PERCEPTIONS OF THE ROLE OF THE TRADITIONAL MEDICAL SYSTEM IN NATIONAL DEVELOPMENT: THE CASE OF GHANA

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Perceptions of the Role of the Traditional Medical System in National Development: the Case of Ghana

by

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Abstract

The role of the traditional medical system in national development is assessed by means of questionnaires and structured interviews. The answers of 169 respondents involved have been summarized into tables and graphs. Respondents were asked to provide various types of information about their interaction with the traditional practitioners.

The findings show that many Ghanaians consider traditional medicine as a valuable component of the health care delivery system, complementing the modern scientific medicine. Although many of the respondents use the two medical systems concurrently when ill, and in some cases prefer traditional medicine to modern medicine, they all attempted in different ways to distance themselves from traditional medicine. A historical perspective is given on the medical systems in Ghana, which shows that traditional medicine had not only been outlawed, but has also gone through a lot of stigmatization.

This study indicates ways in which greater cooperation can be achieved between the traditional and modern systems, assuming of course that there is the political will on the part of the policy makers to effect such change. It has assigned to the Ministry of Health (MoH) a vital role in bringing about the needed cooperation between the two systems. The MoH is expected to make not only those legislative changes considered necessary for the attainment of this objective, but also changes in the people's attitude toward and perception of the traditional medical system through public education. Would a two-tiered medical school system foster mutual respect among all health practitioners? Policy issues are touched upon.

Acknowledgements

I dedicate this work to the loving memory of Stella Pookyie and William Alenuma, my mother and father, whose idea of development it was to have sent me to school despite my sex and the opposition of onlookers, and who always seemed to know intuitively that there can be no development without commitment and sacrifice on the part of those who want to develop.

May they find eternal peace and rest.

I thank Dr. Sam LanFranco of York University for accepting to direct me, and Dr. Henry Veltmeyer for enabling me to complete the program from the University of Tennessee.

To my best friend and husband, Constancio Nakuma, I say in dagaare: "nwo ba puoro tampuori."

And thank you to everyone that has changed me . . . . . a list too long to enumerate.

Table of Contents

Chapter 1

Introduction

1.1. Theoretical Perspective

As developing countries search for alternative paths to break out of their "vicious cycle" of underdevelopment, it seems appropriate to examine the range of approaches to health and well-being that are available to them and which could assist in this effort. One must enjoy physical, emotional and mental well-being in order to have sufficient energy and physical harmony in life to be productive and deal with the development of society, the family and oneself. Having control over one's health means possessing the knowledge of what needs to be done in order to be healthy, having the money with which to purchase health care and the capacity to make the necessary decisions. Without health, life is more painful, slower and happiness more elusive.

As Myrdal correctly points out, an efficient health care delivery system has a tremendous economic value, and plays a crucial role in the developmental process of a nation. Health affects socio-economic factors and is itself affected by socio-economic factors such as income, levels of living, and nutrition. A child's ability to take full advantage of the schooling provided her/him depends on her/his health, and an adult's ability to use the knowledge and skills he/she has acquired depends on his/her mental and physical fitness. On the other hand, the extent to which health conditions can be improved depends on people's knowledge and perception of and attitude toward the

available health practices and resources.[1] These health practices and resources in the case of Ghana, and in that of other developing countries by and large, include resources from both the "traditional" and the "modern" medical systems.

Social and cultural practices around health and illness prevailed in developing countries prior to the exposure of the latter to external sources of information and influence (usually under colonialism). It is customary to refer to the pre-influence practices as "traditional" while referring to the external influences as "modern." The term "traditional (sometimes indigenous) medicine," as will be used in this study, refers to medical practices in developing countries whose origin can be traced to the period before the adoption, by the society, of foreign practices. Traditional medicine is defined as all knowledge and practices, used in diagnosis, prevention and treatment of physical, mental or social imbalances which rely mainly on practical ancestral experience and observation handed down verbally or in writing (WHO 1978). Traditional medicine is practiced by traditional healers/practitioners, a group of people who are recognized by the society in which they live as being competent to deal with health issues. This may be viewed as the treatment component of traditional medicine, centered on a group of "experts." All other members of the society could be actively involved in traditional medicine; they may acquire and use knowledge on health and healing from practical ancestral experience. These medical practices by people who are not recognized traditional practitioners/healers are referred to as "folk medicine." Folk medicine, which

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[1] Myrdal, G. *Asian Drama: An inquiry into the poverty of nations*, Vol. III, pp.1531-1619 Pantheon Press, N. Y., 1968.

comprises health promotion, illness prevention and home remedies, and centers on a wider social process, is thus part of traditional medicine in the broader sense of this word. "Modern," "western" or "orthodox" medicine are used interchangeably in the present discussion to refer to bio-medicine.

There has been a lot of controversy over the definition of the concept of "development." It has been defined and redefined by several social scientists. Seers' (1981) definition, for example, is based on three main problems of the world - **poverty, unemployment** and **inequality.** He argues that an increase or rise in any of these three problems is "not development" even if per capita income has doubled. Development, according to Meier (1989) and Hoogvelt (1989), is "**growth**" plus "**change;**" it is the combination of both **quantitative** (economic) and **qualitative** (social) improvement of mankind. The general point of agreement has been the idea of change for the better - it is an improvement in both the social and economic aspects of human life. "Development," as used in the present discussion draws upon the ideas developed by researchers in the field of community development, and denotes a process "where attempts are made to mobilize the total resources of the community for the protection, support and enrichment of individuals and groups of the whole."[2] It is human-/people-centered development geared towards educating the former to become more healthy, self-reliant and more productive. Development, then, is a function of or an improvement based upon choices made by the people concerned. It refers to the enhancement of the

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[2] Wilson, Fred, *et. al. An Introduction to Community Work*, pp. 26, London, Oxford University Press, 1974.

potential of the people to make choices for and participate in the process of improving their life-style. Julius Nyerere, former President of Tanzania (1968) put it all so well in a nutshell in his proverbial style: development is "the enhancement of human dignity."

People's development goals may be different from those set for them by development planners purporting to act on their behalf. For example, development experts may decide that a given community needs to grow in order to remain viable. But the people within the community may believe that all is well and resist any attempts to change their condition. Ralph Mathews (1977) assessed the success of the Canadian Government's efforts to encourage resettlement of inhabitants of small fishing villages in Newfoundland. The federal government had tried to relocate the population to larger "growth" areas, based on the observation that the villages were no longer economically viable. Ralph Mathews (1977) reported that the majority of the people resisted the move, not because they were opposed to the potential material gains to be had elsewhere, but because they sought to meet development "in their own terms" without having to abandon their community. They wanted a style of development related to their own goals and values. Similarly, in a case study of Ghana on rural infant mortality, Senah (1991) revealed that some of the mothers of the dying children had not immunized the latter against the five deadly diseases, not because they were not interested in preventing their children's death, but because in their minds immunization was not the answer. From their experience and observation, it made children more sick and eventually led to their

death[3]. These cases show that whilst the definition of development may appear problematic, the choices for development are not self-evident either.

Ghana in the process of its 37 years of development experience, has tried various development strategies. The underlying philosophy behind these strategies can be traced to the philosophy of development which stressed the overriding importance of investment in such physical elements of national growth as dams, roads, factories, etc. Models centered on capital/output ratios (except during the nationalist regime of Kwame Nkrumah) have generally dictated the direction of national planning in Ghana. Implicit in this approach is the assumption that "non-economic" factors such as institutions, living standards, attitudes and perceptions can be disregarded with impunity.

Development plans of developing countries have been dominated by theories (usually referred to as modernization theories) that advocate the application of "Western concepts" and analytical models to solving problems encountered by the developing countries. These theories have tended to suggest (or, at best, have often been misinterpreted as suggesting) that for any development to occur, everything indigenous/traditional must be replaced with the (modern) European-American versions. It is through the sustained substitution of the "modern" for the "traditional" that developing countries have come to earn their status of "developing," as development and modernization have often tended to be equated with each other. While a debate on the validity of this equation is beyond the scope of the present discussion, I hypothesize that

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[3] Senah, Kodjo A., "Why the Children Die: The Case of a Rural Ghanaian Community," Paper presented at Colloquium on Social Policy and Development in Ghana, organized by Social Dimensions of Program, Ministry of Finance and Economic Planning, Legon-Accra 12th - 13th December, 1991. (p. 8)

both the status and perceived role of traditional medical systems among peoples of the "developing" world have been adversely affected by this substitution effect. This negative impact is more likely to have been worse in those developing countries where no express post-independence policy had been implemented in an attempt to revive, embrace and promote "tradition."

In order to test my hypothesis, I embarked upon a field research exploring the perception of the role and status of the traditional medical system in Ghana by Ghanaians of different socio-economic backgrounds. The amount of enthusiasm, if any, shown by the people from whom a development effort (as defined in this discussion) originates will depend on their perception of the potential benefits to be derived from the change. If Ghanaians do not believe, for example, that the traditional medical system has a positive contribution to make towards their development, they may not enlist in any effort aimed at promoting the traditional medical system. Such effort, if it is to succeed, would then need to be backed up by campaigns to change the negative perceptions of the participants. The purpose of this thesis is to use the information gathered through this research on the people's perception of traditional medicine as the basis for assessing the latter's contribution, or potential thereof, to Ghana's development, and for discussing the implications for health policy in Ghana.

My belief is that the traditional medical system has the potential, given its place in the history and culture of the people, to make a positive contribution to health development in developing societies. The field research reported in this discussion was conducted in order to ascertain my compatriots' perceptions of and attitudes towards any

role that the traditional medical system might be assigned to play in Ghana. Like any system, neither the traditional nor the modern medical systems have an intrinsic value; they are accorded value on the basis of their perceived contribution towards meeting the health needs and priorities of the people, which in turn determines the amount of patronage they enjoy. Their position in public policy and the type of publicity they enjoy, among other factors, can in turn influence their perceived value. Until recently, political support and publicity, backed by modernization theories, have not been favorable to the traditional medical system in Ghana.

1.2. Country Profile

Ghana, formerly the Gold Coast, is a developing country in a tropical region with a high rate of population growth. It is estimated that the population of the country will double in the next 22 years. The large rural population (69 percent), which is for the most part illiterate and poor, lacks resources to meet its needs (Peter Wondergem et al. 1989). These conditions are also present in other developing countries.

In 1957, under the leadership of Kwame Nkrumah, Ghana gained its independence (the first Sub-Saharan African nation to do so) from British rule. His socialist regime placed the state at the center of economic policy and activity. The Government therefore became the largest provider of health services. As the largest provider of health services, successive governments have experienced and continue to experience great difficulties in meeting the large budget requirements of the health sector. There has therefore been much reliance on external sources to keep the services going. The health sector

contributes to the country's indebtedness (over $4 billion as of January 1994).

Despite these pressures, the country's level of health services since independence is apparently much higher than that which obtained under colonial rule. For example, there are now two medical schools which turn out between 80 and 90 doctors annually, one state-owned pharmaceutical factory and a training school for pharmacists. None of these existed before independence. In terms of public health facilities, there were about 71 health centers and 230 rural health posts as of 1981, as against 10 and 9 respectively at independence. Presently, there are 6 public nursing schools in the country, as against one public nursing training college at independence. These "improvements" however need to be announced within the context of the mass exodus of professionals, which makes the advancement a lot less pronounced. For example, while in 1975 the number of doctors in Ghana was 1031 (i.e. 1 doctor per 9,625 inhabitants), by 1983 this number had fallen to just 600 doctors (i.e. 1 doctor per 20,000 inhabitants), despite the constant production of doctors by the country's medical schools and the increase of the population by over 2 million. Urban dwellers however were enjoying greater exposure to doctors in 1983 than their rural counterparts (i.e. 1 doctor per 7,000 people in urban areas and 1 doctor per 35,000 people in the rural areas).

The implementation in 1975 of a primary health care program, which emphasizes preventive medicine and community involvement in health matters, has been especially effective in terms of making health care more accessible to the people, especially to the rural population. The effect of all these "advances" on the general quality of health has been considerable. In the 1960s, life expectancy at birth (LEB) was estimated at 49 years

for males and 52 years for females. By 1983, these figures had risen considerably to 57 years and 61 years for males and females respectively.[4]

In spite of all these impressive achievements however, the health care system remains a problem to both the government and the people. Governments are unsure of the acceptable ideological underpinnings of health policy, as the provision of public health services remains an intolerable burden on the exchequer, while it continues to be (and despite the improvements just highlighted) a limited resource enjoyed by a few privileged and mostly urban elite. It is generally accepted that, given the socio-demographic characteristics of the country and its inadequate national resources, it is the preventive, socio-economic and educational aspects of the health care systems that are most urgently needed. And yet, the health care system, especially in terms of financing, is still overweighed in favor of its colonially inherited capital-intensive program.

Among other problems, children especially die of preventable diseases. It is estimated that 9 percent of all deaths, or about 16,000 deaths per year, are attributable to malaria. This illness also accounts for 30 percent of out-patient visits and 9 percent of hospital admissions, while 5 percent of all deaths are attributed to measles. With infant mortality at 107 per every 1,000 live births, the infectious diseases of most concern, with regard to the life and health of mothers and children, are malaria, measles, pertussis, gastroenteritis, respiratory infection, helminths, poliomyelitis, tuberculosis,

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[4] The World Bank, *World Development Report 1985*, New York, Oxford University Press, 1985. More recent estimates by the World Bank (*World Development Report 1988*) show a sad decline in LEB, reflecting the tough economic times that the country has had to go through in the 'lost decade' of the 1980s. Men and women have been estimated to have LEB of 52 and 56 years respectively in 1986.

schistosomiasis, guinea worm, tetanus and skin infections (K. Senah, 1989).

Given the enormity of the health problem, aggravated by a fast-growing population rate of 2.3%, and the limitations on foreign exchange, government cannot depend solely on imported medical resources and external aid to meet the health needs of everyone. It seems not only reasonable but also imperative under the circumstances that all efforts be made to mobilize internal resources (including traditional medicine) and human skills (such as those of indigenous healers) to assist in the task of improving the health status of the people. But there is more than one good reason why this mobilization of internal resources for health improvement has not been an easy task. As in many other developing countries, Ghana's process of modernization has sought to stifle and did indeed succeed in minimizing the contribution of indigenous resources (traditional medicine included) to the success of the modernization effort. While, through strategic planning, a lot of foreign exchange could have been saved or even earned through the exploitation of traditional medicine, the overall political tendency has been to neglect anything "traditional." After so much destruction, one must now ask how exploitable traditional medical resources are in Ghana. I felt that the initial step to make towards answering this key question was to first find out how the Ghanaian people perceive their traditional medical system in terms of its (potential) role as a complementary health resource. This is the major question I ask and for which I intend to find an answer in this thesis. The traditional medical system still co-exists with the modern medical system and is gradually receiving national and international recognition of its potential in social development. However, since the influence of the modern medical system is greatest on

the formally educated, the christian and the urban population, I hypothesize that:

i. in general the higher one's level of education, the less likely it is that one will visit a traditional practitioner when ill;

ii. christians, as compared to non-christians, are less likely to seek the help of a traditional practitioner when ill;

iii. since modern medicine is urban biased, and therefore more available in urban areas, the urban dweller, as compared to the rural dweller, is less likely to seek the help of a traditional healer when ill;

iv. since modernization occurs at the expense of traditional practices, the traditional medical system is likely to be enjoying only a marginalized status in a modernizing country like Ghana.

1.3. Methodology

This thesis draws heavily on information gathered in a field research I conducted in November 1991 - January 1992 on the perception and prospects of traditional medicine in Ghana. The purpose of the survey was to find out how traditional medicine is perceived by various demographic groups in Ghana, including male and female, literate and illiterate, rural and urban dwellers, christian and non-christian religious groups. Based on the findings, I speculate on the feasibility of traditional medicine as an appropriate and complementary health development resource among Ghanaians, assuming that there is the political will and commitment to promote it as such.

The research sample included a cross-section of the Ghanaian population - male and female, literate and illiterate, rural and urban dwellers, christian and non-christian religious groups. In conducting the survey, an effort was made to have these groups represented in the proportions highlighted by the (then most recent) population census data

of 1984. It was especially important to obtain a fair representation of the illiterate group, whose inability to read and write made structural interviewing necessary. Questionnaires were administered on two separate occasions. The choice of individual participants within each group was random, as all members within the group had equal chances of being respondents. The first set of 160 questionnaires yielded a sample of 94 respondents, a response rate of 59%. In this first sample, the representation of the female and illiterate populations turned out to be very low, (only 21% each), despite the precaution. The low representation of these groups speaks (although not conclusively) to a social phenomenon: the marginalization of women in the rural Ghanaian society in the domain of literacy. It turned out that the illiterate rural women were virtually not represented in the first sample.

In order to eliminate this limitation, another set of 100 questionnaires were distributed, this time with instructions that at least 55 of them be administered to women, especially illiterate and rural women. Potential respondents were pre-interviewed to determine their demographic category before being invited to participate. This measure has insured that the women/men, illiterate/literate, christian/non-christian and rural/urban groups were more or less balanced. Seventy-five of these questionnaires were mailed back to me, representing a 75% response rate. That brought the total number of respondents to 169 with a female representation of 51%, an illiterate representation of 56% and a rural population representation of 56%. These proportions are representative of the various demographic groupings of the entire Ghanaian population, judging from the Ghana Bureau of Statistics' 1987 publication, *Ghana in Figures*. It is important to note

that the proportions reported in *Ghana in Figures* are based on the 1984 population census data. In the absence of national statistics on the proportions of the christian/non-christian groups in the overall population, it has not been possible to determine how representative our sample is in terms of this demographic breakdown of the Ghanaian population. It is possible that the christians outnumber the other religious groups by a few percentage points. The ratio of non-christians to christians in our sample is 0.92:1, which, hopefully, is representative of these groups in the overall Ghanaian population.

An exploratory library search was also conducted on materials that have already been written on the subject. The next chapter presents an overview of what the literature has to say about medical systems in Ghana, in the various economic and political settings of the country's development experience since colonialism, and on how the place of traditional medicine has changed over the years. Chapter thr e contains a report on the results of the survey, while chapters four and five discuss their implications for health policy in Ghana.

Chapter 2

Overview of Medical Systems in Ghana

The existence of other medical systems in most African countries, alongside contemporary Western medicine, has been well documented over the years. Implicit or explicit in all discussions on the subject is the issue of the changing role of traditional medicine, starting from its non-profit but prestigious socio-political status of the pre-colonial period, through its state of total suppression and stage of illegal practice in the colonial period, to its present day socio-economic role in a developing world. Bannerman (1983); Bibeau et. al. (1982); Harrison (1979a & 1979b); Koumare (1983); Mullings (1984); and Wondergem et. al. (1989), among others, acknowledge that traditional medicine and its practitioners play a very vital role in African health systems, far out-numbering modern health professionals.

Of these traditional practitioners, over 90% work in the rural areas, while the remaining 10% or less cater to the underprivileged population in the urban areas. Not only are traditional healers responsible for over 90% of all births in rural areas, but they also play various roles as psychotherapists, psychiatrists and sociologists. It has also been acknowledged that African traditional medicine does not only represent an affordable health delivery system, but constitutes a dynamic and evolving system, one that is turning into a lucrative business enterprise and becoming a major part of the informal economic sector of urban Africa [Bibeau et. al. (1982); Semali (1983); Mullings (1984); Good (1987)]. The underlying implications of this development will be examined later in the

study. I shall now examine how the three evolutionary stages (colonial, post-colonial and the present) were played out in Ghana, first of all for traditional medicine and secondly for modern medicine.

