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POSTDOCTORAL STUDIES**

**John Paul Nyonator**

-----  
AUTEUR DE LA THÈSE / AUTHOR OF THESIS

**M.A. (Sociology)**

-----  
GRADE / DEGREE

**Department of Sociology**

-----  
FACULTÉ, ÉCOLE, DÉPARTEMENT / FACULTY, SCHOOL, DEPARTMENT

**Informal Knowledge and Biomedicine: Ghanaian Assemblages**

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TITRE DE LA THÈSE / TITLE OF THESIS

**Julie Laplante**

-----  
DIRECTEUR (DIRECTRICE) DE LA THÈSE / THESIS SUPERVISOR

**Louise Bouchard**

-----  
CO-DIRECTEUR (CO-DIRECTRICE) DE LA THÈSE / THESIS CO-SUPERVISOR

**Philippe Couton**

**Nathan Young**

**Gary W. Slater**

-----  
Le Doyen de la Faculté des études supérieures et postdoctorales / Dean of the Faculty of Graduate and Postdoctoral Studies

# Informal Knowledge and Biomedicine: Ghanaian Assemblages

John Paul Nyonator

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Comité

Julie Laplante (Directrice de Recherche)

Louise Bouchard (Co – Directrice)

Philippe Couton

Nathan Young

Université d' Ottawa



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395, rue Wellington  
Ottawa ON K1A 0N4  
Canada

*Your file* *Votre référence*  
ISBN: 978-0-494-73745-3  
*Our file* *Notre référence*  
ISBN: 978-0-494-73745-3

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## Abstract

The field study took place in Dzodze, Ghana, over a period of 4 months in 2009. The data was collected through semi directed interviews and ethnography. The aim of this study was to investigate how localized practices provide a lens to gain larger insights into national and transnational politics of healing and knowledge. Precisely, how are current relationships between informal healers and biomedical practitioners performed in the everyday life of Dzodze, Ghana? The results of the study indicate no direct or institutionalized collaboration between biomedical practitioners and healers, however there is some form of relationships between informal birth attendants and public midwives. It is also apparent that the power relations linked with formal practices decrease possibilities for collaboration with informal medicine and also have a negative influence on any possible medium of innovation. The study also shows that people continue to use informal medicine because it works for them yet government reaction towards integration of informal medicine into national health system remains slow.

*Keywords:* informal medicine, biomedicine, relationships

## Dedication

To Max Cyril Zormelo

## Acknowledgements

I would like to thank Julie Laplante and Louise Bouchard for their valuable comments, guidance and advice during the writing of this thesis. My sincere thanks also go to all participants in the field who gave me information leading to this study. My special thanks also go to Mr. James Agboada and Togbui who assisted me to gain quick entry to the hospital and the healers. I also express my deepest gratitude to Mr. Kenneth Kpedekpor for his enormous assistance during the field work. I am also grateful to members of the thesis committee. I am also grateful to the Faculty of Graduate and Postdoctoral studies - University of Ottawa for their financial support for my field work.

Finally, I say thank you to Dr. Sam Aggrey for editing my thesis and my girlfriend, Savior, for her emotional support and encouragement.

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## Introduction

After several decades of denial of indigenous knowledge as a form of legitimate knowledge of medicine, the World Health Organization (WHO) and the International Community began in the 1970s to recognize the social standing of indigenous healers and their knowledge especially in areas that can be verified in the laboratory and reduced to measurable entities. Even with that, Torri and Laplante (2009) reported that there is still a common tendency to regard ‘traditional’ knowledge as unorganized and ‘primitive’ or as a treasure to store and document for posterity before it is lost, rather than seeing the dynamics that underpin the creation and dissemination of knowledge, in which local communities are key protagonists. The recent change in attitude as Taylor (2001:23) observes can be attributed to the drive by the pharmaceutical and scientific communities to develop new effective drugs. The last three decades have witnessed the massive explosion of international conferences on ‘traditional’ medicine and its integration into the National Health Care Systems. Regional and National networks have developed to discuss how to use informal medicine to find cures for HIV/AIDS, chronic disease and the future of informal medicine. The 1977 report of the thirtieth World Health Assembly of WHO supports the development of training and research of ‘traditional’ medicine (Pillsburg 1982:1825). A year later, at Alma – Ata, the international conference on primary health care, a resolution was passed supporting the acceptance of ‘traditional’ practitioners in the national health care system.

It is in line with this that this study examines ‘informal’ healers and their relationships with formal practitioners in Dzodze, Ghana. It is a qualitative research that aims to understand forms of knowledge at play within these relationships. Many perspectives on healing practices provide insights into structures, power relations, etc. Although very real, these do not suffice in

understanding the relationships between healers and biomedical practitioners and that is why I chose to do a qualitative assessment of concrete practices embedded in experiences of both healers and biomedical practitioners at this intersection. In examining informal and biomedical knowledge, the study questions how localized practices provide a lens to gain larger insights into national and transnational politics of healing and knowledge. Precisely, how are current relationships between informal healers and biomedical practitioners performed in the everyday life of Dzodze, Ghana? In an attempt to provide insight into this question, I conducted semi directed interviews (14) and ethnographic fieldwork that looks symmetrically into the practices of informal and biomedical practitioners. In order to visualize the relationships that exist between practitioners, I rely on theories of knowledge and power struggle from Michel Foucault (1973), Barnett & Blaikie (1992) and Watkins (1994). This research is necessary and important at this historical moment when Ghana is confronted with serious shortage of biomedical professionals, frequent agitations and strikes by biomedical professionals for better pay and the world resurgent interest in informal healing and people's science.

The study is structured into five main chapters. The first chapter highlights historical and anthropological concepts with a particular focus on the history of health care and medical pluralism in Ghana. In chapter two, I discuss theoretical consideration focusing on power/knowledge relations. In chapter three, I deal with methodology that was used to conduct this study. In chapter four, I discuss the relationships between formal and informal practitioners and factors hindering collaboration. Chapter five marks the conclusion of the thesis. The chapter discusses global health and informal medicine and how it reveals itself in Ghana. Finally, the chapter opens new directions for future research.

## **Chapter One: General Ghanaian Context**

In this chapter, I discuss briefly colonial Ghana, history of its health care system, and medical pluralism. Discussion on this chapter helps us to understand how biomedicine in Ghana develops out of colonization and subsequently becomes a dominant force in Ghana through state support and other international organizations. The chapter also discusses practices of the healers. It is necessary to examine the practices of practitioners as it opens the door for discussion on knowledge and also give us the lens to see beyond our own realities.

### **1.1 Colonial History of Ghana**

Ghana was the first country in Sub Sahara Africa to gain independence on 6<sup>th</sup> March, 1957. Prior to the coming of the Europeans, Ghana was dominated by the Ashanti Kingdom. The country was formally known as Gold Coast by the Europeans because of the abundant deposit of gold found in the country. The Portuguese were the first Europeans to arrive in the Gold Coast in 1482. In 1482, the Portuguese built Elmina Castle where they traded slaves, gold, beads and guns. They protected themselves from other European competitors in Gold Coast for a century. During the 17<sup>th</sup> and the 18<sup>th</sup> century, the Dutch and English came to Gold Coast to challenge the Portuguese. The Portuguese left Gold Coast after the loss the Elmina Castle to the Dutch in 1642. The Dutch stayed in Gold Coast until 1850 when they departed. The British then gained possession of all the Dutch forts and took dominant power over Gold Coast (Government of Ghana Official Website).

The national movement for self government started when the United Gold Coast Convention (UGCC) party was formed in August 1947. Dr. Kwame Nkrumah, who was then the secretary of UGCC, broke up with the party and formed a new party known as Convention

People Party (CPP) in 1949. The aim of CPP was self government now. On 6<sup>th</sup> March 1957, Nkrumah and his party brought political freedom to his people and put an end to colonial rule and domination.

After independence, the first president Dr. Kwame Nkrumah named the country Republic of Ghana after the medieval West Africa Ghana Empire. Ghana was adopted because of the power and wealth that ancient Ghana derived from Gold.

The Nkrumah government was however overthrown in a military coup on the 24<sup>th</sup> February, 1966 by the National Liberation Council headed by Lt. General Joseph Arthur Ankrah. In 1969, the military government held an election for political parties in the country. The Progress Party (PP) headed by Kofi A. Busia won the election and became the leader of the country. The second Republic came to an end when Lieutenant Colonel Ignatius Kutu Acheampong of National Redemption Council led a bloody military coup in 1972. In July 1978, Acheampong was forced to resign and his position was occupied by Lieutenant General Frederick W.K Akuffo. On May 15, 1979 a few weeks before constitutional election, junior military officers led by Flight Lieutenant Jerry John Rawlings attempted a coup. Although initially it was not successful, on June 4, 1979 the junior military officers overthrew the Akuffo government. The junior officers formed Armed Force Revolutionary council (AFRC). Within three months, an election was held seeing Ghana returning to constitutional rule. Dr. Hilla Limann of the People's National Party won the 1979 election and became the president of Ghana. Limann government stayed in power for less than two years before he was overthrown in a military coup led by Flight Lieutenant Jerry John Rawlings on 31 December 1981. This time Rawlings called the government Provisional National Defense Council (PNDC). From 1981 to date, the country has not experienced any military coup and remains relatively peaceful. Ghana

began its democratic dispensary in 1992. The country went to the polls successfully for five consecutive times. The National Democratic Party won election three times (1992, 1996 and 2008) and the New Patriotic Party won the election twice (2000 and 2004).

Geographically, modern Ghana is located on the West Coast of Africa and shares borders with Togo to the East, Cote D' Ivoire to the West and Burkina Faso to the North. The country's population as of July 2009 is 23, 887,812 (Central Intelligence Agency, 2010). The ethnic groups in Ghana include Akans (45.3%), Mole Dagbon (15.2%), Ewe (11.7%), Ga Dangme (7.3%), Guan (4%), Gurma (3.6%), Grusi (2.6%), Mande Busanga (1%) other tribes (1.4%) other (7.8%) (Central Intelligence Agency 2010), In terms of religion, according to population census (2000), the country is dominated by the Christians with (68.8%), followed by the Muslim (15.9%), traditional (8.5%), others (0.7%) and none (6.1%).

## **1.2 History of Health Care in Ghana**

### **1.2.1. Formal Medicine**

Formal medicine as it was practiced especially in the 1930s to 1960s had enormous power and influence that has allowed its practitioners to define, classify and treat illness. Its powers can be traced to the scientific value of their work and the way in which their knowledge is grounded in precision, accurate and reliable scientific information (Turner 1987:217). To a large extent, the state also promotes formal medicine to emerge as a global power through its various state apparatus. For instance the state issues licenses to formal medical practitioners that allow them to admit, discharge, and prescribe drugs to patients. Medical associations, which are formed by this relatively small homogenous group, have also given them stronger collective voice that allows them to make medical claims and negotiate with state on the conditions of their

practices. The medical power amassed by the formal medical professionals is used virtually to suppress, subordinate and disempower other forms of medical knowledge and practices (Ehrenreich 1974, Lupton 1997.) and define practices contrary to its practices as quacks and unsystematic. In other words it has given them entrenched monopolies over other practices. In this few decades, criticism of formal medicine inability to provide cure for certain illnesses has put pressure on various States and WHO to look for alternatives to supplement formal medicine.

The people of Ghana came into contact with formal medicine through colonization, and since then, governments have placed importance on the provision of scientific medicine as a health care system for her citizens. Formal medicine which is also known as global healthcare was brought to Ghana by the British colonial government in 1844 (Twumasi 2005:65) and as a result it was modeled according to their health care delivery system (Abekah Nkrumah et al 2009). In a study 'in sickness and in health: globalization and health care delivery in Ghana', Senah (2001:83) gave an account of development of biomedicine in Ghana. He categorized the development of health care in Ghana into three phases. The first phase (1471 – 1844) witnessed what Senah called 'medical apartheid'. In this era, the white were bodily isolated from the indigenous people and given western medical treatment to protect them against tropical infections like malaria from unclean environments. According to Senah (2001: 84) the second period begins when the British signed the bond of 1844 with a number of Fantes<sup>1</sup> and other local chiefs. The special treaty obliged local chiefs to submit serious crimes like murder and robbery to British jurisdiction. In theory, the treaty promoted relative peace in the colony, but in practice, it enhanced the British influence, domination, trade, and Christian missionary activities in the colony. Senah (2001) contended that the second phase emerged when health care was extended

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<sup>1</sup> The Fantes are located currently at the southern Ghana. It occupies the Coastal belt of Ghana in the West to the Ga region in the East.

to the local population, colonial civil and military service. The last phase according to Senah (2001) was the establishment of a hospital in 1868 at Cape Coast, the then capital city of Gold Coast, and several dispensaries in the rural areas. This marks the beginning of a new medical paradigm in the colony. The new medical practice received stiff opposition from the indigenous population at the beginning (Twumasi 2005, Senah 2001) in terms of their explanation of causes of disease. The kinship institutions stood firm in support of informal practices citing several empirical evidence from the healing practices of their forbearers. In an attempt to neutralize the opposition of the indigenous population, make the practice of the healers 'useless', and promote the influence and the use of the new medical practice (biomedicine), the Native Customs Regulation Ordinance was passed in 1878. The ordinance banned the practice of informal healing in the colony. As pointed by Senah (2001), the Christian converts were threatened with excommunication if they were found to visit or consult healers. Yet this does not change Ghanaian cosmology on the potent of informal medicine and the traditional religious rites and rituals. Many Ghanaians continue to use informal medicine irrespective of their religious affiliations since they owe allegiance to Christian God and the ancestors. This attitude of people especially Christian converts frustrates early European Christian ministers since their effort to separate Ghanaians from witchcrafts, ancestral worships and informal medicine has not succeeded. The enactment of the Native Customs Regulation Ordinance paved the way for the strong foundation of biomedicine in Ghana even though scholars acknowledged the stiff opposition it received from indigenous population.

### 1.2.2 Post Colonial Formal Medicine

At the end of colonization, it was estimated that less than 10% of Ghanaian population had access to formal medicine and life expectancy stood at 48 years (Senah 2001:84). The Nkrumah government that took power from the colonial government recognized the low coverage of formal medicine and its importance to the Ghanaian populace formulated health care policies that aimed to expand biomedicine through infrastructure expansion and human development to improve on the deplorable health status of Ghanaians. The table below shows the trend in the number of health professionals within 10 years after independence.

**Table 1.1 Number of Health Professionals from 1957 - 1967**

Type	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967
Doctors	120	123	126	227	292	363	379	465	548	597	633
Dentists	12	10	14	14	14	14	28	35	37	39	41
Midwives	345	376	412	481	530	611	954	1,189	1,201	1,394	1,481
Nurses	768	958	1,001	1130	1241	1344	1,453	1,090	2,381	2,660	3,078
Pharmacists	312	311	326	298	329	342	355	355	355	362	367

*Source: Twumasi (2005)*

Apart from the pharmacists, the table shows that doctors, dentists, midwives and nurses increased by more than 50% by 1967. This can be attributed to the medical school that was established in the 1962 by Kwame Nkrumah.

Table 1.2 and 1.3 also reveal that from 2005 – 2007, the number of doctors and nurses has increased from 1,212 to 1,676 and 14,384 to 15,724 respectively, yet this increase does not correspond to Ghana’s growing population. The ratio of doctor to population is 1: 17,899 and that of nurses is 1:1508 nationwide. The increase in the number of doctors and nurses at Greater Accra and Ashanti regions was mainly because of the increase in population of these regions and the refusal of health professional to go to the rural communities to practice where there is no

good potable drinking water, transport and telecommunication, good schools and electricity. They prefer to practice in the urban centers where they are more likely to get additional jobs from the private sector.

The tables below give portrait of number of medical physicians, nurses in relation to the population in present Ghana.

