Toward a Comprehensive Healthcare System in Ghana

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ABSTRACT

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Presently, Ghana is confronted with a health crisis, driven by enormous burden of diseases and poverty. The current health care system, predominantly modern, has proven inept in meeting the needs of Ghanaians as many continually die from preventable diseases. The quality of services available, the geographical access to this care, efficiency of service delivery, and availability of adequate resources to finance and sustain health systems, have placed unnecessary barriers to access available care in Ghana. Continuous decline of health care has consistently failed to compliment the increasing population growth. As a result, the deteriorating healthcare system has forced the majority of the population to seek alternative healthcare services. Traditional health care system, which is the oldest medical system in the country, has once again become the initial avenue of accessing care for about 75% of the population. Traditional health care system is effective, cost-effective, culturally accepted, and have consistently been argued as an effective system that can aid and complement governments’s efforts at ensuring equitable health care. Yet, it remains unintegrated into the current health care structure, and hence remains untapped.

This study sought to analyze and evaluate the importance of full integration of traditional health system as a way of maximizing health care accesses, use, and availability to the public. The study identifies the historical trends of both health care
systems, reviews current health policies and examines the benefits of integrating traditional health care system into the mainstream health care delivery.

The method employed in this study was qualitative one, using semi-structured interviews to gather data. Thirty-three respondents consisting of 12 individuals and 2 focus groups (from Tema Municipality), and 8 key informants (government officials and traditional healers), who uses or have knowledge about the traditional health care system, were selected for this study.

Research findings from in-depth interviews indicated that traditional health care system is widely used, inexpensive, effective with fewer side effects, and easily available and accessible to majority citizens. The results of this study also indicated that traditional health care system is culturally accepted, as it is guarded by a shared local knowledge system that instructs its proper use. The majority of respondents are overwhelming in favor of a policy driven integration process, citing the possible socio-economic benefits of that such an integrated health care system will provide.

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CHAPTER ONE: INTRODUCTION

“We shall measure our progress by the improvement in the health of our people... The welfare of our people is our chief pride, and it is by this that (we) ask to be judged”.

(Nkrumah 1969, p. 51)

Background to the Study

Rather prophetically, Nkrumah vision of the role of health care to national development still echoes today. Assuredly, “health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity” (UN, 2000). Article 25 of the Universal Declaration of Human Rights (UDHR) further indicates that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, ...medical care ...and the right to security in the event of ... sickness, disability” (UDHR, 1948). Therefore, the right to good health care is not only essential, but also a major responsibility of the government (Constitution of Ghana, 1992).

Of course, economic progress of development of a nation is not only dependent on income or the wealth of a nation but on other social services such as improvement in health care delivery. Human resource cannot function at full capacity in the absence of effective health care. Article 34 (2) and 36 (10) of the 1992 Constitution of Ghana, obligate the government to ensure sustainable socio-economic development of its citizens, irrespective of class, ethnicity, gender, age, religion, or geographical location. Interestingly enough, the former president, H.E. John A. Kufuor, visualized Ghana as a
middle-income, with possibly $1000 per capita by 2015, through good governance, private sector promotion and human resource—the “human capital” development (MoH, 2005, p.23-4). In this regards, the role of the health sector is to improve human capital, hence “creating wealth through health” and the “development and implementation of proactive policies that will ensure improved health and vitality among Ghanaians” (MoH, 2006, n.p.). As Sen (1987) states, the development or wealth of a country is based on the “well-being” of the people. Availability and accessibility of health services can make economic development sustainable. In many cases when factors such as accessibility, availability and proper “utilization” of healthcare services are denied, development can be stalled. The health of the nation directly affects the socio-economic indicators that define any important national economic and socio-political growth. In fact, it is a requisite for economic and social development of any country. The health status of a country’s population affects the condition of the labor force, which determines production. In the same way, poor health has critical impact on the education of children. Likewise, it can lead to ill health and even poverty as individuals may end up spending a fortune on their healthcare needs at the expense of other essential provisions of life. To this end, “improving health would lead to significant savings on health expenditure as a result of the reduced diseases burden. A healthy, strong, intelligent and active human capital will be more productive, creating more wealth and thus increasing the Gross National Income” (GNI) of Ghana (MoH, 2005,p.24).

Ghana is a low-income country on the coast of West Africa, with a total population of over 23 million spread over 10 regions. While Ghana is endowed with natural resources, it was estimated in 2005, to have $2,370 GNI per capita, which is
below the average for low-income countries (WHO, 2006a). Though there were some improvements made in population health indicators over time, Ghana continues to experience difficulties in maintaining and providing functional basic health facilities, good nutrition, proper sanitation and enforcement of laws on occupational safety and health hazards (MoH, 2005). There have been many reported cases of death from preventable diseases such as malaria, which is the number one killer disease, especially amongst children and pregnant women in Ghana (MoH, 2005). Many preventable diseases such as malaria, trachoma, cholera and diarrhea (the second single cause of child mortality in Ghana), in the country are sanitation and water related diseases. As one hygiene specialist, Mr Emmanuel T. Nyavor puts it, “poor sanitation poses greater health risk than HIV/AIDS” in the country (GNA, 2008). This problem is acute in the rural and remote areas where geo-political and financial potency determine accessibility to these basic human rights. Many citizens are unable to obtain the most basic health services, as a direct consequence of the scarcity of healthcare personnel in the country and high healthcare costs. The depleting number of healthcare personnel has led to the closure of many clinics and hospitals in remote areas of the country. Often, rural populations are forced to travel significant distances to access healthcare service. In addition, transportation and hospital fees are too costly and many cannot afford them. Poor financing of the health service, inadequate health facilities, coupled with insufficient health personnel still form some of the main constraints limiting health service delivery in Ghana. It is startling that with a population of over 20 million, there are only 0.15 physicians to every 1,000 patients in Ghana (WHO, 2006a). Healthcare personnel—such as physicians, pharmacist, midwives and nurses—have decreased dramatically at an
alarming rate as most migrate to the U.S., Europe, and Canada. Not only are the rural and remote places affected by this migration trends, but major economic cities as well. Thus, the impact is felt all over the country. Unfortunately, with a deteriorating economic growth and high fertility rates, immediate past government’s efforts to improve health care faced major challenges. The growing demand for modern health care (which remain the predominant system of care), declining financial capability to access this form of care, constant migration of health care personnel, and demonization of tradition health systems have presented a stiff challenge to attaining middle income development status in the near future.

Current scholarship on health care in Ghana has renewed efforts and revived interest in researching traditional health systems as means to bridge the gap in the health care demand in the country. Many have argued that health policy should promote the use of indigenous health services to complement the declining services given by modern healthcare system.

*The Challenge of Healthcare Integration in Africa*

With emergence modern health care system in Africa, traditional healers and initiation leaders “were less concerned with distinctions between ‘modern’ and ‘traditional’ medicine; they invited […] modern medical personnel, especially hospital physicians] to bring their ‘antiseptic regime’ and all the actors and agents that this involved into the[ir communities]” (Langwick, 2006, p. 150). Albeit, modern physicians and their assistants welcomed and treated and cared for patients, they were not interested in negotiating a pluralistic health care system, in which case the place traditional health care given will have a legitimate place in care giving.
In fact, many biomedical practitioners viewed traditional healers as bringing chaos to the health care delivery system, and this they argue is an unnecessary burden on the profession. As Langwick (2006) remarked, Stirling, a mission doctor stationed in Tanzania, argued that healers manipulating causations of diseases in terms of spirits and ancestors were against his understanding of the etiology of diseases. Stirling, therefore insisted on biomedical practices being an alternative to traditional healing practices. Actually, he depicted traditional healers “as ‘entirely unscientific’ and ‘commercial’, […whose practices are] ‘painful’ and often ‘ineffective’. He was wary of their medicines, claiming that they were untested at best and poisonous at worst” (Langwick, 2006, p. 160). In effect, modern healthcare personnel became more concerned with controlling traditional healing practices by creating boundaries between modern and traditional health care systems, including those traditional practices that are said to be effective (Langwick, 2006). In this regard, Stirling, like other physicians, continued to set boundaries between modern and traditional health care systems, “purifying the space of biomedicine from all that was not deemed scientific or modern” (Langwick, 2006, p.159).