2.1. Traditional Medical System: The Colonial Situation

Traditional medicine in Ghana has gone through the same roller-coaster experience as described above. Before the arrival of the British in the Gold Coast, the only medical system that existed was the system of medical practice that is now being referred to as traditional. However, during the colonial period (1844 -1957), this practice was frowned upon by the colonial administration and healers were banned from practice, although they continued to practice secretly in rural areas. Traditional medicine was to be replaced by allopathic medicine whose practices and normative structures were reinforced through Christianity and Western education. To some of the "educated," traditional medicine represented a primitive chapter in social development that was better forgotten; and to the devout Christian, spiritual aspects of treatment were easily associated with paganism (Wondergem et. al. 1989).

According to a historical account by Patterson (1981), between 1931 and 1950, there were two healers' associations in the colony: the Society of African Herbalists and The Ga Medical Association. Their aims, as stated in the manifesto of the former, were to raise African medicine to the status of Western medicine (emphasis mine) and to tap the knowledge of healers to serve the health needs of the people. Despite the intent to emulate "modernity" and the ways of the West, these local associations were

proscribed by the colonial administration because their activities were considered too nationalistic. Moreover, the colonial administration was not only interested in supplanting traditional medicine, but was also bent on "administering" western medicine to the people (a euphemism for "imposing" it on them). This is probably why the subject of "cultural domination" is often an underlying issue in discussions about traditional medicine. Mburu (1977:166) for instance, describes the way in which the introduction of Western medicine with colonialism created "dependent individuals" by "abrogating their creative potential." He concludes that "by design or otherwise, such is symptomatic of colonial domination."

2.2. Traditional Medical System: The Post-Colonial Situation

The concern for "cultural independence," as expressed by the new government at independence, is best understood against the background of this form of induced dependency under colonialism. A study by Warren (1986) reported that, in 1963, the nationalist government of Kwame Nkrumah founded the first national healers' organization known as the Ghana Psychic and Traditional Healers' Association (GPTHA), but gave it no legal recognition. This association had two wings - 'psychic' and 'traditional' healing. The psychic wing grouped together magicians, spiritualists, fetish priests, etc., while under traditional healing came herbalists and vendors of herbal medicine. It had offices at the local, district, regional and national levels. However, following the overthrow of Nkrumah in 1966, the association fell from favor with the new military administration that came to power. The Ministry of Health under the Third Republic established contacts with traditional practitioners. The Ghana Psychic and

Traditional Healers Association (GPTHA) was given some recognition on August 25, 1969 and extended membership to priest and priestess healers on February 15, 1973 (Warren et al 1982). The association was charged with the responsibility of registering all healers and ensuring a standard of performance among them. It is however doubtful that anyone was refused membership. Unfortunately, unity was much impeded by serious conflicts within the association. Today, although healers are still anxious to obtain the due recognition from the government, they are more disunited than ever before. At the moment, there is still little common ground for a dialogue with the government.

In 1974, the Center for Scientific Research into Plant Medicine (CSRPM) was established (Senah 1989). At the time of its establishment, traditional healers and physicians of the Ministry of Health (MoH) worked together in diagnosing diseases and treating patients. Now, however, the role of traditional healers in the CSRPM is less pronounced. This is probably partly due to the disunity within their own camp and/or the marginal role that was accorded them in the CSRPM due to the fact that many of them could neither read nor write. It is even possible that the practice of traditional medicine defies the specific form of institutionalization into which the traditional healers are coopted by virtue of joining the CSRPM. This point is developed further in chapters four and five.

Established by Dr. Oku Ampofo, the CSRPM is supposed to be conducting studies to determine the effectiveness of herbal remedies. It seeks alternatives for expensive imported drugs and carries out research on plant medicine, often for diseases against which modern medicine is not effective. It is a pilot clinic where herbal drugs are

prescribed, although, as far as known, no follow-up studies on patients are carried out. The CSRPM aims at mass production of herbal medicine for public health centers. Encouraging results have been achieved with plant medicine against malarial fever, bronchial asthma, rheumatic pains, diabetes mellitus and hypertension, among others (Peter Wondergem, 1989). Scientific output in the form of publications and cause-effect explanations however is quite low. This absence of scientific output may be a symptom of the general problem of attempting to use one standard to evaluate all practices. Practitioners in the traditional medical system have been known for their secrecy, and it is understandable that they will not readily divulge the expert knowledge they have about herbs through scientific discourse.

Wondergem et. al. (1989) reported that a rehabilitation program for the CSRPM was started after a call for support was made in the Ghanaian papers, and, in 1988, a plan was made to dispense in hospitals herbal drugs approved by the CSRPM. Little was heard of the plan afterwards and, as far as is known, it has not yet been implemented.

Apart from the activities of the CSRPM, Ghana is widely recognized as having made one of the first attempts in Africa to train traditional healers, with the Primary Health Care Training for Indigenous Healers (PRHETIH) program, which started in 1979. Due to conflicts among the organizers of the course, the program was stopped some years later. A similar course has been set up in Dormaa Ahenkro. Also in the village of Duong and in the Nandom area in the Upper-West Region of Ghana, experiments are being carried out in the field of bone-setting, with the co-operation of modern and traditional practitioners. Traditional bone-setters in these localities enjoy a

long-standing reputation for efficiency and success in curing fractures of all kinds, which has prompted the official Health system to reach out to them, albeit reluctantly, for assistance with those cases that the system is unable to handle.

As far as policies are concerned, the Ministry of Health's policy is most clearly articulated with respect to traditional birth attendants (TBAs). In the Primary Health Care Program (PHC), the role of the TBAs has been clearly defined. Research on the knowledge and skills of TBAs was part of the Danfa project which was evaluated by Lamptey *et. al.* (1979) and Neumann (1986). Groups of TBAs have been trained all over the country. In 1987, a national survey was undertaken to evaluate the effectiveness of the TBA training program, and plans were made to retrain TBAs and improve the program (Wondergem et. al. 1989).

The experience of the past, as has been revealed in these studies, shows that bringing traditional and modern medicine together is a slow and demanding process. Nor is there any indication anywhere in the literature that some effort has been made to understand, from the people's standpoint, why this integration is slow and painfully demanding. It has been shown (Kleinman 1980) that traditional healers are willing to incorporate aspects of modern medicine in their practice. There is no evidence, however, of Western medical practitioners showing any willingness to incorporate aspects of traditional medicine in their practice. This attitude on the part of the Western medical practitioners to systematically look down on their traditional counterparts may well be a by-product of the so-called "cultural imperialism" that the leaders of the newly independent nations sought to combat, or a symptom of what Kleinman (1980) has

preferred to call their "trained incapacity." According to Kleinman (1980:56-57), the "professional socialization of modern health professionals causes them to regard their own notions as rational and to consider those of patients, the lay public, and other professional and folk practitioners as irrational and unscientific." Whether a by-product of cultural imperialism or a symptom of trained incapacity, the attitude of the modern practitioner is not helping meet the health needs of the largely rural populations.

2.3. Modern Medical System: The Colonial Situation

According to Kwame Nkrumah, colonialism is the policy by which the colonial power binds her colonies to herself by political ties and to her own economic advantage. The nature of this relationship depends on the opportunities offered by the resources of the colony and the power of the colonial power to exploit these resources. The history and development of Western/Modern medicine in Ghana can therefore be explained, in part, by the nature of the political and economic relationship that prevailed between the Gold Coast and Great Britain.

The development of a modern medical system in Ghana is ear-marked by three major phases. The first, which marked the early beginnings of the system, probably dates from 1471 when the first European explorers landed on the coast, to about 1844, when the British signed a peace pact with some coastal chiefs. This period also marked the peak of European mercantilism and the concomitant scramble for colonial possessions. This period was at the same time significant in European history for its advances in medical knowledge: Louis Pasteur's 'germ theory' had revolutionized medical thinking.

This theory perceived the germ as the cause of pathogenic conditions. In the therapy management process, therefore, the individual was atomized and cured. Coinciding as it did with the age of capitalism, this theory ensured that human problems would be individualized.

The main aim of the medical service in this phase was to safeguard the health of European residents through prompt diagnosis and treatment, and through their physical separation from the local population. The colonial policy has been to provide a European quarter in order that the risk of malaria infection from the insanitary conditions of native houses and infected natives may be reduced. However, it soon dawned on the British colonial administration that the health of the European could not be guaranteed unless some effort was made to attend to the health needs of the local population also. The second phase of the medical service was thus born out of this realization.

In the second phase, some Africans in the colonial administration were given medical coverage. A few towns, especially those with a sizeable European population, or those of political significance, were provided with piped water and a few other sanitary facilities. The first hospital was built in 1868 at Cape Coast (the then colonial capital) as a result of a report on the health situation in the colony by Thomas Jones, the colonial surgeon at the time. Subsequently, general hospitals, specialized hospitals and rural dispensaries were built. The Gold Coast Medical Department was established in this phase.

The last phase (1901 - 1957) may be described as the period of consolidation and expansion of the colonial health service. Following the defeat of the Asante in 1901 and

the acquisition of the Northern Territories, efforts were made to cover the entire colony with health facilities. The 1920s especially saw the development of basic infrastructural facilities - roads, harbor, rail network, markets, piped water, decent housing, schools and health centers across the length and breath of the colony. Under Governor Gordon Guggisberg, the highest point in colonial public health delivery was reached with the building of the Korle-Bu Hospital in 1923. This hospital was meant for research into tropical diseases.

Following the attainment of internal self-rule in 1951, the Ministry of Health was created and a commission was appointed to look into the colony's health system. The commission demanded, among other things, that all public hospitals and health centers be placed under the control of the new ministry; that hospital fees be abolished; and that urban and district councils be made responsible for sanitation.

By independence, the colonial health system/modern medical system had developed certain features, some of which were inherited by post-colonial governments. They include:

i. a strong curative and urban bias;

ii. a centralized medical administration with the least concern for the rural communities;

iii. central government as the largest provider of health services;

iv. subordination of traditional healing systems to bio-medical/western medicine;

v. a north-south disparity in the provision of health care services and facilities with the southern half of the country as the greater beneficiary.

2.4. Modern Medical System: The Post-Colonial Situation

At independence, Ghanaians yearned for the better life that they dreamed of and fought hard for. Each town/village wanted electricity supply, roads, better housing, piped water, schools, health services and more. In an attempt to deal with the immense social and economic problems, the provisional Nkrumah government launched a Ten Year Development Plan in 1951. The challenge facing the new government was enormous and the leader, Dr. Kwame Nkrumah, knowing this, declared soon after independence:

> We shall measure our progress by the improvement in the health of our people ... The welfare of our people is our chief pride and it is by this that my government will ask to be judged.

An expenditure of 120 million pounds sterling was proposed, of which 33 percent was to go into providing social services, education, health, housing and social welfare. The table below shows the degree of expansion in health care facilities from 1957 to 1963.

TABLE 1: POST-COLONIAL EXPANSION IN HEALTH FACILITIES (1957-1963)

FACILITY	1957	1958	1959	1960	1961	1962	1963
Health centers[a]	10	12	16	22	27	33	41
Health personnel[b]							
- Doctors	330	342	346	586	726	879	904
- Dentists	18	14	17	17	22	29	36
- Midwives	616	691	789	900	1008	1104	1235
- Nurses	800	986	1627	1848	2023	2191	2366
- Pharmacists	312	311	326	298	329	342	355

Sources: [a] *The Health Services in Ghana* Ministry of Health, Accra, 1967
[b] *Statistical Year Book* Central Bureau of Statistics, Accra, 1963.

For the first time in the history of Ghana, the government's health expansion

program did not favor urban centers and large towns more than the rural areas. As a result of this balanced distribution policy, 35 rural health centers and rural health posts were established between 1960 and 1966. In line with Nkrumah's determination to promote the 'African Personality' - the quest for an authentic African way of life - he initiated steps in 1963 to study and organize traditional healers to form an association for the advancement of their art and techniques in the delivery of health care. It was this effort which had led to the formation of the Ghana Psychic and Traditional Healers Association referred to above.

Although the expansion and provision of free social services such as health was socially, politically and economically necessary and warranted, it nonetheless placed a heavy burden on the national economy. For instance, 31 percent of the central government's expenditure for 1963/64 (144 million pounds) was budgeted for social services. This was at a time when Ghana's main foreign exchange earner, cocoa, had suffered a massive price decline on the world market. Thus, even though cocoa production had doubled by over 200 percent from 1956 to 1964/5, this could only fetch the country an increase in revenue of just 7.7 percent. Consequently, there was a financial strain on the central government's budget which led to the imposition of restrictions on imports and foreign exchange allocation. A capital-intensive service such as the modern medical system immediately felt the impact of the restrictions, as new equipment and other essential medical supplies could not be procured; nor could faulty ones be repaired.

The National Liberation Council (NLC), the military junta which overthrew the

Nkrumah government in 1966, was pro-west. In its bid to court western financial assistance, it started to reverse the Nkrumah government policy of involving the state deeply in a wide range of social and economic tasks. Hospital fees were raised and their collection strictly enforced. The Busia administration took over in 1969, and this was the beginning of an apparently irreversible state of political instability. The former was overthrown after 27 months by the National Redemption Council which was also overthrown by the Supreme Military Council (SMC). In 1979, the SMC was overthrown by the Armed Forces Revolutionary Council headed by Jerry John Rawlings, which handed over to civilian rule under the leadership of Hila Liman only to return after 27 months on 31st December, 1981, to resume power under the name "Provisional National Defence Council (PNDC)." After all the political instability, the nation was now suffering from serious economic crisis. The per capita GNP had fallen from $539 in 1974 ($1 = 1.15 cedis), to $163 in 1981 ($1 = 2.75 cedis). Real wages had declined by 80 percent, and total volume of imports by 50 percent. The import of medicine and modern equipments were also therefore reduced. By 1981, about a third of the nation's earnings were being spent on crude oil. Inflation was running as high as 116.5 percent. This situation reached its peak in 1983 when cocoa production dropped to as low as 40 percent of the 1960 production level while capacity utilization in the manufacturing sector was only 20 percent (UNECA, 1985). To aggravate the problem of a sick economy, a long drought had set in causing wide-spread bush fires and food shortages.

In the health sector, the picture was even more gloomy. Drugs and other medical

supplies were drastically reduced due to inadequate financial resources. In 1983, the introduction of surcharges on the delivery of imported drugs and hospital equipment worsened the situation, as firms which normally imported drugs on behalf of the Ministry of Health found it difficult raising the required amount of money to establish letters of credit. In some public health centers, the situation was so critical that patients had to provide not only their bedding, drugs and food, but also stationery for their medical records. The exodus of professionals from every sector of the economy was affecting the health sector as well.

In an attempt to improve the health services, the PNDC raised fees for all kinds of hospital services. For the first time, non-Ghanaians were discriminated against in the payment of hospital fees. They were required to pay between 100 and 120 percent more than what Ghanaians were to pay, for it was now clear that the state could no longer bear the full cost of health delivery services for even its citizens. According to the Ministry of Health, there were resultant impressive financial returns. In 1986, the ministry received in hospital fees the equivalent of $100 million in local currency (496.1 million cedis), an unprecedented figure in the country's hospital revenue history. The institution of fees as well as the skewed distribution of health facilities, among other things, reinforced the South-North and urban-rural disparity.

2.5. The New Approach: Primary Health Care (PHC) in Ghana

In the 1970s it became clear to health policy makers that something radical had to be done about improving the quality of health services, since not much impact had been made on the health of the people despite the huge financial outlays since the 1960s. The new thought was that since the rural areas especially experienced the highest mortality and morbidity (but also fertility) rates, an integrated approach to rural health problems would be most appropriate. In 1970, the Danfa Comprehensive Rural Health and Family Planning Project took off with the important aim of developing an effective, high quality and affordable primary health care delivery system in rural areas. As a joint project between the Ghana Medical School and the School of Public Health, University of California in Los Angeles, it was mainly demonstration, teaching and research oriented. Then in 1974, perhaps as an attempt to exploit the medicinal potential of the country's plants, and also tap the knowledge of traditional healers, a Center for Scientific Research into Plant Medicine was established in Mampong. It was in 1976, however, that the first most significant step towards PHC was taken, when the Ministry of Health with the assistance of WHO established the Brong-Ahafo Rural Integrated Development Project at Kintampo for training middle-level personnel for the proposed PHC program. The project was also meant to determine, in a practical way, the social processes that would help to institutionalize the participation of traditional healers in a health care program. And the following year, in 1977, Ghana accepted a proposal to adopt a PHC program which would attempt to prevent or treat the vast majority of cases of morbidity and mortality. The goal was to extend health care coverage to 80 percent of the population. The current impetus that the newly-elected government headed by the NDP (National

Democratic Party) is giving to the program, which stems from the WHO Alma-Ata conference declaration of "health for all by the year 2000," must be seen as a manifestation of the government's desire to make health care more accessible and more efficient.

After more than a decade and a half of the PHC program, there is little evidence of how successful it has been. Nor is it easy to find out the degree of success, given the absence of reliable statistics and monitoring systems. However, according to Senah (1989), who draws on Adjei et al. (1984, unpublished), only moderate gains have been made. In terms of figures on the amount of progress, Adjei et al. (1984, unpublished) observed that in 1984, 64 percent of the population had access to health care services in the form of a health post, or clinic within one hour travel time by car. Since access to a car is however the lot of a very small fraction of the population, it is tantamount to saying that access to health care services remains largely elusive. However, according to this report, this percentage is about double the figure in 1977. Immunizations were boosted by public education, and that for measles in particular increased by 60 percent over the record for the previous two years. The report noted also that in terms of pregnancy management, about 92 percent of mothers had been examined at least once by a trained medical personnel during pregnancy. However, between 50 and 70 percent of deliveries were still taking place at home, with over half of such deliveries being performed by traditional birth attendants (TBAs). This signifies the importance of the role of traditional medicine and its practitioners in the lives of the people.

It should be pointed out that the success of the PHC has been limited by a number

of factors related mainly to its organizational structure. The PHC program is structured on three levels: (a) the community level or level 'A'; (b) the health institution level or level 'B'; and (c) the district level, level 'C'. The community level involves three types of community health workers - traditional birth attendants, village family health workers and the village development worker. These are selected (and are supposed to be compensated) by the community. Their training is carried out by the Ministry of Health. It is anticipated that there will be a health team within every 12-square-kilometer area, and that there will be 300 or more of such teams in each district. The main functions of the health team include preventive services, simple curative measures, pregnancy management, environmental protection and mobilization for health-related community projects.

The health institution level is the first referral point for community health workers in level 'A';. A health team at this level is made up of (a) a medical assistant; (b) a community health nurse/midwife; (c) a health inspection assistant and (d) a senior field technician for communicable disease control. These officers undergo retraining to equip them for supervisory activities at the village level. They are to undertake all routine immunization and care for patients at level 'A'. It is hoped there will be at least one level 'B' health institution within every area of about 8 kilometers in radius.

The district level is expected to serve a population of 150,000 to 200,000. This level is supposed to manage the entire system. A District Health Management Team (DHMT) is made up of the following: (a) a district medical officer; (b) a district public health nurse; (c) the district technical officer for communicable disease control; (d) a

senior medical officer responsible for the district hospital and (e) the district health inspector. This team is expected to work in conjunction with the district council to facilitate an integrated approach to community development. It is responsible for the planning, implementation and evaluation of health services for the entire district.

