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PHYTOTRADITIONAL MEDICINE AND HEALTH ECONOMY AMONG THE KABIYE OF KARA IN THE NORTHERN OF TOGO

Atchalé ADI Socio-anthropologist, Administrator of DPHU-Pôle of IAT in Niamey Niger

0. SUMMARY

This study aims to show the place of Phyto traditional medicine in the health economy and the absence of state policy to accompany its management and its economic organization. A survey was carried out among a sample of 160 Phyto traditional actors. The results obtained show that, the administrations of Phyto traditional care are not free and can therefore participate to the health economy by opening them up to the market economy. The determinants of the use of Phyto traditional care compared to modern medicine further explain that Phyto traditional medicine has its place in public health. In fact, the sale of phytomedicines to patients from different socio-professional categories represents a shortfall with the public authorities that it is possible to make up for by formalizing Phyto traditional practices.

Keywords: Phyto traditional medicine, Health economics

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1. INTRODUCTION

The challenges faced today by health systems result from part of demographic and epidemiological transitions, in particular fast changes in public health through forecasted budgets for: diagnosis and treatment, screening and treatment, prevention, immunization and family planning. In everything, we have been told that, public health programs do not take into account the Phyto traditional services benefits. This Phyto economy disinterestedness is total when, the Phyto traditional medicine management or economic organization is never part of the prerogatives of public authorities in health economy. In such a context, decision-makers, technical and financial partners, researchers and users need reliable, up-to-date information's in order to contribute to improving the performance of health systems, mainly, the practices in the Phyto traditional sectors. According to the World Health Organization, all the developing countries especially African still depend to 80% of the Phyto traditional care. As in some countries, 85% of the Togolese people practice Phyto traditional medicine.

The active part of Phyto traditional medicine being consciously ignored in the health economy, it is up to this study to define its place by the main indicators of health. These indicators that everyone knows, but which seem non-existent in the main programs and politics of health development. It is within this framework of health and development that, it is essential to involve Phyto traditional medicine as a link in the Millennium Development Goals. Today, among the Kabiyè, it is impossible to avoid Phyto traditional care, just as it is also malicious not to recognize the place occupied by its care in the health economy. This study sets itself the task of highlighting the causes and the fundamental factors which require reflection on the formalization and rationalization of this medicine in the health economy among the Kabiyè of Kara, in the north of Togo.

1.1 Problem Statement

With a Gross National Income (GNI) per habitant of 540$ US (World Bank, 2015), Togo is one of the low-income countries. However, there are encouraging signs in terms of economic growth. "This economic growth has increased over the past five years, from 2.4% in 2008, growth is estimated at 5.4% in 2015. Likewise, depth and extreme poverty have started to decline slightly

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from 58.7% in 2011 to 55.1% in 2015. Despite this positive development, the country has not made significant progress on the social level. By way of illustration, Togo is in 162nd place out of 188 countries classified" (Main Health Indicators in Togo, 2015, p.5). This shows that significant efforts still need to be made in many sectors, particularly in health, especially in the restructuring of Phyto traditional medicine.

In this aspect precisely, we note only a carelessness, but also an almost total indifference of the public and political authorities in charge of the health sector. "Until 2015, the attendance rate of health formations was 38.9% for a bed occupancy rate of 46.2% against an average of 80% for good performance" (Main Health Indicators in Togo, (2015, p.5). This suggests that many sick people practice prevention by self-medication or prefer to treat themselves in the structures of Phyto traditional medicine at any cost as long as they find a complete cure. The drop in morbidity and mortality rates must be shared between both modern medicines and Phyto traditional, this must not be doubt. However, of all the deductions from the analyses based on the statistical data of health, none reveal the benefits of the services Phyto traditional medicine which is shelved.

This study aims to analyze the direct, but also indirect causes of the participation of Phyto traditional medicine in the social economy. It is about rationalizing and organizing the practices of this medicine which can become a source of income. The Phyto traditional actor must go beyond all feeling to live only on the scientific aspect. To achieve such a possibility, it is recommended to explore the history of this medicine to highlight the determinants of its resistance to the introduction of Western medicine. Obviously, the introduction of money or the monetary system in the management of all human activities, and especially in health, has awakened the consciousness of the traditional Kabıyɛ practitioners who have also begun to like mercantilism in their practices. Phyto traditional actors are following in the footsteps of doctors who wish to live from their medical practices. Phyto traditional medicine, which was experienced as a free activity over time, leaves this economically unproductive framework by legitimizing fee-based consultations and sales of phytomedicines.

It does not take more for it to participate, by the same token, in the economy and in socio-sanitary development, if it was integrated into a logic of productive activity. Until then, insurance

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companies and investors in public health have shown little interest in this medicine, however much it represents and constitutes the mode of care for more than 90% of the Kabıyɛ populations. Thus, nobody measures this shortfall, when we forget to also do research to promote profitability in the economy and health. This is why such a situation gives rise to the problem with a general question:

- ✓ ***What place does Phyto traditional medicine occupy in the socio-health economy in Kabıyɛ country?***

To understand Phyto traditional medicine in the economy and health in Kabiyè country, it is important to proceed by specific questions:

1. ***Why do the Kabıye continue to practice Phyto traditional medicine despite the advantages offered to them in conventional medicine?***
2. ***Can Phyto traditional actors make an economic living from their practices in Kabiye country?***
3. ***How can Phyto traditional practices contribute to health economics?***

These questions will guide our research in the field from the hypotheses which constitute preliminary answers.