Nonetheless, the majority of the people were still engaged in the traditional way of healing, claiming that certain practices and herbal medicines were effective and safe. Even when physicians have witnessed the potency of certain herbal medicines, such as mtomoni tree, which contain tannic acid, in treating burns, they continued to purify their categories of medicine, categorizing such herbal medicines as “Other” (Langwick, 2006). In their view, such herbal medicines are used for many other purposes aside from treating ailments, hence they are neither “generally comprehensive to science and biomedicine
nor particularly threatening” and hence needed to be classified as other (Langwick, 2006, p.162). Similarly, Langwick stated:

Of course, hospital doctors typically saw patients for whom nonbiomedical treatments did not ‘work,’ because people who went from the healer’s home to the hospital were generally motivated by the feeling that their condition had continued to be untenable even after the healer’s treatment. Yet [Stirling, like other physicians] claimed that all healers’ diagnoses and treatment were ‘guesswork.’ It was possible that a person’s complaint might be addressed by an appropriate herbal medicine, but in Stirling’s view, those rare occasions happened by coincidence or good luck, not because healers understood the natural arrangements and relations of scientific world. (2006, p.160)

Till today this comparisons and separations of healthcare methods that led to the creation of the boundary between traditional and modern health care systems still exist and such boundaries continues to instruct healing practice in many countries (Langwick, 2006). This legacy still weighs heavily on post-colonial health policy directions. The hesitation to provide integrative care, though suggests a potential socio-economic gains, is essentially mired in this uncomfortable imperial legacies.

Statement of the Problem

Ghana, like most developing countries, is struggling to find the means to provide a comprehensive health care system to its citizens. The current system, fashioned after the modern health care delivery system, has proven woefully inadequate in meeting the basic health care needs of citizens. In addition to the chronic shortage of health care personnel, there is increasingly insufficient training of health personnel and a geographical discrepancy in health care accessibility. The high costs of imported drugs and user fees have made western health care services very expensive; hence, the majority of the people are unable to afford them. In addition, western health care service has proven inept in handling most tropical diseases such as malaria and boils, among others.
Consequently, doubts linger in the minds of users of modern health care of the system’s efficacy when it lacked the capacity to address their needs. What is now popular among Ghanaian citizens is the self-administration of medicine. Additionally, the decaying condition of modern health care has fueled the emergence of fake health care practitioners and medicines to bridge the gap created by the declining use of modern health systems. Indeed, many Ghanaians are now accessing alternative healthcare provisions. In fact, even citizens who can afford orthodox medicine and/or have geographic access to western health care systems are swiftly turning to the traditional health care system because of its availability, accessibility and utilization (WHO, 2001a). Hence, herbal medicines and other traditional forms of healthcare giving have become the primary health service for the vast number of the population. Considering the current drift to access traditional health care, previous governments have done little to reform and fully incorporate this system into the modern health care structure.

While modern medicine is concerned with a scientific (as well as the natural) concept of healing and disease control, traditional medicine has increasingly focused on both the natural and supernatural concepts. In other words, while modern medicine uses science to determine the causes of diseases, traditional approaches, on the other hand, have focused on holistic methods of diagnosing and treating diseases—indeed, diseases, from this medium, are attributed to imbalances between the body, mind, spirits and one’s interaction with the environment and people. In fact, herbal medicines are constantly adapted to the changing environment to treat both emerging and re-emerging diseases such as yellow disease (kokoo), lethal diseases, problems with sexual potency, infertility, hernia, hypertension and malaria. Traditional healers are also using their holistic
approaches in the treatment and prevention of HIV/AIDS with much success. According to a 2001a report by WHO, the traditional health care system has demonstrated “efficacy in areas such as mental health, disease prevention, treatment of non-communicable diseases, and improvement of the quality of life for persons living with chronic diseases as well as for the ageing population” (p.4).

The growing popularity of traditional health care services among citizens is met by stiff government policies that limit their use. Concerns are constantly raised by government officials, health authorities, international organizations and researchers as to the reliability and safety of traditional health care services. Specifically, the quality of herbal medicine and products and qualifications of traditional healers are persistently questioned (WHO, 2001a). Regardless, the traditional system seems to function efficiently despite the heavy criticism. However, in this approach to health care given, whereby the traditional system is constantly marginalized in favor of unaffordable modern system, is very problematic. It seems reasonable to suggest that since many already depend on the traditional system, with full integration, the nation could drive double benefits from the healthcare system. This, I also, presume, might give the government substantial control over how, when, and under what conditions should this comprehensive system functions. It is in this concerns that this research project negotiates a claim for policy reform and advocates for a full integrated healthcare system in Ghana.

Purpose of Study

The primary purpose of this research is to analyze and evaluate the importance of full integration of traditional health system as a way of maximizing health care accesses, use, and availability to the public.
Other objectives of this study are:

a. To ascertain what perceptions Ghanaians have about the use of traditional health care,

b. To examine the socio-economic role and benefits of traditional health care system in Ghana.

c. To evaluate how traditional health care system can be integrated into the mainstream health care delivery system.

Research Questions

This study seeks to answer the following key research questions:

1. What are the perceptions on the current conditions of traditional health care’s accessibility and availability?

2. What have been the experiences with the use of traditional health care services?

3. What are the socio-economic implications for fully integration both health systems?

Significance of Study

This research will increase knowledge and add to literatures in this academic field. The study brings to the fore insights into the importance of traditional health care and creates awareness of the limitations of modern health care. It is important to expand knowledge on the socio-economic benefits of traditional health care use in health care system. Increased knowledge about traditional health care can foster ways to maximize health care delivery.

Also, the analysis of this study will provide vital information that will be useful to government’s policy concerns and the current debate on full integration/comprehensive
health care. Specifically, it will be most useful to the Ministry of Health (MoH), which is directly responsible for the provision of public health services delivery (in terms of policy formulation, monitoring and evaluation, resource mobilization and regulation of the health services delivery) (MoH Website). The study may be valuable also to the Traditional and Alternative Medicines unit, whose duties include monitoring and evaluating the delivery of traditional and alternative health care in the country (MoH Website). This study provides useful information on popular perceptions regarding the importance of traditional health care. This information could inform government policies design that is responsive to citizen’s needs. Equally it will be a major contribution to the volume of scholarships currently on traditional health care available to the Health Research Unit, which has the mandate to coordinate and conduct research into health-related issues to facilitate policy formulation and program implementation (MoH Website).

Furthermore, the study may be useful to groups or organizations such as WHO, which is working with Ghana and other developing countries in developing national policies on the evaluation and regulation of traditional health care practices, and in promoting safe, effective and affordable traditional products and practices (WHO, 2003a).

The findings from this research may be useful to the pharmaceutical companies, as well as to the general public, who are concerned about the current health care system or their health status. The findings may have broader application, particularly for other organizations and countries that are considering implementing a traditional health care system program.
Delimitation of the Study

In all the ten regions of Ghana traditional healthcare services coexists with modern health care system; however this study was limited to three communities in the Tema Municipal District, of the Greater Accra region. Also, only government officials and traditional healers were interviewed as key informants in this research. This study may not be representative of traditional health care system throughout Ghana.

Definition of Terms

The term “brain drain” (which originated in the 1960s), also known as international migration, refers to the migration of skilled or qualified persons, such as scientists, doctors, academics and engineers from one country to another (Myint, 1968; Awases et al., 2004).

Health personnel/professionals, in this study is defined as “all people engaged in actions whose primary intent is to enhance health,” including those who promote and preserve health as well health management and support workers (WHO, 2006a, p.1). In this study, health personnel and professionals are used interchangeably to describe modern health care workers.

Herbal medicine refers to any product that contains only medicines of plant origin, and use to treat, prevent or promote health. Most herbal medicines are made from the roots, stem, bark, leaves, seeds or flowers of medicinal plant.

As Dovlo and Nyonator (1999) state, Medical Assistants “are nurses with 5 years experience trained for additional year as prescribers providing services mainly in rural health centres” (p.10)
In this study, medical pluralism refers to “a medical system incorporating two or more medical traditions” (Bannerman, 1982 in Wolfers 1990, p.6). According to Kleinman (1976, p.568), medical pluralism is found in most contemporary societies where there are different, coexisting, complementary or competing medical systems arising from different traditions, practices and bodies of knowledge.

Medical practices are used interchangeably to describe traditional or modern health care services.

Migration of personnel is defined as, “the voluntary movement of workers from one employment station to another in search of different working arrangements. It occurs within and across national boundaries” (Awases et al., 2004, p.1).

Modern health care system is variously referred to as western, biomedicine, orthodox, allopathic or scientific medicine in Ghana. Berliner (1984, p.30) states that scientific medicine is the generic term for a specific mode of healing therapies characterized by the assumption that disease is materially generated by specific aetiological agents such as bacteria, viruses, parasites, genetic malformation or internal chemic imbalances; a passive patient; and the use of invasive manipulation to restore/maintain the human organism at a statistically derived equilibrium point (health).