To make the PHC program more effective, the PNDC government set up in 1984 a higher level National Primary Health Care Committee made up of 17 governmental and non-governmental organizations all of which are involved in health-related activities. This committee has selected areas for maximum promotion. These include: (a) expanded program on immunization; (b) control of diarrhoeal diseases; (c) health education; (d) environmental sanitation, and (e) growth monitoring.

One of the problems associated with the 3-tiered structure of the PHC program is that the structural linkage from the district to the national headquarters is not clearly defined. Consequently, the districts find themselves without any support from the top. This lack of support from the top is explained in part by the fact that the National Primary Health Care Committee has not been very active. As of 1989, it had held only two meetings since its inception in 1984. The PHC program is also faced with a problem of inadequate technical support (Senah, 1989). The staffing projections are yet to be realized. Many of the districts lack financial autonomy since the Government makes no budgetary allocations directly to the PHC program.

Problems at the grass-roots level that have been identified and communicated to policy makers have been those that concern the availability of medical supplies and other physical items, such as basins, gloves, "aspirin and bandage," etc. Yet the success of the

primary health care (PHC) program, which attempts to blend the traditional and modern medical systems, depends just as much, if not even more, on social factors such as the attitudes and perception of the people, a much difficult area for officials to investigate. Little has been documented, for example, on what has happened to Ghanaians' perception of traditional medicine since the arrival of western medicine and the denigration of the former since colonialism. Before even asking what the role of indigenous medicine in a fast-"modernizing" country like Ghana can possibly be, it seems crucial to me that one begin by determining what the attitude of the people is vis-a-vis the traditional medical system. If, for example, it was determined that this system is generally perceived as being totally unsuitable for it to be assigned a role in the health care delivery system, then it would be necessary to begin any role assignment by first trying to change th. people's perception of the traditional medical sector from negative to positive. Many a development project has failed, which would otherwise succeed were the planners aware of the recipients' goals, attitudes and values, simply because no preliminary investigation was done to determine the type and degree of response to be expected from the people. The results of the survey on Ghanaians' perception of the status and role of the traditional medical system which I report in the next chapter do indeed help understand various facets of the problem that the PHC program has faced since its implementation in 1977. It is clear that little has been done to improve the ima_e of traditional medicine before the people, a step which has simply bee neglected due to the fact that officials have been unaware of the extent of damage caused by decades of "de-traditionalization." The issue as to what needs to be done to encourage cooperation between the modern and traditional

medical systems in order to improve the health of the people begs the question of the people's acceptance of the traditional medical system. The fact of the matter is that many of the people do not even want to be identified with the traditional medical system, because they perceive it as a primitive chapter in the nation's history that must be forgotten. Health planners ought to pay much greater attention to raising the image of the traditional medical system prior to assigning it a role in the official health care delivery system.

The next section is a report on the findings of the survey I conducted.

Chapter 3

Research Findings

The information reported in this section comes from field notes taken during conversational interviews and from written responses to the questionnaire announced under section 1.3. above. Some two hundred and sixty questionnaires were distributed across the country, of which a hundred and sixty-nine were returned well completed. A sample questionnaire is attached in Appendix B. Structured interviews were carried out in the case of illiterate respondents. On the basis of the information gathered from these questionnaires, an attempt is made to answer the specific questions that were raised under section 1.2 above.

3.1. Ghanaians' Perception of Traditional Medicine in the 1990s

During the colonial period, traditional healers were banned from practice, but they continued practicing clandestinely in the rural areas. This official ban was a scare to potential clients of the traditional health delivery system, who could be persecuted for condoning a criminal practice. Christians were also prohibited from using the services of the traditional medical system, since the spiritual aspects of the treatment this system offered were easily associated with paganism.

Over three and a half decades ago, on March 6, 1957, Ghana attained political independence from Great Britain. Various attempts at reviving traditional medicine have been made in Ghana, as pointed out earlier, and one must wonder what impact these

attempts have had in terms of changing the people's attitude towards traditional medicine from its basically illegal and demonic status to a more positive one. Figure 1, (based on table 1a in Appendix A), illustrates Ghanaians' perception of traditional medicine as of 1992, based on their expression of preference for a practitioner during illness.

Participants were asked to indicate whom they would most readily consult if they were to fall ill, given the choice between a traditional practitioner, a modern practitioner, or either one depending on the situation. None chose to consult a traditional practitioner, 51% of respondents said they would consult a modern practitioner and 49% said it would depend on the situation. Given what we know about the status of traditional medicine in the system, it is not surprising that no one chose outright to consult a traditional medical practitioner. However, when probed further to explain their choice, 2% of those who said it would depend on the situation confessed that they would first consult with the traditional practitioner in order to save on costs, and only if the condition did not improve would they consult the more efficient but also more expensive modern practitioner. This meager 2% of respondents could be viewed as being reluctantly pro-traditional medicine. Some of those 51% of respondents who declared that they would prefer to consult a modern practitioner explain the extraordinary circumstances under which they could envisage consulting the traditional practitioner.

The perception that traditional medicine is less costly and more readily available constitutes the most prevalent reason why those who declare their preference for modern medicine might eventually consult a traditional practitioner. The next most recurrent reason why those who declare their preference for modern medicine might eventually

consult a traditional practitioner is that modern medicine does not have the treatment or cure for all types of illness. Hence, their choice will also be motivated by the type of illness. For disorders such as hunch-back, ulcer, bone-dislocation, boils, piles, AIDS, gonorrhoea, habitual miscarriage, epilepsy, fits, poison[5] and the spell of witch-craft, they would prefer to see traditional healers because they are perceived as the better providers of the most effective and least costly treatment.

Several reasons were listed by respondents for their preference of modern practitioners over the traditional practitioners. These reasons were closely associated with the availability of certain facilities and qualities deemed unique to modern medicine. Examples include laboratory tests, blood and water transfusion, hygienic surgical operations. The effectiveness of modern medicine in the treatment of hernia, headache, malaria, and fresh cuts (anti-tetanus treatment) was also listed as a factor influencing their preference.

Of the 51% of respondents declaring their preference for the modern practitioner, some 10% clearly state that under no condition would they consult a traditional medical practitioner; they would, as one of them put it, rather **'look to the Lord Jesus, he will heal . . .'**. For all 51% of respondents in this category, the most prevalent reasons for their choice of modern medicine include its ability to rightly diagnose illness, its use of modern equipment, its accuracy ('no guess work', in their own words), its overall effectiveness, and its hygienic and diversified investigative nature.

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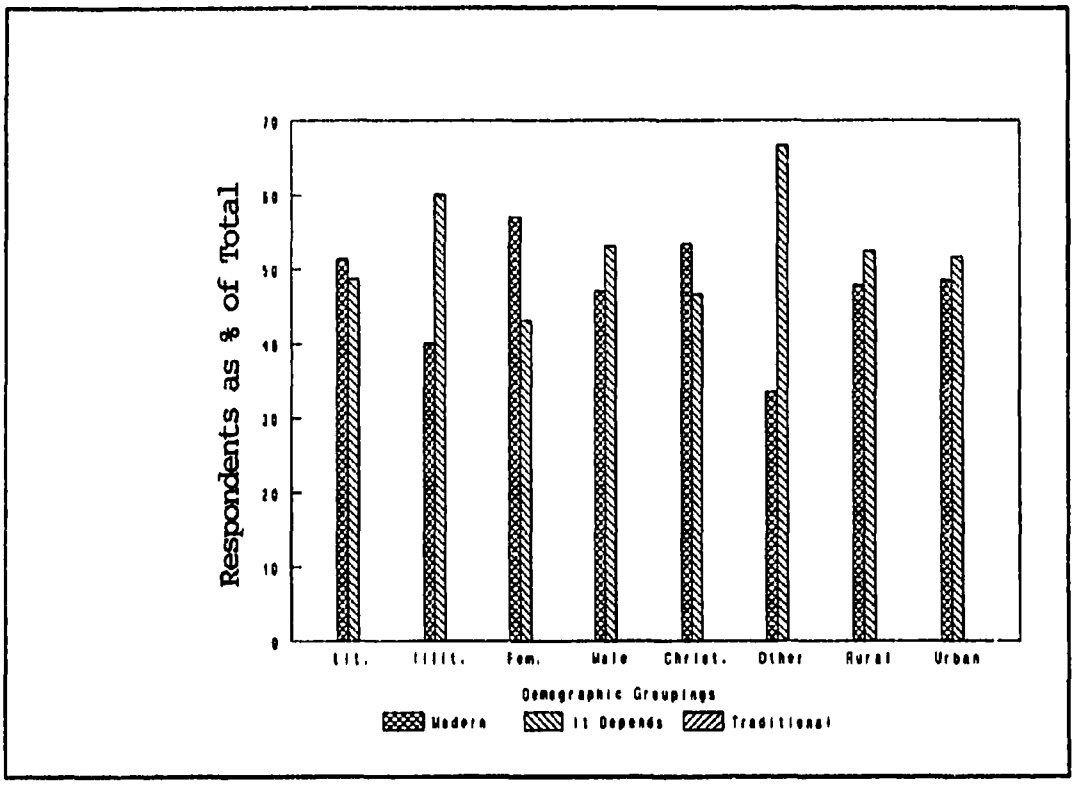
[5] Note that "poison" also refers to

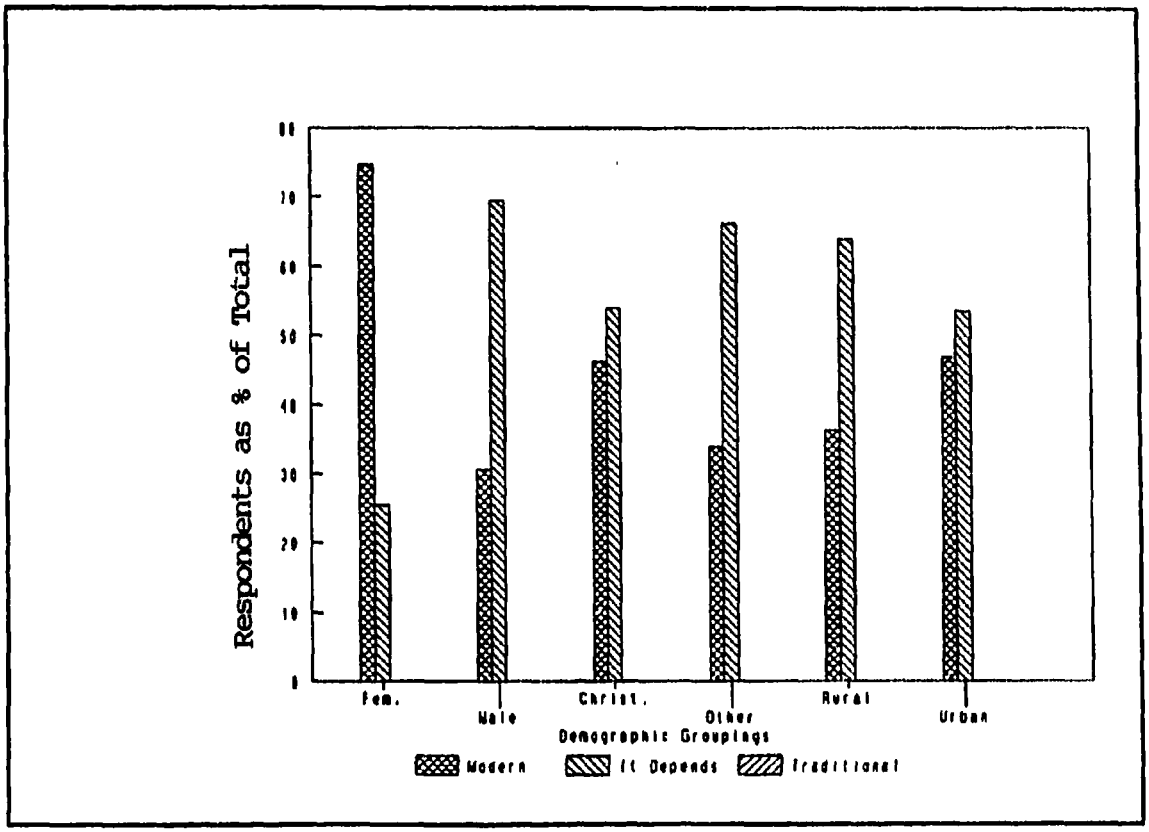
Figure 1 Preferred Choice of Practitioner by Demographic Groupings



These results show that the prejudice of the past has left a stigma on traditional medicine which permeates all demographic strata, as highlighted by figures 2 and 3, and irrespective of schooling. Figure 2, which is based on table 2a in Appendix A, shows that there is **no express desire** on the part of illiterate Ghanaians to prefer traditional medicine to modern medicine. The same is true of the literate population, as highlighted by figure 3.

One must compare figure 4 to figures 2 and 3 to realize that **some conscious attempt is being made by all respondents to distance themselves from traditional medicine.** Figure 4 shows, in fact, that between 58% and 82% of all respondents within each demographic category have ever been treated by a traditional practitioner. More respondents have confessed to having been treated by traditional practitioners than

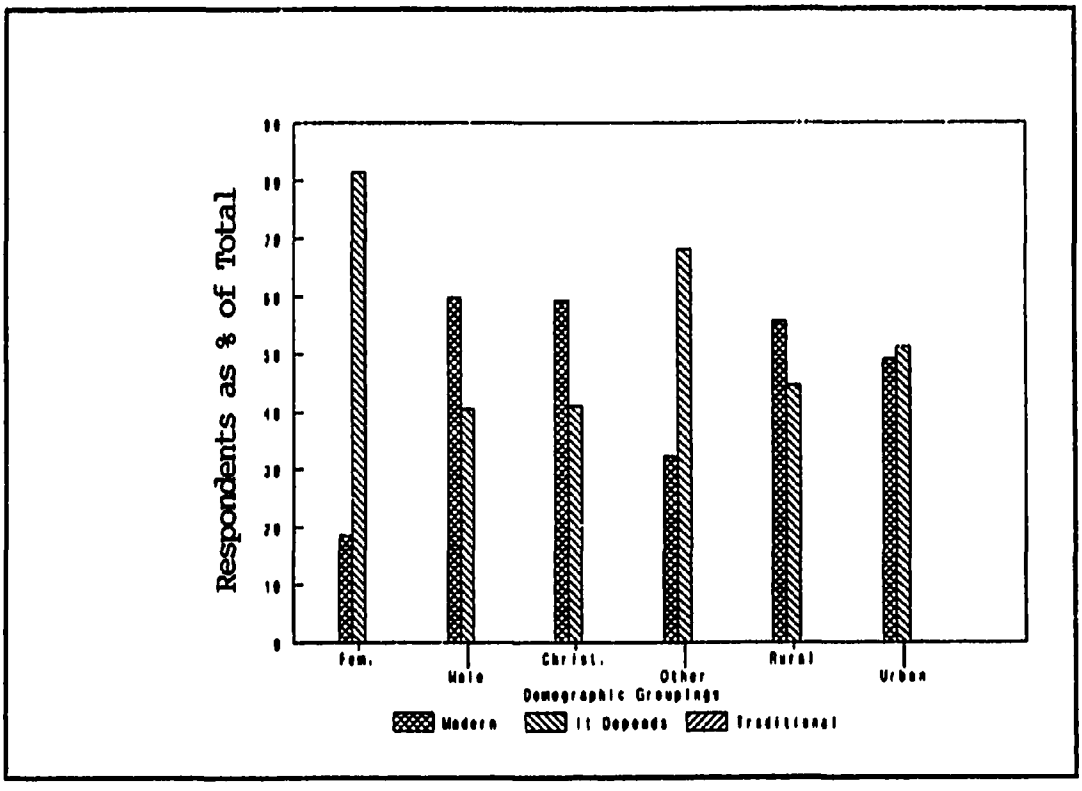
Figure 2 Preferred Choice of Practitioner: Breakdown of Illiterate Group



their pattern of preferences indicates, as highlighted in figures 1 to 3. So the decision to consult a given type of practitioner is not always guided by preferences. The modern and traditional medical systems do in many ways complement each other, which is how the majority of respondents say they view them, when asked in question 18 to provide additional comments.

The kinds of disorders for which they were treated include (in decreasing order of frequency): sprains/bone fractures (32%), guinea-worm (14%), boils (11%), poison (9%), snake bite/scorpion sting (9%), abdominal disorders (7%), skin infection/rashes (7%), dysentery (5%), cholera and diarrhoea (4%), eye problems (4%), swollen limbs (4%), malaria (4%), chest pain (4%), the spell of witch-craft (4%), hepatitis (4%), jaundice (4%), convulsion (4%), headache (4%), asthma (2%), epilepsy (2%), piles

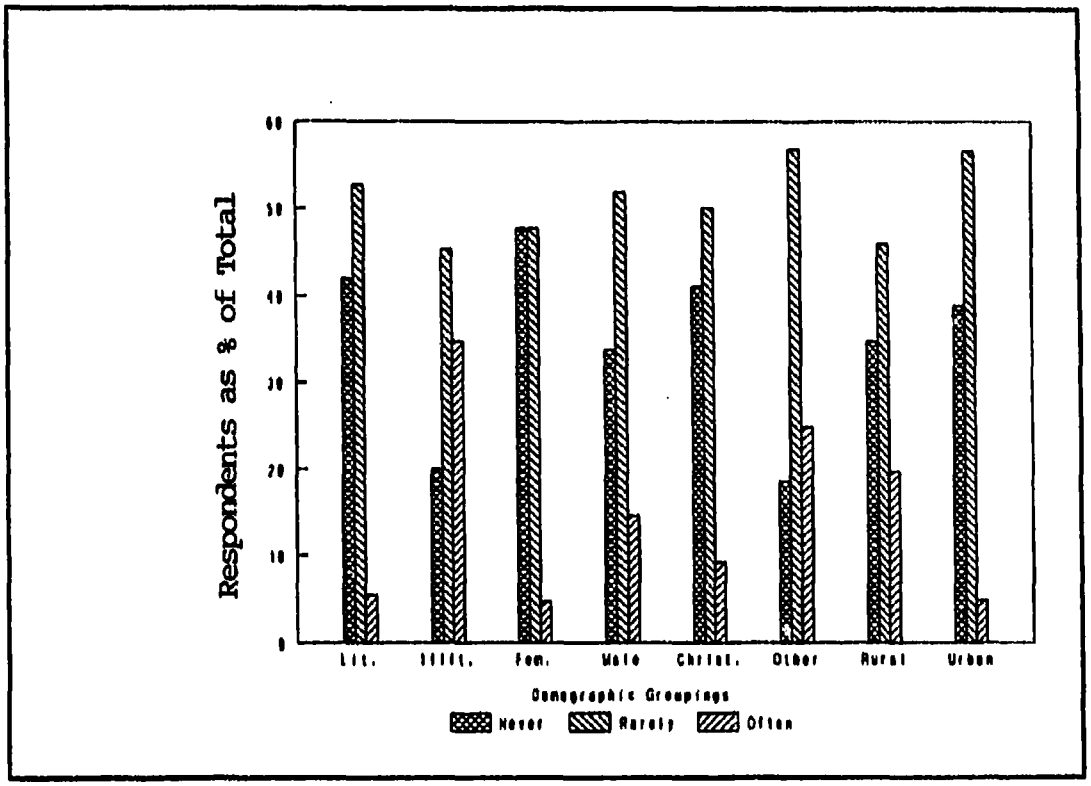
Figure 3 Preferred Choice of Practitioner: Breakdown of Literate Group



(2%), body ache and general body weakness/fatigue (2%), rheumatic pains (2%), secondary fertility (2%), heart attack (2%), fever (2%), gonorrhoea (2%), fresh cuts (2%), burning body sensation (2%), waist pain (2%), "kaka" (2%), pneumonia (2%), lightening shock (2%), and breast engorgement (2%). Figure 5 presents a pie chart of the five most popularly treated illnesses by traditional practitioners. From the frequencies, traditional medicine appears to be a force to reckon with when it comes to the treatment of sprains/bone fractures, guinea-worm, boils, poison, amongst others. This would seem to indicate that when the public is shopping for health care, they know which way to go; modern or traditional depending on the type of illness. They however admit reluctantly to having anything to do with traditional medicine.