1.2 Assumptions

The hypotheses make it possible to bring out the various plausible explanations of the phenomenon to be studied and the process to be followed to achieve the objectives. Guidere (2004) justifies this reality in his thesis by asserting that "the hypothesis must also have an explanatory value, that is to say that it must offer an explanation of the phenomenon studied" (Guidere 2004, p.74). On the strength of this, the general idea that answers the first question of the problem is that: the practices of Phyto traditional medicine occupy an important place in the health economy among the Kabiyè of northern Togo. Socioeconomic Phyto traditional practices require specific explanations in order to understand the importance of their place in health.

The search for the effectiveness of health care obliges patients to continue Phyto traditional practices regardless of their cost. By analyzing the practices in the Phyto traditional structures or

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sectors, we discover the contribution of this medicine in the health economy. Through some determinants, this study will attempt to explain the economic life of the Phyto traditional actor. Phyto traditional medicine, which was experienced as a priesthood in the days spent among the Kabɪyɛ, is losing its free healthcare to open up to the market economy. It becomes a lucrative business and openly displays its intentions which are now known to everyone. Everyone, in Kabiye country, now knows that we no longer go to the hospital as to the Phyto traditional actor without money.

1.3 Delimitation

The present study is limited to the physical framework of the Kabiye of Kara in Togo, particularly to the socio-category groups of actors within Phyto traditional medicine in Kabiye country. The data was collected to from the practitioners of this medicine living in fifteen cantons of the prefecture of Kozah and its surroundings. Temporarily, as it is a systematic field research study, everything was done in the year 2019.

1.4 Object and Interest of the Research

Research on the place of Phyto traditional medicine in the health economy offers an opportunity to understand the concrete practices of the actors of this medicine in the different sectors, the management of daily or occasional interest and who denounce the shortfall in public health. The object of this study is to bring the public authority to reflect on the formalization and restructuring of Phyto traditional medicine in the health economy system.

1.5 Labor Subdivision

Besides the introduction and the conclusion, this work is subdivided into three chapters. The first chapter deals with generalities on Phyto traditional medicine in health economy. The second chapter is essentially centered on the methodological approach which made it possible to collect and analyze the data. The third chapter is devoted to the interpretation and criticism of the results. In addition to the concepts directly involved in the title, it is obvious to mention the terms related to the socio-health economy and Phyto economy.

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1.6 General information on Phyto traditional Medicine in the health economy

The concept takes its meaning from the context from which it is taken and organizes reality by retaining its distinctive and significant characters. Therefore, it becomes necessary that the key concepts of this study be defined, because the theoretical and practical meanings built around the concepts give the facts, a more explanatory and extended content.

• Health economy

It is a branch of the general economy which is interested in the field of health especially in the production of goods and medical services, in their distribution, in the elaboration of their prices, in the financing of productivity and in the health projects. This dimension will be variously felt by different health actors, namely: the doctor, the administrator and the socio-economist who seeks to establish the balance and interrelation between patients and caregivers on the one hand and on the other hand between the administration and politics to achieve the goals that enable development. Thus, the health and economy dynamic will analyze from a financial point of view the different characteristic activities of the health sector, the use of goods and medical services according to the different categories of beneficiaries, measure the overall effort made by the community to finance health especially in the area of expenditure on Phyto traditional care which includes both consumption of care and medical goods, all this set of elements must be taken into account to calculate or evaluate national health expenditure.

The economy and health dimension are perceived in Phyto traditional medicine among the kabıyε as the basis of a perspective of formalizing this same medicine so that it becomes a means of development. It is in this logic that it is possible for Phyto traditional actors to open up to collaborate with the public authority, which for its part, will endeavor to discover the productions of useful and necessary care, to evaluate them before their authorization of placing on the market

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while ensuring their moral property. Everything is possible and can be done in another system called Phyto economy.

Phyto economy is an area of health economy that is particularly concerned with economic management: of finance, projects, and the administration of the receipts and expenditures of Phyto traditional medicine. Phyto economy remains a reality, an evolving concrete fact in the formalization and restructuring of Phyto traditional medicine.

• **Phyto traditional medicine**

The term socio-terminological, Phyto traditional medicine which is at the center of the study dates back to the international days of health in 1988 in the report of the communications organized by the WHO. It is defined as all the structures of production, knowledge, techniques of preparation and use of plants and other substances by explicable practices based on lived experiences and observations transmitted from generation to generation and which are used to diagnose, prevent or eliminate an imbalance in physical, mental or social well-being. From this definition emerge the different uses of plants and their combinations with other substances according to the specialized sectors in Phyto traditional medicine, namely magi therapy, cast therapy, phytocentric and phytotherapy.

Those who practice cast therapy and phytobacteria have for anthropological reference God and ancestral ritual practices by following the transmission from generation to generation in a logic of belonging to the family, the clan or the tribe. This is why the term Phyto-traditional is made up of two words: herbal medicine and traditional. Phytotherapy is a branch of Phyto traditional medicine based on plant extracts and natural active ingredients to treat ailments. We can distinguish two types of practice:

First, it is a traditional practice with an explicit therapeutic aim, sometimes very old based on the use of plants according to the virtues discovered empirically or either in a totemic or mythological way. The expression traditional herbal medicine is not defined only in the way of transmitting, but by what is experienced and is put into practice which does not evolve within populations. According to the WHO, this herbal medicine is considered traditional medicine and is still widely

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used in some developing countries. Nowadays, it begins to evolve because it abandons the traditional fees after recovery to plunge into commercialism with tariffed treatments and the systematic purchase of phytomedicines.