Organization of Study

The study is divided into five chapters. Chapter one, which is the introduction, presents the background information of the research topic, defining the statement of the research’s concern, stating the purpose of the study and research questions that the project seeks to answer, highlighting the significance of the study, pointing to the
limitations of the study, and defining key terms that will be used constantly in this project.

Also, the chapter two is dedicated to the review of literature in the field. It gives a historical overview of the health care sector in Ghana since colonial era to current times. It also reviews government’s policies in place and analyzes how the arrangements of these mandates limit possibilities for full integration of traditional health care into the national health care economy. The importance of traditional health care system is also discussed in this chapter.

Chapter three discusses the methodology used in gathering data for the study. It also provides justification for the approaches used in gathering data. Furthermore, chapter four is an analysis and discussion of the findings of the study. Finally, chapter five includes summary, conclusions and recommendations for further study and for policy development by governments.
CHAPTER 2: LITERATURE REVIEW

Introduction

This chapter will explore the trend and development in modern and traditional health care systems, while accessing the challenges through which the modern health care system is produced in Ghana. In fact, my engagement, here, is structured around historical lens that examine the present healthcare system in Ghana as a conjunction of the political, social and economic influences. This chapter is divided into three sections; the first section will analyze the historical trends—from colonial through the present—in health care development in Ghana. This section raises concerns about how colonial legacies of healthcare management have informed current practices. Also, it access how the implementation of the Structural Adjustment Program (SAP) affected or aided a comprehensive development of health care system in the country. The second section will examine health policies and how these policies encourage or discourage the attainment of a comprehensive health care giving. This will include reviews, analysis and evaluation of existing policies and programs in place. Section three will address and project the importance of traditional health care systems to bridge the current gap in modern health care delivery.

Historical Overview

History of Ghana

Ghana, the first sub-Saharan African country to gain independence in March 1957, was known as the Gold Coast. In the 15th Century, the Portuguese in search of gold arrived in Ghana, where gold was copious. The Portuguese established trade paths and built the Elmina (meaning the Mine) fortress on the coast, in 1482. Other Europeans
followed suit, all wanting a share of the gold trade. With this, the name “Gold Coast” was adopted by the English colonizers (Ghanaweb.com). With accessible coastline and the availability of abundant gold, the country became the centre of all European activity in West Africa. Within a short time, the trade in gold included slave trade, which increased dramatically during the 17th century. The slave trade continued until the 18th century.

The turning point for colonized Ghana was in 1957, when Dr. Kwame Nkrumah, the leader the Convention People's Party (CPP), led a campaign that eventually resulted in the country gaining independence on March 6, 1957. However, as the first Prime Minister, Nkrumah’s dream of self-government and Pan-Africanism was short lived. On February 24, 1966, Nkrumah and his government were overthrown through a military coup led by Lt. General Joseph Arthur Ankrah of the National Liberation Council (NLC). The new government gave way to a multi-party election in 1969 and Dr. Kofi Busia of the Progress Party became the new leader of Ghana. Again, a military coup in 1972 headed by Colonel Ignatius Acheampong of the National Redemption Council (NRC), which was later changed to the Supreme Military Council (SMC), forced the Busia administration out of power. With a collapsed economy and increasing discontentment, Colonel Acheampong was forced to resign. In July 1978, he was replaced by General William Akuffo from the SMC. In May 15, 1979 the young Flt.-Lt. Jerry John Rawlings and the Armed Forces Revolutionary Council (AFRC) attempted a coup but was aborted. However, upon his release, Flt.-Lt. Rawlings took power over the country through a coup in June 4, 1979, few days before a planned election. However, the desire for a democratic Ghana increased, therefore, in June 18, 1979, through election Dr. Hilla Limann and his People's National Party won and became the new head of state in September 1979.
Again, we witness a short-lived democratic country as Flt.-Lt. Rawlings unsatisfied with the new government economic progress overthrown it in a military coup. The Provisional National Defense Council (PNDC) was established spearheaded by Flt.-Lt. Rawlings. With democracy still its agenda, Flt.-Lt. Rawlings established local committees. Elections took place in Ghana, with Rawlings and his government winning on two occasions. In 2000, however Rawling’s presidency ended as John Kufour from New Patriotic Party (NPP) won election. In 2009, John Atta Mills from National Democratic Congress (NDC), formerly known as PNDC, became the president of Ghana through election.

*Early Development of Health Care Systems in Ghana*

Prior to colonialism, indigenous health practitioners were the only recognized and established health practitioners in the country. The modern and traditional health care systems in Ghana developed into the modern ages through different historical, political, economic and social stages. However, their relevance to the nation is undeniably central. This section, then, evaluate the historical trajectory of such developments.

*Modern Health Care System*

The genesis of modern medicine is a contested claim. Scholars have passionately disagreed on the emergence of modern health care system in Ghana. In his study, “In sickness and in health: globalization and health care delivery in Ghana,” Senah (2001) gave a persuasive account of the development of modern health care system in Ghana. He categorized this development into three phases; the first phase (1471-1844) saw the emergence and the subsequent establishment of biomedicine. The introduction of the new health system was, however, solely the preserve of the colonial masters, established to protect them against the possible contraction of infectious diseases from the “unhygienic”
conditions of the “natives’ environment” who they interacted with on a daily basis (Senah, 2001). What is clear, here, is that colonial health care practices segregated majority citizens from health care giving, as European healthcare personnel attended only to expatriates.

Furthermore, Senah indicated that the signing of a bond between the British and some local chiefs in 1844 marked the beginning of the second phase of colonial health care system in Ghana. Not only did the signing of the bond enhance European commercial and Christian missionary activities in the hinterland, but it also promoted the realization that the colonial masters could not enjoy good health without ensuring that the health needs of the natives were also met (Twumasi, 1975; Senah, 2001). As a result, colonial health services as well as other sanitary facilities were extended to domestic servants, those in the civil and military service that were in constant contact with their colonial masters (Senah, 2001).

Educated Ghanaians--those working in urban and colony areas, and those exposed to western ideas--became accustomed to biomedicine and western ideas, and were, therefore, more receptive to modern health care services (Patterson, 1981). The educated Ghanaians from the coastal area living in the northern region, for instance, were quick to seek modern healthcare services than the Dagomba villagers who have been restricted from such services for decades (Patterson, 1982). Furthermore, with the provision and utilization of sanitary facilities, living conditions improved. Consequently, people’s negative perceptions about biomedicine began to gradually erode. As Patterson (1981) remarked, the standard of national health status dramatically improved (p.9).
The third phase started in 1868, when the first hospital was built in Cape Coast, as well as dispensaries in several rural communities (Senah, 2001). As Patterson (1981) rightly observed, Ghanaians were employed into the modern health care setup in the nineteenth century, however, due to the “rising racism and a desire by Europeans to monopolize higher posts in the empire blocked the careers of educated Africans in all branches of the colonial service” (p.13). The unfortunate irony is that, with the increased demand for more health personnel to attend to the health needs of citizens, racist act suppressed possibilities of hiring of more local practitioners (Patterson, 1981). In the same vein, Ford (1971), Delancey (1978) and Jackson (2003), among other writers, acknowledged that the increased modernization efforts such as the construction of dams and roads altered the pattern of disease management in the country. These modernization project increased cross-country interaction, hence diseases such as tuberculosis, smallpox, and trypanosomiasis, which previously were never prevalent in Ghana, began to emerge as a major health problem.

With the fall of the Asante kingdom in 1901 and the annexation of the northern territories, Gordon Guggisberg, the new governor, designed a new national health structure, which included the building of the first national hospital, Korle-Bu Teaching Hospital, in 1923—purposely built to serve Ghanaians’ health needs, and also to serve as a center for research into tropical diseases (Senah, 2001). However, discrimination in health care giving did not improve but rather institutionalized. For instance, African medical personnel were restricted from serving European clients, and to a large extend, they were also prevented from serving some Ghanaian citizens. Also, some Ghanaian physicians, through the rigorous training they had received, acquire medical competence
that dwarfed the expertise of colonial doctors, yet they were given lesser salaries and they often had to compete for a lower status in the professional ranks (Patton, 1996). Not only did this slow down the growth in number and ranks of Ghanaian health workers, but also perverted the ethical position in the healthcare profession. Consequently, by 1922, there were only two African Medical Officers; “three in 1927, six in 1929, three or four in the depression years and ten in 1938” (Patterson, 1981, p.14). Interestingly, disease prevalence and infant mortality rates were increasing dramatically, yet, as Patton (1996) pointed out, colonial officials continually refused to employ or promote African health workers. To Guggisberg, African health workers were incompetent and needed an extra year of clinical training before they are even ready to be placed in inferior positions. In fact, he terminated most of the health programs that helped train natives.