It is worth noting that the list of illnesses for which respondents have been treated

Figure 4 Medical Treatment Received from Traditional Practitioners by Demographic Grouping



is three times as long as that for which they gave traditional medicine credit for when they were giving reasons to justify their preference for modern medicine. The strategy of distancing themselves from traditional medicine has taken different forms, one of which being to minimize the latter's potential contribution to health improvement, where it has been possible for them to do so by preterition. Another form has been to blatantly deny preference for traditional medical practitioners, yet provide evidence which shows that they have sought treatment from them anyway.

Questions 5 and 6 of the questionnaire[6] investigate how often the two categories of practitioners refer patients to each other -- in other words how much interaction there is between the two systems. Figures 6 and 7 summarize the findings.

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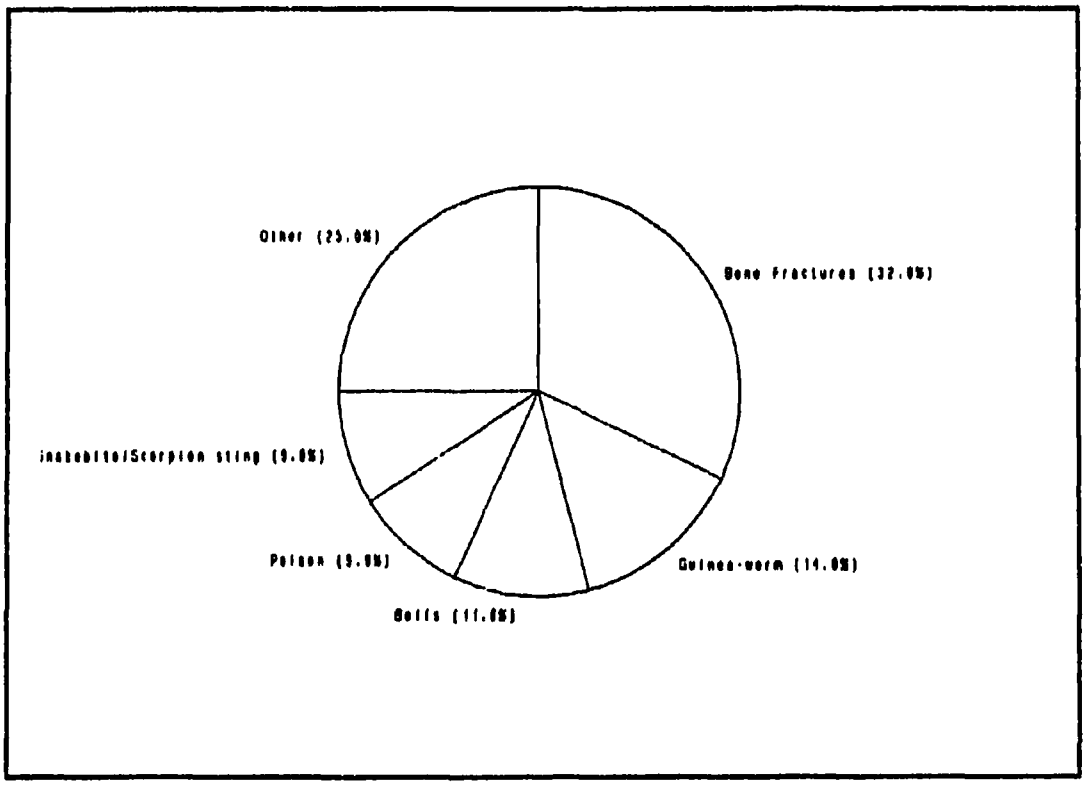
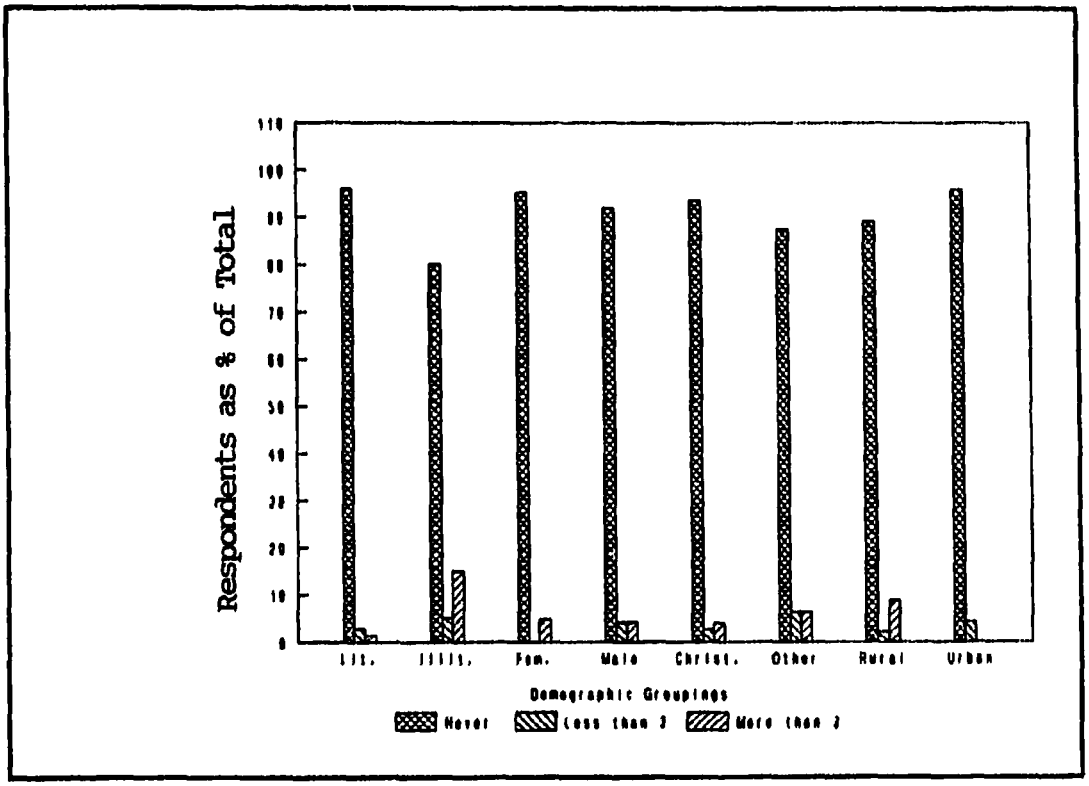
[6] For more information on these questions, see sample questionnaire in Appendix B.

Figure 5 Illnesses Most Frequently Treated by Traditional Practitioners



From figures 6 & 7, we know that neither modern practitioners nor traditional practitioners do much referrals across systems, but the modern practitioners seem to do slightly better in that regard than the traditional practitioners. While the numbers indicate that both types of practitioners may refer to each other some of their patients, especially when faced with a situation beyond their control, this practice is rather limited. One could infer from this limited scope of referrals either that both types of practitioners are competent in their respective domains or that there is such rivalry between the two camps that they only choose to refer patients in really extreme cases. It is difficult to draw a conclusion either way based on our questionnaire. There is even a third way of interpreting this limited scope of referrals, related to the very use of the term "refer" in the questionnaire.

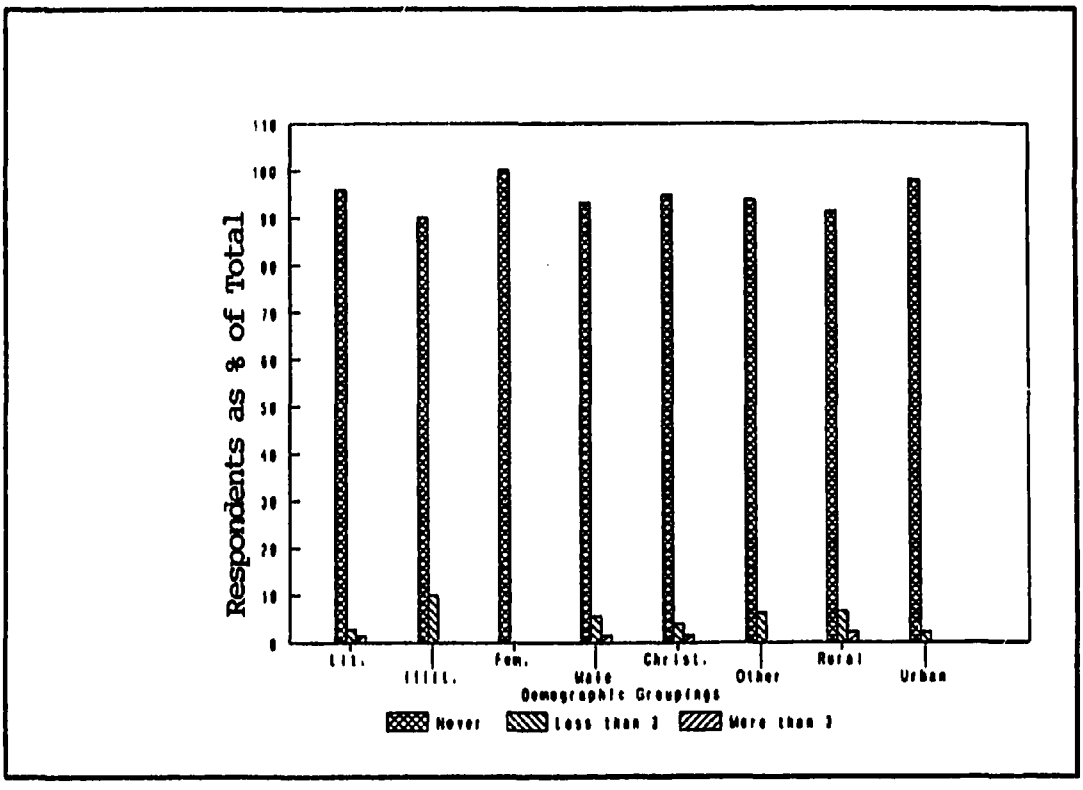
Figure 6 Frequency of Referrals by Modern to Traditional Practitioners



I was unaware, at the time of formulating the questionnaire, of a technicality which was pointed out to me by a member of the hospital administration in Jirapa. The use of the term "refer" was judged inappropriate by the hospital personnel, who explained that, technically speaking, they are prohibited from "referring" patients to traditional practitioners. However, they may "advise" a terminally ill patient, for example, for whom no cure is available, to seek the expertise of "other" practitioners. Since the only "other" practitioners around usually are the traditional practitioners, they need not be identified by name, as such explicit reference to them would constitute a violation of the hospital's code of ethics.

There is therefore some latent rivalry between the two systems, which the formal health system enforces through administrative procedures. Whether the traditional

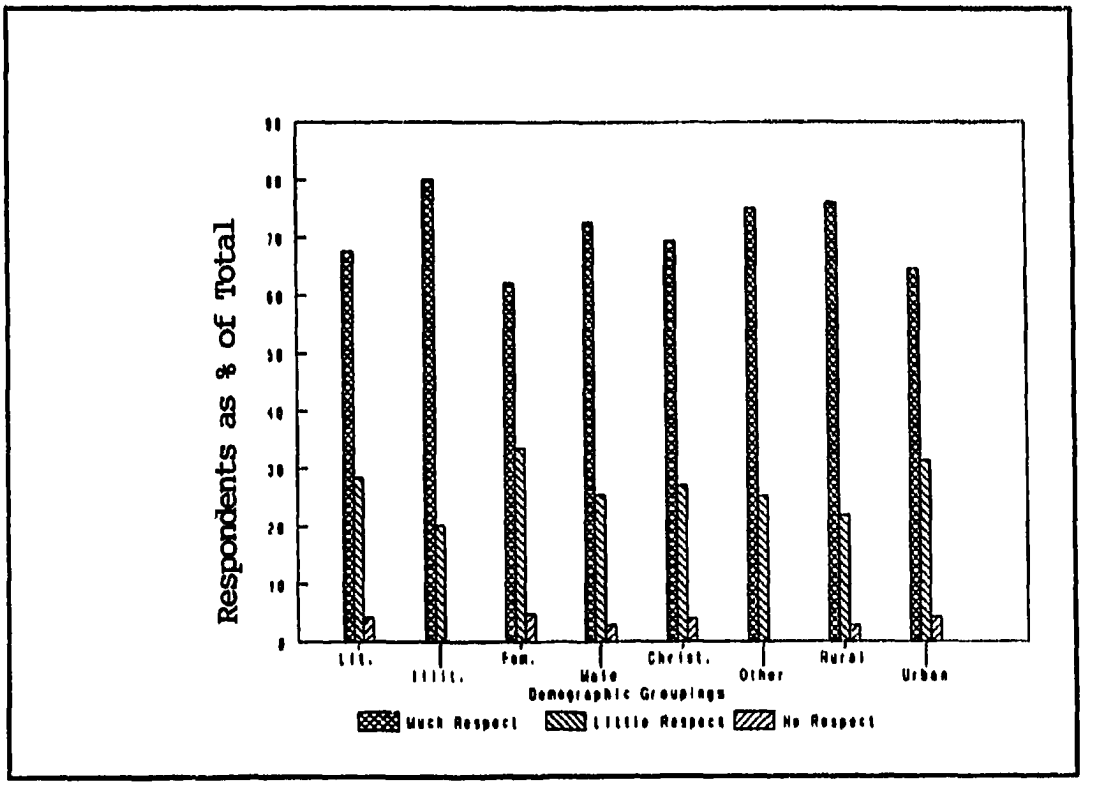
Figure 7 Frequency of Referrals by Traditional to Modern Practitioners



medical system is aware of and/or even consciously participates in this antagonistic relationship is a question that I have not been able to clearly answer. However, there has been more lip service paid to the provision of alternative health services than real policy measures taken to effect such provision of alternatives, when the government decided to "revitalize" the traditional medical system by placing it under the umbrella of the very formal health establishment that clearly despises a working relationship with traditional medicine.

Another way of finding out Ghanaians' perception of traditional medicine was to ask them about how much respect they thought that traditional medicine enjoys from members of their communities. Figure 8 reveals that only a very small proportion of respondents believe that no respect is accorded traditional medicine in their communities.

Figure 8 Respect for Traditional Medicine in Community



Up to 80% of the illiterate population, as opposed to 68% for literate population, believe that much respect is accorded traditional medicine, while 65% of urban dwellers, as opposed to 76% for rural dwellers, hold the same belief. The belief that the traditional medical system enjoys much respect in the immediate communities of respondents is overwhelmingly strong. It makes one wonder why there should be so much respect for a system from which the very people make every effort to distance themselves. Respondents were probed for answers and these were some of the reasons they provided.

Of those who said little respect is accorded traditional medicine in their communities, explanations include such factors as the overshadowing of traditional medicine by modern medicine in terms of effectiveness in treating many types of illnesses, the latter's ability to rightly diagnose diseases; the money-conscious, as

opposed to the patient-conscious nature of some traditional healers; the fact that most traditional healers are only known by the people around them; and the fact that the spread of christianity and formal education makes those so affected feel uncomfortable with the spiritual aspects of traditional medicine. Explanations for why they think traditional medicine enjoys this high level of respect include (in decreasing order of frequency): (i) the ability of traditional medicine to treat certain kinds of illness faster and better than modern medicine; (ii) the fact that traditional medicine has been effective in most cases; (iii) the fact that traditional medicine is the oldest medical system the people are more familiar with; it is also considered to be in line with their belief system, according to which illness is caused by evil spirits, and traditional healers also take care of the spiritual aspects of the patient; (iv) the fact that traditional medicine is less costly and more available than modern medicine and hence very helpful to the people.

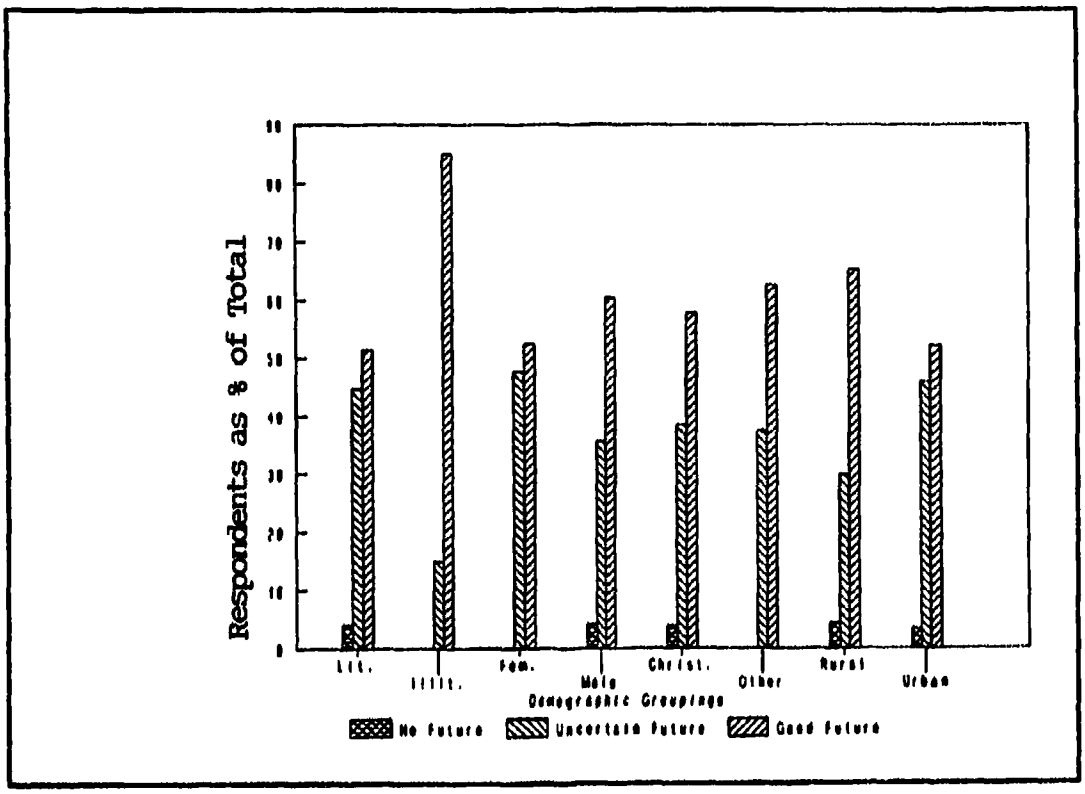
Noteworthy are the two very different perceptions held by the two groups - namely those who think it is accorded little respect versus those who think it is accorded much respect in their communities. This is an illustration of the two-sided nature of the traditional medical system; it has within it both the good and the bad. When people engage in what experts in Human Resources Management (such as Quin and Cameron, 1988; Smith and Berg 1987) term splitting, they tend to see only one side of the picture. The result is that polar groups are formed around the extreme negative or positive aspects of the issue, as exemplified by the two opposed perceptions just described. An effective way to resolve the split and encourage the use of the traditional medical system will be to persuade the two groups to think paradoxically, in other words to understand that the

presence of "bad" does not necessarily mean the absence of "good" and vice versa. This is something a mass media public campaign can easily embark on, with the right political will.