The second type of herbal medicine is a practice based on scientific advances and evidence that research active extracts in plants. The active extracts identified are standardized. This practice leads, depending on the case, to the manufacture of pharmaceutical drugs or phytomedicines of any nature, and according to the regulations in force in the country, their circulation is subject to the marketing authorization (AMM) for ready products and the regulations on raw materials for pharmaceutical use (MPUP) for compound preparations of medicinal plants, these being delivered exclusively in pharmacies. In this dimension, we can speak of pharmacognosy or pharmaceutical biology. Research on these products is no longer based on the traditional heritage described above, but largely based on personal experiences and inspirations, then on curiosity and openness to each other's experiential gains. In Kabiyè country, anyone can be declared a phytotherapist, because of the knowledge of the plants that everyone has and that they use spontaneously in the event of an illness. Health through plants is very essential for the Kabiye.

The traditional word comes from the Latin traditio: action of giving, evokes what, within a society, is transmitted in a living way from generation to generation through speech, writing or ways of acting. In this sense, tradition, according to the image that evokes the active sense of etymology, conveys more than ideas capable of logical form: it embodies a life that includes both feelings, thoughts, beliefs, aspirations and behaviors. Far from considering sufficient the achievements of past centuries as an intangible deposit, it gives rise to a whole series of possible reinterpretations which in return maintain it, consolidate it, update it or renew it. From then on, traditional medicine delivers, through a kind of fruitful contact, what the following generations also have to understand and what they have to bequeath as a permanent condition of vivification, of participation in a reality or individual effort and successive can draw indefinitely without exhausting it.

This traditional medicine is variously differentiable and appreciable because of its specific methods, which relate to or suit its different sources or origins and socio-anthropological and

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religious practices. We often fear its sources which are: ancestrally caustic or familial that we can group together in the terminology of phytobacteria medicine; totemic, mythological, divinatory and fetishistic that one classifies in the cast phytotherapy; witchcraft and charlatans in magi phytotherapy. It suffers, in the eyes of modernists, in its practice, because it combines both sacrificial rites of animals and the very use of plants in a religious faith that seems to them to be magical and mysterious representations.

The word or the expression Phyto traditional medicine contains anthropological realities which are characterized by the practices in the sectors: magi (Phyto) therapy, cast (Phyto) therapy and phytobacteria. These are the most numerically representative and observable practices or channels in all social communities. The phytotherapy sector remains familiar, in its everyone can find themselves, because at least everyone knows a medicinal plant, but not everyone is attached to it to exercise it as a profession; it is only a minority of people who do it occasionally or casually. The Phyto traditional practices are complicated and multifaceted, a specialty study is necessary to distinguish them and classify them in order to give them a logical terminology according to their practice and deontology.

2. RESEARCH METHODOLOGY

Progress in science is closely linked to progress in method. This is why, according to Madeleine GRAWITZ:

> "Any research or application of a scientific nature in the social sciences as in the sciences in general must include the use of rigorous, well-defined, transferable operating procedures, capable of being applied again under the same conditions, adapted to the type of problem and the phenomena involved" (GRAWITZ, 2001: 252-253).

For this, this chapter is essentially focused on the description of the study population, the sample, the techniques for collecting data and analyzing the results.

2.1 Study Population

The population or the survey universe is the set of human groups concerned by the objectives of the survey cut into a sample. This target population represents in the present context the population

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of Phyto traditional actors from which the sample is drawn. As GNAKOU explains (2003, p.31): "each actor participates according to his position, his status and his role to ensure, under conditions guided by rules, practices, values and representations, the permanence of the system". Therefore, each actor or group of actors has a name according to its identification in Phyto traditional medicine. The study population is the set of the four groups of actors (magi-Phyto therapists, cast therapists, Phyto casts and Phyto therapists) living in the fifteen cantons of Kozah and in the other prefectures where the phyto-traditional Kabiye actors are partly located, namely: Binah, Bassar and Doufelgou.

2.2 Sample

As it is not possible to submit the entire population to a questionnaire, the operation consisted of a selection of individuals, Phyto traditional actors by sector. The aim is to make the sample drawn representative of this total population in order to claim a generalization of the results. According to MUCCHIELLI (1982: 436-44), "it is necessary to construct a sample, that is to say limit to a small number of individuals (i.e. 1/10) who will form the sample within the population investigated". In constituting this sample, we took into account several parameters which are the identity, the specialty and the mode of production of Phyto traditional care among the actors. So, our sample is built on chance but selective from the elements that were identified and grouped by locality or by canton in Kozah as beyond, in other prefectures where we can find the Kabıye. It is from this sample that it was possible to collect the data classified by table or graph.

During the investigation, we noticed that the female Phyto traditional actresses were very few in number compared to the men. So, we decided to add them directly to the sample that is taken from each Phyto traditional pathway.

Group A, magitherapist sector …….....297
Group B, phytocast sector ……...140
Group C, castotherapist sector ……157

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Group D, phytotherapists sector ……..406

Group of phytotraditional women (all sectors combined) ……... 62

TOTAL ……1062

The target population without women is 1,000 Phyto therapists, all specialties combined. The women registered and representing the four different groups are only 62, after having traveled through all the localities. The quota of 1 / 10th was used as the basis for the choice of our sample. By dropping the number after the decimal point, we get: group A, 29 individuals; group B, 14 individuals; group C, 15 individuals and group D, 40 individuals. However, this quota was not respected for the small number of women, taking each in its specialty to ensure the most balance in the sample. Although all women are considered, parity has not been established. There is a slight difference between the quotas for men and women throughout each group. We therefore interviewed 98 men and 62 women, making a total of 160 individuals. Ca fait partie des résultats

2.3 Collection and analysis of Data

2.3.1 Opening of Phyto traditional treatments to the market economy

The patient who arrives at the healer pays for his products already prepared and preserved in the dimension of a price fixed by the Phyto traditional, while in some cases, the healer seeks on the spot the products in nature that he offers to the patient. The opening up of Phyto traditional care to the market economy has revolutionized this medicine which no longer accepts free care. The data collected from many players in this medicine and patients who consume phytomedicines help to understand that the Phyto traditional does indeed participate in health economy.