Increasingly, colonial masters became more interested in establishing more health facilities rather than training natives as health professionals to manage these facilities. As a result, they rejected Dr. Innes, the then Director of Medical and Sanitary Services’ (D.M.S.S) proposal for an inter-colonial medical school in Accra on the grounds that a medical school was premature (Patterson, 1981). Alternatively, colonial administration created a scholarship scheme that would enabled only a few natives to study medicine in the United Kingdom. It is, therefore, not surprising that the many Ghanaian were not interested in entering the medical profession; and that only a very few of the already limited Ghanaian physicians were willing to accept the inferior positions.

Indeed, the refusal to appoint native health workers, coupled with shortage of staff and high rate of diseases, meant that only a few health facilities could be built and managed efficiently. In consonance with the above view, Prof. Cox opined that
healthcare giving during the colonial times was unevenly served and organized to favor the Europeans. In his lecture, “Conquest and Disease or Colonialism and Health?” he argued that there was one doctor for every 17 Europeans and one doctor for every 22,000 natives. Also Patterson (1981) while acknowledging the uneven distribution of health care facilities and medical personnel in the country, observed that during World War II and the great depression, colonial governments cut back on the number of medical officers in the country as most were tasked with military duties. The acute lack of funds to pay medical officers what they are due also meant that many were dissatisfied working in the colonial system, hence, many who have retired by this time are unwilling to take up the low-salary medical jobs that had become available. As a corollary, most hospitals and clinics were chronically unstaffed, and hence, resulted in the closure of most clinics and medical stations, or the downgrading of most medical stations. Medical facilities in the rural areas suffered as a result due mostly to closures. To Patton (1996), since the health needs of the general population was neither a priority to the physicians nor the main concern of the colonial administration, the colonial officers concentrated on improving health facilities in urban center where they lived. For instance, in 1927/1928, of the 39 hospitals in the country, 28 were based in the colonial seat of government (which had 54% of the total population), 6 in the Ashanti region (18%) and 5 in the Northern region (Patterson, 1981). In addition, there were only 25 African doctors by 1934, all based in the urban centers (Patterson, 1981). This implies that the rural population neither had any Ghanaian doctors to serve them nor hospitals to access in cases of health needs. Even with the new health infrastructure, Senah (2001) agreed that only 10% of Ghanaians in urban and colony areas had access to the colonial medical services. Not only were the
modern health care system urban-biased, but also they charged exorbitant fees for services provided, which meant that these 10% who could access these services had to be rich urbanites. Natives’ accessibility to the new health care system, did not only pose severe challenges to the use and constant reliance on traditional health systems, but also became a sign of affluence to which many citizens aspired.

It was not until the 1940s that a number of native health workers and health programs increased in colonial Ghana. For instance, by 1952 there were over 350 nurses with various qualifications and about 400 trained midwives working in various positions in the colony. The number of dispensaries also increased from 28 in 1939 to 38 in 1945, and by 1952 there were 124 dispensaries in the colony (Kissieh 1968; Patterson, 1981). The increase in the number of Ghanaian health workers, especially in the number of women workers, was as a result of the establishment of a school for Native Authority health staff at Kintampo and the establishment of a nursing school in Kumasi to recruit only women for SRNs (Patterson, 1981; Osei-Boateng, 1992; Addae, 1997).

Regardless, health therapy was ineffective and insufficient in reducing the increased disease burdens. Of course, the colonial masters were caught in the contentment of medicine and social medicine as effective means of improving health conditions of the population, that they focused all their focus on social medicine at the expense of developing the administrative part of healthcare system to manage it (Patterson, 1981). Accordingly, Medical Officers of Health (M.O.H) ended up as sanitary inspectors, looking for mosquito larvae, excess lodgers or unauthorized buildings; or as collectors, collecting fines from those who “relieved themselves in a place other than the filthy public latrines, sold food on the streets without an expensive cover, or dumped
garbage in a handy gutter rather than a distant and already overflowing dustbin” (Patterson, 1981, p.20). From the above observation, it is evident that because of the contentment with the decline of diseases outbreaks using the social medicine approach, colonial officers focused on training more M.O.Hs to go into the communities to summon and fine those violating sanitary ordinances, instead of treating the sick or improving healthcare facilities and conditions. Indeed, M.O.Hs did not gain new medical skills or improve on the old knowledge as they were not allowed to practice as medical practitioners or improving their knowledge base to take up addition medical responsibilities. Moreover, it is likely that most were not well trained as M.O.Hs, and thus, when some were faced with challenging problems they needed to apply the knowledge acquired or even to improvise, they failed. Consequently, failure to efficiently perform attracted severe punished (Patterson, 1981). For instance, in Ashanti region, some medical practitioners were convicted of manslaughter for negligence as 14 people died from illegal injections over a 32 months period in the early 1940s.

Moreover, the social medicine approach to controlling diseases was a limiting strategic approach to fully capture the exact rate and seriousness of disease in the country. For instance, trypanosomiasis found in the Ashanti and Northern region were viewed as not a threat to the colony; therefore, the colonial masters and medical practitioners diverted their focus away from containing the diseases and even suspended tsetse investigations between 1918 and 1923 (Scott, 1965). However, the uncontrolled disease led to major trypanosomiasis pandemic, and the colonial administration were not aware of this condition until a major trypanosomiasis and blindness diseases pandemic hit the country (Grischow, 2006).
In essence, this colonial health project established a strict legacy of cost-sharing in health care services; central government as the largest provider of health care service; subordination of indigenous healing systems to biomedical standards; urban-bias health care structure; and health and health related infrastructural services designed, maintained and governed by the central colonial authority (Senah, 2001). These legacies have transcended time and seeped into current Ghanaian health care practices. These legacies continually shape public health policy contents.

*Traditional Health Care System*

Colonialism slowed the development of traditional health care system as British colonial authorities imposed the practice of biomedicine and modern health care system, a foreign health care system, upon the people of Ghana. It was not surprise, then, that the traditional practitioners developed a negative predisposition toward the modern scientific approaches to health care giving. Twumasi (1982) puts it succinctly that the indigenous healers believed in a state of balance between man, the environment and immutable supernatural laws in explaining disease causation. Therefore, they viewed biomedical knowledge of germ theories to disease causation as irrelevant to their traditional cosmology concepts of disease. Despite the popular Ghanaian view of modern health personnel as powerful figures, whose skills in anesthesia and surgery won their respect, they were equally puzzled by the behavior and attitudes of the health workers. As Patterson remarked, Ghanaians perceived physicians as “strangers who had to use an interpreter … [and] often asked impolite questions; demand, for unknown reasons, samples of blood, urine, and feces; and sometimes cut open bodies of the dead. Some were so disagreeable that people avoided them” (1981, p.15). In as much as colonial
masters attempt to educate Ghanaians on the causation and prevention of diseases, many people frequently avoid their services and continued to use their own indigenous healthcare system—herbal medicine (Senah, 2001). This buttresses Twumasi’s (1982) view, who had contended that at the emergence of the new healthcare system, “indigenous (traditional) healers monopolized the health market” (p. 202), therefore, colonial reform to healthcare giving threatened role of traditional healthcare system.