**TABLE 1. 2: MEDICAL PHYSICIANS IN GHANA BY REGION**

	Number of Doctors	Doctor population Ratio	Number of Doctors	Doctor population Ratio	Number of Doctors	Doctor population Ratio
Ashanti	428	10,667	378	11,681	323	13,221
Brong Ahafo	96	22,479	83	25,365	61	33,672
Central	63	29,260	57	31,675	47	37,625
Eastern	128	18,141	104	22,019	86	26,260
Greater Accra	755	5,202	669	5,624	495	7,280
Northern	24	92,046	32	67,154	28	74,657
Upper East	30	33,111	34	28,897	32	30,369
Upper West	15	43,253	14	45,568	11	57,026
Volta	66	28,269	72	25,430	62	28,981
Western	71	33,794	71	32,746	67	33,625

SOURCE *The Health Sector in Ghana Facts and Figures (2008)*

**TABLE 1.3: NURSES IN GHANA BY REGION**

	Number of Nurses	Nurses population Ratio	Number of Nurses	Nurses population Ratio	Number of Nurses	Nurses population Ratio
Ashanti	2251	2024	2067	2136	2019	2115
Brong Ahafo	1099	1099	1034	2036	1020	2014
Central	1249	1476	1145	1577	1144	1546
Eastern	1977	1173	1831	1251	1878	1203
Greater Accra	4011	979	3789	993	3693	976
Northern	1131	1868	1011	2126	1044	2002
Upper East	798	1243	757	1298	711	1367
Upper West	537	1266	485	1315	464	1352
Volta	1074	1266	1406	1302	1421	1264
Western	1197	1993	982	2368	990	2276

Between 1991 and 2003, statistics reveal that hospital facilities nationwide have increased in numbers from 251 to 286 and health centers have increased from 1138 to 1487 within the same period (Ghana Statistical Service 2005). Percentage wise, there was an increase of 13.9% and 30.7% respectively over the 12 years (Ghana Statistical Service 2005). According to Global Health Leadership Institution (2009:7), 50% of the health facilities belong to the government, 40% are owned by the private sector, 9% are owned by mission churches and the remaining 1% is owned by quasi government. The increase in health infrastructure saw a corresponding increased in training of health experts.

**TABLE 1.4: HEALTH FACILITIES IN GHANA - 2007**

Regions	Teaching Hospitals	Regional Hospitals	Psychiatric Hospitals	Hospitals							Poly Clinics	Health Centers & Clinics							Maternity Homes			CHIPS <sup>2</sup>	
				CHAG	GOVT	ISLAMIC	PRIV	QUASI GOVT	CHAG <sup>3</sup>	GOVT		ISLAMIC	PRIV	QUASI GOVT	GOVT	PRIV	QUASI GOVT	GOVT	PRIV				
ASHANTI	1			17	22	3	48	2		32	140	2	161	9	3	105		4					
BRONG AHAFO	1			9	7	1	6			8	123		18	4	3	37		11					
CENTRAL		1	1	3	8	1	8	1		9	68		62	2		34		43					
EASTERN		1		5	12		5	3		19	165		63	7	1	47		44					
GREATER ACCRA	1	1	2	3	7	2	79	6	7	5	42	1	232	16	2	53	1	4					
NORTHERN		1		4	8		1	2		25	120		5	3	9		10						
UPPER EAST		1		1	4					15	54		11	1	2		55						
UPPER WEST		1		2	3	2	1			14	60	3	4		6		39						
VOLTA		1		8	11		7	1	1	9	192		23		24		19						
WESTERN		1		3	11	1	1	7	2	20	95	2	109	22	60		56	2					

SOURCE: The Health Sector in Ghana: Facts and Figures (2008)

<sup>2</sup> CHIPS – Community Health Planning Services  
<sup>3</sup> CHAG – Christian Health Association of Ghana

As of 2007, Table 1.4 reveals that a total of 3,011 health facilities exist in Ghana with a population of 23,585,501, but these facilities are not evenly distributed across the country. While majority of the facilities are concentrated in Ashanti, Greater Accra and Western region, there are relatively few health facilities in Northern (including Upper East and Upper West) region.

In 2007, there were a total of 296 health facilities in Volta region (where the research took place) that serve over 1.9 million people. The breakdown of the figures shows that there are only 28 modern hospitals (including government, private and missions), 224 health centers and clinics, 24 maternity homes (all private) and 19 Community Health Planning and Services. The ratio of health facilities to the population is 1:6418.

It is also worth noting that despite government attitude towards rapid development of biomedicine, mental health which is also an integral part of biomedicine has received less attention. There are only three psychiatric hospitals in Ghana, two at Accra and one in Ankaful.

It is obvious from the analysis that the health facilities and the health professionals are insufficient to meet the health of the entire population especially those in the rural communities. In the rural communities where majority of Ghanaian are located, there are about 1,975 health centres and clinics across the country which are staffed with paramedical and health auxiliaries. What this tells us is that there are many rural communities that are without biomedical services and that rely entirely on informal medicine for their health needs. It is also reasonable to infer from the statistics especially in the area of mental health that many would go to see healers since the mental health resources are woefully inadequate to meet mental health needs.

### **1.2.3 Financing Formal Medicine in Ghana**

Prior to 1969, health care in Ghana was free. In the 1969 government introduced cost sharing into the health sector. By 1985, 'cash and carry system' was implemented because of economic recession that befell the country in the 1980s. In the early 1980s, Ghana's economy was in a total state of collapse. There was a severe drought in 1983, the country's major exports, cash crops and minerals (Cocoa, gold, diamond) and standard of living declined dramatically. The famine became aggravated when Nigeria expelled one million Ghanaians. The situation in the health sector was nothing but a 'broken system'. Senah (2001) lamented that inadequate financial resource badly affected the supply of drugs and other medical supplies. He recalled that patients who went to hospitals for treatment were asked to provide their own beds, drugs, food and stationery for medical records. In the face of this economic and social crisis, the PNDC government headed by Jerry John Rawlings accepted the IMF/World Bank Structural Adjustment Program in order to restore the economy. Under the structural Adjustment program social expenditures were cut and user fees were increased tremendously. The objective was that revenue derived from these user fees would be used to improve the quality of services. With the full cost recovery in place, Asenso- Okyere (1995:87) aptly observed that children pay fees ranging from 50% - 67% of adult fees depending on the service level and location while foreigners pay 133% - 267% of what Ghanaians pay.

### **1.2.4 Practice of Medical Doctors**

While the healers are interested in multi dimensional cause and treatment of the patient, medical doctors are looking at the biological cause of the disease. They stick to the knowledge that every disease has a causative organism. From molecular biology, they were taught at the

medical school that certain changes in the body are prone to certain illnesses. Disease are deemed to be caused by pathogenic microbial agents like viruses, bacteria, fungi, protozon, prion and others and not the magico religious explanation of illness offered by the healers. The knowledge of the doctor is technical, limited to disease classification and follows the reductionist parameters. The mode of treatment is based on what they see, what they have proof of, laboratory investigations and examinations carried out on the patient, and medical history taken from the patient. The practices of the doctors are such a way that they try to tackle only the cause that may have lead to the disease. Thus the practice of the doctor is based on establishing relationships between causality and symptoms of the disease. For instance a patient with headache goes to the doctor for treatment; the doctor knows that headache may result from several sources. It could be from infection, malarial bacteria, hypertension, stress, or unconscious strain of the eye. The source of the headache is determined by the doctor through the interview he or she conducted for the patient. Questions that the doctor ask the patient include how is it happening to you, when did it start, is that the first time you are experiencing that, what intervention have you taken when you started experiencing that feeling? Pills are given to the patient based on the connections that the doctor made between the results of the interview and the symptoms of the disease.

The relationship that exists between the doctor and the patient is the one that resemble the relationship between uncaring father and child. While the latter believes in the abilities of the former and trusted all his or her personal information in his hand, the former only sees the latter as one who is in need and wants his or her personal assistance. The father only provides the physical materials that the child needs but fails to give the emotional and psychological support that the child needs to restore his/her confidence. The uncaring father is the doctor who only

listens to the patient's concern and give pills to the patient based on what he thinks is the problem. The patient's emotions, feelings are totally ignored during diagnoses and treatment.

Although medical doctors work within the standardize procedure of their profession, sometimes some of them operate in the informal within the formal standard practice of their work. During my field work I happen to meet a nurse who narrated to me how a medical doctor that she worked with at Northern part of Ghana used to give herbs to pregnant women to chew who are bleeding but cannot deliver their babies. According to her, within a few minutes, the bleeding stopped and the pregnant woman delivered safely. She gave me an instance where she was bitten by a scorpion at her home. Initially, pain killers were given to her by her colleagues at the hospital to help reduce the pains she was experiencing at that time. The pains never stop until a medical doctor who has knowledge on herbs came to squeeze the juice of an herb on the spot where the scorpion bite before she was relieved from the pains. Doctor G.K for instance gives his cream that he prepares from herbs to patients who have skin rushes. Biomedical practitioners who appropriate some form of knowledge from the practices of informal healing into their practices are the ones who grew up in the villages and have tested informal healing themselves. Their experiences with informal healing have made them to understand the perspectives that are involved in the practices of informal healing.

### **1.3 Informal Medicine**

Traditional medicine as defined by the Traditional Medicines Practitioners Act 575 of Ghana (2000) is 'practices based on beliefs and ideas recognized by the community to provide health care by using herbs and other naturally occurring substances.' According to section (4) of the code of Ethics and Standards of Practice for Traditional Medicine Practitioners, informal

medicine practitioners who are duly registered shall use the title N/Dr. (Native Doctor) in addition to any other title traditionally conferred on them. In Ghana, there is no homogenous group of traditional healers. We find a multiplicity of healers including herbalists (Amagbedalawo), bonesetters, Muslim healers like mallams, traditional birth attendants (vixelawo), spiritualists like 'hunua', 'bokors', tronua, diviners (Amegashies), and as well as christian healers.

There is no documented evidence on when informal medicine started in Ghana or elsewhere in the world. It's worth noting that people have had informal medicine practice long before the emergence of modern medicine in more or less in the early 20<sup>th</sup> century and people continue to use it after the surfacing of modern medicine. With the introduction of colonization, informal healing, which is people's medicine, was despised and discredited as unsafe and ineffective. Twumasi and Warren (1986) pointed out that during the colonial government in Ghana, the then Gold Coast, it was an offence to practice indigenous healing or for clients to use the services of healers, however, this offence was only enforced when a person dies while undergoing medical treatment from informal healers. They comment that 'Traditional' healers were thought to be insincere, to be quacks who lived on the neurosis of their illiterate folks.

After independence the Nkrumah government re-introduced informal healing as a way to promote African culture, art and identity. The notion of promoting and integrating informal medicine into the national health care was well known in Ghana a decade before the WHO, Alma Ata resolution (1978) was passed to support the utilization of indigenous healers in National Health Care Systems. The Ghana Psychic and Traditional Healing Association was established in 1963 but officially recognized in 1969 (Warren 1982:1875) with the objectives to: promote and encourage the study of herbalism and psychism in Ghana and Africa as a whole,

support and protect the conduct, status and interest of psychic and traditional healers, repress malpractices, provide central organization in Ghana for research into traditional medicine and establish clinics in all the regions for treatment of those disease and ailments which biomedicine has not found cure for and to treat common disease alongside biomedical practitioners. The livelihood of the association and the national agenda to solidify national health care came to an end after the Nkrumah government was overthrown in a military coup by the National Liberation Council government. As Last and Chavunduka (1986) reported, matters concerning the association were relegated to the background by the Ministry of Health. Last and Chavunduka (1986) pointed out that it was a deliberate effort by the National Liberation government to discredit the work of the Nkrumah government.

The activities of the informal healers were revitalised when the Acheampong government came into power. In 1975, the Acheampong government established the centre for scientific research in herbal medicine at Mampong under the centre for scientific research into the Plant medicine act 1975. Under the Act, the centre is supposed to (a) conduct and promote scientific research relating to the improvement of plant medicine (b) ensure the purity of drugs extracted from plants (c) co-operate and liaise with the Ghana Psychic and Traditional Healers' Association, research institutions and commercial organizations in any part of the world in matters of plant medicine (d) undertake or collaborate in the collation, publication and the dissemination of the results of research and any other useful technical information (e) establish where necessary botanical gardens for medicinal plants (f) perform any other function that the Government may assign to it. The establishment of the centre was an attempt by the government to scientifically study the herbs that are used by the indigenous people. Within the center there is a clinic that diagnoses and treats patients with informal medicines. When I visited the centre after

I graduated from the University of Ghana, I observed that the clinic has modern nurses, doctors, lab technicians working there. The doctors who work at the clinic prescribe only herbal medications to patients who consult them. The clinic also works closely with herbal practitioners who send their herbal products to the centre for scientific verification. Evidently today, 35 years after the establishment of the center, government has not demonstrated any commitment to replicate the center in any part of the country.

Today in Ghana, it is estimated that 70% of Ghanaians living in rural areas use informal healing for their health needs (Akosah–Sarpong 2007, Warren 1982:1873). Statistics also indicate that on average the ratio of healers to population is 1:200 compared to the ratio of medical doctor 1:20,000 (A.U 2005:3). It is important to note that in reality only few healers are known to Ghana’s Ministry of Health.

The healers are recognized and respected in their communities. They use plants, animals (especially blood), inanimate substances that are deeply rooted in their community’s culture to treat physical, mental, social and spiritual illness. Bierlich (1999:319) and Twumasi (2005:24) noted that the herbal medicines that are used by the herbalists are not potent in themselves; their power is derived from supernatural world and without the ancestral power the herb remains important.

#### **1.4 Types of informal Healers**

There is no single consistent methodology used by the informal healers to diagnose and treat patients. This research study reveals that various informal healers use different skills and technologies in their practices. I must acknowledge here that each of the techniques used by the

healers are complex in nature. During my field work, I interacted with informal birth attendants and healers.

#### **1.4 1. Informal/Traditional Birth Attendant**

Informal birth attendants are often referred to as 'vixelawo' in Dzodze. They are often middle aged women who are typically illiterate or have very little form of formal education. I met the traditional midwives at the villages of Dzodze where there are no good roads and other basic facilities. The only way that people go and come out of the village is by walking or through the use of motor bikes. The informal midwives are consulted only when the pregnant women are in labor or having some form of contraction. The informal birth attendants are not only confined to the walls of their villages but also move to surrounding villages where there are no biomedical facilities. In the past, pregnant women who were referred from Hospital 'S' to Hospital 'R' and cannot afford to pay the hospital bill also go to the informal midwives for delivery. The practices of the informal birth attendants also extend to antenatal care in their community. During the antenatal period, she also advises the pregnant women on things they ought to do and things they should not do. In addition to these, the informal birth attendants also advice the pregnant women on the type of food they should eat for the proper development of their unborn children. Their services also extend to maternal and child health services, family planning, health education and counseling of marriage couples. They also oversee the disposal of the placenta after child delivery and teach mothers how to breastfeed their babies.

Child delivery by the informal midwives follows a very naturalist process. Women were not forced to push but are allowed to deliver at their own pace. Even the positioning of the pregnant woman during delivery is natural. Women do not lay down on any tall bed with their

legs hanging on the bed rather they are made to kneel down on a mat, hold the two knees, sit on their heels and open her thighs apart. The two heels support the buttocks. This position enhances the descent of the fetus. It also helps to open the pelvic bone and cervix for easy delivery according to the informal midwives.

When a pregnant woman who is in labor is brought to informal midwife, she examines the pregnant woman by the use of the human senses. That is through touching the pregnancy, watching the pregnancy to see whether contractions are taking place and using the ears to listen to the fetus in the uterus. They also insert the middle finger of the left hand into the vagina to see whether the fetus has positioned itself well or not. All the five fingers are not used because it would damage the uterus of the woman and sometimes can render her barren. When the finger touches the head of the fetus, it implies that the fetus has positioned itself well for delivery. On the other hand, if fetus shows its foot or buttock at the entrance of the cervix then there is complication. Complication may also be in the form of water surrounding the fetus. Interestingly, orthodox TBAs<sup>4</sup> use intuition and other spiritual mechanisms to turn and reverse the feet or the buttock of the fetus to the head position for delivery. The traditional birth attendant rubs shea butter in her two palms and uses it to palpate the fetus. Before this shea butter is used by the informal midwife, it is sent to the fetish priest who invokes the spirit of the ancestors on it. They also administer orally pounded okro to pregnant woman if the cervix is narrow. The pounded okro produces mucus and make the fetus slippery for delivery. Modern TBAs<sup>5</sup> when confronted with complications of pregnancy refer pregnant women to the hospital for Caesarian section.

