. (2012). A comprehensive review of the policy and programmatic response to chronic non-communicable disease in Ghana. *Ghana Med Journal, 46*(2), 69-78.

[7] Boutayeb, A., & Boutayeb, S. (2005). The burden of non-communicable diseases in developing countries. *Int J Equity Health, 4*(2). https://doi.org/10.1186/1475-9276-4-2.

[8] Champion, V. L., & Skinner, C. S. (2008). The health belief model. In K. Glanz, (Ed.), *Health behaviour and health education: Theory, research, and practice*. (pp. 63-88). San Francisco: Jossey-Bass.

[9] De-Grafta, A. A., Awuah, R. B., Anarfi, J. k., Agyemang, C., & Ogedegbe, G. (2014). Prevalence, awareness, treatment and control of hypertension in urban poor communities in Accra, Ghana. *Journal of Hypertension, 32*(6), 1203-1210 doi: 10.1097/HJH.0000000000000165.

[10] Dokosi, O. B. (1998). *Herbs of Ghana*. Ghana Universities Press: Accra.

[11] Gulabaniet, M., John, M., & Isaac, R. (2008). Knowledge of diabetes, its treatment and complications amongst diabetic patients in a tertiary care hospital. *Indian Journal of Community Medicine, 33*, 204-206.

[12] Hochbaum, G. M. (1958). *Public Participation in medical screening programmes: A socio-psychological study*. Public Health Service, U. S. Department of Health, Education, and Welfare.

[13] Iyalomhe, G. B. S., & Iyalomhe, S. I. (2012). Health-Seeking Behaviours of Rural Dwellers in Southern Nigeria: Implications for Healthcare Professionals. *International Journal of Tropical Disease & Health, 2*(2), 62-71.

[14] Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education and Behaviour, 11*(1), 1-47.

[15] Kleinman, A. (2015). *Patients and Healers in the Context of Culture*. Berkeley, CA: University of California Press.

[16] Kiawi, E., Richard, E., Shu, J., Unwin, N., Kamadjeu, R., & Mbanya, J. C. (2006). Knowledge, Attitudes, and Behaviour Relating to Diabetes and its main Risk Factors among Urban Residents in Cameroon: A qualitative Survey. *Ethnicity & Disease, 16*, 120-131.

[17] Krejcie, R. V., & Morgan, D. W. (1970). Determining sample size for research activities. *Educational and Psychological Measurement, 30*(3), 607-610.

[18] Kretchy, I. A., Owusu-Daaku, F.T., & Danquah, S. A. (2014). Mental health in hypertension: assessing symptoms of anxiety, depression and stress on anti-hypertensive medication adherence. *Int J Ment Health Syst, 8*, 25.

[19] Kroeger, A. (1983). Anthropological and socio-medical health care research in developing countries. *Social Science & Medicine, 17*(3).

[20] Landrine, H, & Klonoff, E. A. (2016). Cultural diversity in causal attributions for illness: The role of the supernatural. *J Behav Med, 17*, 181-193.

[21] Mbiti, J. S. (1987). Creation in African Religion. *Christian Jewish Relations, 20*(1), 31-43.

[22] Mbuya, F. E., Fredrick, F., & Kundi, B. (2014). Knowledge of diabetes and hypertension among members of teaching staff of higher learning institutions in Dar es Salaam, Tanzania. *Tanzania Journal of Health Research, 16*(2). https://doi.org/10.4314/thrb.v16i2.5.

[23] Mohan, V., Suresh, S., Deepa, R., Pradeepa, R., Rema, M. (2005) Large-scale diabetes awareness and prevention in South India. *Diabetes Voice, 50*(4), 11-14. ISSN 1437-4064.

[24] Olujimi, J. (2006). Significant factors affecting patronage of health facilities by rural dwellers by Owo-Region, Nigeria. *The social sciences, 1*(3), 206-215.

[25] Oman, D., & Thorensen, C. E. (2002). Does Religion Cause Health? Differing Interpretation and Diverse Meanings. *Journal of Health Psychology, 7*, 365-380.

[26] Pallant, J., & Manual, S. S. (2010). *A step-by-step guide to data analysis using SPSS*. Berkshire UK: McGraw-Hill Education.

[27] Shehu, A., & Ogunsola, A. (2014). Demographic Factors as Correlates of Health-Seeking Behaviour of the People of Oyo State, Nigeria. *Ghana Journal of Development Studies, 11*(2). doi: http://dx.doi.org/10.4314/gjds.v11i2.7.

[28] Shillitoe, R. W. & Christie, M. J. (1989). Determinants of self-care: The health belief model. *Holistic Medicine, 4*(7), 3-17.

[29] Surjadi, C., Ismoyowati, D., Susilo, D., & Djarir, H. (2012). Perception of non-communicable diseases predict consumption of fruits and vegetables. *Universal medicine, 31*(3).

[30] Tabi, M. M, Powell, M., & Hodnicki, D. (2006). Use of traditional healers and modern medicine in Ghana. *Int Nurs Rev.*, *53*(1), 52-8. doi:10.1111/j.1466-7657.2006.00444.

[31] Watkins, A., Quinn, L. T., Ruggiero, L., Quinn, M. T., Choi, Y. (2013). Spiritual and religious beliefs and practice, and social support relationship to diabetes self-care activities in Africans Americans. *PMC journal*, *2*, 10-15.

[32] WHO (2014). *Global Status Report on Non-communicable Diseases*. World Health Organization.

[33] Yawson, A. E., Abuosi, A. A., Badasu, D. M., Atobra, D., Adzei, F. A., & Anarfi, J. K. (2016). Non-communicable diseases among children in Ghana: health and social concerns of parent/caregivers. *Afri Health Sci*, *16*(2), 378-388.

[34] Basu-Zharku, I. O. (2011). "The Influence of Religion on Health." *Inquiries Journal/Student Pulse*, *3*(1). Retrieved from http://www.inquiriesjournal.com/a?id=367.