Evidently, one inference that can be drawn from the account of the development of traditional healthcare system is that the increased utilization of herbal medicine, irrespective of the development of modern health care, was due mostly to its immediate accessibility, and availability to local use—in light of the fact that colonial administration had cut back the number of health workers, equipment and hospitals; limiting biomedicine’s accessibility and availability. It could also be argued that the process of non-formal acquisition process of this form of health care was highly attractive to the majority of the population whose educational background was heavily limited. Additionally, inexpensive use of herbal medicine was not only attractive to popular use, but was an inherited tradition. In this stead, a strong culture of dependence was design around herbal medicine use, which meant that break from this structure could equally signal a break from tradition, a concept that eluded the colonial masters demanding that natives modernize their way of living. The use of herbal medicine, in itself, could be read as a form of resistance. But with the colonial fantasy with this modernization project still growing, policies were enforced that prevented or frustrated the use of this health care system.
Consequently, traditional healing and all other indigenous practices were legally restricted and banned, and the Native Customs Regulation Ordinance was passed in 1878, as “an attempt to neutralize the influence of healers and to promote the new health dispensation” (Senah, 2001, p.84). This, I argue, was a way for the colonial officers to impose not only the idea of science and biomedicine on the natives as superior, but to distort local worldview so they uphold the modernist project. Twumasi and Warren (1986) suggested in their study, “The Professionalisation of Indigenous Medicine: A Comparative Study of Ghana and Zambia”, that biomedicine was institutionalized as a means to “liquidate native practices of herbal medicine” (p.122). Senah’s work demonstrated how indigenous healers were denied any official mandate and legitimacy to practice medicine. Consequently, Ghanaian civil servants were forced to obtain a certificate of disability only from colonial medical officers, and converted Christians who consulted traditional healers were threatened with ex-communication. In Twumasi and Warren’s account, traditional medicinal practices lost their prestige as traditional healers were discredited and consistently portrayed as insincere, quack, incompetent and illiterate. This campaign to de-legitimatize and stigmatize traditional health systems was fully aided by the “church” (Twumasi, 1982, p.202). Inevitably, with the growing expansion of the church in Ghana meant that the efforts at removing traditional healthcare use from nation consciousness grew. While data on the traditional health care practices in Ghana is limited, both studies from Senah and Twumasi and Warren revealed and explained the reason for the secret nature of traditional medical practices and why up till now some individuals, especially churches, still view traditional healthcare delivery as indecent.
Notwithstanding, Ghanaians were secretly seeking herbal medicine. Most importantly, as Patterson (1981) aptly observed, Ghanaian women who were often uneducated and did not have direct contacts with the colonial authorities, and for this reasons, had little exposure to biomedicine. Thus, the women, solely, used traditional healthcare system. They were suspicious of biomedicine and reluctant to be examined by male, white physicians, and a “stranger” for that matter.

Additionally, given the local customs, which did not permit young females to give care to non-relatives, it made it a taboo for women to enter the medical profession, even as nurses (Twumasi, 1979). Prior to 1928, the only female nurses in the country were all from foreign countries, especially from Britain (Akiwumi, 1971). In fact, the establishment of a maternity hospital in Accra in 1928 was what led to local women joining the medical profession. As Akiwumi (1971) pointed out, colonial officers were able to recruit the women because the role of a midwife was closely aligned with the traditional role of women in the Ghanaian society.

Many Ghanaians were taking a mixed approach, using the best elements of both healthcare systems for their healthcare needs. Often accessing biomedicine obviously for yaws and broken limbs, when they are unable to access the traditional healthcare system for efficient results, or when family member/friends have advised them to (Patterson, 1981). Traditional healers, due to legal restrictions, could not see a sick patient and hence began to pass some of their knowledge to the community for self-use. This could have attributed to the enormous use of self-administration of medicine during this period.
The Post-Colonial Situation

The early stages of modern and traditional medical systems paved the way for a different mode of health care system in Ghana. The legacies of colonialism ushered in a post-colonial condition where the attitudes of Ghanaians toward both traditional and western healthcare systems were deeply affected. Here, I explore how the newly independent nation changed, improve, and in some case abandoned modes of healthcare given during this time.

Modern Health Care System

So devastating was the effect of colonialism that at the time of independence in 1957, the health sector was in a deplorable condition. While still drenched in the spirit of independence, Dr. Kwame Nkrumah (the first national leader of the newly independent Ghana) health care objectives broke away from colonial prerogatives. His main political platform embraced certain core principles of socio-political relevance that projected the needs of Ghanaian citizens above all else. He immediately focused his attention on building effective social welfare service, and a comprehensive health care system as platforms to Ghana’s development projects (Nkrumah, 1969).

Realizing the need for health infrastructure, President Nkrumah in 1962 established a government-sponsored and free medical school, known as the University of Ghana Medical School, to locally train Ghanaians in biomedicine. Also, he enlarged and modernized the Korle-Bu hospital as a teaching hospital for the use of those trained physicians (Opare & Mill, 2000; Brobby & Ofosu-Barko, 2002; Dovlo & Nyonator, 2003). To Rose (1987), the advent of the first medical school impacted the development of nursing education and practices in the country. Several state registered nurses (SRNs)
were offered the opportunity to train in the United Kingdom as specialized nurses in fields such as genitourinary and orthopedic (Rose, 1987). As Osei-Boateng (1992) remarked, “the need to raise standards of nursing care and nursing education” was also realized as important factors for a comprehensive function of nurses within the healthcare system (p.175). The government, therefore, invited a former member of the General Nursing Council (GNC) of England and Wales, Marjorie Houghton (a very influential person of British nursing education in Ghana at that time) to evaluate the nursing training programs (Rose, 1987). Also, the government asked her to help start training more women as nurses and to assist trained nurses to acquire registration status in their post-basic courses in Britain (Kisseih, 1968; Rose, 1987).

Furthermore, Rose (1987) highlighted the need for more nurse tutors and clinical instructors, and recommended a comprehensive 4 years training, the discontinuation of the Pre-Nursing Course, and for all candidates to have the West African School Certificate. Based on this recommendation, in 1963, the first university-based diploma program for nurses was established at the University of Ghana, to prepare nurse tutors, supervisors and administrators, in order to function effectively (Chittick, 1965; Kisseih, 1968). The nursing training program was fashioned after the British system, in collaboration of the Ghana government, the World Health Organization (WHO) and the United Nations International Children’s Education Fund (UNICEF) (Kisseih, 1968). This “marked a shift in the control of nursing education from the hospital to educational institutions and a broadening in the focus to include the community,” asserted Opare and Mills (2000).
While the health care sector was financed by the state, by 1962 the services provided by this institution were made free of charge to citizens (Senah, 1999). Senah (2001) suggested that “between 1957 and 1963 the number of health centers increased from 1.0 to 41”, and of the £144 million that government budgeted, between 1963 and 1964, for projects, as part of public expenditure, about 31% went towards the social services with much attention given to the health sector (p.85). Moreover, government’s health expenditure increased from 6.4% in 1965 to 8.2% in 1969 (Patterson, 1981). The above statistics show that the government spent more on the health care and human resource development compared to other departments.

Notwithstanding, the quality of care began to decline in the late 1960s, mainly because subsequent governments failed to invest in the health care system (Osei-Boateng, 1992). The lack of funding resulted in inadequate teaching facilities, educators, equipment, medical books, and other medical aids (Osei-Boateng, 1992). Although, the implementation of the Africanization policy provided the momentum for nurses to further their education and take up senior positions, it was also one of the reasons responsible for the decline in medical educators (Opare & Mills, 2000). According to Rose (1987) and Patton (1996), the Africanization policy led to severe shortage of tutors and fewer qualified tutors as most tutors, particularly the experienced ones, were White expatriate who due to the decolonization process and the new policy had left the country. As Osei-Boateng (1992) pointed out that the lack of equipment made it difficult for the already limited tutors to teach the right techniques. For instance, although the GNC syllabus was revised in the United Kingdom in 1952, the nursing curriculum in Ghana, which was and continued to be closely aligned with the GNC syllabus, was still based on the 1952
syllabus (Rose, 1987). Besides, textbooks were unavailable, and even if they were, they were often decades-old textbooks and very expensive, making the care delivered to patients inaccurate and inadequate (Opare & Mill, 2000). Because of the shortage of tutors, administrators and supervisors, students mostly worked without supervision (Osei-Boateng, 1992, p.176). Consequently, health workers and students became unsatisfied and frustrated at their jobs as skill acquire could not meet the challenges of increased disease outbreaks.

An ongoing problem during this period was the emergence of a new kind of intraprofessional conflict. Whereas during the colonial era intraprofessional conflict was a result of professional disparities between Ghanaian doctors and European doctors, with the introduction of the Cold War, intraprofessional conflict was mainly between Western-trained physicians and communist-trained physicians (Patton, 1996). The medical culture of the Western bloc, such as Britain and the U.S., was typically based on long training in general medicine and surgery, which equipped physicians with broad knowledge to handle diverse problems in both central and isolated areas. On the other hand, training in the USSR and the Eastern bloc, focused in training specialists on a short term (Patton, 1996). In other words, communist-trained physicians were specialists and were accustomed to work in teams of specialists, unlike the western educated medical workers who worked best as individual professionals (Patton, 1996). Given that Ghana was, then, a socialist sympathizer, Moscow gave much support by providing Ghanaians in health education scholarships to study in its Eastern bloc (Patton, 1996). As a result, eastern trained medical professionals outnumbered the Western-trained physicians. To Patton (1996), this type of specialization training posed a threat to Ghana, where there was a
shortage of physicians and there was a greater need for primary care physicians. Consequently, Western-trained physicians and those trained in Ghana (who also had western training), “did not take kindly” to the new communist-trained physicians that returned to Ghana (Patton, 1996, p.222). They lodged complaints against the communist-trained physicians, arguing that they lacked appropriate clinical expertise for more general health needs of patients (Patton, 1996).