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<sup>4</sup> Orthodox TBAs are informal midwives who have not received any form of workshop training from the public midwives.

<sup>5</sup> Modern TBAs are informal midwives who are given some form of formal training by the public midwives in the hospital.

In order to make informal child delivery stand against the test of modernity, informal midwives have appropriated some knowledge from the public midwives to make their practices look modern. Formally, informal midwives used a mixture of salt, sand, herbs and Soot (a black powder that surrounds cobwebs (ajorbla) to treat the umbilical cord of a baby. This, they observe led to convulsions and subsequently resulted in the death of some babies. They now adopted the use of spirit from the biomedical practitioners to treat the umbilical cord. They also prescribe paracetamol (an analgesic) for the mother to take for abdominal pains. Nurses also appropriate some form of knowledge from the informal birth attendants. For example, public midwives ask women who have delivered to sit in warm salt water. This would heal wound that the woman have early.

Twumasi (2005) postulated that women who are interested in informal birth midwifery receive their training through apprenticeship. He also pointed out that the trainee is also trained in the preparation and administration of herbs needed for assisting deliveries. Contrary to this finding, my field work reveals that traditional midwifery is not learned through apprenticeship rather it is a 'family thing' that one inherits. It is only through inheritance that one can understand and know the skills and the techniques that are involved in child delivery. Mama Klenam, the oldest informal birth attendant I spoke to explain to me that;

*The person can be trained in traditional midwifery but she will never be an expert in it.*

*The person will not be able to listen to the rhythm of the fetus in the mid of the arm. She can never hear it in the veins.*

Mama Klenam statement points to the fact that one can only become an expert in midwifery through calling or through the 'family blood'. Thus, the inheritance of knowledge is through the blood line. The person who inherits the knowledge of the informal midwife is her most loving

daughter. The information on who inherits the knowledge of the mother is accessed through divination. The same procedure of transfer of knowledge is also followed by the healers.

#### **1.4.2 Healers perspectives on Illness and Diagnosis**

Everything in the world has two sides; that is good and evil, positive and negative. This way of seeing the world is translated into medicine by the healers. According to the healers every illness has two sources of origin. It either comes from a good source or from an evil source. Illnesses that come from good sources are referred to as natural illness and those from evil sources are referred to as spiritual illnesses. Natural illnesses come as a result of our contact with dirty environment, the food we eat, the air we breathe and the water we drink. Sometimes they come as a result of reaction of the organs in our body to foreign bodies. Spiritual illnesses which are referred to as evil illness is believed to come as a result of attacks from witches and evil forces that prowl the world. Causes of spiritual illnesses may be attributed to breaking of taboos, casting of spells on the ground for people to walk through, incest and punishment from the ancestors. It is interesting to know that, to the healers all the natural illnesses have its counterpart in the spiritual realm. For example we have natural stroke and spiritual stroke; natural malaria and spiritual malaria; natural festering sores and spiritual festering sores and so on. The spiritual illnesses show the signs and symptoms of the natural illnesses; so if one is not careful one would assume that he or she is suffering from natural illnesses while in actual fact he/she is suffering from spiritual illness. The difference between them is that spiritual illnesses when taken to the hospital, the symptoms can only be managed but the person would never be cured. The root cause of the illness would still persist and it would continue to recur until sent to the healer for

appropriate treatment. The question now is how do the healers know that the illness is natural or spiritually caused?

## **1.5 Power of Healers**

The powers of healing and the diagnostic methods use by the healers are linked with the ‘invisible’, that is the divination (Afa or Kakeh) and voodoo (idols). The power of healers is also socially and culturally embedded in their communities. The healers are respected by the community because of their God given wisdom and knowledge in healing and socio-cultural practices, their competence to provide answers to unknown occurrence or misfortune and their moral stands on traditional beliefs and practices. Politically, they are also opinion leaders in their communities.

### **1.5.1. Divination (Afa or Kakeh)**

Healers diagnose illness through divination. Divination is a practice whereby the practitioner communes with the spirits to see things beyond the physical. It is a kind of spiritual impartation and initiation. There are different and varied ways of divination. The healer must be initiated into the practice of divination for him or her to be able to see things in the spirit. The diviners in Dzodze manipulate cowries, ordinary water, book, and other objects depending upon the type of training and initiation they receive from their master craftsman to discover the unknown. When the diviner is using cowries or animal bones, he or she interprets the objects according to the way they appear on the mat. Those who use the mirror and ordinary water in calabash or container see visuals in the mirror or ordinary water to tell the problems their patients are facing. If a patient is brought to a healer, the diviner is summoned; he implores the spirits to

help him tell the cause of the problem, solution to the problem and the evil person behind the cause of the problem. In the past, healers used to disclose the evil person's name during the divination to the family of the sick victim. The evil person is then arrested and tried through 'ordeal'. Through that the evil person confesses into detail how he or she bewitched the sick victim. Currently, the Code of Ethics and Standards of Practice for traditional Medicine Practitioners in Ghana (Ministry of Health, 2004) forbids the trial by ordeal and public declaration of witches and wizards by healers to the family of the sick victim. This is to help put an end to possible conflict that arises between the family of the sick victim and that of the evil person.

### **1.5.2 Safe**

Like the microscope that is used by biomedical practitioners, healers also use 'safe' on their patients. The safe is a simple medical technology that is developed by the healers themselves to diagnose illnesses. They put the safe on the chest of the patient to see the type of illness that patient is suffering from. The safe is made of the skin of an animal that has a mirror at the center of it. The healer invokes the spirit of the ancestor on the safe and is able to see the illness the patient is suffering from through the mirror on the safe. Interestingly it is only the healer that can see the illness because he or she is the only person that has the spiritual eye to the illness. Through the safe, healers are able to see measures that they should take in order to provide cure for their patients. Herbs that they should use for the patients are also revealed to them through the safe.

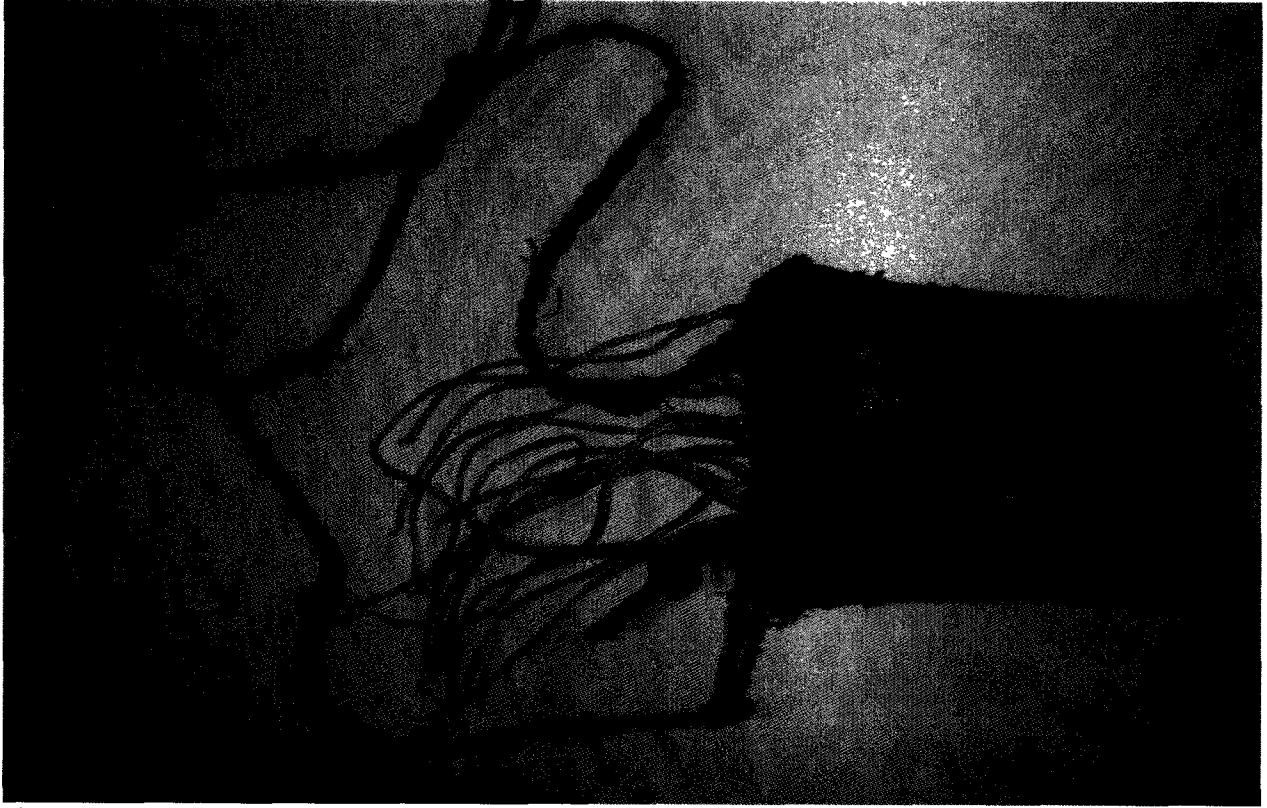


Figure 1.1 Safe is a medical technology that is used by healers to make diagnosis

Apart from these medical technologies that are employed by healers in diagnosis, they also engage in physical examination of the patient. They ask questions on 'how does it hurt you' 'where it hurts you' 'when you started feeling the pains'. They also trace the genealogy of the illness by asking questions on patient's family background. After a thorough examination of the patient, the healer may ask the patient, if necessary to bring along fowls (specific type), goat, hard drink and some amount of money for treatment to commence. Part of the animal is sacrificed to the gods and the spirits and some part is cooked and eaten by the household of the healer and the patient. This demonstrates great solidarity between the household of the healer and the patient. It is important to note that healers do not charge specify amount of money for their services but rather patients are required to make a promise of items to bring to the gods after treatment.

## Voodoo (Idol)



**Figure 1.2** Idol of one of the healers. Sometimes the healer consults this idol for diagnosis and counsel

Another way that healers use to know causes of illnesses and medium of treatment is ritual possession. During ritual drumming, singing and dancing, healers become possessed with spirits and they speak strange language. During the process, the spirits communicate to them the cause of illness and the medium of treatment.

**Table 1.5 Etiological Explanation of Illness by Healers**

Type of illness	Spiritual Cause	Physical Cause	Signs	Interventions	Non Intervention
Lunacy	<p>Invoking strange incantation/ Spells locally called 'Gabara'</p> <p>Witchcraft/Sorcery</p> <p>The power of the gods inflict Lunacy on the descendants of Descendants of forbears who Owned deities but after they Death the deities were neglected</p> <p>Invocation of the power of the moon</p>	<p>The effects of High Fever</p> <p>Excessive use of narcotic drug like marijuana</p>	<p>say words that are incoherent</p> <p>Striping him/herself naked but not knowing he/she is nude</p> <p>complaining that he sees wild animals trying to devour him</p> <p>Mentally deranged</p> <p>Violent and uncontrolled</p> <p>They sometimes bark like dogs – 'woo' 'woo' 'woo'</p>	<p>Sacrifices to pacify the spirits. Specific animals Like pig, dog, goat, fowl are used depending on the severity of the lunacy.</p> <p>They sprinkle the blood of the sacrificial animal on the herb together with other items and perform ritual bath for the sick victim.</p> <p>A tot of alcoholic drink mixed with black powder</p> <p>Or healers whistle into the ears of the patient to calm him</p>	<p>If the lunatic goes to the market place to settle or eat from the market place, the lunacy cannot cure completely because the spirit behind lunacy is from the market when the lunacy last for long period before the patient is treatment he or she cannot be cured.</p>
Stroke	<p>Thunder lighting on a person or particular spot. Wicked people collect the leaves of grasses around the lighting spot and process it into black powder. The wicked sprinkle the black power across the path of his target and once the target walks through the powder, he becomes affected</p>		<p>Tongue becomes loose muscles become weak the patient becomes paralysed</p>	<p>Sacrifice to purify the lighting spot</p>	
Festering Sores Or Ulceration at the foot	<p>The sorcerers strike the targeted person with a sharp object when he/ is at sleep and inflict wounds on the limb</p> <p>Sprinkling of black Powder in the path</p>		<p>The wound never heals. It develops into festering sore</p> <p>Doctors may amputate the Limb but the condition still Persist.</p> <p>The legs become swell</p>	<p>Exorcising the evil force</p> <p>Beseech the spirits to help get the necessary herbs</p>	
Tuberculosis	<p>Incest (blood ties) or Sexual depravity</p>	<p>Air we breath</p>	<p>persistent cough</p>		
Infertility or Childlessness	<p>Spiritual removal of womb by witches using spiritual objects to block the entrance of the cervix</p>	<p>Problem with menstrual cycle</p> <p>It may be due to loose cervix or endometrial sac</p>		<p>Insert finger into the woman's vagina to feel the womb to know whether the womb is close or not.</p> <p>If the entrance of womb looks like the egg of a dove, then the womb of</p>	<p>if the cervix is narrow and the womb is small there is nothing we can do.</p>

				that woman cannot carry a baby. But if the entrance looks like the egg of hen, then the woman can carry a baby. A woman whose entrance of the womb looks like the egg of hen but barren can become pregnant when we prepare herbal medicine for the woman to drink to enable the cervix to contract and the endometrium to become firmer in order to hold pregnancy.	
Women whose gestation period has passed but cannot deliver	Has been locked with spiritual padlock		Cannot deliver	Unlock the spiritual padlock	

### 1.5.3 How healers know that patients are healed

Healers I interacted with at Dzodze have several ways of detecting whether their patient is healed or not. They observe and compare physical outlook of the patient as against how he or she was when he was brought to them for treatment. When they are totally healed, the symptoms of the disease are no longer seen in them and they no longer feel pains. Moreover, after healing, the patient voluntarily goes to the healer for cleansing rituals and thanksgiving. They also interacted daily with patients to know how he or she is doing, whether he or she is still experiencing the same symptoms as he was brought to them. After treating the patient, the healers put the 'safe' instrument on the patient again to find out if he/she is healed. Surprisingly enough, healers have certain medicines they give to patient after treatment to see if the illness will recur, that's if they are certain the one is cured. If the illness resurfaces again during the test of reoccurrence, then it means that the patient has not fully recovered and needs to be re examined. But if the patient is able to stand against the test of reoccurrence then it means that the

patient is fully recovered and can be discharged. After the patient is declared as fit and healthy by the healer, there are certain rules the patient must follow if he or she is to remain healthy. One of the healers that I interacted with at Dzodze told me that he recently had a case of reoccurrence simply because the patient failed to adhere strictly to the taboos associated with the recommended medicine. So as long as the patient remains a servant of the cult, he must obey the laws of our traditions that treat him. In the case of this particular healer, the patient was advised not to sweep and wash his clothes after 6pm. If he does, those problems that he was facing in relation to his health will reoccur.

### **1.6 Medical Pluralism in Ghana**

In an article 'the importance of knowing about not knowing' Last (1981), questioned the systematization of informal healing and proposed that there is such a thing as a 'non system'. Last based his argument on the premise that healers lack a single consistent theory to explain illnesses and have wide differences in the usage and meaning of medical terminologies in everyday lives. In the later part of Last's article, he contradicts himself by acknowledging that technical specialists of informal healing like 'traditional' midwives, bone setters might constitute a system. Lewis (in Littlewood 2007) in his field work in New Guinea comes to the conclusion that there is no medical system among the people of Gnao because they lack special department of knowledge and practice concerning understanding and treatment of sickness. Lewis therefore agreed with Last to call informal healing as non system. Although there are discrepancies and contradictions in informal healing theories like the use of one herbal formulation to treat several illnesses, different causes attributed to one illness by different healers and different approaches use to treat one disease condition, I think we can still draw some similarities from their practices.