Table 1: Method of production of Phyto traditional care

Mode of production of care	Phyto traditional actors					
	Magitherapists	Castother apists	Phytoca-sts	Phytotherapists	Staff	%

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Openness to the market economy	10	04	40	95	149	93,125
No openness to the market economy	01	05	05	0	11	6,875
Total	**11**	**09**	**45**	**95**	**160**	**100**

Source: Field survey (January-August 2019)

According to Table 1, practically all Phyto traditional players (93.125%) have opened up this medicine to the market economy. However, how to organize this socio-economic aspect of Phyto traditional medicine, this is where there are misunderstandings. For some, that is to say the charlatans, the marabouts, the spirito therapists, apo therapists and the castotherapists (6.875%), it is not necessary to speak about the systematic opening to the economy of the market but rather of the recognition generally conclusive care received at home. This recognition is taxed according to the head of the patient, and according to the work and energy investment put into it. On the other hand, Phyto casts and Phyto therapists totally accept the opening of this medicine to the market economy because, all have already started to put it into practice and therefore have accepted any rational organization of the production of Phyto traditional health care. Despite the sacredness that characterizes the method of producing Phyto traditional care, it is still easily accessible.

2.3.2 Production of Phyto traditional care

Table 2: Paid / free consultation

Mode of consultation	**Phyto traditional actors**					
	Magi therapists	**Castotherapists**	**Phytoca-sts**	**Phyto therapists**	**Staff**	**%**
Free consultation	00	09	45	00	54	33,75
Paid consultation	41	00	00	65	106	66,25
Total	41	09	45	65	160	100

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Source: Field survey (January-August 2019)

Regarding paid consultations, according to Table 2, the group of charlatans and Phyto therapists fully accept it (66.25%). The castotherapists and the Phyto casts do not admit it on the basis of identification of the patients and the presumed origin of their disease. The Phyto casts totally reject this fee-based consultation because, according to them, the patients who come to them already know the nature of the disease and it is up to them to check by simply asking them a few routine questions. The consultations, whether paid or not, do not except anyone. However, there is a difference between men and women in the purchase of phytomedicines among traditional Phyto-actors.

Table 3: Purchase rate of phytomedicines in men

Socio-professionnel patients situation	**Phytotraditional actors**								
	Magitherapists Charlatans		Castotherapists		Phytocasts		Phytotherapists		Total
	Staff	%	Staff	%	Staff	%	Staff	%	
Employees	15	9, 37	20	12,5	45	28,12	80	50	160
Un-salared	30	18, 75	35	21,87	35	21,87	60	37,5	160
Apprentices and student	05	3, 12	08	05	47	29, 37	100	62,5	160
Pupils	01	0,62	02	1,25	62	38,75	95	59,37	160
Other people	45	28, 12	35	21,87	35	21, 87	45	28,12	160

Source: field survey (January - August 2019)

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Table 3, presents the rates of purchases of Phyto traditional products in men. It shows that, drugs manufactured by herbalists are bought more than those of charlatans and castotherapists. This rate rises to 50% among wage earners while it is 9.37% among charlatans. The self-employed account for 37.5% among herbalists against 18.75% among charlatans. It is 62.5% in herbal medicine among students and apprentices against 03.12% among charlatans. The rate of purchase of Phyto therapeutic products among students (boys) is 59.37%, while it is 0.62% among charlatans. The other people represent all those who have problems finding money, getting into the government, being in love, and associating with charlatans in order to solve them. These people buy the products of Phyto therapists at 28.12% as much as those of charlatans also at 28.12%.

The following largest percentages are recorded in the purchases of Phyto cast products which amount to 38.75% among pupils against 01.25% among castotherapists. Apprentices perform 29.37% and students 05% among castotherapists. Employees achieved 28.12% while it is only 12.5% among castotherapists. It must be recognized that Phyto therapists sell their products more, followed by phyto casts and charlatans; the last are the castotherapists because the representative rates of the purchase of their products are too low compared to the whole. However, this loser in the purchases of products from men can be compensated or caught up by women who rather prefer the facilities and magic of charlatans better than the products of herbalists and Phyto casts who require serious application and follow-up care.

Table 4: Purchase rates of phytomedicines among women

Socioprofessional patients situation	**Phytotraditional actors**								
	Magitherapists Charlatans		Castotherapists		Phytocasts		Phytotherapists		Total
	Staff	%	Staff	%	Staff	%	Staff	%	
Employees	60	37,5	70	43,75	20	12,5	10	06,5	160
Unemployees	90	56,25	50	31,25	15	9,75	05	03,12	160
Apprentices and student	45	28,12	50	31,25	10	06,25	55	34,37	160
Pupils	15	9,37	25	15,62	50	31,25	70	43,75	160

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Other people	70	43,75	10	06,25	05	03,12	75	46,87	160

Source: Field survey (January-August 2019)

The data in Table 4 indicate that the highest purchase rates of phytotraditional products go to products from the group of magitherapists (charlatans, etc.), 56.25% among self-employed women, followed by other people (these are people unemployed or not exercising any profession) who make 46.87% of the purchases of products from phytotherapists. The other types of percentage of purchases of products from castotherapists is 43.75% among employees. 43.75% of the students buy the products of herbalists and 43.75% of the products of the magitherapists (charlatans, etc.) are bought by other people. In this table, the lowest rates are recorded in the purchases of phytocast products, that is 03.125% among other people and phytotherapists or herbalists only sell 03.125% of their products to self-employed women. These low percentages are explained by the fact that most of the time, it is women from the informal sector: traders, hairdressers who live with their husbands or not at home who rarely attend herbalists and phytocasts, and who have no major concerns for their physiological health.