Incidentally, studies done on Ghana during the late 1970s and the 1980s detailed the rise in petroleum import costs and inflation, which affected import capacity of the country. Consequently, other factors such as, over-valued currency and deteriorating exchange rate contributed to the drastic decline in Ghana’s entire development efforts. Eventually, government was forced to cut down its already limited public expenditure, hence reducing the standards of living for the majority of the population (Hutchful, 1989; Frimpong, 1997; Senah 1999). Compounding this harsh economic conditions were a three-year severe drought, outbreak of bush fires in the early 1980s, and high inflation rates after 1976 (Hutchful, 1989; Frimpong, 1997). From Senah’s perspective, the influx of about one million Ghanaians expelled from Nigeria in 1983 augmented pressure on the already poor food situation and unemployment. This view stemmed from analysis done by Hutchful (1989) and Frimpong (1997) which concluded that the resultant economic crisis led to most Ghanaians becoming skeletons overnight and an increase in mortality and morbidity rates as many were eating whatever they lay their hands on—mostly poisonous roots and leaves.

The precarious economic situation badly affected the already devastated health sector. There is no doubt that government financial constraints during this period
“affected the supply of drugs and other medical supplies” (Senah, 2001, p.86). This further led to the deterioration in the quality of health care provided. Senah also asserted that the economic crisis had a compounding effect—it placed heavy financial constraints on both the health care delivery system and the patients accessing these delivery facilities. This is particularly true as in some public health centers, patients had to provide their own food, beddings, drugs, and even stationery for their medical records (Senah, 2001). Extra financial burden on the health care sector, especially with regards to government cutbacks in wages, meant that many health care workers had to find other means to supplement income in the face of harsh economic reality, thus resorted to selling public health care equipments and services for private gains. This pervasive condition worsened health delivery as the already limited equipments were illegally sold and profit transferred into private accounts. As demonstrated by Patton (1996) and Senah (2001), mismanagement and robbery became the norm of the public health institutions whereby free medicines, refrigerators, doctor’s coats among other health amenities found their way into the open market being sold by health care worker for their own gains.

**Traditional Health Care System**

As part of President Kwame Nkrumah’s campaign to create a national identity and encourage local initiatives, traditional medical system was re-initiated, thus officially professionalized in 1969 (Maclean and Fyfe, 1986). The first association of traditional healers, the Ghana Psychic and Traditional Healers Association, was formed in 1961 (MoH, 2007). The Ghana Psychic and Traditional Healing Association was established to improve and encourage the study of traditional health system, as well as research into herbal medicine in Ghana. By 1973, the association expanded to accommodate
spiritualists and faith healers, priests and priestesses, traditional herbalists and traditional
birth attendants (Warren, 1986). Clinics were established in all the regions for the
treatment of diseases and ailments which orthodox medicine had not found cures for or
simply neglected, and to treat common diseases alongside modern health practices.
Emphasis was placed on collaboration between traditional and modern health
practitioners. In line with this development, a Centre for Scientific Research into Plant
Medicine was established in 1975 at Mampong, under the Acheampong military regime
(MoH, 2007). Although traditional healers were willing to treat patients, many
spiritualists, priest and priestess, and faith base healers were not readily to cooperate with
modern health standards. This was mainly due to the secret nature of their practice and
their core disagreement with the scientific explanation of the concept of disease nosology
(Twumasi, 1982). Realizing the needs of the rural population and the need to assure
traditional healers about their practices led to the development of models sensitive to
local conditions, such as the Danfa and Kintampo project, to study rural health conditions
(Twumasi, 1982). This, according to Neumann et al. (1979), was an attempt to find local
solutions to local problems by incorporating traditional healers and the local population
into decision-making and management processes of community health (cited from
Twumasi, 1982). Under the Kintampo project, for instance, Twumasi noted:

Herbalists were willing to cooperate by bringing their plants to the attention of the village
health care attendant…. The bone setters agreed to cooperate with the village health care
units by sharing their experience with local health workers and visiting physicians.
Finally, the council agreed to remunerate any healer who cooperated with a village health
care unit to treat illness in the area. It was also decided that herbalists would be paid for
the herbs they brought to the unit that were sent to the National Plant Center. This
measure acted as an incentive to cooperation (p.211).

Similarly, the traditional birth attendants, given their importance in maternal and
child health care were given training by physicians, public health nurses, midwives, and
social workers (Twumasi, 1982). According to Twumasi, they were taught how to use
hygienic tools and techniques with respect to prenatal care, postnatal practices, delivery,
and midwifery procedures. Several other large-scale health projects were initiated in the
1970s, including the Primary Health Training for Indigenous Healers (PRHETIH) which
served to advance the knowledge and skills of traditional healers. While Bannerman,
Burton and Wen-Chieh (1983) acknowledged that collaboration and exchange of ideas
between traditional practitioners and modern health personnel enhanced health care
delivery.

The Period of Structural Adjustment Program (SAP)

Recognizing the impact of economic crisis not only on the health care sector but
also on the whole economy in 1983, the government implemented the Structural
Adjustment Program (SAP) as a means to end deepening economic decline. Frimpong
(1997) and Aryeetey and Harrigan (2000) (among others) agreed that with the help of the
International Monetary Fund (IMF), the World Bank (WB) and other multilateral and
bilateral donors, the government of Ghana implemented SAP as a positive approach to
economic recovery. The aim for this economic recovery program was to reduce and
prevent further economic crisis and to ensure that the basic needs of the population were
met (Frimpong, 1997; Aryeetey & Harrigan, 2000). Frimpong (1997) emphasized that
under SAP, about five billion dollars in aid was channeled to Ghana—more than ever
before; yet the health status of the people remained very poor. What he does not explain
is how the aid was distributed and how that affected the health care sector. A point worth
highlighting is that government had little, if any, control over how the aid was distributed
and on what area aid was to alleviate crisis, making it difficult for government to increase support for the health sector, when that is not on the patron agenda.

*Modern Health Care System*

As part of the IMF and the World Bank’s prescription for economic recovery, the user fees, commonly known as the “Cash and Carry” system, was introduced in Ghana’s health care system. Under this new health care policy, patients have to pay for the cost of their care and medication. The rationale behind this was to generate internal revenue improve quality of care, rather than depending on external help, which constantly instruct where aid should go. However, the introduction of the cash and carry system was a significant barrier to health care accessibility and utilization. Given the fact that the majority of the population were unemployed and are living below the poverty line, the introduction of the user fees further impoverished them. Empirical evidence indicates that patients were denied treatment because they were unable to pay prior to their treatment. In cases when patients are able to get the money, there were little, if any, hope for treatment as delayed diagnosis and treatment has caused their ailments to deteriorate. This was dehumanizing as patients without the financial means were left to die. Once again, the poor and the rural population, especially women and children, bore the burden of such harsh policies.

Oppong (2001) explored the condition of the health care sector under the SAP and concluded that cutbacks in government expenditure and the withdrawal of subsidies from the already deteriorating health sector as compliance to the IMF and the WB conditionalities was what affected the health care system. For instance, in mid 1990s, “the percentage of GDP allocated to public health care expenditures from government
revenue through MOH decreased to reach a low level of barely 1%” (Government of Ghana (GoG), 2002, n.p.). This resulted in large staff redeployment, layoffs and significant salary reductions, which in themselves were primary reasons why the health status of the people worsened.

It is possible that due to under-funding of health care, fewer personnel were trained and recruited. Removal of subsidies led to a restricted operation capacity of the health care system, which resulted in a decline in the quality of service provided. In view of this, Oppong asserted that many health professionals were forced to take second jobs to supplement economic demand. Hence, Oppong’s argument suggested that the economic condition for which the SAP was introduced failed, in as long as the implementation of this Economic Recovery Program (ERP) did not eliminate conditions that pre-existed the implementation—in many cases these condition persisted and in some cases worsened. One of the major unintended consequences of the SAP implementation was the colossal exodus of healthcare professionals from the country to seek greener pastures in foreign lands. Vogel (1988) estimated that the number of physicians declined from 1700 in 1981 to 800 by 1984. Within three years, Ghana lost more than half its trained physicians. In relation to this, Anarfi, Kwanky, Ofuso-Mensah and Tiemoko (2003) stated that more than one half of the qualified doctors, and a significant amount of nurses migrated from the country to seek better economic conditions. The excessive migration of health care workers resulted in the under functioning of many health centers. Therefore, many centers were without health personnel and, in cases where they did, these personnel were hardly present in these centers or they had to divide their services between other public or private centers that had no health professionals. Accordingly,
health centers without health care workers received, little if any funding, from the
government. In effect, many health facilities had no choice than to close down, while
remaining ones, largely in rural areas became more of consulting clinics without drugs
and medical staff (Oppong, 2001). Obviously, this is one of the factors contributing to the
uneven distribution of health care across the country. For example, Abbiw (1990)
commented that there was only one medical doctor to 70,000 people in the rural areas
compared to one medical doctor to 4000 people in urban centers. This implies that the
health care status of the people in rural areas deteriorated, causing increased mortality
rate and disease outbreaks during that period.