Given the fact that traditional medicine is believed to be so much respected, and yet none of the respondents was ready to openly accord it priority over modern medicine, it was unclear to me what the future prospects of traditional medicine would be in Ghana. This question was directly asked in the questionnaire and answers to it are reported in the next section.

3.2. The Future for Traditional Medicine in Ghana

Figure 9 Future of Traditional Medicine in Community



The future of traditional medicine in Ghana was generally rated as good by a

greater proportion of respondents, and most especially so by the illiterate and rural respondents, as shown in figures 9 and 11. A small proportion ($\leq 4\%$) believe that there is no future at all for the traditional medical system in the community, while the proportion of respondents who believe that the future of traditional medicine in the community is uncertain also remains fairly high, and especially so among the female and urban respondents (48% and 46% respectively vs. 36% and 30% for the males and rural dwellers).

History has shown that traditional medicine has had hard times since the arrival of modern medicine. It seems to be gradually regaining recognition. The areas showing most progress are those in which the Government provides some material as well as verbal support. One of those areas is the training of traditional birth attendants (TBAs), a program supported by foreign donors and ear-marked for expansion in the near future (Government of Ghana, 1989). It is the only field which has significant national support, both materially and verbally. Another field which has the potential to become more articulated in future is the development, promotion and utilization of herbal drugs in the health care system, although this will not be without a lot of difficulties. As the Ministry of Health (1988) has observed, "though there is scientific evidence that a number of herbs are efficient in the treatment of many conditions, practitioners of orthodox medicine have been very slow, if not reluctant, in applying this knowledge." As noted earlier, this reluctance may be the tip of the iceberg (with respect to the lack of trust and cooperation) of a sour relationship between the traditional and modern medical systems.

3.3. Perception of measures to protect traditional medicine

As has been mentioned earlier, there has been an awakening of awareness of the potential role and contribution of traditional medicine in Ghana since independence. This post-colonial development has its roots in both Kwame Nkrumah's efforts to promote the activities of traditional healers and the international community's (especially WHO's) awareness of and support for national policies geared towards exploring the potential of traditional medical systems in Africa and the third world as a whole. By the 1970s it had become clear to policy makers that western medicine is not only too expensive and out of reach to the majority of rural poor, but that there is enormous human resource in traditional medicine that could be exploited to complement western medicine. A model to capture this rapport could look something like figure 10. The Ministry of Health makes medical supplies available to both traditional and modern medical systems, which share medical facilities, where possible, but train their own personnel and practitioners. Each sub-system however specializes in the provision of those medical services in which they have a relative advantage in terms of efficiency and cost management. For example, the traditional system would cater to the bone-setting needs of the people, while the modern system would take up surgery, etc.

In Ghana, the complementarity of the modern and traditional medical systems has been echoed officially through such national policies and programs[7] as: (i) the Primary Health Care Program (PHC); (ii) the training of Traditional Birth Attendants (TBAs);

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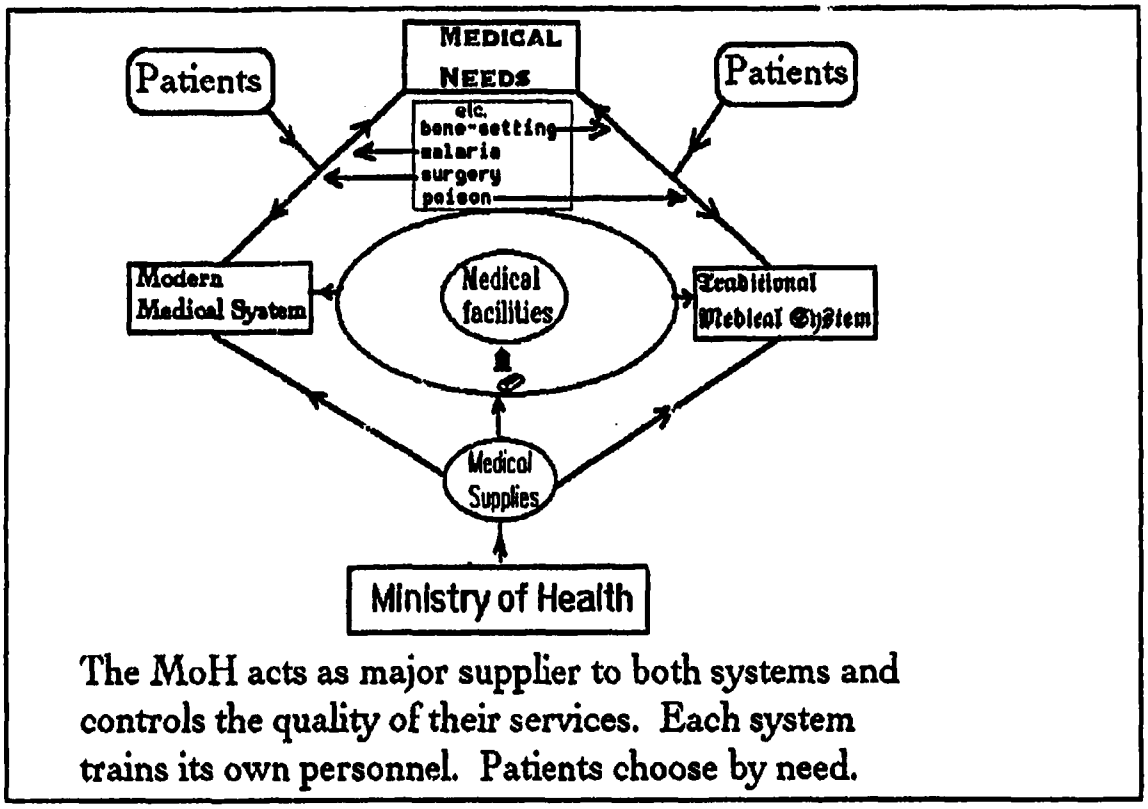
[7] Details on these policies and programs have already been discussed in preceding sections of this paper.

Figure 10 Model of Cooperation: Modern and Traditional Medical Systems



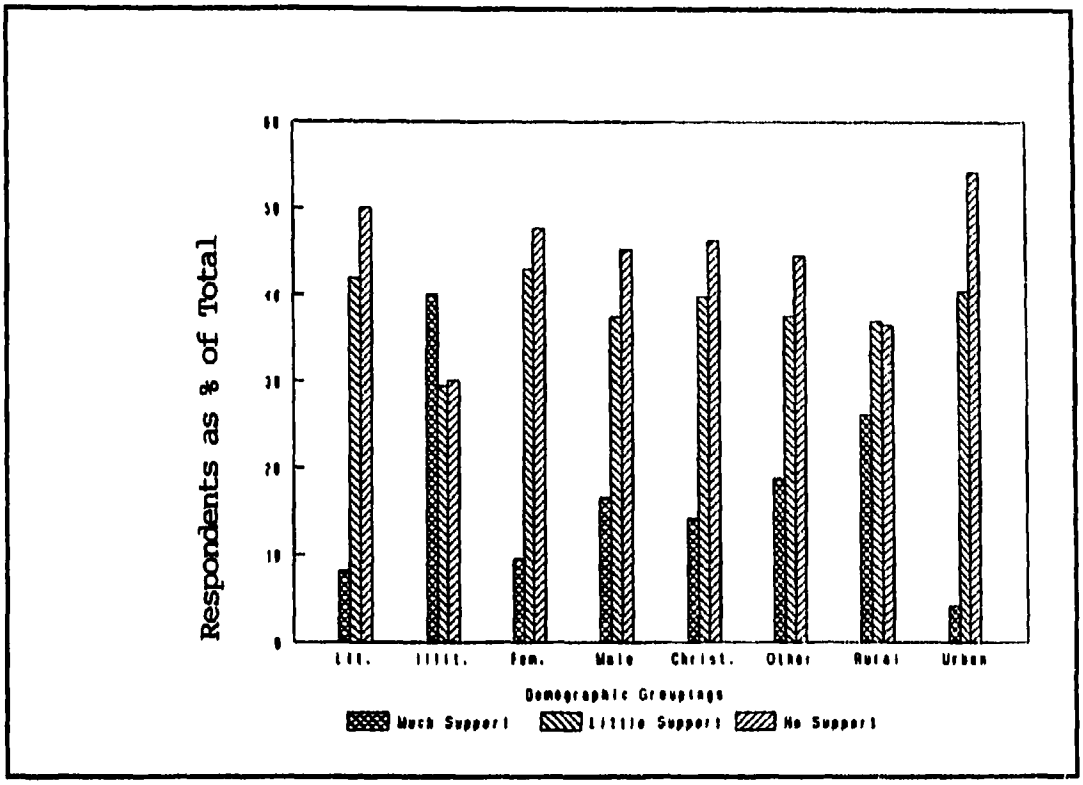
(iii) the Primary Health Training for Indigenous Healers (PRHETIH) program; (iv) the establishment of the Center for Scientific Research into Plant Medicine (CSRPM) and (v) the recent projects in the building of clinics for traditional bone-setters.

The respondents were interviewed on their awareness of the existence of any such support in their communities and in Ghana as a whole[8]. Figures[9] 11 and 12 summarize their responses. Awareness of support at the community level was highest among the illiterate and rural populations, who thought that there was much support for traditional medicine. The literate and urban populations, on the other hand, thought there was little

[8] See Appendix B for details on the specific questions that were posed.

[9] See corresponding questions (10 and 11) in appendix B.

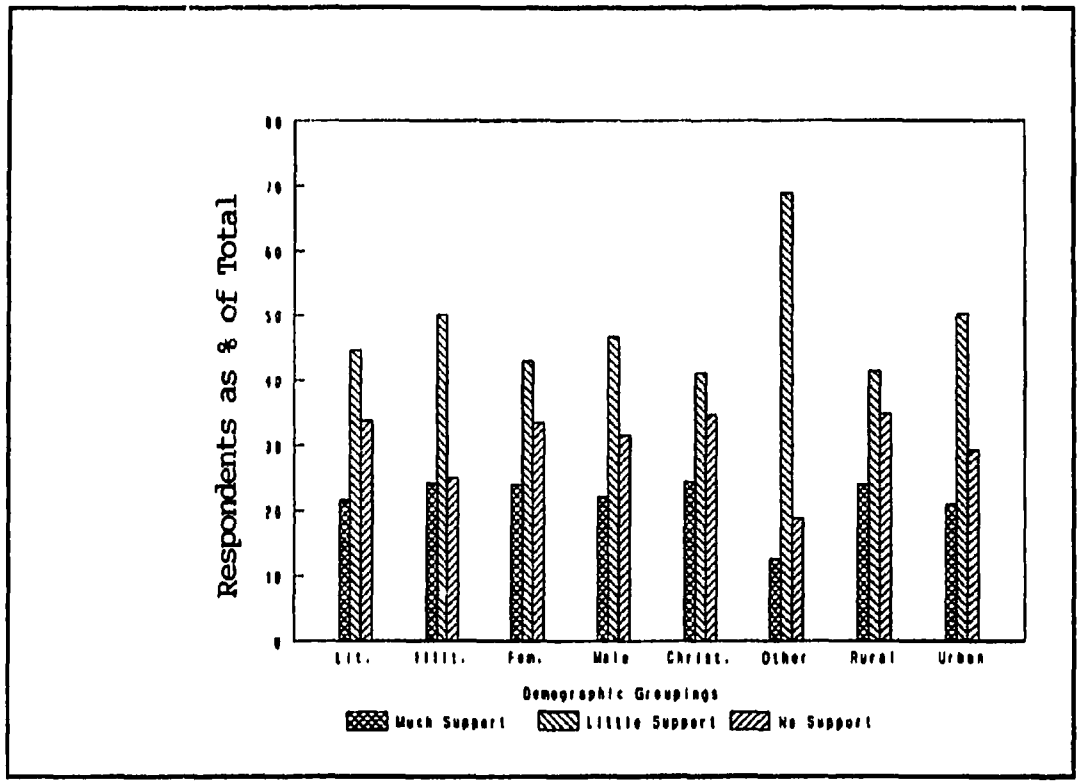
Figure 11 Support Programs for Traditional Medicine in the Community



or no support at all. Some of the urban participants were clearly not well informed of the existence of such support, even though the support was there to a noticeable extent. The rural literate participants on the other hand were generally very well informed of the amount of support given, but were dissatisfied with the amount of support and felt that more could be done by the government. A participant from the christian urban literate group mockingly made the following statement which probably sums up the general attitude of members of his category: "traditional medicine ... is for traditionalists. I'm not traditionalist enough to bother about it."

Support for traditional medicine in other parts of Ghana was generally rated as either non existent or of little significance. In general, there is an acknowledgement of the existence of some support, which makes the question of how successful they feel such

Figure 12 Support Programs for Traditional Medicine in the Country



support has been in helping traditional medicine make an impact on the lives of people an interesting one to investigate. Figure 13 provides an answer[10] to the respondents' perception of degree of success of the support given to traditional medicine.

Asked how successful such support has been in making an impact on the lives of the people, the illiterate population, followed by the rural population, thought the support has been very successful, all other groups thought that the support has only been moderately successful. Women believed either that the support was moderately successful or that it was not successful at all.

Some of the reasons given for the failure of outside support to make an impact include: (i) hindrance from modern medical practitioners; (ii) the illiteracy of traditional

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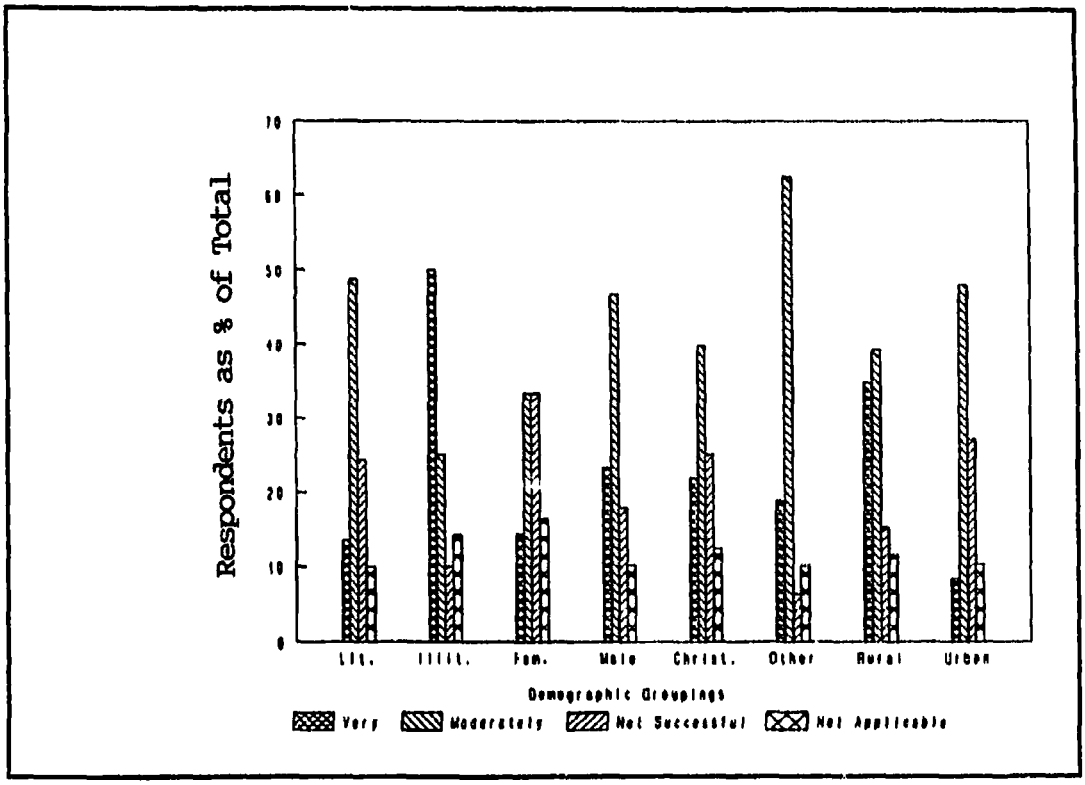
[10] See question 12 in appendix B.

Figure 13 Success of Programs as Perceived by Respondents



practitioners, which makes them lack a systematic, accurate and therefore more reliable approach to treatment of patients; (iii) the secrecy factor in traditional medicine; (iv) the fact that the support does not reach the people it is meant for; (v) the fact that it takes time for government policies to have an effect on the majority rural population.

Those who thought the support was successful said the success might have been due to: (i) the recognition and popularity of traditional medicine; (ii) the co-operation and understanding between the two medical systems; (iii) provision of buildings to accommodate patients, and of pain-relief tablets and bandages to traditional practitioners; (iv) improvement in the skills and confidence of traditional birth attendants. It would appear from this picture that the programs have had a mixed impact on the people. Those who think that the programs have been considerably successful in reaching out to

the people and making a change in their lives see a great deal of cooperation between the two medical systems, while those who think that there has been no success perceive much animosity between the two systems.

3.4. Other Socio-Economic Factors Influencing Perceptions

Disparities in perception, as noted between members of the same category, seem to indicate that beyond the eight broad socio-economic factors closely examined by the survey, other factors may be of significant influence. While literate urban dwellers generally have little or no knowledge of developments affecting traditional medicine, those in the rural areas were, in general, very well informed about such development. In fact, many literates in the rural areas play a major role in pressuring the government to develop the health care delivery system in their localities, a reason for their higher level of awareness. The structure of benefits by locality and professional category within the nation seems to be a factor which explains the diversity in perceptions.

People's personal experiences with one aspect of the medical system or the other also influence their perception. A striking example of divergent perceptions of the traditional medical system, which seem to be explained by personal experiences with the latter, is given by the following opinions on the future of traditional medicine: Participant A, literate christian teaching in a rural elementary school who broke his rib during a soccer match and was told in the local hospital that it would take more than three months of hospitalization before he could be considered cured, chose to accept the hospital treatment all the same because he had more confidence in the level of hygiene

he would enjoy there. He had been told that the traditional bone-setters have a more effective treatment and that it would take only three weeks for their treatment to be completed. He however turned down the traditional treatment option. He writes the following comment about his experience under item 18 of the questionnaire: "After three months in rigid caging, my chest almost got rotten from the heat. There was a big lump at the point of the fracture when the caging was removed. I thought I would have to live with it for the rest of my life. But look at me now! I'm all straight and smooth, thanks to the traditional bone-setters. They broke my rib again and reset it using their own methods. The infection I had feared never occurred. That is why I fight so hard to have the health and state officials invest in those traditional health services which work. Bone-setting is one of those, and I am proof that it works." I take this comment as a strong endorsement of traditional medicine from a literate Ghanaian. It contrasts with the following comment, which has been cited earlier, also from another literate Ghanaian: "traditional medicine ... is for traditionalists. I'm not traditionalist enough to bother about it." Given the impact of personal experiences on perception, it may serve no useful purpose for one to try to lump all people into limited socio-economic categories as has been done in this study. Therefore, generalizations on views expressed by members of any socio-economic category must not be interpreted in any exclusive way.