All physical health constraints are sometimes taken into account by their husbands in modern healthcare structures. On the other hand, these employees and non-salaried women after their marriage, are often tested by delays in conception or problems of sterility. Despite the therapeutic persistence which does not lead to the expected results among conventional medicine physicians, they are forced to turn to phytotraditional care and especially among specialized castotherapists (43.75%) and magitherapists in general (56 %). In this same list of women, we must add those who are reaching menopause and who are experiencing a lot of problems in their health.

These women, generally, are sometimes retired, salaried or self-employed reduced to simple housewives called upon to manage their daily lives. Often, they do not get any satisfaction from modern doctors and courageously turn to charlatans, marabouts, castotherapists and herbalists, despite their assurances that cover them only in conventional care. However, it is not for lack of insurance coverage for phytotraditional care that worries the most, it is especially the insolvent

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debts often of patients in the field of purchases of phytotraditional products that cause some players in this medicine to fail. not to live from their profession.

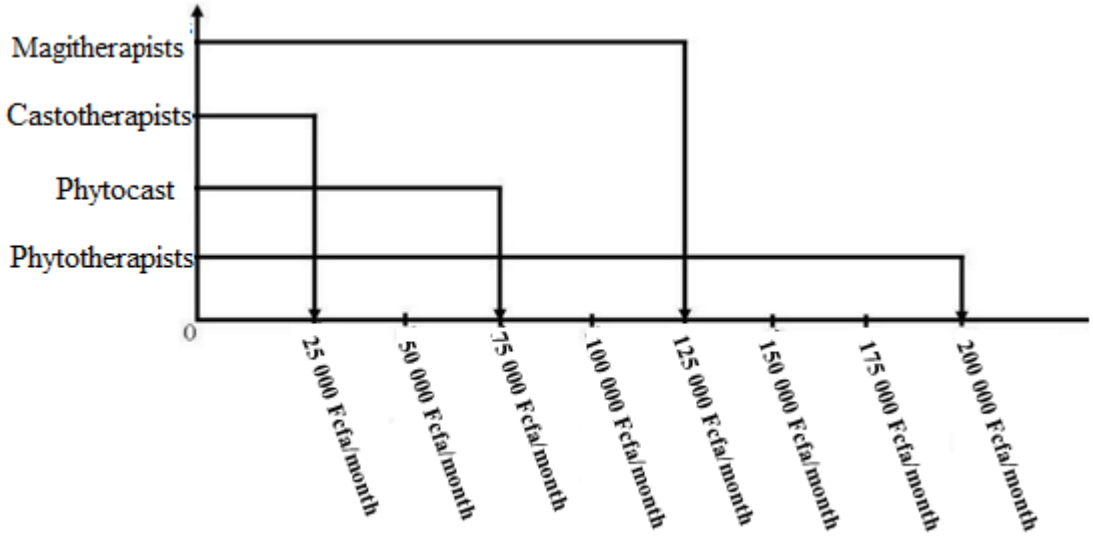

Figure 1: Representation of the market for traditional plant products

Source: Field survey (January-August 2019)

Figure n ° 1, verifies exactly the observation according to which the numbers of consultation which are in reference on the tables n ° 3 and 4, the phytotherapists receive more patients. Therefore, in this graph, they earn more money selling their products to patients who come to see them and to those who self-medicate. This is why their turnover is 200 000 F CFA / month. The last in the sale of phytomedicines are the castotherapists who are also less frequented. Their turnover does not exceed 25 000 F CFA per month because they are less open to the market economy. For this, it is even difficult to evoke the problems of care in patients wanting to be treated in phytotraditional actors.

2.3.3 Public and financial assistance

Table 5: Management of phytotraditional care

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Knowledge and financial companies	**Phytotraditional actors**	
	All phytotraditional actors	**Percentage (%)**
Parents	60	37,5
Neighborhood friends	15	9,37
Service colleagues	10	06,25
Patient himself	75	46,87
Social service	00	00
Insurance	00	00
Total	160	100

Source: Field survey (January-August 2019)

By examining the data in Table 5, we note that the patients admit having no assistance from social services or even health insurance in their area (00%). It is only the patient himself (46.875%) and his parents (37.5%) sometimes friends of the neighborhood (9.375%) and of his service (06.25%) who contribute by charity to buy the phytotraditional products. To conclude at this stage, no one doubts the importance of phytotraditional medicine, especially in Kabıye country, although no funding supports its practices.

Table 6: Funding to support phytotraditional practices

Backers	**Phytotraditional Actors**			
	Magitherapists	Castotherapists	Phytocasts	Phytothérapists
WHO	0	0	0	0
Banks	0	0	0	

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FMI	0	0	0	0
GB	0	0	0	0
ETAT	0	0	0	0
Other donors	0	0	0	0

Source: Field survey (January-August 2019)

Table n° 6 presents this sad reality of the public authorities' vis-à-vis phytotraditional medicine. There is no organization that can defend their rights and duties in this logic, there can be no associative funding to encourage the actors of this medicine. In addition to this, there is nowhere in the city of Kara a plant for traditional scientific research nor a training school and a botanical forest. The only phytotraditional pharmacy located in the center of the city of Kara under the name "Green health" pharmacy was created from the private initiatives of agents from very complex specialties. The nationwide union or association of traditional healers has had repercussions in all regions. In the Kara region, this union exists, but its management cannot prove its existence. The people involved in such an organization do not have a concrete responsibility to play because there is no statute or office. Each of the people manages themselves and the members meet when they are told that there is information. Phytotraditional actors have no financial assistance. They are called upon to manage their daily life as much as they can through their activities, agriculture (especially when it comes to charlatans, castotherapists and phytocasts) or other parallel income-generating activities, despite the number of patients they receive per month.