In the Ghanaian context with Dzodze as the focal point, I refer to informal healing as a system. Last and Lewis notion of system is centered on elite perspective. A system goes beyond theoretical knowledge as source of skills; it requires maintaining social order and solidarity through knowledge and skills that is acquired and inherited. Like the biomedicine, which consider all diseases to be caused by biological organism, informal healing has developed a comprehensive body of knowledge that include the concept of magico religious theory to understand and explain social etiology, diagnosis, mode of transmission and treatment. This body of knowledge is respected and socially valued by members of the community.

Ghana, like many other countries in Africa and Asia has a plural health care system (Bannerman 1982, Baer 2004, Nichter & Lock 2002). The people of Dzodze patronize the service of multiple health experts freely, depending on the type of illness they are suffering from. The choice of medical system depends largely on people's understanding of disease and the possible causative factor that may be responsible for the disease. Also there are certain illnesses (like malaria, typhoid fever, waist pain, anaemia) that have been classified by Dzodze community as 'hospital illness' and others as illnesses (madness, infertility, unhealed wounds and kooko<sup>6</sup>) that need urgent attention of the healers. In other words, people cope with disease through sometimes a single usage of medical system and sometimes through a combination of the so called 'scientific rational approach' and 'healer's non rational approach'. This tells us that biomedicine alone is not sufficient to solve people's health problem and that people would continue to use informal medicine since it works for them. As Nichter & Lock (2002:4) point out 'patients are, almost without exception, pragmatic and see nothing inconsistent about liberally combining different forms of therapy in their quest for restore health'.

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<sup>6</sup> Kooko is pile in English. It is a common disease in Dzodze.

Most often when patients are admitted at the hospital for treatment and medical practitioners cannot provide cure for the illness, the relatives of the patients consult healers for treatment while the patient is still at admission. The healer goes to the hospital, impersonating as one of the relatives of the patient. The healer goes to the patient only to observe how the patient is doing. Based on the healer's observation, patient's history he took from the relatives and the outcome of divination, he prepares herbal product for the patient which is administered in secret. Sometimes scarification marks are given to the patients while they are on admission. Protective amulets which are believed by the healers to hold the spirit of the patient alive are hidden under the pillow of the patient. When medical doctors see scarification marks with black powder on the patient during their ward rounds, they become angry and sometime threaten to discharge the patient if relatives do not stop using local medicine for the patient. To the medical doctors, combining modern medicine with local medicine makes it difficult for them to know whether their medicine is working effectively or not without any source of complications. Although medical doctors at the hospital insist that only modern medicine should be given to patient who visit their facility, relatives of patients whose condition are not improving still call on the healers to provide treatment for their patient. Warren (1982:1873) argued that 'ironically, the separation of scientific and traditional medicine on public policies does not correspond to the attitude within society'.

Interestingly, class division and social hierarchy play a significant role in choosing medical system in Dzodze. Patients that I met with the healers are farmers, fishermen, petty traders, teenagers who are not financially independent and educated. The patients with the healers mostly came from the healer's locality or from nearby neighboring villages. Some of the patients depend on the healer for their food and daily upkeep. Patients who are healed but are not

discharged by the healer assist the healer in farming. The produce derived from this is used to feed patients who do not have the means to cater for themselves. It is important to note that apprentice who are with the healer also assist the healer in farming or any other occupation the healer is engaged in. At the hospital, patients that are admitted come from middle class income group or have relatives that support them to pay hospital bills. This is not to say that the 'bourgeois' do not go to the healers for treatment but you would hardly see the 'bourgeois' with the healers seeking treatment. As Baer (2004: 111) observes, 'patterns of medical pluralism tend to reflect hierarchical relations in the larger society.'

### **Summary of Discussion**

In this chapter, I argue that Ghanaians came in contact with formal medicine through colonization. Although it did not have a smooth beginning especially from the traditional social system, it grew to become powerful health system that has subordinated other healing practices. The new medical intervention did not only introduce new illnesses, classification and methodologies of diagnoses and treatment, it also imposed itself on the people and colonized people's body. In other words it has implanted itself through colonization and neo colonization to establish its power over other healing practices.

Lastly, I pointed out that there are multiple health cares in Ghana and the choice of medical system depends largely on the type of illness one is suffering from, people's understanding of the disease and whether the patient and kin group regard the illness as a 'hospital disease' or illness that is caused by the witches. Within the plural health system, there is often back and forth between practices and knowledge.

In my next chapter I shall discuss theoretical consideration.

## **Chapter Two – Theoretical Consideration**

### **Introduction**

In this chapter I examine knowledge and how it reveals itself in Dzodze. First of all I look at the various epistemological arguments within literatures on medical knowledge. I continue to look at experiential knowledge of the healers and how some biomedical practitioners appropriate the experience of the healers into their standard procedure of work while others turn to despise it and make validation claims to scientific rationality.

### **2.1 Knowledge Epistemologies**

Knowledge claims concerning illness and its treatment is often contested between formal/global healthcare and informal medicine. The formal draws on modernists' notion whereby knowledge claim is centered on western epistemology that focuses on universal truth, objectivity, experimentation, value free knowledge and minimizes the possibility of errors and irrational behaviors (Watkins 1994). Thus scientific test, standard of measurements are considered to be neutral and detached from the particularity of the knower and cultural context. This form of reasoning rests on the assumption that evidence backed by scientific validations, norms and statistical results produce the best outcome, while marginalizing and bracketing other forms of medical knowledge as irrational and quacks.

Epistemologically, formal medicine is deeply rooted in positivism reasoning. Its practices are held to conform to the standards of scientific methods; and its practitioners are judge dand described as people who make rational decisions based on scientific evidence. Diseases are constructed as empirical realities that can be observed and measured in the laboratories. It is in the context of the modernist assumption of looking at health that informal practitioners are

extremely pressurized by external forces (WHO, State, Scientific Communities) to subject its practices to evidence based medicine (EBM). EBM is the ‘process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions’ (Rosenberg & Donald 1995: 1122). Mykhalovskiy & Weir (2004) reported that the evidence based medicine working group criticized clinical decision based on personal experience as hopeless and out of date. It is not surprising when biomedical practitioners advocate for the withdrawal of spiritual healing when it comes to the inclusion of informal healing into the national health care system. Spiritual practices and ritual that accompany the use of the herbs are deemed irrelevant to science since they are in opposition to the worldview and philosophy of western medicine. Tsey (1997:1071) and Langwick (2008) observed that efforts to integrate traditional medicine into National Health Care System is only limited to herbal physical treatment of illness. Herbal medicine is supported by scientific community because it is the only aspect of informal healing that is quite understood by the scientific community and can be tested at the laboratories and reduces to molecular entities. This kind of scientific filtering/knowledge selection (that is taking the herb out of the context of healing) undermines and devalues the local knowledge on health and also makes it difficult to win the support base of the healers during the integration process. As Bishaw (1991:199) has demonstrated, “any attempt to separate the empirical from the spiritual for the purposes of appropriating and incorporating only the empirical into the modern health care system is bound to result not in the promoting of traditional medicine, but on the contrary, in rendering it as mechanical and segmented as modern medicine may have become of late.”

The modernist position however is challenged by some scholars (Good 1994, Barth 2000, Douglas 1985, Plough and Krimsky 1987, Watkins 1994, Csordas 1996) who argue for revitalization of knowledge through the periphery. Most of the arguments point towards the necessity to take 'experience' into consideration; experience of technologies, experience of colonization (memory) and experiential knowledge (especially in the case of the healers, but as well with regards to the doctors). A path breaking to the positivist claims comes from interpretivists who claim that reality does not exist separately from our perceptions of it; rather it depends exclusively on the social and cognitive construction of meaning of groups and individuals. For that matter, no interpretation is more valuable or valid than the other; yet groups especially scientific community makes validation claims and expert power over other interest groups (Watkins 1994).

Blaikie (1992) argues that when people do not act in accordance with scientific reasoning, it does not necessarily mean that they are acting irrational. They may be acting based on another explanation which may be driven by witchcraft, customs, sorcery and scientific variables. As Barth (2000:10) pointed out 'people construct their worlds by their knowledge and live by it.' What may seem reasonable and logical to some people may become irrational to others as soon as they do not understand certain aspects of that reasoning. Our decision to define an act as rational or irrational become subjective in the sense that actions that conforms to our principles become rational and actions that contradict our world become irrational to us. Much of the controversies surrounding knowledge production in anthropology of health and illness are centered on questions of efficacy and evidence. There is huge confusion among scholars about methods that should be used to test efficacy.

Reflecting on formal and informal knowledge, I have come to accept the conclusion of Barth, Watkins (1994), (2000) and Blaikie (1992) that formal and informal bodies of knowledge are useful to inform practices; we should consider both together rather than separating them. Thus formal/live experience is part of knowledge we acquire in the world. We cannot treat one as superior to the other since all bodies of knowledge are fluid and dynamic.

### **2.1.1 Experiential Knowledge**

Experiential knowledge is the collection of skills that informal healers have worked with in their everyday lives and found them to be therapeutically effective. It works through self practical every day engagement with the real and spiritual world, trial and error procedures until the best clinical result has been obtained. The healer knows what he knows through what he has seen, heard and shared from friends. Medicines are tried on the patient and the one which do not produce the needed results are discarded as the healer looks for more powerful one to replace existing one. The search for new medicine may be done sometimes through collaborative networks among healers and at other time the spirit of the medicine man may transcend into the spiritual world to interact with ancestors and the gods on possible solutions to the cause of an illness.

Apart from the spiritual encounters that informal practitioners have, they also depend largely on their environment to find cure for illnesses. They know where medicinal plants are located, where medical plants should be cultivated, how it should be harvested and stored, the season to collect the medical plant and the processes that accompany the plants after harvesting to remain potent. To put it in the precise context, the healers have direct relationships with the plants over time. According to healers I interviewed on the field, some of the medical plants are

biologically active and effective when harvested at midnight in a certain part of the community or outside the community. Some are also potent when collected at noon. The decision to collect herbs at a particular spot lies in the fact that a particular medical plant has various species and the ones that work for that particular illness can only be found at that place. They identify the various species by the size of the leaf and sometimes by the smell of the herb.

After spending months with healers and doctors, it became increasingly clear to me that the experiences of the healer are usually screened by scientists when identifying herbs to transform into pills. What is currently refined in the practices of healers is their knowledge of how to collect the plant, where, when and how to combine, prepare and offer the plant for healing. In a way the experiences of the healer do influence the work of scientists in the laboratories. Having said that, there are differences in the way that scientists and healers understand how medicine plants work. The difference is scientists are able to explain with statistical figures the biological, chemical and the toxic level of medical plants while healers find explanation in ancestral secrets. This in itself does not mean that the healers are naïve of their knowledge. What this suggests is that healers construct their realities through magico religious beliefs.

In Dzodze where I did my ethnographic research, I have seen some biomedical practitioners who have adopted and refined some therapeutic skills of the healers and incorporate them into their standard practice of work. In my interaction with doctor G.K, he told me:

*He became diabetic somewhere along his professional career. As a medical doctor, he used oral diabetic and many other drugs but they did not help him to recover. Around the same period, he developed partial blindness. He changed lenses more than four times but he was not able to see clearly. So he finally went for magnifying glass to enable him to*

*see. He used the magnifying glass in his consultation room, in theater and everywhere he goes. One day he resorted to an herbal preparation which he developed himself. Now he can see clearly without the aid of magnifying glass. He can also read books with smaller characters without any difficulties. Apart from the herbal preparation he discovered for eye problems, he also discovered interesting findings in the area of cancer and skin conditions. He accidentally discovered an herb which he initially used for the treatment of cancer and later refined it to become a cream which is now used for skin conditions. The herb was experimented on the tumor for four days. At the end of the four days, the tumor becomes soft and looks like it is going to burst. The tumor is excised and later sent for pathological assessment. Report indicates that cancerous cells in the tumor had died before incision. The report of the pathological assessment informs the formation of the cream phrasing.*

Healers usually innovate through the above medium and deal with standardized health concepts in their practices pointing towards indigenization of global health protocols. Biomedicine as it is practiced today emanated from informal healing practices. As Chen (2001:272) observes the ‘Chinese played a major role in the development of science in Europe... medicine in China produced great physicians before Hippocrates’. It is always indigenized for it to work in various socio-cultural contexts. For instance, the drugs that are used by biomedical practitioners come from a small concentrated molecular chemical extract of plant components, which in some cases has been found through looking into the practices of traditional healers, sometimes peasants, farmers... depending on the specific plant. Quinine, Digoxin, Aspirin, Atropine, Morphine and Ephedrine were all discovered from plants (Gilani & Rahman 2005: 43, Elujoba, Odeleye &

Ogunyemi 2005:48). In Ghana, people use the bark of neem tree (*Azadirachta indica*) to treat malaria which works equally like quinine according to Dr. Edmond (Interview: 2009).

### **2.1.2 Power/Knowledge Relation**

From the Foucauldian perspective, knowledge is closely linked with power and there is no power relation without corresponding field of knowledge. Power as it operates from the Foucauldian sense can be seen as possibility to speak and to act upon the actions of others with relation to knowledge legitimacies – in other words here ‘biopower’; knowledge in biology legitimize certain actions. Foucault’s writing enables us to see how biomedicine has particular forms of power relations that may supersede those of other healing practices. In Foucault’s analysis of the relationship between power and knowledge, he noted that scientific bodies of knowledge acquired by medical scientists has given them a particular medical ‘gaze’ (P. 29) in defining what constitutes deviance and social disorder (Foucault 1973). Disease is categorized and differentiated from the body. The doctor subjects the body to clinical analysis and subsequently the body becomes the object of treatment. To be precise, the body is manipulated and medicalized in a unilateral way. The doctor has the expert gaze to see in the body of the patient what is wrong and link it to symptoms of one or two categories of disease. Following Foucault, it is apparent that the domination of biomedicine is deeply rooted in the reliable scientific knowledge that is acquired by doctors on one hand and the power they gain through the various social networks like the state, WHO and other international agencies.

The biomedical practitioners that I interacted with in Dzodze are not against the inclusion of informal healing into the National Health Care but have expressed sentiment/apprehension about the efficacy, safety, dosages and the scientific validity of the drugs of the healers. Informal

healing has been under extreme pressure to standardize its practices and make it evidence based medicine to meet global health practices. Healers have been criticized for not giving the exact quantity or volume of drug to patients at a particular time as compared to the biomedical practitioners who rely on other experts to be specific in the dose of the medicine, yet do not have more knowledge than the healers, sometimes less, on the particular drugs they are prescribing; other than they are clinically tested and approved. The healers for all the days of their life have lived with the plants, tasted the plant, and they understand the conditions under which the plant works. Their knowledge is cultural embedded in their communities. Healers explain that the volume of drug that a patient takes depends on the pains the patient is suffering from. The patient with severe pain threshold is given a big cup of drug to take and the one with mild pain is given small cup of drug to take. The size of the cup reduces as the patient begins to feel better. What this means is that some patients with high severity of pain are likely to take high doses of the drug which biomedical practitioners think might subsequently lead to kidney failure and abuse of drug.

Another practice of the healers that come under severe criticism by the biomedical practitioners is the way healers prepare their drugs. Healers that I have interacted with in Dzodze mostly use alcohol locally known as 'akpeteshi' in the preparation of drugs. Its alcoholic content is above 50%. The plant part is dissolved in a quantity of akpeteshi which is given to the patient to take at a regular interval. The idea is that herbs that are dissolved in akpeteshi work faster or quicker than when the patient takes it in its raw state. Biomedical practitioners comment that giving alcoholic drug to a patient who is already a chronic drunk would in the long run damage the patient's liver and kidney.

The knowledge of the healers on biology also came under scrutiny by the biomedical practitioners. The healers' source of knowing the cause of illness, the understanding of physiology, human anatomy, the biochemistry, chemical ingredients of a drug, the short and long term effect of the drug on the patient were questioned and regarded as primitive. But do the biomedical practitioners themselves know exactly the side effect of a drug in the long term? The biomedical practitioners themselves have no clue; only the pharmacologist and the chemist have a clue of the drug composition and the possible effect on one part of the body within limited period of time. Do any of the medical groups have the ability, the technology and the power to make a drug that would be side effect free?