Chapter 4

Implications for Health Policy in Ghana

Although the survey shows that traditional medicine has the potential of being a complementary health resource, there has been inertia, both at the national and community levels, which prevents quick and innovative measures from being taken that could speed up the process of unleashing this potential. There have been highly publicized official efforts to organize and mobilize traditional medical resources and to link them with modern medicine for the economic and social progress of the country. However, there is much uneasiness in the rather ambiguous rapport which the state officials seem willing to forge between the modern and traditional medical systems, uneasiness which stems from attempts to put new wine in old skins.

Hospital personnel, for example, still stand in violation of the ethics of their profession if they should refer any of their patients to the traditional medical system. This code of ethics was in existence during the colonial period, when traditional medicine was outlawed, and has not yet been changed. The maintenance by the official health machine (modern medical system) of a code of ethics which is hostile to a harmonious, cooperative rapport with the traditional medical system clearly betrays the lip service that officials are paying to the revival of the traditional system. This is one example of an ambiguous attitude displayed by officials, and which tends to perpetuate the long-held stereotypes and prejudices against traditional medicine. Moreover, when a placebo effect is not attributed to some of the harmless practices of traditional medicine, the latter are

usually taken to be a manifestation of ignorance, superstition and quackery.

4.1. The Two Medical Systems: Identified Strengths and Weaknesses

Fako (1985:191) explains that African healing strategies have not been properly understood because of continuing pent-up suspicion and prejudice, which has been supported by modernization theories of development. These theories have tended to be hostile towards what they have poorly defined as traditional societies and tradition in general, suggesting that African traditional ways and thought (traditional medicine inclusive) have been and still are particularly lacking in objectivity and systematic pursuit of knowledge. He points out that as a result of this official denigration African traditional medicine had to contend with an underground, illegal, subordinate status vis-a-vis Western medicine, since the latter had not only the official backing, but also the economic backing to sell itself. Moreover, modern medicine had brought dramatic improvements in both the treatment of illnesses such as infection, poisoning, injury, and nutrition, personal and environmental hygiene, those conditions in which material factors play a major part in the etiology. This dazzling success of modern medicine in such limited areas, coupled with the stigmatization of traditional medicine, further blinded people to the limitations of the former.

It is therefore not surprising that the only weaknesses of modern medicine, as identified by responde include its inability to treat illnesses having their origins in witchcraft and poisoning, and its being expensive and inaccessible. In terms of strengths, modern medicine is known to be hygienic, to have access to scientific facilities and tests,

and to diagnose and prescribe dosages accurately. Traditional medicine, on the other hand, is commended for being effective, yielding quick results in the treatment of fractures, witchcraft and poison, and for being the oldest and most familiar health system which remains relatively cheaper and more accessible. Its role as part of the African cultural heritage was also mentioned by a number of literates and presented as a factor that should not be disregarded. The weaknesses of traditional medicine, as identified by respondents, include its unhygienic nature, its lack of modern facilities and the inaccurate diagnoses and dosages of which practitioners are habitually guilty.

These identified strengths and weaknesses of the two systems singularly highlight their complementarity, which, in terms of health policy, ought to bring about a balance in the amount of attention, both budgetary and organizational, that both systems are given. This has not, unfortunately, been the case. The national health policy is still firmly and exclusively more favorable to modern medicine and focuses on the provision of capital-intensive facilities for curative purposes. For example, Bannerman (1983:319) reported that the National Health Planning Unit of Ghana stated that at least 70% of the population did not have easy access to the formal health care system. Yet over 75% of the population live in villages that accommodate between 500 and 5,000 people. The health budget represents about 3% of the total government budget and 88% of that amount is used for curative, as opposed to preventive services. Only 1% of the country's total population of an estimated 15 million has access to the specialist services on which 40% of the health budget is expended. The other 45% of the health budget spent on hospital and clinical services caters for only 9% of the population, while the

remaining 90% of the population are left with only 15% of the health budget. Not only does this result in poor health service delivery, but it also produces a situation in which traditional medicine is repressed and left lacking in the scientific facilities required for it to effectively serve as a complementary medical system in meeting the changing needs of the people. This trend can be changed in order for the traditional system to attain its fullest potential as a cost-effective and reliable source of health service.

The strengths of traditional medicine, as identified by the respondents, indicate that the present programs on traditional bone-setters and TBAs should be taken more seriously at the policy-making level since it is an area in which the complementarity of the two systems is most clearly outlined. This can be done, in my opinion, as outlined in figure 14 below. Although the idea of further developing the linkages of traditional medicine and bio-medicine has an inherent appeal, the establishment of these linkages is proving to be difficult. It requires not just budgetary and organizational resources but also a coordination of effort and ideas between the "planners" and the "planned for." Health policy makers may therefore find it useful to review some of the factors, as identified by the people, that can inhibit the present co-operative approach to the medical systems in Ghana, and consider these inhibiting factors in relation to some of the people's suggestions on how they could be eliminated. The next section is an assessment of some of the problem areas, as identified by the people, some solutions proposed, and their implications for national health policy.

4.2. Some Solutions to Problem Areas in the Co-operation Process

One of the problem areas, as identified by respondents, is hindrance from modern practitioners of the support programs that attempt to establish co-operation between the two systems. This problem has also been documented by other researchers in other countries, including Cosminsky (1983), Leslie (1983), Good (1987). In the case of Ghana, this survey has revealed that traditional healers are willing to incorporate aspects of modern medicine in their practice. For example, traditional bone-setters are willing to use bandages in place of their traditional mats or tree barks for rigid support of the fractured member. There is no evidence, however, of modern medical practitioners showing any willingness to incorporate aspects of traditional medicine into their practice. This attitude on the part of the modern medical practitioners could be a by-product of "cultural imperialism," or what Kleinman (1980) has called "trained incapacity," by which he meant that "professional socialization of modern health professionals causes them to regard their own notions as rational and to consider those of patients, the lay public, and other professional and folk practitioners as irrational and unscientific . . ." (Kleinman, 1980:56-57). It is probably a combination of both. What this implies in terms of health policy in Ghana is that for any successful co-operation to exist, there must be a change in attitude among the professionals from the two systems. Education will take on this task.

A course on the Ghanaian ethno-medical system should be introduced into the curricula of the medical schools and nurses training colleges. A knowledge of some of the underlying political, economic, social, and historical issues leading to the

marginalization of traditional medicine could enable them rethink traditional medicine and deal with some of their prejudices. The experience of the Chinese medical system is proof that this is possible. The fact that it took a revolution to change this attitude of the modern professionals in China, however, shows that the task is not an easy one, and that only strict policy measures and a firm commitment to them can change the situation. Again, education is needed.

The secrecy factor in traditional medicine was mentioned as a hindering factor in the co-operation process, although secrecy need not be viewed as being necessarily a hinderance. Ademuwagun *et al.* (1979) also report that many African doctors and other members of the official health establishment frequently refer to the "secrecy" factor in traditional medical practices and use it as a rationale for avoiding contact with the work of local healers. Such secrecy does exist in a varying degree and, to some extent, probably discourages interaction between traditional and bio-medical practitioners. However, Ademuwagun *et al.* (1979, pp. vii) attempt to explain the logic behind this secrecy by pointing out that most African healing systems have not been formalized in print, a step which could open up their principles to outside scrutiny. Secrecy then could be viewed as the "traditional patent," or the most readily available means for traditional practitioners to safeguard their knowledge from being usurped. Some respondents have even defended secrecy by arguing that part of the ethics of many African healing systems is secrecy; this protects the society against the indiscriminate use of such medicines by certain individuals. There is no doubt that such secrecy also reflects the fact that the knowledge of indigenous medicines can be an index of one's power and influence in

society. Just as western practitioners of medicine guard their profession through tedious methods of registration and induction, so does the African traditional medical class obtain the same protection through secrecy. Unfortunately, the success of that secrecy has resulted in a serious blow to the credibility of the entire traditional medical system. Many people, including many urbanized "western-educated" Africans, deny the existence -- not to mention the efficacy -- of indigenous African medicine, about which they have often heard, but of which they have had little formal knowledge. Some education of the public and health officials on the rationale behind secrecy, and a reminder that the modern medical system is not any less secretive, could help in changing attitudes. Legislation may also be necessary to enable the granting of intellectual property rights and patents to traditional healers based on criteria other than the application of "scientific method." Yet another perspective on secrecy is presented by Good (1987), who revealed that traditional healers do share professional knowledge *"when respect for their integrity and a genuine desire to learn from them are communicated."* (emphasis mine). Secrecy may therefore sometimes be nothing more than the traditional practitioners' way of responding to insincere overtures from intruders. In any case, as Koumare (1983) rightly indicates, the surrender of the traditional psychiatrist's "secrets" should on no account be a condition for collaboration.

The problem of distribution of resources and facilities, which results in the support not reaching the people for whom it is destined, was also on the respondents' list of problems. Such inefficiency is not the exception but rather the rule where government agencies are responsible for any distribution efforts. This problem could be eliminated

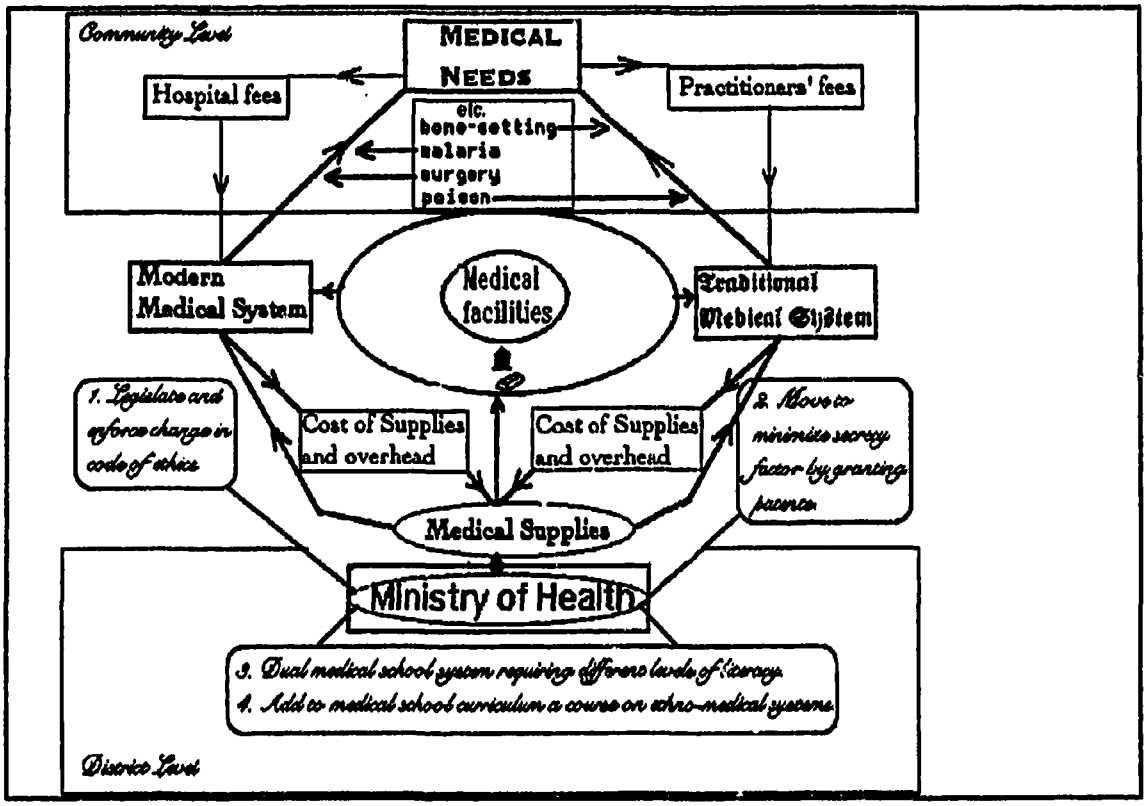
through the formation of a non-governmental agency with branches all over the country, which will be reaching out to the people, involving them in the decision making process, and planning the projects and programs with them but not for them.

A leitmotif echoed throughout the research by respondents was, "the government should . . . " This is an indication of the extent to which people are relying on the government to take initiative. It also shows how the people define their role as one of passiveness, where "the rest of us" (the public), as opposed to "them" (the government), are powerless. This mentality could be changed through educating the public on the various ways in which they could improve on their situation with the available resources, without being dependent on the government.

4.3. Scope of Action and Some Areas of Emphasis

The problems highlighted and some of the solutions proposed by participants, together with my own additions, provide a framework for action, represented in figure 14. In this framework, the Ministry of Health (MoH) will be invested with authority to oversee and coordinate the distribution of medical facilities and supplies, channeling them to both the modern and traditional medical systems. The MoH will also implement a two-tiered medical school system, one for traditional medical practitioners requiring minimal or no literacy at all and the other for practitioners in the modern medical system, where a high level of literacy is required for its efficient operation. Although literacy is not and has never been a necessary ingredient for the efficient operation of the traditional medical system, it has served as a reason and justification for the

Figure 14 Integrating the Modern and Traditional Medical Systems



marginalization of traditional medical practitioners. The two-tiered medical school system being recommended in this plan purports to bridge the literacy gap between the two systems and set up a common ground for dialog. The two medical systems can indeed operate efficiently in spite of differences in required levels of literacy, a fact which the national health establishment needs to acknowledge in order to tap the resources of the traditional medical system. The modern system will add a course on ethno-medical systems to its medical school curriculum, while the traditional medical school will mandate functional literacy in the first Ghanaian language of the practitioner. These steps will contribute to improved dialog between the two systems and possibly lead to greater mutual respect.

The Ministry of Health will also legislate and enforce change in the code of ethics

for the modern medical system, so as to enable modern practitioners to make referrals to their traditional medical counterparts, and vice versa. Furthermore, the MoH must move to reduce the secrecy factor characteristic of traditional medicine, by granting patents and licenses to the traditional medical practitioners based on evidence of curative successes and not on the basis of familiarity with or application of "scientific method", a literacy-biased criterion of selection.

Medical supplies received by each system will be paid for through the patients' contributions to maintaining the health system in the form of either practitioners' fees or hospital fees. With both systems specializing in what they treat best, it is hoped that rivalry between the modern and traditional systems will be reduced, while the patients get the best of care. Particular emphasis must be laid on the following areas.

(i) Education and Conscientization

For any change in the status of traditional medicine to occur, there must be the political commitment to undo the stigma attached to traditional medicine. This can be achieved through public education of the people on the origins of the stigma. If this awareness is created at all levels and people no longer feel reluctant to admit publicly to being pro-traditional, traditional medicine will enjoy greater patronage, and the inertia in the programs on traditional medicine at the national and local levels would cease to exist, or at least be greatly reduced.

What the average Ghanaian may not be aware of is that until the beginning of the nineteenth century all medical practices were what we now call traditional. It was from

then on that the great philosophical upheaval of the renaissance began to introduce Cartesian scientific materialism into all human activities and notably into the theory and practice of health care. The new way of looking at things subjected all assumptions to experiment and statistical validation, and foresaw the future in terms of research and organization. Of necessity, it introduced doubt where previously there had been belief; it emphasized intellect and logic and belittled emotion and intuition.

The application of scientific method to medicine and public health brought dramatic improvements in all those conditions in which material factors such as infection, poisoning, injury, nutrition or personal and environmental hygiene play a major part in the etiology. In degenerative conditions, however, the results have been less striking, and in conditions where behavioral, emotional or spiritual factors play a major role, it would be difficult to argue that the scientific method has produced noticeable improvements. Traditional medicine seems to take care of the behavioral, emotional and spiritual dimensions of the being, thriving in general on its holistic approach to health care.

The official backing which crowned the application of science to individual and social well-being blinded most people to its limitations. Today, it is precisely in societies which have a long experience of scientific medicine that a serious reawakening of interest in the emotional, spiritual and irrational aspects of health is expressing itself by the rediscovery of local traditional practices from abroad. For example, it is not uncommon these days to see T.V. commercials on the African Tora and the Psychic Hot-line in the U.S. If the average Ghanaian were aware of these changes all over the world, he/she

would probably remove the stigma attached to traditional medicine, knowing why and how it came about. This could effectively be done with the help of the media in Ghana, for even the most remote of villages now has access to some source of information, either from the GBC T.V. or radio. Similarly, the health officials and decision makers should be constantly reminded that unless a different approach towards traditional medicine is adopted, they will not only be faced with a bigger burden of importing modern/western expertise and facilities in the near future, but also of having to import the equivalent of the current traditional medical resources (both human and herbal) that they already have. On the other hand, quick dedicated steps could lead to not only the preservation of the much needed foreign exchange, but also to earning some from the exportation of the local medical resources.

Bannerman, Burton, & Wen-Chieh (1983:241) acknowledge that not all of the traditional therapeutic methods practiced in Europe are of European origin. *Acupuncture,* as practiced in the West, they point out, has its roots in China. From the 19th century onwards, it has been popular for some time in France, in other European countries such as Austria and Germany, and in Scandinavia. The interest in acupuncture has diminished somewhat in the present century. For many years it was considered in Western countries as "superstition." Following intensified contacts with China in the late 1960s and early 1970s, the use of various forms of acupuncture in surgery received wide publicity by mass media. Acupuncture is now more tolerated and partly accepted by official medicine. It is claimed that there are over 5,000 acupuncturists in Europe. This shows that what may be looked down upon today may not necessarily be as bad as it may be made to

appear. Traditional medicine, despite its imperfection, needs to be reevaluated and revalued for what it has to offer.

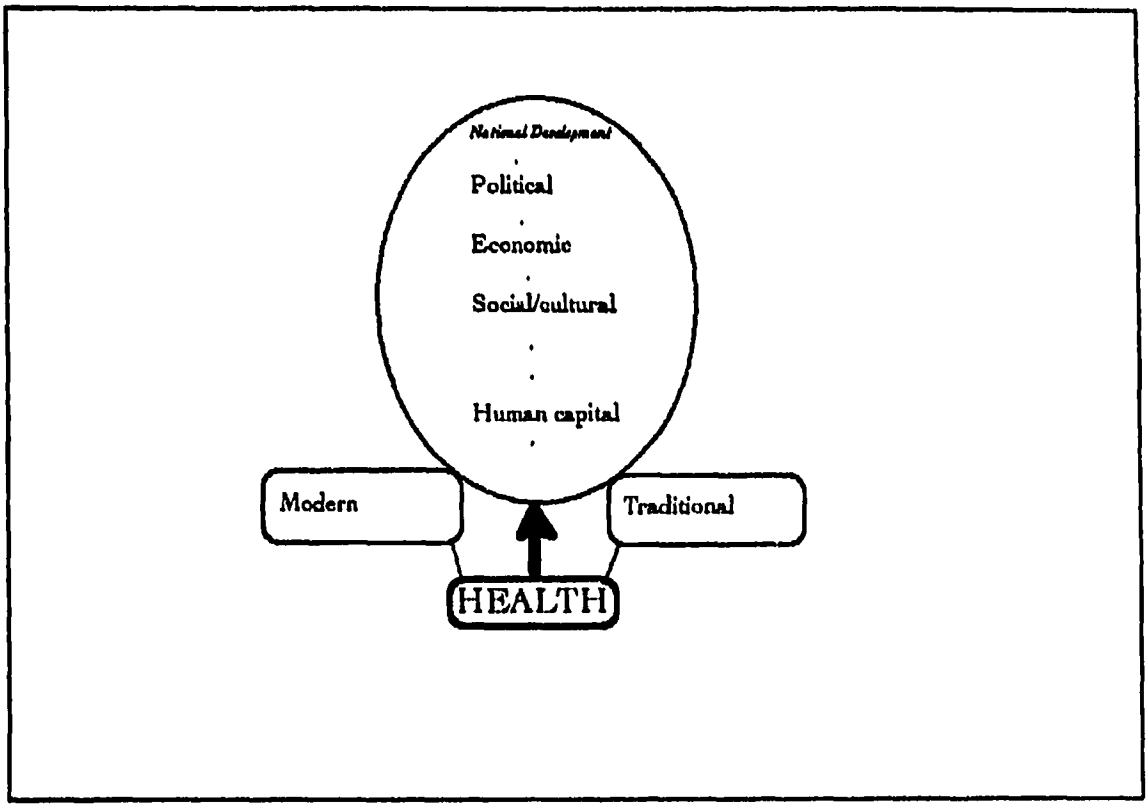
The world is becoming a global village and values are changing. Even the British, who frowned upon Ghanaian traditional medicine in the past, are now importing forms of its equivalent from Asia. For example, due to the large numbers of immigrants from Bangladesh, Pakistan, and Moslem areas of India, traditional practitioners of the Unani system of medicine have established themselves in Britain. It is estimated that there are about five resident "hakims" in every city of Britain with a large Asian immigrant community. Some "hakims" fly to Britain for temporary consultations.