3. INTERPRETATION AND CRITICISM OF THE RESULTS

With the market economy and a macrosocial context marked by the scarcity of salaried employment and the development of poverty, phytotraditional activity is invested more and more as a source of subsistence and as a means of social existence, in at the same time that it continues to be justified by non-economic motivations. The results of field surveys make it possible to reconstruct the different cultural foundations used by phytotradipraticians to legitimize their

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activities and position themselves in the social space. The data collected reveal the macrosocial context in which the identity of practitioners is constructed, describe the situational constraints and the interrelationsystems in which they find themselves placed and which distinguish them according to behavioral logics.

These results from the sale of phytomedicines can also testify to the disorder caused by the absence of the state at the level of phytotraditional structuring. Indeed, the state often loses economically by opting for indifference in the management of this medicine. Moreover, some patients and consumers of phytomedicines find that if the public authority in charge of research, planning and health partners accept a restructuring and rationalization of phytotraditional medicine, this shortfall can be made up to be able to initiate development. The relevance of the data confirms the economic losses of the state and means that there is an urgent need to reconsider the concessions that must be made in the field of phytotraditional.

The shortfall lies in the failure to take into account the action of phytotraditional actors on the pharmaceutical market, although undeniable over time. It also stems from the culpable ignorance, underestimation and indifference of the public authorities towards phytotraditional medicine and its actors. All this is encompassed in a non-evolving ideology which is called the "tradition" in which this medicine is locked up. This terminology is considered pejorative today, because it is rudimentary, outdated, empirical, archaic and belongs to the domain of ignorant pessimists who judge it without any scientific methodology. If we are to consider the turnover of the various phytotraditional actors, apparently there is no concern about their survival. However, it is clear that the existence of these actors depends for the most part on the parallel activities that they practice and which generally provide them with what to survive. These estimated numbers would be real if their patients paid for all the products and there were no debts.

Apart from these economic realities, there are interactions between actors of modern medicine and those of phytotraditional at the level of care to be given to different patients. They can exchange patients depending on the severity of the disease or the specialty of the caregiver. Many times we have seen patients with broken bones taken from modern hospitals to traditional phyto-centers which have managed to treat them better than in hospital and at lower cost.

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However, all unanimously recognize that there is insurance, but these services created by the State or by private parties to facilitate or help the care of patients who have subscribed to them, do not agree to cover the care of patients of phytotraditional medicine. Surveys have revealed that everyone recognizes the relevance of phytotraditional care, but they refuse to cover it for various reasons: some equate phytotraditional care with magic and witchcraft; the authorities in charge say that the law does not recognize phytotraditional care; Others take up the traditional remarks according to which the actors of this medicine do not know the dosage and the expiration date of their products.

While these comments are now outdated in practice by all players in this medicine.
The problem they raise is at their own level, because these agents of the insurance services ignore and do not distinguish or do not know how to differentiate between the charlatan, the marabout, the spirit therapist, the apotherapist, the castotherapist, the phytocaste and the herbalist commonly called the phytotherapist who sometimes comes out of the ranks of medical assistants and doctors of modern medicine. Their ignorance can also be apparent, because they sometimes follow the recommendations of the public authorities who are in charge of this health sector and who have always ignored or sometimes rejected the good benefits of phytotraditional. This indifferent attitude of the authorities towards the phytotraditional was at the base or at the origin of the passive and active corruption on the part of the patients who are obliged to go to do the formalities papers at certain doctors to be able to benefit insurance coverage.

Usually these same authorities, as most of the respondents say, make fine speeches that ennoble this medicine from the outside but deep down and on a practical level, they undermine it at the base, which is why this interaction between insurance and phytotraditional practices always results in total disagreement during exchanges and discussions. The economic aspect in phytotraditional medicine is virgin territory which calls on various specialists and researchers to push or issue initiatives aimed at helping to find the right tracks to improve the health situation of populations who want to treat themselves with effective natural products and less.

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3.1 Determinants of the use of phytotraditional treatments today in the face of modern medical practices

Despite the relative free care for those who are recognized as miserable and the success of the medical service introduced by the Germans before independence, continued by the French maintained by the Togolese government after independence, a disaffection of patients with modern care has been observed. (NAPO, 1995, p.168). At the beginning, one would have thought of the anchoring of traditional habits of care and of the limits of modern medical action which was only at its beginnings or of an external cause which is the fundamental difference of modern medicine compared to the nosological system of the Togolese which would justify these attitudes of reluctance of indifference and somewhat resistance to the mode of production of modern care. Far from there! Because the evaluation of public health practices covered a set of interventions that were found in the various social development plans of the country. And this assessment of modern medical practice was not negative.

This is therefore a presentation of the conception that marked health policies during the two decades following the period of independence, the lessons of this experience presented in critical terms, the new forms of change in the general context perceived as consequences of a deadlock situation. This evolutionary approach leads to a review of the new trend in health policy in Togo (GNAKOU, 2003). It is a question of seeing how the colonial heritage in terms of health care practice was appropriated, managed, updated, rethought and inculturated in some of its contours until the populations experienced certain shortcomings by compensating for them with traditional medicine? In fact, the policy of geographic accessibility and the coverage of indoor environments with structures and medical personnel had been the objectives that the State had imposed on itself to pursue by taking control of public health for the past 20 years which would follow independence. These goals of extending structures with free access to consultations and products continued until the 1979-1980 recession years and even until the democratization of the country in 1990 endorsed SAMBIANI (2000).