### **2.1.3 Limits to Knowledge**

It is becoming increasingly obvious that our knowledge about the physical world is limited and that we are unable to control new dangers and disease that threaten our existence on earth. Evidently today there are several illnesses that we do not know and several of them that we are unable to find cure for as human; illustrating the narrow scope of our knowledge. As Latour (2003) pointed out mastery is impossible and control over action is now seen as completely modernist fiction. This is evident within biomedical and informal healing paradigm that doctors/healers sometimes know the root cause of the ailment but do not have the right treatment to the ailment. Sometimes the cause of the illness might not respond to the treatment available. I also observe that treatment might be available there but the disease may be so advanced that it might overwhelm treatment. What this tells us is that as experts of any field or individuals, we are limited by what we know and our minds are limited. From my stand point we need to look at other ways of knowing like informal practices in order to have tacit knowledge to combat disease

that threaten our life. Speaking from my field work I was told by Dr. G.K that hemorrhoid<sup>7</sup> (kokoo) which cannot be cured without reoccurrence is effectively handled by informal healing practitioners. Doctor G.K for instance referred patients with kokoo to informal healer for treatment. The healer does the work without any reoccurrence. There was a case of kokoo that the healer treated which had no reoccurrence for 16 years.

#### 2.1.4 Knowledge Legitimacy

Both scientific and informal forms of knowledge are useful to inform a practice; the former has global legitimacy, the latter has only local legitimacy and is more fragile due to semi literacy status of the healers. Although government has done legal work to recognize informal practices, formal practitioners do not want to recognize informal practitioners. Formal practitioners continue to label informal practices as ‘meaningless pseudo psychological mumbo - jumbo, which is positively harmful’ (Green 1997:311). My field work reveals that doctors do not want to interact with healers because the latter have never been to school to learn how to read and write. To them, it would be difficult to work and share ideas with healers who do not have basic formal education on human anatomy and physiology. In an interaction with one of the doctors, he categorically told me that;

*If healers want to be like us or to be called doctors, the procedure is simple; go to school, pass your exams and be known as doctors. You don't seat at your backyard working on people's psychic and expects to be called doctor.*

From this doctors' perspective the criteria for recognition and legitimacy is embedded in formal education. Biomedical practitioners want healers to be educated on first aids so that they can

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<sup>7</sup> Hemorrhoid may be closely referred to a disease in Ewe known as Kokoo. Medical doctors argued that kokoo as use in Ewe language is broad and has many symptoms than hemorrhoid. Since the word remains vague, I use kokoo from the local perspective.

provide some basic health care services to the sick in the community before referral to the hospital. The above recommendation by biomedical practitioners points towards 'scientification' and domination of informal practices. The point I want to stress is training of healers should not be subjected to biomedical evaluation as they always do and want to do. Training healers in the biomedical form of practice would change the makeup and sense of feeling people derive from informal practices. Instead of providing biomedical training to the healers, it could be an option to think that the training of the healers could be geared towards enriching the healers' local knowledge and skills in their area of competence so that at any point of time there would be continuity of care. This would enable healers and the biomedical practitioners to identify disease and conditions beyond their competencies and refer to the appropriate health facility. Currently in Ghana healers are being trained based on WHO training manual. The document has been adapted to suit the Ghanaian situation and global health standards. The document has been translated into three Ghanaian languages (Ewe, Hausa and Twi) to make training meaningful. Pictures are also used to illustrate ideas to the healers.

Another area of interest is how the healers themselves see the legal legitimacy of their status with the National Health Care. From my observation, healers who are well known and receive wide recognition from their communities and within the country for their practices see legal legitimacy as a threat to their practices. For them they stand to gain nothing from legal legitimacy. They see legal legitimacy as a strategic of government to control their practices and also take money from them in a form of taxes. Let me say that this position comes from small proportion of healers. The majority of the healers express their willingness to gain legal legitimacy. These healers understood legal legitimacy as an opportunity to gain state support in a form of funding to expand their practices and also to work with formal practitioners. From this

perspective, the more respected a healer is the less compassionate he is on legal legitimacy (Fassin and Fassin 1988).

#### **2.4 Summary of Discussion**

This chapter suggests that formal/informal knowledge is part and parcel of knowledge and that knowledge needs to be situated within cultural context before it is categorized as 'irrational'. When people do not find explanation in formal medicine, they may find explanation in witchcraft and other beliefs which is rational in its cultural context.

## **Chapter Three – Specific Ghanaian Context**

### **Methodology**

#### **Introduction**

My interest in the topic partly emerged from live stories that I heard from friends in Ghana that informal healing worked better for certain illnesses than hospital treatment. As a Ghanaian citizen myself, and having lived there all my life, I have never personally consulted a healer. My grandfather was a medical assistant at the hospital so any time I fell sick I was taken to the hospital for treatment. Coming from this home, I had a biomedical perspective of what may cause disease. But as I interacted with friends I became deeply moved by the amazing stories I heard from my friends on informal healing and became concerned, about the loss of knowledge surrounding these practices, hence my turn towards an anthropological understanding of the question. This true lived experience, events of the everyday that I heard from friends tells me that indeed if healers provide healing for certain illnesses that biomedical practitioners are not able to address, then there is the need to look at new realities of intersection between informal healing and biomedicine.

This chapter deals with the methods that were used to conduct the study. Specifically, I describe the scientific approach use in this study and my case study.

#### **3.1 Scientific Approach - Ethnography**

The qualitative methodology that I use in this study is ethnography. Its roots can be traced back to the 1900s, particularly among cultural anthropologist such as Bronisław Malinowski, Radcliffe – Brown, Boas, Evans – Pritchard who carried out fieldwork in different cultural settings. Although ethnography has been in used for decades, its conceptual meaning and

application differs among scholars particularly social scientists. According to Spradley (1978:3) ethnographic is 'the work of describing a culture' and the goal is 'to understand another way of life from the native point of view. Spradley emphatically pointed out that 'rather than studying people, ethnographic means learning from people' (p.3). Babbie (2001:281) suggests that ethnography focus on detailed and accurate description of cultural setting rather than explanation. I was able to learn from my participants through observation of their practices, listening to their conversations and asking relevant questions that are relevant to my research questions.

Like many other methodologies, ethnography does not exist without limitation. Critics of this methodology often argue that the findings of ethnography are based on subjective impression rather than rigorous scientific investigation. However, a number of social researcher especially feminist scholars have argued against the value free position of researchers. Feminist scholars encourage researchers to be involved with the subjects and also be self reflective (Berg 2009).

I use ethnographic methodology because by immersing myself into the culture and observing the actual practice of formal and informal practitioners in their natural setting, I stood at a point to understand the relationships that exist between the formal and informal practitioners which I could probably not understand better if I were far away from the culture setting.

### **3.1.1 Entry into the field**

The selection of Dzodze for the study was based on my practical knowledge of the area. I grew up in an area (Denu) that is not far from Dzodze and I have good friends who are native of Dzodze. My mother and immediate extended family members are still at Denu and I am familiar

with many aspects of this cultural area although much is still to learn. This greatly facilitated my entry into the field and provides me with specific concrete practices from which to speak of the relationships between doctors and healers. Although this specific ethnographic research cannot be generalized, it can nevertheless inform about the ways transnational and national health policies can have an effect on local practices as well as inform transnational and national health policies by providing knowledge about how things occur in a specific area.

I was able to reach all the five healers through the assistance of torgbui, the chairman of 'traditional' healers association. I got to know torgbui through a friend who works at Hospital 'S'. Torgbui who became my friend recruited two informants; an agric extension officer and a son of one of the healers who took me to all the five healers. The healers were happy to see me (a young man) who is concerned with their knowledge. They were more than willing to participate in the study.

I was able to get access to the informal birth attendants through a list of names that was provided to me by the head of public health unit at the hospital. The hospital has collaborative program with the informal birth attendants and has a book which contains the name of informal birth attendants, hence an already partially organized collaboration in this case.

I started negotiations with the hospital 'S' two months before my arrival at Dzodze, Ghana. This I did through the networks that I have in and out of Dzodze. The principal of a college where I taught for two years who knows the medical superintendent and Administrator of the hospital 'S' introduced me and my intentions to the Administrator and the medical superintendent through an official letter he wrote to them prior to my arrival at Dzodze. I later on sent a formal letter to the Administrator requesting permission to use their facilities for my thesis. Even though initially I envisaged encountering some difficulties with bureaucratic

procedures at the hospital, to my surprise I was accepted and embraced by the hospital community on my first day of visit. The administrator later on asked the secretary of the hospital to introduce me to the staff of the hospital. This makes it easier for me to familiarize myself quickly with the staff of the hospital and also reach participants for the research in this site.

### **3.2 Study Area (Dzodze)**

According to oral tradition, the Dzodzies who are from the Dogbo Clan were part of Ewes who first settled in Ketu in the Yorubaland of Nigeria. In Yorubaland, the Ewes learned the art of ‘Afa’ and ancestral worship. While in Ketu, they were forced to move to Dahomey in Benin because of severe drought and famine. Later, they crossed to Togoland and settled at Nortsie in the West of the Mono River where they found fertile soil and rivers to fish. At Nortsie, they were under a powerful kingdom headed by King Agokorli, who was described as cruel and heartless. By description one can equate the wickedness of King Agokorli to the pharaoh of ancient Egypt in the Bible during the days of Moses. The political array in Nortsie made it in such a way that every subject, ‘tom and hurry’ have to obey the laws of King Agokorli no matter how difficult the laws were. Due to the wickedness and the stiff laws the Dogbo clan led by Torgbui Wenya and Torgbui Sree fled from the dreadful King Agokorli of Nortsie to finally settle at Anloga. From Anloga, the Dogbo Clan begins to spread to other location hence the present location of Dzodze.

Geographically today, Dzodze is located at the south eastern part of the Volta Region in the Ketu North district of Ghana. It is about 87 Kilometers from Ho, the capital town of Volta Region and 95.99 kilometers from Accra, the capital of Ghana. It has a population of 31,751 (Dzodze Town Council 2009). The main economic activity in the area is farming and small

scale trading popularly known as ‘smuggle’ that cut across the borders of Ghana and Togo. The festival of Dzodze is ‘Deza’ which translates into Palm festival. They celebrate Deza because they cultivate palm trees from which they obtain ‘Dzomi’ red oil ‘Deha’ palm wine, and ‘Akpetseshi’ local gin. During the festival, chiefs showcase their rich cultural heritage through traditional dancing which has several symbolic meaning. The local dialect of the people of Dzodze is Ewe, which is also my first language.

Before the advent of the Catholic Church in Dzodze in 1913, there was only ‘Yeve cult’, a traditional religion. The practitioners are called ‘yeveshie’ and the shrine is ‘yevokpor’. People become members of ‘Yeve’ through three means. First of all people are given to ‘Yeve’ by their family as a way of paying for the service they received from the shrine. Secondly, people who are destined to become members of Yeve and finally people who search for remedies for their problem and have committed themselves to the shrine. The Catholic Church converted some of the yeveshie to become practicing Catholics. Apart from the religious activities of the church, the Catholic Church also engaged in developmental project like building of dispensary which was run by the reverend sisters to serve the native people in the areas of child delivery, snake bites and fever. The dispensary office was transformed by Bishop Anthony Konnings to become hospital S in the 1960. The Catholic Church is the dominant church in Dzodze that people worships God. The church is respected and recognized for its lead role in developmental works in Dzodze especially in areas of health and education. Hospital ‘S’ is the only hospital in Dzodze. It attends to the health needs of the people of Dzodze and referral cases from other part of the Ghana and across the borders of Ghana.

Table 3.1 and 3.2 show the state of hospital ‘S’

### The State of Hospital S

	2006	2007	% increase from 2006 - 2007	2008	% increase from 2007 – 2008
No. of Beds	160	160	-	160	-
Total Admission	3490	3580	2.5	5822	38.51

Table 3.1 Source: Hospital S annual report (2008)

### Number of Professional at Hospital S, Dzodze in December 2008

Types	Number
Medical Specialist	0
Physicians (Ghanaian)	4
Expatriate (Physicians)	16
Anaesthetist	1
Nurses	19
Midwives	20
Physiotherapist	1
Pharmacist	2

Table 3.2 Source: Hospital S annual report (2008)

The top causes of admission at the hospital include malaria, anaemia, Hernia, road traffic accident, Gastroenteritis, Broncho-Pneumonia, Hypertension, Septicaemia, Retention of Urine, CVA (Annual Report 2008).

## 3.3 Methodology

### 3.3.1 Key informants: Informal and formal health practitioners

What I know and relate in this thesis I learned with healers, doctors and registrar of informal healing, most of them men while the women were nurses and informal birth attendants. Although I originally planned to learn with healers who are men and women, it was difficult meeting

women who are healers. The women are either 'vixelawo' birth attendants or diviners. There is a clear evidence of gender role up to the type of occupation that men and women engage in. I conducted semi-directed interviews with 5 healers, 4 medical doctors, 3 informal birth attendants and 2 nurses. Out of the 14 participants interviewed, only 5 (3 of were vixelawo and 2 were nurses) of them were women. Vixelawo and nursing profession in Ghana is often regarded as occupation for women. Initially I planned to interview only medical doctors who are working at the hospital. But during my fieldwork I was re directed to a doctor at another Hospital outside of Dzodze who works with healers and this was most relevant with regards to understanding relationships between these health practitioners. Out of the 5 healers and 3 informal birth attendants I interviewed, only one of the healers and one birth attendant practice full time. The rest of the participant informal healers and birth attendant engage in other occupations like farming and pottery to earn extra money to supplement what they earn from informal healing. The ages of participants range between 30 to 80 years. Overall there is no clear cut difference between the practices of a healer who is a herbalist and a healer who is spiritualist. The selection criteria for the healers and the birth attendants were based on the following:

- Have a working experience of at least 5 years
- Demonstrate ability to heal patients as determined by his colleagues and members of the community where he/she lives
- Must be willing to share his/her knowledge freely

### **3.3.2 Data collection**

I conducted series of semi-directed interviews with the above-mentioned actors from the period of September to December 2009. The interviews were conducted in two languages;

English and Ewe. Biomedical practitioners were interviewed in English while healers were interviewed in their native language Ewe. I collected 22 audio recorded interviews; each lasted for 30 minutes at most. All interviews were audio recorded on a digital recorder. While Ewe interviews were translated and transcribed verbatim into English, interviews that were conducted in English were transcribed directly. In order to ensure the reliability of the interview, one question was asked in two or three different ways. Questions that I detected were not probably understood by the participants, were re structured through modification of the language. Interview questions range from knowledge of the participant on illness, their practices, standardization and collaboration. I also observed the practices of some of the participants on their own request. Final drafts of the transcribed interviews were submitted to the participants to validate, confirm or clarify the information they have provided. Healers and birth attendants were interviewed from their shrine and home respectively where they practice. Two of the biomedical practitioners were interviewed at their residence and the remaining two were interviewed at the consulting room at the hospital. Very convincing photographs were also taken of 'traditional' instruments that are used for diagnosis. The visuals were provided to give my readers a clear understanding of how sophisticated technologies are also part of the healers practices.

Data collection techniques that were used in the field included field notes, memos and digital recorder. The field notes served as a reference for some of the interview questions in the subsequent days. It also helped to develop themes from the interviews. The audio recording allowed me to listen to and review some of the vital information that we were not able to capture in the field note. Each interview that was granted started with the introduction of the research topic and its objectives. Participants were told why there is the need to record their voice.

Analytical memos were written on the environment in which the interviews took place and healers' attitude during the interview.

### **3.3.3 Data Analysis**

Data that was collected from the field was categorized into a group of actors that were interviewed from the field. Group 'A' contained the interview transcripts of healers, Group B for traditional birth Attendants; Group 'C' for doctors; Group D for nurses; Group E for registrar. I compared the view of individual participants within their group to look for similarities and diverging view. I also made cross comparison among the groups. From this analysis, broad themes and sub topics were developed. I also adopted some of the interviews in the thesis to reflect the realities on the ground.

### **3.3.4 Ethical Considerations**

Information that involved our participants' personal identities are not disclosed. Pseudonyms are used for the participants instead of their real names. Formal informed consent forms that were approved by Ethic Board, University of Ottawa was issued to all participants to read and understand before taking the decision to participate in the study. In circumstances where participant could not read, I read and interpreted the content of the consent form to them. The participant and one witness were made to sign the informed consent form. Another safeguard strategy I took to ensure confidentiality was the removal of names of locations and shrines of our participants. Information provided by participants was used only for the purpose of the study.