Report from ISSER (1994) admitted that “disparities between regions in terms of
availability of health care institutions [were] compounded by significant under-utilization
of the available services” (p.150). ISSER further stated that “out-patient attendance in
government institutions fell from 10-11 million in 1973 to about 3.7 million in 1992
mainly as a result of declining standards or quality of service” (p.150). In some cases
shortage of hospital beds were very severe that patients were forced to sleep on the floor
(Frimpong, 1997). This indicates that the implementation of the SAP did not improve the
mismanagement and unprofessional practices that typified the health care system in the
1970s. The introduction of the SAP, which was intended to generate income and curb
mismanagement, failed since the post-SAP conditions worsened—there were inadequate
supply of drugs and other essential amenities needed to operate an effective health care
system. Frimpong (1997) added that the lack of basic health facilities under the SAP led
to very high mortality rate in the country, particularly in rural areas. To add to this, the
lack of basic health facilities or inferiority of health service resulted in high disease
prevalence rates as well as the emergence of new infectious diseases as both patients and
health personnel became exposed to infections. For Oppong (2001), the “reduced funding
for blood screening, poor hygienic practices in clinics (e.g., inadequate or no sterilization
of equipment) due to funding cutbacks … [contributed to the] spread [of] HIV in health
care facilities” (p.360).

Deepening even further, government’s subsidy removal across sectors also meant
that many households were unable to afford a decent meal, affecting their health status,
and with scarce income many could not afford to access even the worsening health care
system. Frimpong (1997) affirmed that many could not afford certain food items needed
for nutritional upgrade as prices of those items “were equivalent to the daily wage, or in
some cases even more” (p.99). An example from Vickers’ (1991) research indicated that,
in June 1984, whiles minimum wage was 35 cedis per day, the market cost of a minimum
nutrition diet in the urban areas was 168 cedis per person per day. Not surprisingly, many
people were malnourished (The Institute of Statistical, Social and Economic Research
(ISSER), 1994). Not only that, but reports from MacKenzie (1992) illustrated that
incidence of diseases rose and infant mortality rate and pre-school malnutrition rose from
35% in 1974 to 54% in 1984. A vivid picture is painted in the ISSER (1994) report,
which projected that in 1986, 58.5% of pre-school children were underweight and
suffered from acute or chronic undernutrition, which was twice the level reported in
1961—8% suffered from marasmus and kwashiorkor and 70.1% of pregnant women
were anaemic by WHO standards. Clearly, solutions to the management and control of
mortality rate associated with the growing poor health condition, at the time, was
dependant on the fundamental changes that the SAP implementation brought. Cutbacks in
health care finance and closure of most health care facilities made it impossible to treat some of these curable diseases, which worsened under the economic reforms.

Indeed, this situation was made worse with the introduction of the user fees and cost recovery programs, which were a means of generating adequate revenue for the health care sector. Although, some cost sharing was introduced by the Busia regime in 1971 under Act 387—Hospital Fees Act of 1971—Coleman (1997) argued that this law was never implemented until SAP was introduced. By 1992, user-fees (Cash and Carry) were applied to medical, dental and surgical treatment, medical examinations, outpatient attendance, hospital accommodation, drugs, laboratory and other investigations, and catering as means of generating profits to improve the quality and availability of services (Creese 1991; Kutzin 1994; Coleman, 1997). The unintended consequence of this implementation ensured that the concept of “health for all” became essentially “health for some”. Many patients were detained in hospital, including babies, longer than necessary because of their inability to pay. As a result, many ended up paying more due to prolonged stay. Accordingly, many patients refused to use the modern health care system with fears of being detained and charged excess fees (Senah, 2001).

Traditional Health Care System

The traditional health system was equally affected by the ERP. With removal of subsidies from the public sector, the health sector had to prioritize its limited funds. Consequently, traditional health care system was marginalized, in the same way the rural population was neglected to find creative means of finance projects they considered important. Since the ultimate prerogative of the government was to satisfy the SAP conditions, more attention were given the commercial expects of modern health care
delivery. The irony here is that because of the ERP modern health care giving became very expensive, therefore, many people who could not afford turned to the traditional system. But since government is barely supporting this sector, people did not derive the maximum benefits from it either. In effect, health care deteriorated as economic conditions deepened.

As part of the SAP conditions, trade liberalization was introduced to create competition in the market. What occurred as result of this initiative was that the market was flooded with modern healthcare products and was sold at a cheaper rate. Developing traditional healthcare product to sell in the market, because of government subsidy removal came at an expensive manufacturing cost to the local producers, hence had to increase the price of their product on the market in order to break even.

Also, to generate adequate revenue on the market the government approach trading in the competitive advantage doctrines. In this case, they turn to the exportation of raw materials, especially medicinal plant. Instead of attending to the sick, traditional healers were now providing medical plants to the government who then exported to industrialized countries for new drug production, or they were providing value information on certain medical plants for foreign researchers. Yet, when medicines were manufactured on a commercial base, traditional healers were not been compensated for their intellectual property rights. Thus, traditional healers with their knowledge and expertise were no longer abolished by the law, but were exploited. Releasing this exploitation and that the government was not protecting their intellectual property, practitioners, especially spiritualists and faith healers were reluctant to subject their medications to scientific testing if an external power was controlling it, or subjecting their
medicines under public scrutiny (Twumasi & Warren, 1986). As a result, the majority of the traditional healers began practicing in secrecy and refused to cooperate with either government officials or foreigners.

**Current Conditions of the Health Care Sector**

Health indicators and status of Ghanaians have improved, yet, in recent times, certain health conditions have worsened for various reasons. Here, attempts are made to examining how colonial rule and foreign influences shaped both health systems. The growth of modern medicine and its contribution to the health sector is also examined. Reappraisal and attempt at integrating traditional healthcare system into the mainstream health system will also be discussed.

**Modern Health Care System**

Ghana has a growing economy and all the political administrations have made substantial efforts to improve health care. Reports from the Government of Ghana (GoG) indicated that health conditions have improved--immunization against measles increased from 57% in 1997 to 82.4% in 2001; DPT3 rose from 51% in 1996 to 80% in 2001; and antenatal coverage increased from 84% in 1996 to 98% in 2001 (2002). The same report indicated that from 1997 to 2001 geographical access and utilization of public health service increased by 25%, with the highest of 95% observed in the Northern region. Likewise, under five mortality rate has decreased, from 155 to 95 deaths/1,000 live births from 1988 to 2003 (MoH, 2007a; WHO, 2007a). However, health conditions have worsen in some districts in the Northern Region, where “infant mortality is pegged at 114 deaths to every thousand live births while under 5 mortality is estimated at 237 per 1000” (Senah, 2001, p.85).
Indeed, immunization, geographical access and utilization of health care were possible because of the increase in “a variety of providers in the public, private and informal sectors”, especially in the number of NGOs and Christian Health Association of Ghana (CHAG) (WHO, 2007b, p. 8). These achievements are not felt across the entire country. While MoH and WHO have documented that about 60% of the population (92% in urban and 45% in rural areas) have adequate access to health facilities (within one hour travel), it is also clear that half of the population do not have access when the travel time is halved (WHO, 2007b). Others have argued that, compared to other African countries, Ghana’s health care is not doing badly, but a question worth asking is what about the 40% who still do not have access to healthcare? Are they not part of the “health for all” goal? Then again, how sustainable is the quality of service provided to the 60%? Besides, high consultation and treatment fees prevent the majority of the people among the 60% to access these available facilities. Many people in rural areas travel long distances for health care service because of isolated hospitals or clinics, and are forced to wait for long hours before being treated. As Senah (2001) noted, “only 3 percent of rural households live in communities where there is a doctor; for 36 percent of rural households, a doctor is about 1.5 km away and for 18 percent a doctor is about 50 km away” (p.85).