At that time, we no longer spoke of phytotraditional medicine which was relegated to oblivion. Certain phytotraditional interventions were found not only to be ridiculous and inappropriate, but also scandalous in the eyes of certain actors of modern medicine who castigated and openly

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accused them in public health structures and made official on the national television channel. . You could say that phytotraditional medicine was buried once and for all and forgotten forever. The phytotraditionnelle was charged with all kinds of accusations: ranging from complications of seizures in some patients to being the cause of death in others, including the delays it creates before the admission of patients to the hospitals modern health facilities

In Kabıye country, the generations marked by the surge in the benefits of modern medicine, abandoned the educational logic of their parents, based on orality to get confused in the meanders of the new school. At the school level, students who fell ill were quickly admitted to a health facility through a visit book and left loaded with tablets that some could not bear to take and threw along the way. However, a very basic observation will help to understand the factors behind the use of phytotraditional care in this time of independence. The free period covered a very long period: from the two colonial forms, German and French, to the welfare state, that is to say a period of about a century. Meanwhile, from the recession to the rationalization of public health care delivery methods, it only lasted five years.

This last step being very sudden, it consequently produced very serious psychological shocks at the level of traditional ideologies still attached to the mother of medicines and also within all Togolese populations. The following observations prove that populations are right to resort to phytotraditional care. Poverty: we have focused on highlighting the criteria of poverty external to the care environment, such as goods, expenses or monthly income. The poverty addressed here as a social fact is constructed from the situations as they are experienced and present themselves to the observation in the social relations of the care environment in modern structures.

In the absence of a statistical distribution of data of a qualitative nature of information, we based the analysis mainly on the exploitation of speeches and observation of attitudes. From these speeches, it emerges that are identified as poor, patients who have prescriptions but who are unable to buy the prescribed drugs and who are waiting or looking for social assistance, those facing food insufficiency. , those who do not have health insurance, the sick who have a low income or whose only resource is subsistence agriculture whose profitability is questionable per season. GNAKOU

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(2003, p.196) shares the same criteria, because according to him, “These criteria express the convergence between the representation of poverty and the objective reality of poverty. They say they are poor and they really are. They are almost excluded from the possibilities of cure for lack of means which condition access to modern care ".

Indeed, one had to imagine the cost of care and the price inflation on pharmaceutical products that were not up to the stock market of this population of Kara when suddenly the conventional health structures were decidedly open to the economy of the market not to say to trade. By considering the poverty line in Kara, we realize the difficult living conditions of the Kabıye populations and it is this precariousness that is reflected in the situation of patients faced with increases in prices for pharmaceutical products, the costs of consultations. , hospitalization and medical analysis.

According to the field survey (January-August 2019), the main bad facts blamed by patients against agents practicing modern medicine, public health structures are: verbal aggressiveness, insults, yelling at patients, shouting at users, implicit demand for ransom, priority given to patients of higher status, discrimination, neglect, contempt or indifference and recklessness towards patients, brutal reaction to the mistakes of patients, the unavailability attitude of some caregivers, haste in questioning, hasty prescriptions, the authoritarian attitude of some caregivers, the impersonality of communication, the impassibility of caregivers and the theft of products from patients , chauvinism and familialism.

All these facts represent a set of recurring problems raised by the respondents to the actors of conventional medicine and which are further justified by the speeches reported by GNAKOU (2003, p. 248-249) which describes corruption and denounces it because of its scale in public health posts. "For patients and their parents, corruption has become a constant, a means that cannot be done without if we wish to encourage the caregiver to be docile in his services". The more free money you give to the agent, the more you benefit from his great services. So the poor thing who has nothing, if he screams and complains, no one hears him. Aside from corruption, one of the most common complaints raised by patients is product theft. The problem of theft raised involves

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caregivers in the disappearance of drugs. All this is verified by the ease of corruption of caregivers which means in the eyes of users that they are capable of theft.

Among the respondents, some deplore the fact that these events lead them to understand the action plan of the economic policies of the metropolitan powers whose hands continue to make and to undo the governments of African States according to the logic that facilitates their relations or their gives to feel at ease. According to them, in a first step, the metropolitan powers, wanting to do away with phytotraditional medicine to avoid any competition, have installed their mode of production of health care on the basis of free access. Through free access, this enabled them to empty and flow their pharmaceutical stocks, which were sometimes tending towards expiry, in order to acquire outlets and also to open up vast fields of medical experimentation.

For this, it did not cost them to take several decades in a second stage, to observe and force Africans to assimilate this form of medicine that has become conventional and to which they must cling to it with all their might for it to fit now fully in their care habits. Now, these same Westerners, by a strategy already subtly planned (change of government policies by the democratization of States and by policies of recession) have forced Africans, supposedly masters of themselves to resolutely open this system of care public to the market economy. This mercantile policy based on health (which from now on is priceless according to a French expression) will allow the Whites to control all pharmaceutical production: "We produce what we want, we sell to whom we want and where we are especially wants to earn money".

In the third stage, through the intermediary of capitalist companies or large pharmaceutical firms which have become channels of exploitation of the African market, these Westerners extract the usufruct of their free investments during the colonial periods and colonial post in Africa to make colossal fortunes at home. Today, the Africans who have acquired these systems of production of care and who are entirely responsible for the succession, convey this medical art of the white man and are unable to adapt it to the ideologies of the African populations by sometimes dubious and tainted prescriptions all the vices of immorality, because they want to enrich themselves in the same way as their White bosses. All this leads us to reflect on the factors of recourse to phytotraditional care today.