The informed consent form was not given to the healers and birth attendants because they could not read and understand. Instead of the informed consent form I adopted explanation model where detail content of the study was explained to participants (healers and 'traditional' birth attendant) in the mother tongue (Ewe) with wording appropriate to their cognitive level. The informed consent form was however given to the doctors and nurses. It explains the content of the study and risks and benefit of the study. Participants were asked to summarize in their own words the understanding of the study. This is to ensure that they have understood all information presented to them. I was also flexible to accommodate all questions that participants have about the study. Base on this, participants were asked if they are still willing to participant in the study.

After I have finished collecting my data on the field, I went back to my participants to say a word of thank you. Since I ended my data collection during the Christmas period, I gave gifts to all my participants for the Christmas. They showed their appreciation through various calls I received from them.

## **Chapter Four**

### **Relationships between Formal and Informal Medicine in Dzodze**

In this chapter, I present the current relationships between biomedical and informal practitioners and the influence of both practices on each other in Dzodze. I argue that the relationships between the formal and informal practitioners are cordial on the one hand but on the other hand are characterized with tension, hatred and power struggles. I also look at factors that may be hindering collaboration at the grassroots level and suggest some propositions that would help reduce the current power struggle.

#### **5.1 Relationships between Healers and Doctors**

Overall, I would describe the relationships between healers and doctors as one that is characterized with power struggles and competition for patients and prestige. From the field work, it is evident that some of the healers have strategically positioned themselves to compete with the hospital for patients. One of my respondents, who is a well known Hunua in Dzodze is about 200 meters away from the hospital. His bill board is tactically positioned opposite to the entrance of the hospital. Nobody goes in and out of hospital S without seeing the billboard of the healer. The bill board reads; 'Do you have any problem? Contact Hunua Mawuli for your quick relieves.' Although the healer has been in Dzodze for only five (5) years, he is known in the community for his magical power to heal patients especially in the area of spiritual and psychiatric illnesses. Most of his clients are those who have been to hospital S but were not cured and those who are in the hospital but are not responding to treatment. As healers and biomedical practitioners compete for patients, their relationships are intertwined with tensions. Doctors

generally do not want to work with the healers because they believe healers engage in malpractice and mismanagement of patients. Doctor Edmond claimed that:

*Medicine is not like carpentry that we should allow anybody to practice. When you put a patient on surgical table and cut him or her, you hold the person's life. If you put medicine into a patient mouth to swallow, it is like putting poison into the patient's mouth. So, those who should be allowed to practice should have the pre requisite knowledge. Why should we encourage traditional healers to practice when they use cow dumps to dress patients' wound and babies' umbilical cord? Mothers often bring their babies to the hospital with neonatal tetanus. We can only have good relationships with healers when they are ready to learn from us.*

Healers on the other hand felt that doctors do not have all the knowledge to treat every disease. This is what one of the healers told me:

*I know that in medical practice there is theoretical and practical aspect. I have the practical knowledge of medicine. I know that if you add this herb to that herb, you will get X medication to treat Y illness. The doctor only knows that X medication is derived from Y plant to treat Z illness. The doctors do not know the processes involved in preparing X medicine. So you see, doctors cannot claim they know more than us. We all have limit to our knowledge.*

Despite the power struggle, we sometimes see reciprocal exchange of patients between healers and biomedical practitioners. Doctors who have long experience in the biomedical practice and who have personally experienced informal healing are the practitioners who sometimes refer

patients to healers. Doctor G.K, for instance, refer patients with ‘kooko’<sup>8</sup> illness to a healer he knows cure this illness and the healer also refer patients to him. My interaction with him reveals that the more you work in the medical field, the more you see complicated medical conditions or strange illnesses that you have little or no idea about and the more you meet patients who tell you their own experience with healers. He told me that;

*I came to know one good healer through a patient that I have worked on for some time. Now I refer informally to that healer because he does the job without reoccurrence. I have personally worked on some herbal remedies and believe that there are some herbs that are effective for malaria, hypertension and other illnesses. Sometimes I also give an opportunity to patients to use herbal preparations instead of expensive hospital drugs.*

The story is different for the newly trained doctors from the medical school and doctors without the experience of informal healing. For this category of doctors the practice of informal healing is primitive and harmful to human life; until its practices conform to evidence based medicine, they advise that informal medicine should not be prescribed to patients. It even disturbs their imagination why some patients would prefer informal healing to hospital treatment since they have modern technologies to treat them. Of course, this attitude of younger generation of doctors is expected because the current imported western education system has separated us bodily and mentally from our culture; hence making elite Ghanaians to regard these practices as primitive.

Although it is obvious that there is some form of work relationships between some experienced doctors and healers, the relationships are more informal than a formal system. Doctors do not give any form of referral notes to patients to give to the healer. Rather they suggest to the patient a healer they know who work on a particular illness effectively. To put it in the right context, the referral pattern deals with individuals rather than systems. In other words,

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<sup>8</sup> Kooko is referred to in English language as piles. It is a common disease among the people of Dzodze.

medical practitioners who are familiar with a particular healer, know the type of illness they treat, which biomedicine has no available treatment to, refer cases to these healers. The problem with this referral system is that it is not sustainable. It ends when the healer or biomedical practitioner dies or moves to another geographical location. A healer narrated to me his good relationships with a medical doctor and lamented how the relationship came to an end when the medical doctor was transferred to another hospital.

*A sick person who was a teacher at Agbozume was admitted at Hospital S in the 1980s. According to the healer, the teacher was diagnosed of festering sores and treated but the wound never healed. In his case, within three days of his condition, all his toes had festered off. It was then that doctor invited me to see the patient. When I went, I observed that the teacher had walked into “black powder” sprinkle, a kind of juju which causes festering sores or ulceration at the foot or leg. The doctor asked me not to demand a goat, fowl or any animal for sacrifices but rather whatever money would be spent on buying the items. I complied and prepared the medication of “black powder”, one separately for drinking and the other for application at the foot to stop the festering. I was able to stop the festering thus preventing his leg from being amputated. The teacher is now doing well. But after Dr. K was transferred to another hospital, our relationships come to an end. Now none of the doctors invite me to hospital S again to consult patients.*

The engagement of some doctors with healers plays a critical role in intersections of informal and formal biomedicine. However lack of greater political will to institutionalize informal healing sometimes collapses the relationships between doctors and healers and at other times prevents doctors from going outside their standard work rules and procedures to refer to healers.

## **5.2 Relationships between Informal Birth Attendants and Public Health Nurses**

Although the Alma Ata resolution (1978) has not achieved its objective after thirty one years; health for all by 2000, and inter - sectoral collaboration between practitioners, evidently, today in Dzodze, there are unilateral collaborative programs for traditional birth attendants and Public Health Nurses. The public health nurses and the midwives at the hospital re engage traditional birth attendants in a formal western training where they are taught timing of the fetus, safe delivery and safe motherhood, family planning and family planning methods, nutrition, and the three stages in labor. After the training, working kits such as drugs, cotton, spirits and standard equipment to sterilize their instruments were given to participants. Certificates were issued by hospital S to the participants as a sign of recognition. Traditional birth attendants who have the certificate display it on their walls in the living room where everybody can see the work they do. The certificate gives the traditional birth attendants a form of legitimacy from which they practice and speak. Mama Adzo who was trained by the hospital but unfortunately did not receive her certificate was disappointed because she felt she has no prove of her occupation. These are her words:

*As for me I only want the certificate to prove that this is the work I do.*

After training, traditional birth attendants work in their communities but this time more closely with the hospitals and health centers. After delivery, they write the date of birth of the baby, the name of the mother and the father in a book and sent it to the hospital for record purposes. They also send babies that are delivered by them to the hospital for immunization. Difficult or complicated labor cases that cannot be handled or require caesarean sections are written on referral cards and sent to the hospital. The hospital has records of the traditional birth attendants and in cases where a patient has been mismanaged by the traditional birth attendant, the hospital

sends its personnel to go and talk to the particular birth attendant in question. In extreme cases, the traditional birth attendant is sanctioned. Symposiums and seminars are organized for birth attendants to enhance their professionalism.

From this perspective, it is obvious that midwives at the hospital do not accept informal birth attendants as colleagues who they would share and exchange ideas with but rather regard them as their 'school girls'. The midwives impose on the informal birth attendants their own definitions of what constitutes the reality of child birth. For the informal birth attendants who are in search for recognition, legitimacy and desire to cut into biomedical dominance, see training provided by biomedical practitioners as a way of entering into biomedical domain.

The apparent reason why collaboration between 'traditional' birth attendants and biomedical practitioners work to some extent is that traditional birth attendants do not pose a major source of competitors to the biomedical practitioners. They do not make a claim to cure several illnesses because their work is only related to obstetrics, gynecology, and its related problems. Most often, informal birth attendant work in deep rural communities where there are no health facilities or the next available health facility are miles away from them. Looking at other healers like bone setters and herbalists, they have developed elaborate traditional clinics in the urban sectors that compete with biomedical practitioners for patients.

Another reason is traditional birth attendants respect the authority of the biomedical practitioners and show no sign of challenging the authority of biomedical practitioners.

However, the good relationships that is existing between public midwives and formally trained TBAs is currently under threat as TBAs noted that the relationships between them and the public midwives have not been beneficial to them. The TBAs complain of government

partiality and discrimination as it pays monthly salary to their counterparts in the hospital without giving them anything. This is what one of the traditional birth attendants told me:

*The current relationship existing between us and the hospital is good because it helps us as health workers to save the life of mothers and new born babies but it is not beneficial to us. We deliver for mothers and sometimes, under critical conditions, we use our own money to transport pregnant women to the hospital for caesarean session. But for all these life saving jobs we do, government do not pay us any money for our services. Our counterparts at the hospitals are paid every month for the same child delivery job. We know that we do not have the certificate to take the some money with the midwives at the hospital but government should be fair to give us some allowance since also do child delivery and contribute to the health care in Ghana.*

Mama Klenam, for instance, does not want to establish any relationship with the hospital because her friends who were trained by the hospital did not get any direct benefit from the relationship.

These are her words;

*What do my friends got from the relationship with the hospital nurses? Nothing! Sometime, my friends use their own money to transport pregnant women to the hospital. The hospital does not refund the transport fare to them. Sometime, the nurses at the hospital even insult them when they did not send the pregnant women to the hospital on time. I prefer to work alone.*

With the introduction of free universal delivery policy in the country, the number of pregnant women that frequent TBAs for delivery has been reduced drastically, leading to decrease in their income. TBAs who delivered 15 -20 babies in a month in the past now deliver 2 babies in a

month if they are lucky. The current situation not only made TBAs redundant and unemployed in their communities but has also put more workload on public midwives.

### **5.3 Factors hindering collaboration**

Even though healers are respected in their communities for their epistemology on illnesses, this respect is not given to them within the biomedical community. There are many barriers to collaboration between informal healers and biomedical practitioners.

The first factor that I have identified as a hindrance to the relationships between formal and informal practitioners is illiteracy. Formal practitioners do not want to work with informal practitioners because they are illiterate and are viewed as not understanding scientific reasoning. In response to the exclusive boundary that has been created by the formal practitioners, some informal practitioners do not want to associate with biomedical practitioners because they are not properly educated to share their knowledge with those who hold more power. Some of them prefer to work isolated from the hospital. When I posed the question to my respondents, ‘Would you be ready to share your valuable knowledge, skills and experience with doctors at the hospital?’ more than half of them were quick to give derogative answer. Below is the comment of mama Klenam, an 80 year old traditional birth attendant who has been practicing child delivery for more than 50 years.

*I do not want to share my experience or work with the hospital people because they are trained in how to deliver babies for pregnant women. I do not want to go to the hospital because I am not educated. If I go to the hospital today, the staffs of the hospital will complain that I am not educated. They would say that they have gone to school to read midwifery. They would question the sources of my knowledge. To avoid all these*

*embarrassing and humiliating statements, I prefer to work on my own and collaborate with my colleagues.*

Mama Klénam may not be the only birth attendant with this impression and sentiment about biomedical practitioners. Some section of the healers has similar views to mama Klenam. Healers indicated that the inability of their great - grandfathers to go to school and document informal healing practices is the cause of delay in making informal healing known globally, and it is also the reason why biomedical practitioners underscore their power of knowledge on healing.

The comments of the formal and the informal practitioners reveal the problem with our educational system. Our current educational system seems to categorize knowledge rather than appreciating various sources of knowledge. I propose that there should be cross boundary forms of teaching where recognized healers are allowed to teach at the medical, pharmacy, nursing schools and medical teachers should also teach healers. Cross boundary teaching alone would not promote collaboration. Time should be allocated within the academic calendar when students from the medical school and apprentices from the healers socialize together and exchange ideas. This would help both medical cultures to appreciate each other. Let us take the analogy of a carpenter and a metallurgist for instance; a carpenter would say that it is good to create a door with wood instead of metal. A metallurgist would also think that it is better to construct the door of metal. But when these two artisans come together, they would realize that perhaps the best way to create the door from wood and part from metal. No knowledge is complete, standards are useful yet it is tacit knowledge that makes them work towards restoring health.

Difference in the religious beliefs is another intricate factor that is hindering the relationships between formal and informal practitioners. One healer told me;

*It hurts me that as health workers we are not able to work together because of our religious affiliations. We have allowed religion to divide us and prevent us from exchanging our knowledge. Now our people die from illnesses that can be prevented. It's a pity.*

In Ghana, informal practices are linked to voodoo and idol worshippers while formal practices are associated with Christianity. Christians are forbidden to associate themselves with idol worshippers. Patients who are Christians but visit healers for consultation and healing are considered not to be children of God. They are seen as people who will not go to heaven since they have not received and confirm Christ as their personal lord. Majority of biomedical practitioners are Christians and hold this Christian doctrine to the brim. This Christian philosophy which biomedical practitioners developed unconsciously affects the way they think, and relate to informal healing practitioners. What makes the case more complex is that in the villages where healers work, the hospitals or clinics are owned by the Christian missions who want the hospitals to go according to the doctrines that the church professes. The mission hospitals forbid biomedical practitioners who work in their institutions from having relations with indigenous healers. According to one doctor I interviewed on the field, only church chaplains are allowed in wards to pray for patients to boost their spiritual level. If patients' spirit is lifted, it helps the recovery of the patient.

Another factor hindering relationships are current biomedical ethics. Biomedical professional ethics that bind the professional conducts of biomedical practitioners do not allow practitioners to refer patients to healers. In circumstance where smaller biomedical health

facilities lack expertise and advance technologies to treat complicated health issue, they are required to refer patients to a higher facility that practice orthodox medicine. The ethics forbid biomedical professionals from referring to healers because they are not certain of the exact treatment healers will provide to patients. However, patients who are tired of biomedical treatment can seek discharge against medical advice. The patient charter gives patients who are 18 years and above the right of choice to seek a second opinion in terms of medical treatment.

There is an increasing assumption among some scholars that the integration of knowledge systems would be difficult to achieve since the informal and scientific knowledge operates on different worldviews, have different ways of healing, expertise, knowledge and beliefs (Offiong 1999, Twumasi 2005, Islam 2005) and are organized from different power relations. Thus the medical systems should be allowed to work separately (Islam 2005) but cooperate together. Offiong (1999:118) 'concluded that outright integration would be too ambitious and practically impossible but that some form of cooperation is possible given political will. As Coulter (2004) observed, the biomedicine and traditional medicine 'hold fundamentally contradictory metaphysical beliefs and differing philosophies about health and health care'. Thus Western medicine operates on the principle of nature rather than supernatural (Twumasi 2005). ' The dichotomy that is drawn between the categories of medical knowledge by scholars in the academia is itself a barrier to collaboration. It has presented host of complexities in collaboration than we ever thought. The differentiation that is drawn that informal healing is local, biomedicine is global; informal healing operates on the principle of supernatural and magico religious factor while biomedicine operates on cause and effect has promoted some kind of suspicion among practitioners. Each of them stay at the extreme side of the poles thinking that

their mode of treatment is the best and also inventing each other's categories in opposition to one another rather than seeing spaces of shared knowledge, practices and concerns.