(ii) Social and political Aspects: Women and Development

Policy issues tend to be interrelated at the macro level, and health policies will undoubtedly affect other aspects of the life of the entire population in different ways. Recognizing these interrelationships, Myrdal cautioned against the oversimplification of our understanding of health, which would tend to isolate the latter from other socio-economic, institutional, and related factors of development, as is sometimes done in health planning, particularly in the design of analytical models for health planning.

Myrdal maintains that planning for better health, more than any other type of planning, must proceed by an intuitive process, wherein information from various sectors, together with informed estimates, are fitted to the outline of a strategy. In that process the certainty that social conditions are interdependent will lead the planner to attack the problem on the broadest possible fronts; specifically, he will seek to combine

Figure 15 Health and National Development



a number of mutually supporting policy measures. This implies that, rationally, the health problem becomes integrated into the general problem of planning for development. Figure 15 captures this enlarged vision, integrating the political, cultural, economic, social and medical aspects of development into a model of development which enlists the contribution of the traditional system. Thus, it is important for health that agricultural production, for example, be increased, that education be improved, and even more generally, that the "masses" be lifted out of poverty. Figure 15 depicts the notion that good health is the fuel of national development, lifting up the baloon of national development which finds its balance through the wings of both the traditonal and modern systems.

The investment approach to development tends to ignore the fact that institutional

and attitudinal reforms, which depend on political decisions rather than on budgetary considerations, are needed to make investments in health "pay off." It also tends to take into account the broader considerations that the success of health programs depend as much on the policies pursued in other fields as on the direction of the health programs themselves. An illustration of this narrow "investment" focus in health planning is the announcement of the institution of higher hospital fees in Ghana on 15th July 1985, under the then Structural Adjustment Program. The main rationale, which was to obtain revenues to sustain social services, was realized in grand style: a total of 496.1 million cedis in 1986 (about $99 million). However, the health sector did not improve financially as a result of this inflow of revenue, since no policy measures were taken to ensure the prudent use of the extra financial resources and the newly-acquired facilities, and to avoid wastage in the health sector. Moreover, the increase in hospital fees resulted in a rise in the infant mortality rates in rural areas, as the cost of using the new facilities had risen far beyond what the rural population could conceivably afford. The repercussions of the fee increase on the potential clients of the health service sector were not thought through before the policy was implemented, with the adverse consequences that it had. Therefore, if the maximum is to be achieved from any policy, it should be considered in relation to all the other aspects of the economy: social, political as well as economic.

On the socio-political level for example, the PHC, or any attempts at bringing about co-operation between the modern and traditional medical systems, for that matter, will make little if any head way, without including women in the planning and

implementation process. The now popularized saying that "if you educate a man, you educate one person, but if you educate a woman, you educate the whole nation," correctly captures this strategic role of women in development.

Some of the reasons why women should be the central focus of any plans and strategies for a change in health services, in Ghana and elsewhere, are implicit in the elements of the proposal put forward at the Alma-Ata Conference on PHC in 1978, which I quote:

> A main social target of governments, international organizations and the whole world community . . . should be the attainment by all peoples of the world by the year 2000 of the level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development . . . which includes at least, education concerning prevailing health problems and the method of preventing and controlling them; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs (WHO, 1978)

Many of the activities which contribute to a level of health that permits a "socially and economically productive life" fall quite naturally within the domain of functions that women in all parts of the world perform on a day-to-day basis. These activities include preventing illness, providing for adequate food supply and proper nutrition, being responsible for basic household sanitation, taking care of oneself and of one's children, bearing responsibility for childhood immunizations and treating illnesses and injuries when they occur, and many other health-related activities. It seems only right, therefore, that the particular needs, beliefs, and practices of women be specifically addressed, most especially in the Ghanaian society, where women are considered the natural teachers and caretakers of their children.

This can happen only when women are educated and empowered socially, politically and economically. The areas of focus for this kind of attainment should be female education, political participation, participation in the labor force, and the prevention of maternal and infant mortality. In a study[11] (in which I participated as a research assistant), it was revealed that in relation to its per capita income, Ghana is not doing too badly in catering to its women's advancement. It is also on record that the Department of Community Development, the Non-Formal Education Division of the Ministry of Education, the 31st December Women's Movement, the PAMSCAD and other non-governmental agencies are all addressing themselves to this issue. However, it should be no reason for Ghanaians to be complacent, for the majority of women in the rural areas are still untouched by these efforts and policies.

Women should be involved as full, active participants in all health systems and at all levels. To achieve the goal of "Health for all by the year 200," as set by the WHO, international development projects and activities concerning women's health must be directed to the formulation of policies that are relevant and inclusive of women. Many researchers have argued that emphasis on women's health will have a more direct effect on the health improvement in the Third World. This is essential due to the role of women in these societies as family health providers and promoters, food preparers, water carriers, etc. with the result that any breakdown in their health immobilizes the entire day-to-day well being of the family.

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[11] Ahooja-Patel, Krishna, *Gender Distance Among Countries* Working Papers in International Development, No. 91.6. International Development Studies, Saint Mary's University, Halifax, N.S., Canada, August 1991.

(iii) Legal and Economic Aspects

Since the advances in modern scientific medicine began, legal regulation of health care has followed a similar pattern throughout Europe. In other words, legislation was designed to regulate the delivery of health care as a monopoly of formally educated physicians and a few other professionals. Subsequently, even the practice of the allied and auxiliary health professions was limited to licensed persons. Since almost all the rest of the world, with the exception of China and Japan, was under the colonial domination of a few European countries, the concept of health care regulated by law as a monopoly and prerogative of licensed professions was introduced throughout what is now called the developing world, including Ghana. The motive underlying such laws was not only to ban traditional medicine, but to ensure that the type of health care provided was exclusively modern/western medicine. Traditional healers continued to practice in secret and, of course, were never commended for their accomplishments (at least not at the national and official level) but were severely penalized for their mistakes which were well publicized.

The policies for the legal regulation of traditional medicine at present can be described as tolerant. This means that, although only the modern medical system is recognized, the practice of various forms of traditional medicine, at least to some extent, is allowed to happen. The Medical and Dental Decree and the Nurses and Midwives Decree of 1972, authorize the practice of indigenous forms of therapeutics, provided that the practitioner is an indigenous inhabitant of Ghana, and provided further, that no act is performed that is dangerous to life. Subsection 2 limits the treatment of eye diseases

to practitioners of modern medicine.

Recent policies include the mandatory registration of all recognized traditional healers, who are also made to pay taxes to the nation. Although this in itself may appear to be a good step, since it leads to more effective supervision of the operations of the healers, in some cases it has had adverse effects on the health service delivery system, having led to higher fees being imposed on the clientele of these practitioners and resulted, in other cases, in traditional healers' unwillingness to renew their registration, (thereby either giving up the practice or reverting to illegality), since they cannot afford to pay the taxes due to the fact that their operations are not profitable.

In this instance, it would be beneficial for health policy makers to study the various faces of traditional medicine before implementing their policies, for although traditional medicine is usually perceived as stagnant, this study has shown that it has changed and evolved over the years. There is the need to have different policies for the different forms of practice. The urban practitioner for instance is a very lucrative business person, who can readily afford to pay taxes without going bankrupt, and should therefore be the target for taxation purposes. The rural practitioner, on the other hand, is still essentially a benevolent professional whose operations are non-profitable in scope, and usually ekes out a living from activities other than his medical practice, such as farming. The latter should therefore be exempted from taxes, if (s)he is to remain a viable practitioner.

The urban practitioner of traditional medicine will also need stricter regulations than the rural practitioner, in order to avoid malpractice and cheating in the towns and

cities, since urban environments tend to be rather impersonal and not as closely monitored by members of the community as rural environments are, probably due to the anonymity of urban life. The likelihood of charlatans corrupting traditional medicine seems to be far greater in towns and cities than in the villages.

A thriving business in traditional medicine is the sale of herbs in large towns, in the markets, and at the lorry stations. This 's certainly economically viable and risks attracting more than those who are knowledgeable in herbal medicine into the trade, a danger that needs to be checked by more stringent regulation. Vendors of herbal medicine should probably be required to operate at one location, with a permanent address to which they can easily be traced by both clients and law enforcement agents.

Another brand of medical practice that has evolved over the years is the "indigenized" version of modern medicine - the sale of all kinds of modern chemicals by people who have not been trained as pharmacists for the modern medical system. Most at times, they assume the role of the modern practitioner by diagnosing diseases and prescribing drugs to cure them, or even injecting and treating patients who cannot sacrifice their time to travel to the nearby clinic or health post. This development is possibly largely caused by the abundance of drugs from the WHO's Essential Drugs Action Program administered by the International Network for Rational use of Drugs (INTRUD). This initiative is aimed at providing affordable health care at a lower cost to people with low health service budgets. At the macro-level, the procurement of and "rational" use of "essential" drugs seems to make sense. However, the policies have been so enthusiastically and hurriedly implemented that little time was left for

investigating their impact on the people they were supposed to be serving. "Rational" use of "essential" drugs was probably not meant to include the activities of "indigenized" modern practitioners, but once faced with a *fait accompli*, one has to agree with a member of the Pharmacy Board of Ghana who, in a discussion, said that

> "If a villager develops an asthmatic attack, but can be saved by a shot of aminophline from a chemical seller, surely, this is against the law but we can't be too strict on that!"[12]

This is a good reason to develop policies that will enable the training of people, to ensure a more effective and regulated use of their enthusiasm in health practice. This could be the Ghanaian version of the Chinese barefoot doctors. The bottom line to all this, is the need to be consistent and realistic. Sometimes traditional practitioners are encouraged by flamboyant statements made by politicians into believing that traditional medicine is a national heritage which they have the responsibility of safeguarding. At the same time, little is done to abolish the more pernicious heritage of unrealistic legal and fiscal barriers put in the way of the traditional practitioner, which cripple his activities. More than a historical monument to be preserved, traditional medicine has not outlived its usefulness and continues to be a health care delivery system that has a large clandestine clientele.

Legal actions should not only legitimize the role of the traditional practitioner, they should also provide him with some foothold in the medical profession, over which the modern medical system currently wields professional monopoly in terms of medical

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[12] Senah, Kodjo A., "Why the Children Die: The Case of a Rural Ghanaian Community," Paper presented at Colloquium on Social Policy and Development in Ghana, organized by Social Dimensions of Program, Ministry of Finance and Economic Planning, Legon-Accra 12th - 13th December, 1991. (p. 12).

resources. Such legislative changes will encourage traditional practitioners to improve the efficacy of their practice and to provide for the changing needs of their communities. Traditional practitioners will be granted patents, for example, which will reduce the need for them to be secretive about their science. In the same vein, doctors and nurses will be given the professional freedom to refer patients to traditional practitioners whose healing methods are known to be more efficient than those which the modern system can provide. Mutual respect and help between the traditional and modern systems, of the kind that is being advocated here, will, in a local community, be the cornerstone of the development of an efficient and accessible health care delivery system.

Chapter 5

Conclusion

The survey has shown that many Ghanaians consider traditional medicine as a valuable component of the health care delivery system, complementing the modern scientific medicine. Although many of the people use the two medical systems concurrently when ill, and in some cases even prefer traditional medicine to modern medicine, they were unanimous in attempting to distance themselves from traditional medicine. There are qualities and weaknesses unique to each system, they agree, and only in principle, but they would rather not say much good of traditional medicine. Rather, they prefer to highlight the qualities of modern medicine, the system with which they want to be associated.

Traditional medicine has been discredited, not so much for any inherent and irremedial weaknesses that characterize it, but for not following a determined line of operation, otherwise called the scientific method. Although various attempts have been made to develop and promote the under-utilized resources in traditional medicine, there is still a long way to go in terms of providing for the basic health needs of people. The stigma attached to traditional medicine is still quite strong, and only reluctantly do respondents admit having anything to do with traditional medicine. Ghanaians will have to be educated to perceive traditional medicine in a more positive light if the latter is to assist modern medicine in the task of delivering health care to reach all as targeted by the Alma-Ata declaration of 1978.

This study has indicated ways in which greater cooperation can be achieved between the traditional and modern systems, assuming of course that there is the political will on the part of the policy makers to make such a change. It has assigned to the Ministry of Health a vital role in bringing about the needed cooperation between the two systems. The MoH is expected to make not only those legislative changes considered necessary for the attainment of this objective, but also changes in the people's attitude toward and perception of the traditional medical system through public education. Would a two-tiered medical school system foster mutual respect among all health practitioners?

Policy issues have been touched upon here, but need more profound study, an aspect which I plan to focus on when I begin work on the Ph.D. program.

Appendix A

Tables

Table 1: Choice of Medical Practitioner by Demographic Distribution

Preferred Consultant	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Traditional	0	0	0	0	0	0	0	0
Modern	38	38	49	39	47	27	51	30
It Depends	36	57	37	44	41	54	56	32
Total	74	95	86	83	88	81	107	62

Table 1a: Choice of Medical Practitioner by Demographic Distribution (in percentages)

Preferred Consultant	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Traditional	0	0	0	0	0	0	0	0
Modern	51	40	57	47	53	33	48	48
It Depends	49	60	43	53	47	67	52	52
Total	100	100	100	100	100	100	100	100

Table 2: Breakdown of Illiterate group by Sex,Religion & Demography

Preferred Consultant	Sex		Religion		Demography	
	Fem.	Male	Christ.	Other	Rural	Urban
Traditional	0	0	0	0	0	0
Modern	44	11	18	19	29	7
It Depends	15	25	21	37	51	8
Total	59	36	39	56	80	15

Table 2a: Breakdown of Illiterate group by Sex,Religion & Demography (in percentages)

Preferred Consultant	Sex		Religion		Demography	
	Fem.	Male	Christ.	Other	Rural	Urban
Traditional	0	0	0	0	0	0
Modern	75	31	46	34	36	47
It Depends	25	69	54	66	64	53
Total	100	100	100	100	100	100

Table 3: Breakdown of Literate group by Sex,Religion & Demography

Preferred Consultant	Sex		Religion		Demography	
	Fem.	Male	Christ.	Other	Rural	Urban
Traditional	0	0	0	0	0	0
Modern	5	28	29	8	15	23
It Depends	22	19	20	17	12	24
Total	27	47	49	25	27	47

Table 3a: Breakdown of Literate group by Sex,Religion & Demography (in percentages)

Preferred Consultant	Sex		Religion		Demography	
	Fem.	Male	Christ.	Other	Rural	Urban
Traditional	0	0	0	0	0	0
Modern	19	60	59	32	56	49
It Depends	81	40	41	68	44	51
Total	100	100	100	100	100	100

Table 4: Frequency of illness vs. treatment by Traditional Practitioner

Times Treated	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Never	31	19	41	28	36	15	37	24
Rarely	39	43	41	43	44	46	49	35
Often	4	33	4	12	8	20	21	3
Total	74	95	86	83	88	81	107	62

A Breakdown of the Illiterate Group

Times Treated

Never	30	5	14	12	25	5
Rarely	25	23	17	25	16	9
Often	4	8	8	19	19	1
Total	59	36	39	56	80	15

A Breakdown of the Literate Group

Times Treated

Never	11	23	22	3	12	19
Rarely	16	20	27	21	13	26
Often	0	4	0	1	2	2
Total	27	47	49	25	27	47

Times ill per year

Never	7	5	8	7	7	10	12	4
< 3 times	49	57	49	56	58	51	60	45
> 3 times	18	33	29	20	23	20	35	13
Total	74	95	86	83	88	81	107	62

Table 4a: Frequency of illness vs. treatment by Traditional Practitioner (in percentages)

Times Treated	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Never	42	20	48	34	41	19	35	39
Rarely	53	45	48	52	50	57	46	56
Often	5	35	5	14	9	25	20	5
Total	100	100	100	100	100	100	100	100

A Breakdown of the Illiterate Group

Times Treated

Never	50	13	36	21	31	33
Rarely	42	64	44	45	45	60
Often	7	22	21	33	24	7
Total	100	100	100	100	100	100

A Breakdown of the Literate Group

Times Treated

Never	41	49	45	12	44	40
Rarely	59	43	55	84	48	55
Often	0	9	0	4	7	4
Total	100	100	100	100	100	100

Times ill per year

Never	9	5	9	8	8	12	11	6
< 3 times	66	60	57	67	66	63	56	73
> 3 times	24	35	34	24	26	25	33	21
Total	100	100	100	100	100	100	100	100

Table 5: Referral patterns showing interaction between the two systems.