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Many people say that, modern doctors own all the organizational structures for health in the country. They have organized themselves into trade unions, prevail over state policies subject to their ideologies and want to pretend that they know everything, they can everything. None of these actors in modern medicine want to reiterate the ideologies of white people by embracing exclusion, they continue to torture, to confuse with their negative personalist and reductionist discourses, the physiognomy of the phytotraditional.

Seeing in the cities and the countryside the evolution and the dazzling development of the phytotraditional, these interested disciples of the modern medicine continue to awaken what was the weakness of the phytotraditional medicine which they repeat like a leitmotif the already outdated accusations to the place of the actors of the latter is saying that those do not know the doses and the expiry dates of their phytomedicines that they themselves design and manufacture. Respondents' reactions to prescription-related problems crystallize in relation to opportunity prescriptions established according to the needs for the sale of drugs available in the clandestine circuit and which only substitutes are or not to those recommended in relation to the nature of the ailment or disease. Users also find prescriptions too hasty and long, ineffective for the disease they are suffering from.

Nowadays, it is not the high cost of products that patients fear, but the relevance and effectiveness of the products prescribed to them in modern healthcare settings. Sometimes the patient has the money but cannot find the real products that work to treat the condition. Why this phenomenon?
The West, endowed with technical means and very efficient laboratories for research, manufactures what it wants and wishing at all costs to exploit the African market, sells its products to whom it wants to impose itself without first studying the microbiological realities ground. As Africans do not have the logistical means to manufacture their own medicines suitable for treating or curing their ailments, they are forced to consume any medicine as long as it is prescribed by the conventional doctor.

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These doctors maintain clandestine networks for the sale of pharmaceutical products and enrich themselves at the same time as the latter. In Togo, where there is a lack of biomedical scientific research centers, the pharmaceutical field carries several capitalist companies that come to deliver their drugs. China has succeeded in establishing itself by simply setting up its pharmaceutical industry (Tong Mei) in Togo in the port area. Apart from Chinese pharmaceutical companies, we note the presence of Indian, French, American, Nigerian, Ghanaian and Moroccan pharmacies, to name only those who come to dump their drugs which will be in Togo.

All these drugs of diversified origin that come to the pharmaceutical market in Togo are never verified in the true sense of the term due to lack of technical means in equipping efficient scientific research laboratories. What is regrettable unlike the sale of drugs, these multinational companies often quarrel and cannot agree to jointly exploit the Togolese market, especially when the drugs of the imperialist powers who have a right to Togo freeze in pharmacies and public authorities were immediately seized and arrested. Consequently, regularly on the meager African companies with their products which are sometimes seized and burned under the accusations of "street drugs" with the unpublished speeches of the trade unionists of Western medicine. We have the impression that because of the shortfalls of Westerners and their particular interests, our own medical brothers, actors of modern medicine, openly attack phytotraditional medicine which continues to save lives and maintain the health of the populations which knows its effectiveness.

Nowadays, we very much suspect the learners who apply to render service in the field of health, because this situation creates a problematic as for the real definition of their vocation. The question arises whether these people commit by vocation, that is to say by respecting the Hippocratic oath: "To render service out of love and for the respect of the lives of men"? Or as they have seen their brothers get rich so quickly in this field, do they get involved in getting rich like them on the backs of sick people? These questions come and betray a logic in Togo on the side of young people who find it difficult to bear the weight of several years of unemployment and who finally start by chance in the health field as soon as a training competition is organized in the said field. After a few years of training, they graduate from medical schools but in the field, faced with the demanding practice of giving everything as a priesthood, they often show reluctance which results in all the vices that

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have just been mentioned above. Some of the respondents react by saying that: it is often these people, maintained, nourished and enriched by the phytotraditional, who are conquered by the lucrative interests today of modern medicine and who criticize negatively the traditional medicine instead of seeing the lives of the sick who are at stake.

More than ever, the Kabıye like all black Africans are aware of the limits of this white health science and are never surprised by the human behavior of its actors who are not saints. They are quiet, because faced with the indexing of hundreds of drugs by the Europeans because of their very deadly or harmful side effects, patients who consume Kabıye or Africans have never united to try to prosecute doctors prescribing these conventional products but killers.

The reasons for using phytotraditional treatments can be summarized as follows: the search for efficacy in treatments, the search for real products, and the incessant price inflation on pharmaceutical products, passive or active corruption among healthcare workers. modern, cumbersome care and reception in modern health structures; all these factors mean that many patients are forced to revert to phytotraditional medicine, even if at times it is the subject of several conflicting views.

CONCLUSION

Integrating phytotraditional medicine into the health economy remains a very important reality, and avoids total health dependence on the outside which continues to draw heavy funds from the pockets of poor African countries. The interest of this study is to discover the economic dimension in the formalization and rationalization of phytotraditional medicine. It is true that this study had the merit of being the first to attempt a reflection on phytotraditional medicine in the socio-health economy in Togo. At the end of the investigations, the results obtained show that there is a possible urgency to constitute or create a socioeconomic base from the management of phytotraditional practices.

Today, there is no longer any free product in the production of phytotraditional care which opens up to the market economy through the sale of phytomedicines. However, despite the innovative

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results, this research work has limitations; because, it must be recognized that like any research, this one can also have shortcomings. This study, which was to lead to the completion of a concrete and immediate project, can only be carried out when the players in this medicine and the authorities in charge of the health sector have drawn up the social and legal statuses of each sector according to the recognition of appropriate socioterminology. This is why this study deserves to be continued in the direction of an improvement which extends to the insurance companies up to the planning of projects in public health

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