#### **5.4 Appropriation of Knowledge**

In the midst of the trend to look at the incorporation of healers into the National Health Care Delivery System, some researchers have reported on the social changes that have occurred in the practices of informal healing as a result of the influence of biomedicine. Anthropologists including Oppong (1989), Johoda (1961), and Gessler et al (1995) have drawn attention to the influence of biomedicine on informal healing without looking at the reverse influence. In the face of encounter between formal and informal healing, I have discovered new changes in the practices of both practitioners as a result of influences coming from both sectors. Although the relationships between formal and informal medicine is marked with power struggles, both appropriate knowledge from each other sometimes knowingly and at other time unknowingly. Healers now prescribe certain biomedical drugs especially pain killer to patients to reduce pain before they embark on treatment. For example, some healers give Paracetamol to patients when they have headache to relieve pains before they embark on treatment. Some of the healers also go to the hospital for treatment when they are sick. Healer Osofo Tsidi told me that he went to the hospital when he was poisoned. My immediate response was why didn't you heal yourself when you were poisoned since you are a healer? His response was I did attempt healing myself in the initial stage but I realized that I was not poisoned spiritually, so there is the urgent need for me to go the hospital for treatment. They gave me some pills which were effective. He however added that going to the hospital does not mean that western medicine is better than traditional medicine. Both are good and effective depending on the type of illness. Traditional medicine

works effectively in treating spiritual illnesses and western medicine works well for physical illnesses.

Herbal medicines are also transformed into capsules, tablets and syrups with dosage description on the label and are sold in the chemical stores. Some products are also advertised on the media. This practice by the healers is leading to commodification of herbal products. Some patients no longer go to see healers for treatment but buy their products and use them. The biomedical practitioners on the other hand are beginning to learn the psychological treatment and the social care practice by the healers. I have observed that nurses especially are no longer shouting on patients as they use to do and the abuse of patients by nurses is gradually reducing. In a day workshop that was organized for outpatients nurses at Ho which I participated to, health workers were taught to emulate the care that healers and informal birth attendants give to their patients.

### **Summary of Discussion**

The current relationship between informal and biomedical practitioners can be described at different level. While traditional healers have fragile relationships with doctors, traditional birth attendants have relatively strong relationship with hospitals. The fragile relationship together with the power struggles that we see between doctors and healers can be attributed to doctors' insistence that healers' practices be standardized to conform to scientific parameters. However, the most common observation that I can deduce from the current fragile relationship is patients die out of preventable and curable or treatable disease. The antagonistic relationship interface between informal practitioners and biomedical practitioners cause more disservice to society. It is also apparent that the power relations linked with formal practices decrease possibilities for

collaboration with informal medicine and also have negative influence on any possible medium of innovation.

## **Chapter Five**

### **Global Health and Informal Medicine in Ghana; Current and Future Prospects**

#### **Introduction**

Within the last few decades, informal medicine has become popular and a topic of global interest to many in the academic, pharmaceutical, industrial and international world because of its medical claims and economic relevance. The situation has become a matter of concern to health experts raising questions on efficacy, safety, quality and standardization of informal medicine. In attempts to institutionalize informal medicine into national health system, the World Health Organization has provided a framework for policy to assist individual nations to develop national policies to regulate informal practices and products.

In this chapter, I discuss regulation and standardization of healing practices in Ghana. This section will be followed with a conclusive debate on integration and the WHO policies of collaboration and how they pan out in Ghana. Finally I discuss why informal medicine continues to persist despite the social and economic changes.

#### **5.1 Regulation and Standardization of Informal healing**

Although informal medicine has been in use in Ghana for centuries, regulating and standardizing its practices according to WHO protocols has been a current phenomenon in Ghana. The Ministry of Health and informal practitioners from the period of 2000 to date have got into the ideas, declaration, recommendations by the WHO and World Health Organization Regional Office for Africa (AFRO) as far as traditional medicine is concerned. Ghana is a signatory to African Union (A.U.) declaration on traditional medicine. Flowing from that

commitment, government has established the Traditional Medicine Practice Act 575 (2000) to regulate the practices of healers in Ghana. The Act 575 establishes a Traditional Medicine Practice Council that oversees the practice and standards of informal healing, register practitioners, license practitioners; regulate preparation and sale of herbal products in the country.

The Ministry of Health has set up a directorate towards the promotion of traditional medicine. This directorate is now setting up structures that would facilitate collaboration between formal and informal healing practitioners. The directorate is observing the Chinese and Indian models of informal medicine and hope to adopt some of their best practices into the Ghanaian model. The directorate hopes to take advantage of the continuous educational opportunity China is providing both at professional and academic level to enhance the training of the healers in Ghana. The directorate is in network connection with some Chinese informal medicine practitioners who are professors in different Universities who would help Ghana to study the Chinese technology, their advancement, their regulatory systems and strategies of the development policies and regulatory mechanisms. (Registrar of Traditional Medicine Practice Council 2009).

The policy unit of the directorate recently published a code of ethics and standards of practice for informal healing medicine practitioners. The code serves as a regulatory instrument for the informal healing practice that would instill discipline and professionalism into the practices. The code of Ethics as a regulatory mechanism would help to streamline bad practice within informal healing profession and bind them within the boundaries of the law. Article 17 of the code of Ethics for instance forbids practitioners to prescribe any medicine containing parts of the human body or organs or indulge in human sacrifices (Ministry of Health, 2004: 4). Despite

the adoption, in an interview with the registrar of Traditional Medicine Practice Council, he stated unequivocally that healers find it difficult to abide by the code of Ethic. For example, healers fail to register their products with the Food and Drug Board before putting it in the market.

In February 2009, the Ministry of Health issued directive requesting all informal health practitioners be registered. The objective of the registration exercise is to ‘weed out quacks’ from the system and define who is a legitimate healer. In the absence of any meaningful and verifiable entry requirement into the practice of the informal healing profession, anybody can wake up overnight to become practitioner. Currently 900 practitioners are registered with the directorate of traditional medicine. To qualify for registration, a practitioner must have a minimum education of high school; possess evidence of trade in a form of training and show evidence of belonging to some practice group where it is believed that self regulation would be exhibited. That is not to say that ‘grandfather/mother’<sup>9</sup> practitioners who are currently practicing and do not have their minimum basic qualification will not be allowed to register and practice. The grandfather practitioners cannot be subjected to any formal classroom education but they should be taken as they are and upgrade their standards, knowledge, skills and service delivery. The directorate hopes to enforce strictly the criteria for registration of healers after the end of the window period (the death of the grandfather practitioners).

Another regulatory tool adopted by the directorate to ‘weed out quacks’ and charlatans is the fee regime. Indigenous Ghanaian practitioners pay 20 Ghana cedi (\$15) annual subscription fee for practicing and 30 Ghana cedi (\$21) for their premises like shrine. Those who are foreigners like the Chinese pay 200 (\$150) Ghana cedi as annual subscription and 500 (\$350)

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<sup>9</sup> Grandfather/mother practitioners are old practitioners who acquired their skills, knowledge and competencies through visions, dreams, observations and from apprenticeship program that they learn from their master craftsmen who might be their relatives, friends or whoever they think fit to teach them the trade.

Ghana cedi for their premise. The fee varies depending on the nature of practice. The fee regime is instituted according to the registrar of the directorate to serve as deterrent to people who are not genuine practitioners. The fee regime however does not weed out quacks but rather promotes quacks. This is because the mechanism has the possibility of introducing bribing and corruption into the system. Those who have money yet are unknowledgeable on the practices of informal medicine have the possibility to bribe officials at the ministry to get registered as healers.

The practitioners are also regulated by way of an association. The ministry has successfully brought all the practitioners' groups under one umbrella which is called federation of Traditional Medicine Practitioner Associations. However not all practitioners' group and practitioners are part of the association. There are some who would like to uphold their constitutional rights hence are not compelled to go under the federation by government. They are on their own as individual associations. Notwithstanding that, government deals with them as groups. To be registered as a healer, the application of the practitioner must be refereed by the district chairman of the association, community leader or the district coordinating director.

The Ministry of Health has instituted a training program for the healers and from this year (2010) the training programs, as directed by Parliamentary Select Committee, will be targeted towards practitioners who are duly registered. Practitioners who do not complete a certain number of hours for the training program are not qualified to renew their license. Sanctions are imposed on those practitioners who do not attend the training program at all. The Kwame Nkrumah University of Science and Technology has instituted formal training of students in herbal medicine in 2001, the first of its kind in Africa (Registrar of Traditional Medicine Practice Council, 2009). The program is a multi- disciplinary course that is jointly run by Faculty of Pharmacy and the School of Medicine in alliance with the Faculty of Social

Sciences. Students are trained to master the botanical, pharmacological and chemical component of plants. Interestingly, community healers are involved in the training of students. Students are attached to healers in the communities to gain practical knowledge of the procedures healers use in diagnosis and administering of drugs to patients. So far 70 graduates have been trained since the commencement of the program. However, the Ministry of Health is confronted with the problem of placement of graduates into the National Health Care System. The key questions that serve as blockage to the incorporation of herbal graduates into the National Health Care System is what salary scale would they place the herbal graduates? Would they place it at par with doctors, pharmacists or nurses? Due to this constraint, some of the herbal graduates are now working with the Center for Scientific Research into Plant Medicine, Food and Drugs Board and others are employed by self style healers.

The Parliamentary Select Committee has also mandated the directorate of traditional medicine to invoke legislation to control the sale of herbal medicine in passenger's vehicle. The directorate has realized that citizens are at risk if herbal vendors continue to sell their product to them in vehicles. The safety and quality of these herbal products is not known and the vendors who are selling these products do not collect marketing permits from the Food and Drug Board. In an interview with the registrar of traditional medicine practice council, the directorate is yet to initiate discussion with Prometra International, Ghana Private Road Transport Union (GPRTU), Police and other security agencies on how to 'weed out the quacks' and charlatans of herbal vendor who sell herbal products in vehicles.

In an attempt to institutionalize and professionalize the trade of informal healing medicine, the Ministry of Health in consultation with a team of experts from the University of Ghana, Kwame Nkrumah University of Science and Technology, Noguchi Memorial Institute of

Medical Research and the Federation of Traditional Medicine Practitioners Association has published a recommended list of herbal medicine formulations with scientific validation for safety and efficacy for diseases of public health priority. The recommended list of herbal products consists of 145 medicinal products covering 14 disease conditions. The recommended herbal products list is a regulatory mechanism to fade out fake herbal products in the system for self medication, ensure accessibility and affordability, broaden patient's options for alternatives within the medical system and establish standards for measuring best practices within the informal healing sector. The herbal formulary in a monograph has been made available to formal practitioners for possible suggestions. However, this has generated huge debate among formal practitioners. Some of the doctors express their reservation about these herbal formularies while others think that informal medicines which are proven scientifically to be safe and efficacious should be made available for formal practitioners to prescribe at the hospitals without necessarily engaging the healers at the hospital since this will serve as a way to control informal practices.

## **5.2 Debate on Integration**

In the 1980s, 1990s and 2000s, various scholars (Offiong 1999, Bishaw 1991, Konadu 2007, Gessler 1995, Green 1988, Tsey 1997, Liverpool 2004) have engaged in the discussion on possible collaboration between healers and biomedical practitioners. While some have called for what I called 'out-and-out' integration of informal healing and biomedicine into the National Health System, others propose a gradualist approach with political will. Offiong (1999) for instance calls for the gradualist approach stating that it would be too ambitious and practically impossible to go for outright integration. Both Offiong and Konadu (2007:177) concur by saying that informal healing and biomedical systems are incompatible at their very core.

The debate on integration has been in Ghana for quite some time now yet not much has been done to achieve this reality. It started in the 1960s when Nkrumah government attempted to revitalize informal practices. The country went a step higher when it initiated some collaborative programs like Danfa Rural Health Project, Brong Ahafo Rural Integrated Development Project, The Primary Health Training for Indigenous Healers Project, for the formal and informal practitioners to improve rural health and family planning. According to Neumann (1974) and Twumasi (2005), the Danfa Rural Health Project was a teaching and research public health initiative program for medical doctors, medical students and other categories of health workers that begun in Ghana in 1970. It was a joint collaboration program between the University of Ghana Medical School and the School of Public Health, University of California, Los Angeles. Under the Danfa project, Hoff (1995) stated that traditional birth attendants were trained to examine pregnant women, refer high risk pregnant women to clinics, promote maternal and child health, properly care for umbilical cord and practice through health education. The Danfa project was closely followed by Brong Ahafo Rural Integrated Development Project (BARIDEP) which was conducted between the periods of 1975 - 1980. Overall 31 community clinics were placed under the BARIDEP ( Antwi 2008) and over 50 traditional birth attendants were trained in 1978 (Hoff 1997: 22). The BARIDEP as Ventevogel (1996) observes was planned to take into consideration all forms of indigenous medicine but healers were not willing to cooperate. The Primary Health Training for Indigenous Healers project (PRHETIH) was the first collaborative program that was initiated between healers and biomedical practitioners in 1979 at Techiman District in Ghana. The aim of the project as Warren (1982: 1876) was to 'augment the knowledge and skills of indigenous healers and to bring about closer cooperation and understanding between indigenous and western oriented health workers'. The healers were

taught 14 topics in all by a team of experts which comprised of six members of the Holy Family Hospital staff, three district level Ministry of Health Workers (Public health nurse, Sanitary Inspector and Medical Field Unit Chief) and two field Coordinators (Warren 1982: 1877). The PRHETIH project is widely publicized by WHO literatures as a successful collaborative project between formal and informal practitioners

In my opinion, it is a delusion to assume that these projects are collaborative in the first place. They are unilateral and repressive in nature. Within these projects informal practitioners were taught by formal practitioners yet no medium was provided for the informal practitioners to express what they know. Ventevogel (1996) interview with the healers reveal that healers perceived the PRHETIH project as ‘something that government and hospital organized for them but not with them’. The experience from the so called collaborative program not only illustrates the unequal balance of power, resistance and conflict, it also reveals the persistent determination of formal medicine to colonize informal medicine.

In an attempt to shift away from unilateral integration and look for new sites of innovation for integration, Konadu (2007:177) proposes that both formal and informal practitioners must acknowledge and accept their areas of expertise and limitations, perspectives and cultural foundations from which they operate. This contribution from Konadu is valuable and great but reality is otherwise; there are often invisible hands<sup>10</sup> that stop this reality from happening. The new site of innovation into the process of integration does not necessarily lie in the resolution of power struggles between formal and informal practitioners; it lies in the attitudinal change in character of the invisible hands. Ghana’s long history of effort to integrate formal and informal practices has not been successful because of slow reaction of government to

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<sup>10</sup> I refer to invisible hands as the state, WHO and other International Organization that are involved in informal and formal medicine.

implement national policy on informal medicine (Green 1988, Pillsburg 1982). In 2000 for instance, the Parliament of Ghana promulgated Traditional Medicine Practice Act 575 but the Traditional Medicine Practice Council that is stipulated in the act to regulate the practice of the healers was only established by government on April 9, 2010. To further prove my point, there are laws in Ghana that oblige healers to register their products but only few herbal products in the public market are registered. While at Dzodze, I took some time to visit the market and the public transport station, my observation was that most of the herbal products that are sold in the public transport have no label displaying their registration. A recent tour by the Food and Drug Board to some of herbal clinics in Tema, Ghana also reveals that operators of herbal clinics do not register all their herbal products before commencing sales in the market. In Ahoto herbal clinic for instance, out of the 15 herbal products that are sold in the market, only 3 of them are registered. The situation is not different from Adom herbal clinic where out of the 12 herbal products, only 5 products were registered (Ghana News Agency 2009). To put it in a different way, the laws are made but they are not binding. The more I reflect on issues of integration, the more it seems to me that key policy makers in Ghana are only interested in getting the legal framework done that will enable formal and informal to continue to coexist in a plural medical system and not to collaborate. I have not seen any practical concrete commitment on the part of government to make informal practitioners work at the hospitals. What Ghana needs now is a strong government commitment in the areas of implementation of the legal framework, funding into research on informal practices and changes in our education institutions. Government must also increase budgetary location for informal medicine and encourage the private sector to invest into informal medicine. This will aid in the expansion of physical infrastructure and also trigger individuals and institutions to embark on research that would transform the informal industry. I

also think that the Government of Ghana should draw a comprehensive plan on how she is going to develop the informal practice. The plan should be made obligatory for governments who come into power to follow and implement. Here society has moral obligation to ensure that present and successive governments implement the Plan.