Modern to Traditional

Referral Frequency	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Never	71	76	82	76	82	71	95	59
< 3 times	2	5	0	3	2	5	2	3
> 3 times	1	14	4	3	3	5	9	0
Total	74	95	86	83	88	81	107	62

Traditional to Modern

Never	71	86	86	77	83	76	98	61
< 3 times	2	10	0	5	3	5	7	1
> 3 times	1	0	0	1	1	0	2	0
Total	74	95	86	83	88	81	107	62

Table 5a: Referral patterns showing interaction between the two systems (in percentages)

Modern to Traditional

Frequency of Referral	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Never	96	80	95	92	94	88	89	96
< 3 times	3	5	0	4	3	6	2	4
> 3 times	1	15	5	4	4	6	9	0
Total	100	100	100	100	100	100	100	100

Traditional to Modern

Never	96	90	100	93	95	94	91	98
< 3 times	3	10	0	5	4	6	7	2
> 3 times	1	0	0	1	1	0	2	0
Total	100	100	100	100	100	100	100	100

Table 6: Respect for Traditional Medicine

Degree of Respect	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Much	50	76	53	60	61	61	81	40
Little	21	19	29	21	24	20	23	19
No	3	0	4	2	3	0	3	3
Total	74	95	86	83	88	81	107	62

Future in Community

No	3	0	0	3	3	0	5	2
Uncert.	33	14	41	30	34	30	32	28
Good	38	81	45	50	51	51	70	32
Total	74	95	86	83	88	81	107	62

Future in Ghana

No	3	0	0	3	4	0	5	1
Uncert.	26	29	37	27	29	35	30	26
Good	45	67	49	53	55	46	72	35
Total	74	95	86	83	88	81	107	62

Table 6a: Respect for Traditional Medicine (in percentages)

Degree of Respect	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Much	68	80	62	73	69	75	76	65
Little	28	20	33	25	27	25	22	31
No	4	0	5	3	4	0	3	4
Total	100	100	100	100	100	100	100	100

Table 6a: (cont.) Future in Community

No	4	0	0	4	4	0	4	3
Uncert.	45	15	48	36	38	38	30	46
Good	51	85	52	60	58	63	65	52
Total	100	100	100	100	100	100	100	100

Future in Ghana

No	4	0	0	4	5	0	4	2
Uncert.	35	30	43	33	33	44	28	42
Good	61	70	57	64	63	56	67	56
Total	100	100	100	100	100	100	100	100

Table 7: The People's Awareness & Perception of Existing Programs

Support in the Community

Degree of Support	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Much	6	38	8	14	12	15	28	3
Little	31	28	37	31	35	30	40	25
No	37	29	41	38	41	36	39	34
Total	74	95	86	83	88	81	107	62

Support in the Country as a Whole

Much	16	23	20	18	21	10	26	13
Little	33	48	37	39	36	56	44	31
No	25	24	29	26	30	15	37	18
Total	74	95	86	83	88	81	107	62

Success of Programs

Very	10	48	12	19	19	15	37	5
Moderately	36	24	29	39	35	51	42	30
Not	18	10	29	15	22	5	16	17
N/A	10	14	16	10	12	10	12	10
Total	74	95	86	83	88	81	107	62

Table 7a: The People's Awareness & Perception of Existing Programs (in percentages)

Support in the Community

Degree of Support	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Much	8	40	10	16	14	19	26	4
Little	42	29	43	37	40	38	37	40
No	50	30	48	45	46	44	36	54
Total	100	100	100	100	100	100	100	100

Support in the Country as a Whole

Much	22	24	24	22	24	13	24	21
Little	45	50	43	47	41	69	41	50
No	34	25	33	32	35	19	35	29
Total	100	100	100	100	100	100	100	100

Success of Programs

Support in Community	Education		Sex		Religion		Demography	
	Lit.	Illit.	Fem.	Male	Christ.	Other	Rural	Urban
Very	14	50	14	23	22	19	35	8
Moderately	49	25	33	47	40	63	39	48
Not	24	10	33	18	25	6	15	27
N/A	14	15	19	12	14	13	11	17
Total	100	100	100	100	100	100	100	100

Pie Chart 1: Kinds of Disorders Treated by Traditional Healers

Bone Fractures	Guinea-worm	Boils	Poison	Snakebite/Scorpion sting
32	14	11	9	9

Appendix B

Sample Questionnaire

Demographic Information:

Name (optional):----------

Place of residence:Town----------Region ----------

Occupation:----------

Age:----------Sex:----------

Religion:----------Ethnic group:----------

Highest level of schooling attained:----------

School location: ----------

General Information:

For each question or sub-question please choose only one option.

1. If you were ill and were to choose between going to a traditional healer and modern medical practitioner, which one would you choose?

   (i) ☐ Traditional practitioner (ii) ☐ Modern practitioner (iii) ☐ It would depend upon the situation

2. Please explain your choice in number 1.

   ---

3. How often have you been treated by a traditional medical healer?

(i) ☐ Never (ii) ☐ Rarely (iii) ☐ Often

4. If you circled (ii) or (iii) in number 3, for what kinds of illness?

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5. How many times have you been referred by a modern practitioner to a traditional practitioner?

(i) ☐ Never (ii) ☐ Less than 3 times (iii) ☐ More than 3 times

6. How many times have you been referred by a traditional practitioner to a modern practitioner?

(i) ☐ Never (ii) ☐ Less than 3 times (iii) ☐ More than 3 times

7. How often on average do you require medical care per calendar year?

(i) ☐ Never (ii) ☐ Less than 3 times (iii) ☐ More than 3 times

8. How would you describe the respect your community accords traditional medicine?

(i) ☐ Much respect (ii) ☐ Little respect (iii) ☐ No respect

9. Please briefly explain your choice in number 8.

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10. What kind of outside support is given to traditional medical practice in your immediate community?

(i) ☐ Much support (ii) ☐ Little support (iii) ☐ No support

11. From your knowledge, what kind of outside support is given to traditional medical practice in other parts of Ghana?

(i) ☐ Much support (ii) ☐ Little support (iii) ☐ No support

12. If you feel there is some support for traditional medicine, would you say such support has been successful in reaching your basic health needs?

(i) ☐ Very successful (ii) ☐ Moderately successful (iii) ☐ Not successful

13 Please explain your response to number 12.

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14. What would you suspect to be the causes of the success or failure you describe in number 13?

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15. What aspects of traditional medicine do you think are worth supporting?

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16. What do you think the future of traditional medicine will be in your immediate community?

(i) ☐ No future (ii) ☐ Uncertain future (iii) ☐ Good future

17. What do you think the future of traditional medicine will be in Ghana as a whole?

(i) ☐ No future (ii) ☐ Uncertain future (iii) ☐ Good future

18. Do you have any comments not included in your previous responses?

Thank you for your time and co-operation.

Bibliography

Ademuwagun, A. Zachaeus, "The Meeting Point of Orthodox Health Personnel and Traditional Healers/Mid-wives in Nigeria: the Pattern of Utilization of Health Services in Ibarapa Division," in Harrison, E., Ira & Dunlop, W., Dunlop (eds.), *Rural Africana: Current Research in the Social Sciences, No. 26, Winter 1974-75*, pp. 1-4, African Studies Center, Michigan State University, 1975.

Ademuwagun, A. Z., "The Relevance of Yoruba Medicine Men in Public Health Practice in Nigeria," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E., Ira; & Warren, M., Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979a.

Ademuwagun, A. Z., "Problem and Prospect of Legitimatizing and Integrating Aspects of Traditional Health Care Systems and Methods with Modern Medical Therapy: the Igbo-Ora Experience," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E. Ira; & Warren, M. Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979b.

Ademuwagun, A. Z., "The Challenge of Co-existence of Orthodox and Traditional Medicine in Nigeria" in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E. Ira; & Warren, M. Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979c.

Ahooja-Patel, Krishna, *Gender Distance Among Countries* Working Papers in International Development, No. 91.6. International Development Studies, Saint Mary's University, Halifax, N.S., Canada, August 1991.

Bannerman, Burton & Wen-Chieh (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, pp. 9-16, 209-221, WHO, Geneva, 1983.

Bannerman, Robert H., "The Role of Traditional Medicine in Primary Health Care," in Bannerman, Burton & Wen-Chieh (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, 1983.

Bibeau, Gilles *et al.*, Traditional Medicine in Zaire: *Present and Potential Contributions to the Health Services*, IDRC, Ottawa, 1982.

Bichmann, Wolfgang, "Primary Health Care and Traditional Medicine," in *Social Science and Medicine*, Vol. 13B, Pergamon Press Ltd., 1979.

Chavunduka, L. G., "The Organization of Traditional Medicine in Zimbabwe" in Last & Chavunduka (eds.) *The Professionalisation of African Medicine*, Manchester University Press, 1986.

Coppo, P., "Traditional Medicine and Psychiatry in Africa," in Bannerman, Robert, Burton & Wen-Chieh (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, pp. 25-332, WHO, Geneva, 1983.

Cosminsky, S., "Traditional Mid-wifery and Contraception," in Bannerman, Robert, Burton & Wen-Chieh (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, 1983.

Djukanovic, V. & Mach, E. P., *Alternative Approaches to meeting Basic Health Needs in Developing Countries*, WHO, Geneva, 1975.

Du Toit, Brian M. & Abdalla, Ismail H. (eds.), *African Healing Strategies*, pp. ix, Conch Magazine Ltd., Owerri, N.Y., London, 1985.

Dunlop, W. David, "Alternatives to "Modern" Health Delivery Systems in Africa: Public Policy Issues of Traditional Health Systems," in Ademuwagun, Ayoade, Harrison & Warren (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Durkin, Maureen, "Ayurvedic Treatment for Jaundice in Nepal," in *Social Science and Medicine*, Vol.27, No. 5, pp. 491-495, 1988.

Foster, G. M., "An Introduction to Ethnomedicine" in Bannerman, Burton & Wen-Chieh (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, 1983.

Fako, Thabo T., "The Dilemma of African Traditional Medicine: The Case of Botswana" in Du Toit & Abdalla, (eds.), *African Healing Strategies*, Conch Magazine Ltd., Owerri, N.Y., London, 1985.

Foster, M. George & Anderson, G. Barbara, *Medical Anthropology*, (pp. 1-51, 123-144, & 223-242), John Wiley & Sons Inc., 1978.

Good, Charles, *Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya*, Guilford Press, N.Y., London, 1987.

Harrison, E., Ira & Dunlop, W., Dunlop (eds.), *Rural Africana: Current Research in the Social Sciences, No. 26, Winter 1974-75*, pp. 1-4, African Studies Center, Michigan State University, 1975.

Harrison, E. Ira, "Traditional Healers as Sources of Traditional and Contemporary Powers," in Ademuwagun, Ayoade, Harrison, & Warren (eds.), *African Therapeutic Systems*, Crossroads Press, 1979a.

Harrison, E. Ira, "Traditional Healers: A Neglected Source of Health Manpower," in Ademuwagun, Ayoade, Harrison, & Warren (eds.), *African Therapeutic Systems*, Crossroads Press, 1979b.

Hoogvelt, Ankie, *The Sociology of Developing Societies*, Atlantic Highlands, N.J.: Humanities Press, 1977.

Horowitz, Michael & Painter M. Thomas (eds.), *Anthropology and Rural Development in West Africa*, Westview Press, Bouler and London, 1986.

Imperato, James Pascal, "Traditional Medical Practitioners among the Bambara of Mali and their Role in the Modern Health Care Delivery System," in Ademuwagun, Ayoade, Harrison, & Warren (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Jahoda, G., "Traditional Healers and Other Institutions Concerned with Mental Illness in Ghana," in Ademuwagun, Ayoade, Harrison, & Warren (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Janzen, John M., *The Quest for Therapy in Lower Zaire*, University of California Press, Berkeley, Los Angeles, London, 1978.

Janzen, John M., "Changing Concepts of African Therapeutics: A Historical Perspective," in Du Toit & Abdalla, H. (eds.), *African Healing Strategies*, Conch Magazine Ltd., Owerri, N.Y., London, 1985.

Janzen, John, "Pluralistic Legitimation of Therapy Systems in Contemporary Zaire," in Ademuwagun, Ayoade, Harrison, & Warren (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Jingfeng, Cai, "Integration of Traditional Chinese Medicine with Western Medicine - Right or Wrong?" in *Social Science and Medicine*, Vol.27, No. 5, pp. 521-529, 1988.

Kleinman, Arthur, *Patients and Healers in the Context of Culture*, University of California Press, California, 1980.

Koumare, I. M., "Traditional Medicine and Psychiatry in Africa," in Bannerman, Burton & Wen-Chieh (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, pp. 33-36, WHO, Geneva, 1983.

Last, Murray & Chavunduka, G., L., (eds.) *The Professionalisation of African Medicine*, pp. 1-19 & 259-269, Manchester University Press, 1986.

Leslie, C., "Medical Pluralism in World Perspective," in *Social Science and Medicine*, Vol. 14B, pp. 191-195, Pergamon Press Ltd., 1980.

Leslie, C., "Policy Options in the Practice of Traditional Medicine," in Bannerman, Robert, H., Burton, John & Wen-Chieh, Ch'en (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, 1983.

Maclean, Una, "Choices of Treatment Among the Yoruba," in Morley, Peter & Wallis, Roy (eds.), *Culture and Curing: Anthropological Perspectives on Traditional Medical Beliefs and Practices*, University of Pittsburgh Press, 1978.

Meier, Gerald, "Dimensions of Development," in Meier, Gerald, *Leading Issues in Economic Development*, 5th Edition, London: Oxford University Press, 1989.

Mensah-Dapaa, S. W., "Observations on Traditional Methods in Ghana," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E., Ira; & Warren, M., Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Mullings, Leith, *Therapy, Ideology, and Social Change: Mental Healing in Urban Ghana*, Chapters 5 & 6, University of California Press, Berkeley, Los Angeles, London, 1984.

Mutalik, G. S., "Organizational Aspects," in Bannerman, Robert, H., Burton, John & Wen-Chieh, Ch'en (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, 1983.

Myrdal, Gunnar, *Asian Drama:An Inquiry into the Poverty of nations*, Vol. III, Pantheon Press, N.Y., 1968.

Navarro, Vincent, "The Underdevelopment of Health or the Health of Underdevelopment: An analysis of the Distribution of Human Resources in Latin America" in *International Journal of Health Services*, Vol. 4, No. 1, pp. 5-26, 1974

Nkrumah, Kwame, *Towards Colonial Freedom*, Windmill Press, Kingswood, Surrey, 1962.

Nordstrom, Carolyn, R., "Exploring Pluralism - The Many Faces of AYURVEDA," in *Social Science and Medicine*, Vol.27, No. 5, pp. 531-544, 1988.

Nyerere, Julius, *Freedom and Socialism, Uhuru na Ujamaa: A Selection from Writings and Speeches*, Dar-es-Salaam, Oxford University Press, 1968.

Odebiyi & Togonu-Bickersteth, Funmi, "Concepts and Management of Deafness in the Yoruba Medical System: A Case Study of Traditional Healers in ILE-IFE, Nigeria," in *Social Science and Medicine*, Vol. 24, No. 8, pp. 645-649, 1987.

Pei, Wang, "Traditional Chinese Medicine," in Bannerman, Burton & Wen-Chieh (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, 1983.

Mathews, Ralph, "'I'd sooner be here than anywhere': economic vitality in Newfoundland," in S. Wallman (ed.), *Perspectives of Development*, (Cambridge University Press), pp. 119-136, 1977.

Read, Margaret, *Culture, Health, and Disease: Social and Cultural Influences on Health Programs in Developing Countries*, pp. 52-69, Tavistock Publications Ltd., London, Sydney, Toronto, Wellington, 1966.

Reuman, Peter D., & Reuman, Alice C., "Health Planning for African Countries: The Question of Priorities and Appropriate Methodologies," in Du Toit, Brian M. & Abdalla, Ismail, H. (eds.), *African Healing Strategies*, Conch Magazine Ltd., Owerri, N.Y., London, 1985.

Romancci-Ross, Lola; Moerman, E. Daniel & Tancredi, R. Laurence (eds.), *The Anthropology of Medicine: From Culture to Method*, Preface, Bergin Publishers Inc., Massachusetts, Praeger Publishers Inc., New York, 1983.

Said, H. M., "The Unani Health and Medicare," in Bannerman, Robert, H., Burton, John & Wen-Chieh, Ch'en (eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, 1983.

Sargent, Carolyn, "Prospects of the Professionalisation of Indigenous Mid-wifery in Benin" in Last, Murray & Chavunduka, L., G., (eds.) *The Professionalisation of African Medicine*, Manchester University Press, 1986.

Seers, Dudley, *Dependency Theory: A Critical Reassessment*, F. Pinter, London, 1981.

Semali, J. A. I., "Associations and Healers: Attitudes Towards Collaboration in Tanzania" in Last, Murray & Chavunduka, L. G., (eds.) *The Professionalisation of African Medicine*, Manchester University Press, 1986.

Senah, Kodjo A., "Problems of the Health Care Delivery System" in *The State, Development and Politics in Ghana*, CODESRIA, Accra, 1989.

Senah, Kodjo A., (unpublished) "Why the Children Die: The Case of a Rural Ghanaian Community." Paper presented at a Colloquium on Social Policy and Development in Ghana, Organized by Social Dimensions of Program, Ministry of Finanace and Economic Planning, Legon-Accra 12th - 13th December, 1991.

Small, Parker Jr., A. & Small, Natalie, S., "Immunization in the Third World: A Dilemma in the Transfer of Technology," in Du Toit, Brian M. & Abdalla, Ismail, H. (eds.), *African Healing Strategies*, Conch Magazine Ltd., Owerri, N.Y., London, 1985.

Spring, Anita, "Health Care Systems in Northwest Zambia" in Du Toit, Brian M. & Abdalla, Ismail, H. (eds.), *African Healing Strategies*, Conch Magazine Ltd., Owerri, N.Y., London, 1985.

Staugard, Frants, "Traditional Health Care in Botswana," in Last, Murray & Chavunduka, G., L., (eds.) *The Professionalisation of African Medicine*, Manchester University Press, 1986.

Twumasi, Patrick A., *Medical Systems in Ghana*, Ghana Publishing Co-operation, Tema, 1975.

Twumasi, Patrick A., & Warren, Michael Dennis, "The Professionalisation of Indigenous Medicine: A Comparative Study of Ghana and Zambia" in Last, Murray & Chavunduka, L. G., (eds.) *The Professionalisation of African Medicine*, Manchester University Press, 1986.

Twumasi, Patrick A., "Ashanti Traditional Medicine and its Relation to Present-day Psychiatry," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E. Ira; & Warren, M. Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Ulin, R. Priscilla, "The Traditional Healer of Botswana in a Changing Society," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E., Ira; & Warren, M., Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Warren, M., Dennis, "The Role of Emic Analyses in Medical Anthropology: The Case of the Bono of Ghana," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E., Ira; & Warren, M., Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Warren, M. Dennis, "Bono Traditional Healers," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E. Ira; & Warren, M. Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Warren, M., Dennis, "Anthropology and Rural Development in Ghana," in Horowitz, M., Michael & Painter, & M. Thomas (eds.), *Anthropology and Rural Development in West Africa*, Westview Press, Boulder, London, 1986.

Warren, M. D., G. Steven Bova, Tregoning & Kliewer, "The Ghanaian National Policy towards Indigenous Healers: The Case of the Primary Health Care Training Program," in *Social Science and Medicine*, Vol. 16, pp. 1873-1881.

Warren, M. Dennis, "The Interpretation of Change in a Ghanaian Ethnomedical Study," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E. Ira; & Warren, M. Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.

Waxler-Morrison, Nancy E., "Plural Medicine in Sri-Lanka: Do Ayurvedic and Western Medicine Differ?," in *Social Science and Medicine*, Vol. 27, No. 5, pp. 531-544, 1988.

Welsch, Robert, "Traditional Medicine and Western Medical Options Among the Ningerum of Papua New Guinea," in Romancci-Ross, Lola; Moerman, E. Daniel & Tancredi, R. Laurence (eds.), *The Anthropology of Medicine: From Culture to Method*, Bergin Publishers Inc., Massachusetts, Praeger Publishers Inc., New York, 1983.

Wilson, Fred, *et. al.*, *An Introduction to Community Work*, pp. 26, London, Oxford University Press, 1974.

Wondergem, Peter; Senah, A. K.; Glover, E. K., *Herbal Drugs in Primary Health Care, Ghana: an assessment of the relevance of herbal drugs in PHC and some suggestions for strengthening PHC*, Royal Tropical Institute, University of Ghana, 1989.

World Health Organization, Alma-Ata 1978, *Primary Health care: Report of the International Conference on Primary Care*, Alma-Ata, USSR, 6-12 September 1978, WHO, 1978.

Young, Alan, "The Practical Logic of Amhara Traditional Medicine," in Harrison, E. Ira & W. Dunlop (eds.), *Rural Africana: Current Research in the Social Sciences, No. 26, Winter 1974-75*, pp. 1-4, African Studies Center, Michigan State University, 1975.

Zeller, Leinwand Diane, "Traditional and Western Medicine in Buganda: Co-existence and Complement," in Ademuwagun, A. Zachaeus.; Ayoade, A. A. John; Harrison, E. Ira; & Warren, M. Dennis (eds.), *African Therapeutic Systems*, Crossroads Press, 1979.