### **5.3 Why the need to Collaborate**

Collaboration among our health professionals is crucial for Ghana and the entire continent of Africa in order to revitalize our health care system. In Ghana and other parts of Africa where there are shortages of biomedical professionals, health facilities are scarce and cultural knowledge/beliefs make it difficult for people to seek biomedical health care, there is the need for collaboration between informal and biomedical practitioners.

There is also the need for us to recognize that knowledge is broad and no one can profess to know everything. Both medical traditions have limits to their knowledge and the only way to close knowledge gap is to work hand in hand for better healthcare delivery system for our people and towards national development. One healer explains to me why he thinks there is the need to collaborate.

*My father once told me that you can have juju to treat people but juju can never transfuse blood or give drip to patient. Our practices are different from that of the hospital people. Sometimes we need each other in order to complete treatment and save patients' lives. I do not give blood or water (drip) to patients when I realize the patient lacks blood. Even though I prepare medicine that gives blood to patients, it takes a long time before the patient gain blood. So when I detect that a patient is urgently in need of blood or drip to survive, I ask the family of the patient to send him/her to the hospital people since they*

*have a quick method of giving blood to the patient. If the illness is a combination of natural and spiritual, the ideal thing to do is to neutralize the juju and sent the patient to the hospital to do the rest. It is only ignorant healers who keep patients with them even when they are not able to heal them.*

As the healer had demonstrated, biomedical practitioners should also do the same by acknowledging their limits. Sometimes you go to the hospital and realize that there are patients who have been admitted at the hospital for long but they are not responding to treatment. The patient sleeps on the hospital bed for long and sometimes develops bed sores. The doctors at the hospital are very much informed that the patient cannot be cured but they do not want to release the patient for the informal healers to work on. They keep on resuscitating the patient until the patient dies. One of the healers shared the experience of one of his patient with me.

*Medawovi is a well known member of this community. He became sick of strange illness and was sent to the hospital for treatment. He stayed at the hospital for weeks but he was not responding to treatment. At the hospital, he became swollen to the extent that bodily fluid was coming out of him and he could not talk. If the relatives were not to identify that the illness their brother was suffering from was not a hospital disease and brought him to me, he would have stayed at the hospital and die there. Look at him; he is now fit and strong.*

The same situation occurs when healers do not release patients to the hospital on time. I have observed from the field that healers admit patients for months and sometimes even years depending on the type of illnesses. The healers only refer patients to hospitals if they have exhausted all their treatment measures and are unable to provide treatment to patients. By that time the referral is done by the healers, the conditions of patients are worsened or patients are on

the verge of dying. This makes it difficult for biomedical practitioners to treat the patient. From my everyday experience with the healers, I had also observed that some of the delay in referral may be due to logistic measures. Simple measures could be instilled to resolve the problem. When there is collaboration, patients who otherwise delayed in seeking medical care from either biomedical services or from informal healers can be attended to quickly to avoid medical complications. In other words, treatable conditions that are left late before referral can be seen earlier and treated. This will help in the long term to reduce the number of people dying of preventable and curable illnesses in Ghana.

Collaboration would also serve the welfare of patients and practitioners. Both medical traditions do the same work but from different points of view. If there is collaboration it would help both practitioners to know herbs or drugs the patients has already taken, what medical intervention has taken place and patients would be ready to disclose information to both practitioners without fear. In other words access to information on patient would be easily available to both practitioners.

Collaboration would also facilitate exchange of expert knowledge among practitioners. Both practitioners are ready to teach each other certain aspects of their practices but biomedical practitioners are not ready to learn from the informal healers because they think informal healers have nothing good to offer them. However, doctors can learn some religious and home therapies from healers. This would help the medical community to respect patients' culture and develop therapeutic strategies that would help patient to recover faster. If a doctor defines what is wrong with a patient and the doctor's interpretations of what constitute deviance do not tally with what the sick person and the family think is wrong, it would be difficult for doctor to persuade patients to accept biomedical treatment. Biomedical practitioners' willingness to learn from healers

would help to rethink certain standards and work together, but in a different fashion. The current practices where formal and informal medicine exists side by side only cause exclusion and polarization.

#### **5.4 Current Resurgence of Informal Medicine**

The persistence of informal healing in Ghana especially in the rural areas can be attributed to the general knowledge in the reality that illness is connected to supernatural worlds – witchcraft, sorcery and ancestral spirits. When people get sick and show strange behaviors or do not recover on time, it is generally known that the illness is not an ordinary one; Ghanaians become suspicious of witches/evil being at work. In search for restoration of health, Ghanaians restore to metaphysical intervention which may be in a form of exorcising of the spirits, ritual bath, animal sacrifice, prayer and fasting. To put it simply, people use informal healing because it is harmonious with their knowledge system, values and most importantly it works for them.

Another reason why rural folks continue to patronage informal healing is it is the only health care that is readily available and of a low cost to the people. Healers are not scarce in the communities as compared to biomedical practitioners that are few and far from many of the rural areas and do not have modern technologies to restore health and meet the demands of the patients. Unlike biomedicine which demands money before service, community members who are financially handicapped seek treatment from healers on credit and pay on a later date since they are well known by the healer.

Beyond the persistent use of informal medicine in the rural areas, informal healing is increasingly used in urban centers in Ghana. The current revitalization of informal healing in the urban areas in Ghana can be attributed to people's dissatisfaction with the efficacy of

biomedicine. This situation is not only limited to Ghana but it is also observed by anthropologists from elsewhere (read Astin 1998, McGregor et al 1996, Furnham and Forey 1994). People have lost faith in the ability of biomedicine to provide cure for chronic disorders and lessen pains. During my fieldwork at Dzodze, I met an old woman who calls me her son. She always wants me to spend most of my days with her. In one of my interactions with her, she revealed to me that she has been suffering from waist and joint pain for the past 10 years. According to her, she has been to several hospitals but has not seen any improvement in her life. She told me

*Son, which medicine have I not taken in this world? Today, they asked me to buy this medicine; tomorrow they asked me to buy another. I bought all these medicines but son look at me, my situation has not changed, I am still suffering. I am just tired of taking all these medicines and all that I want do now is to live my life and die when death comes.*

People are tired of continuous swallowing of pills for their entire life in order to take control of chronic disease. They want to take control of their own bodies instead of seeing doctors without an improvement in their medical conditions.

Finally, people in the urban centers are shifting to informal healing because they are well informed by the healers about the illness they are suffering from. Patients are informed about the cause of the illness, who is behind it and sometimes the treatment procedures. This communication approach by the healers make patients feel they are in control of their bodies and also make them to be careful about the person who is responsible for their illness. The high demand in the use of informal medicine has made healers innovative in creating herbal clinics in the cities in Ghana. They operate mostly in chronic diseases that are incurable by biomedical practitioners. Examples of herbal clinics include Blessed Herbal Clinic, Top Herbal Clinic etc. Some of the herbal clinics operate similarly like modern hospitals and have ultra modern

laboratory service, X- Ray scanning, ultra sound scan, maternity ward and pharmacy with their premises. The Ghana News Agency on 3<sup>rd</sup> September, 2009 published an article that reads:

*The Blessed Herbal Clinic Limited has introduced an immune booster 'Immune Assist 247' for people living with HIV/AIDS, infertility, stroke, diabetes, low sperm count and general pains. 100 patients were put on trial at the clinic and they responded positively (Ghana News Agency, September 3, 2009).*

The establishment of herbal clinics in the cities has introduced huge competition between biomedical practitioner and the herbalists linked with power struggles over urban dwellers. As the use of informal medicine increased, issues concerning national policy, regulations and standardization of informal practice become paramount to WHO and individual nations.

### **Summary of Discussion**

In this chapter, I pointed out that people use informal medicine based on different reasons. People from the rural areas use informal medicine because it is harmonious with their belief system and values. In the urban areas, people are shifting to informal medicine because they are tired with the continuous intake of pills. Overall people are using informal medicine because it works for them. However, this increase in the use of informal medicine has not reflected much in government attitude towards integration of informal medicine into national health system. Government attitude towards formation of legal framework for informal medicine has been great since the 1960s but the concrete practices that are needed to achieve integration are slow and woefully inadequate. This may be partly due to lack of commitment on the part of some government workers that come to power and to low budgetary allocation to informal medicine. As the chapter pointed out integration has several advantages over the current plural health care;

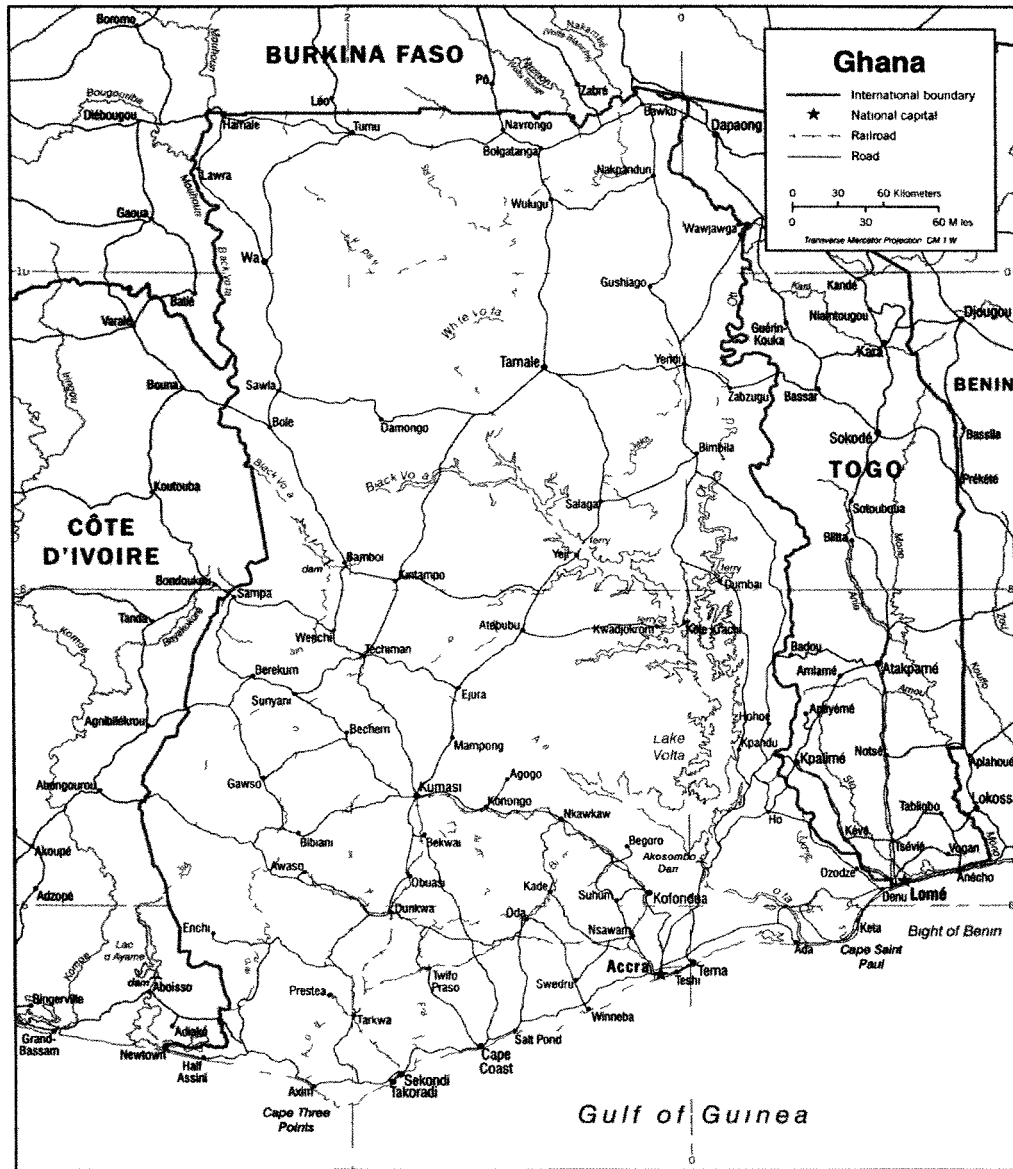
integration may lead to transformation of formal and informal practices and subsequently give informal practices global legitimacy.

## Conclusion

The purpose of this research was to understand how relationships between informal practitioners and biomedical practitioners are performed in the everyday life of Dzodze, Ghana. For this, I introduced the general Ghanaian context and explored how it occurred in the everyday life of Dzodze. Informal medicine remains an active source of health care in Ghana. Although it is believed to be primitive or backward practice by the western powers, scientific communities, religious organizations and some educated elites, it is the first line choice of treatment for at least 70% of Ghanaians. Informal medicine continues to persist because to some, it is the only available and less expensive health care, and to others, it gives them hope in times of distress and discomfort. It is also harmonious with rural folks' beliefs and cultural heritage. No matter what the scientific community does to suppress informal medicine, rural and urban folks continue to use it especially in the area of chronic illnesses and illnesses that are believed to be caused by witches. Doctors who believed in informal medicine would continue to prescribe certain herbal products to their patients and refer patients with certain illnesses to healers. Informal medicine will not disappear because biomedicine has failed to colonize the health care system of Ghana and other parts of the world. Even though my everyday experience with key informants reveals that initiating collaboration between healers and biomedical practitioners is going to be a difficult task, it is important we take pragmatic steps to scale up the formalization and institutionalization of informal medicine to allow official referral from the hospital to the healers. Live experience and formal knowledge are useful to inform practices since both bodies of knowledge are fluid and dynamic. To achieve collaboration, we need strong political will, mutual respect and willingness on the part of each of the medical traditional to accept their limits. There is no single health care system that can take care of all our health problems. We

need tacit knowledge if we are to take control of our health problems. Culture, traditional beliefs and customs play important roles in people health and they should be respected as such.

Appendix: One



Base 803136A1 (G00183 5 07

Figure 1: Map of Ghana (U.S Central Intelligence Agency 2007)

## Appendix Two: Interview Protocols

### Questions for biomedical practitioners

- a. What do you know about traditional medicine and its healers?
- b. In your daily practice, have you come across any healer that cure people?
- c. Is there any form of relationships between you as biomedicine practitioners and healers?
- d. Do you think that biomedical practitioners and healers can work together?
- e. Are you ready to learn from healers?
- f. Are there factors that hinder relationships between you (doctor) and healers?
- g. From your clinical experience, have you come across certain illnesses that you cannot cure and make referral formally or informally to healers?
- h. Have you come across patients at the hospital that combines biomedicine medicine with traditional medicine?
- i. What was your reaction?
- j. Have you ever taken traditional medicine before

### Questions for Traditional Birth Attendants and Healers

- a. Is there any relationship between you as TBA and biomedical practitioners?
- b. What type of relationship exist between you
- c. Is there any frequent interaction between you
- d. How would you like your relationships with biomedical practitioners to look like?
- e. Are there any barriers that is hindering this relationships
- f. How do you see your current relationships with biomedical practitioners
- g. How are your practices differ from that of biomedical practitioners?
- h. How do you know the type of illness a patient is suffering from
- i. How do you know patients are healed?

### Questions for Registrar

- a. What has the ministry done to promote traditional medicine or to integrate traditional medicine into the national health system?
- b. What are the requirements for getting the license?
- c. What do you see when registering healers?
- d. How many healers have been registered under the ministry?
- e. How much do you charge for registration?
- f. How does the ministry intend to weed out quacks in the system?
- g. What standards do you want to reach?
- h. What type of education do you want them to get again?
- i. How different is KNUST's herbal medicine from the training you will provide to the healers?
- j. So far what has been frustrating the ministry in the integration process?

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