The fact still remains that Ghana’s health care does not meet the basic needs required to sustain and enhance health development. As widely documented, Ghanaians are still affected by communicable disease, poverty-related diseases, high maternal mortality rates, and even non-communicable diseases (Senah, 2001; GoG, 2002; CIA Factbook Report, 2007; WHO, 2007b). In fact, “major causes of mortality, morbidity and
disability” in Ghana are related to non-communicable diseases such as diabetes, stroke, cancer and hypertension, according to the Minister of Health (MoH, 2005). Put differently:

Infectious, parasitic, and respiratory diseases remain the main causes of disability and death. At the same time, there has been an increase in the incidence of chronic and non-communicable diseases, cancers, and circulatory disorders, especially among the urban population. Thus, the overall epidemiological picture of Ghana is that of a developing country at the brink of a health transition, acquiring diseases characteristic of affluent societies without having eliminated those characteristic of poor countries” (Obuobi et al, 1999, pp.1-2).

Obviously, the re-emergence of diseases and the HIV/AIDS pandemic, coupled with negative economic growth has severely affected the development of the nation, including the modern health care system. The rising cost of diseases associated with lost productivity is a growing burden for the individual, family, community, the employer and the nation as a whole (see figure 1). As shown in figure 1 diseases reduce the availability of labor supply, savings and investments, and ultimately affect the value of life.
Figure 1: Cost of Diseases

Source: Ghana Ministry of Health, 2005
Chronic under-funding continues to characterize the modern health care system. As shown in table 1, annual GDP growth rate has increase but the total expenditure of health as percentage of GDP continues to fluctuate and hitting its lowest in 2005 (6.3%). This seems to suggest that the government commitment to support the health sector has not received any significant boost. This becomes a problem when the population is growing at 2% annually (see table 1). Government expenditure should also increase significantly to reflect the population growth because population growth inevitably increases healthcare demands. Also, as table 1 illustrates, external resources on health as percentage of the total health expenditure has increased significantly. Looking at the table, for instance in 2005, external resource accounted for 25.7%, of the 6.3% of GDP allocated to the health sector, which means that government only contributed 4.6% of the GDP towards the health sector. The same analysis shows that the actual government spending towards the health sector has decreased, from 6.2% in 2000 to 4.6% in 2005. This indicates a significant shift of responsibility from the government to foreign donors.

Despite the fact that government and donors have made some progress at providing funds for the health sector, the progress still falls far short of the Abuja Declaration target of 15% (IDRC, 2008). At the Abuja meeting, which was held in 2001 member nations of the African Union (AU) made a commitment to improve healthcare expenditure to 15% of national budget every year (IDRC, 2008). In light of this commitment, Ghana’s effort has substantially decreased as commitment towards the 15% increase has not been met neither has there been efforts to improve this.
### Table 1 Ghana Expenditure on Health and Population Dynamics

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<tr>
<td>GDP (current US$)</td>
<td>4,977,488,896</td>
<td>5,309,158,400</td>
<td>6,159,567,360</td>
<td>7,624,164,864</td>
<td>8,871,872,512</td>
<td>10,720,346,112</td>
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<td>GDP growth rate (annual %)</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>6</td>
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<tr>
<td>Inflation, GDP deflator (annual %)</td>
<td>27</td>
<td>35</td>
<td>23</td>
<td>29</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Population, total</td>
<td>20,147,515</td>
<td>20,616,701</td>
<td>21,093,717</td>
<td>21,575,356</td>
<td>22,056,906</td>
<td>22,535,010</td>
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<tr>
<td>Population growth (annual %)</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Total expenditure of health (THE) as % of GDP</td>
<td>6.9</td>
<td>7.1</td>
<td>6.3</td>
<td>6.7</td>
<td>6.7</td>
<td>6.3</td>
</tr>
<tr>
<td>External resources on health as % of THE</td>
<td>9.9</td>
<td>14</td>
<td>16.2</td>
<td>28.5</td>
<td>29.9</td>
<td>25.7</td>
</tr>
<tr>
<td>Health expenditure minus external resources on health (Government contribution) %</td>
<td>6.2</td>
<td>6.1</td>
<td>5.2</td>
<td>4.8</td>
<td>4.7</td>
<td>4.6</td>
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Source: World Development Index and World Health Organization
Furthermore, the majority of the population (69%) resides in the rural areas (Senah, 2001); yet health care funding is prioritized toward the needs in the urban areas (GoG, 2002). It is estimated that the affluent households benefit about three times more from government expenditure on health than the poor households (GoG, 2002). This justifies why health personnel in rural areas continuously migrate to urban cities, where, although funds are insufficient, conditions are better. Thus, a relatively low number of health personnel are left behind to cater for the needs of the larger population. For instance, “about 70% of doctors are located in the Greater Accra Region, which accommodates only 15.8% of the national population … [compared to] the Upper West Region [that] has only 9 doctors and until recently, the Upper East Region had no pharmacist” (Senah, 2001, p.85). The immediate effect is overburdened, inpatient, and frustrated health care workers in rural areas. The outcome of this is inadequate or inappropriate care administered to patients and health personnel constantly going on strike because of poor salary rates, which also reduced the care given to patients (Mensah et al., 2005).

Health professionals are moving from rural areas to urban areas because of lack of basic amenities like water, electricity, decent accommodation, and good quality schools for their children (Awases et al., 2004). Similarly, the mass of health personnel in urban areas, especially nurses, have no housing schemes and lack transportation to work. Agyepong et al. (2004) asserted that accommodation remains a problem; given the low salary received, low availability of accommodation, landlords demand advance rent payments of up to two or three years, and high rents in relation to what staff earn.
Another major issue is the poor career prospects and promotion. Majority of health professionals do not receive the necessary training required to properly do their work. Evidence show that only 50% of health personnel received in-service training in the last year (mostly staff with more years of education), with the majority receiving only one training (Agyepong et al., 2004). Until recently, there were no postgraduate training programs for nurses in Ghana so nurses could not attain further education. Promotions are delayed and many health professionals witness as others with fewer years of service are promoted because they have the right contacts and are better able to agitate for promotion (Agyepong et al., 2004). For that reason those whose promotions are delayed become demotivated and see no future in working in Ghana. Then again, low salary and high inflation rates in Ghana means many cannot secure a safe retirement, forcing health personnel to seek better working conditions and incomes outside the country. As a result, health personnel that traveled initially for education and/or training ended up staying behind after the end of their studies because of the threats of unemployment and other hardships in Ghana (Anarfi et al., 2003). Inevitably, migration of health care personnel has become a norm.

The demand for health professionals by other African countries such as Uganda, Botswana, Nigeria and Zambia and rich countries triggered more health personnel to migrate, in their effort to escape the financial and employment turmoils at home (Bump, 2006). It is, therefore, not surprising that health personnel are attracted to jobs in the UK and the U.S. where there are lots of opportunities for them to improve their professional skills, further their education and receive promotion when due. Again, the departure of
well-experienced and qualified health teacher means poor training of healthcare graduates, affecting the quality of care given. The public health sector is the most seriously affected by the migration of health personnel.

Continually, there is inadequate supply of essential equipment in most health facilities. Agyepong et al (2004) asserted that inadequate supply of equipment includes relatively inexpensive tools, such as dustbins, brooms, disinfectant, sterilizers, gloves, soap, mops, bed sheets, pens, pencils, rulers, etc. This is felt across the country. As a result, health professionals are unable to administer proper care and quality service to patient. Some personnel were infected on the job, as there were no drugs to treat some contagious diseases. With the spread of HIV/AIDS and the lack of equipment to work with, health personnel are increasingly becoming concerned about their health. Arguably, this pushes many health care workers to seek jobs elsewhere (Agyepong et al., 2004).

**Traditional Health Care System**

In response to declining economic conditions and incessant cut-backs of healthcare expenditure, the health care delivery system was decentralized in the late 1980s; however there was no attempt by the government to formally integrate the traditional healthcare system into the healthcare system (Akosah-Sarpong, 2008). One cannot lose sight of the fact that some type of traditional practices such as naturopathy and homeopathy were integrated into the modern health care system and that most successive governments have recognized the importance of the traditional healthcare system, but the fact that government has failed to formal integrate traditional healthcare system into the current healthcare delivery system still remain a concern here.
Obviously, since the government has increasingly shifted the financial burden of health care to the public, the modern healthcare delivery system, in general has worsened, forcing individuals to fall back on the traditional system. According to Dr. Moses Danquah, a trained herbal pathologist and head of the Monadak Plant Medicine, on a typical day at the clinic, he sees over 300 patients, with 150 patients waiting to see him for various chronic diseases such as strokes and fibroid (VOAnews.com, 2006). He further contended that, although most of his patients have access to modern healthcare, since they are in Accra the capital city, for various reasons they have given up on modern healthcare system. Many Ghanaians are self-medicating or seeking medical assistance from traditional healers not only because of financial hardships, but also due to the fact that modern health care services were inaccessible and some cases ineffective to control or cure certain health problems.

Besides, rarely does one find modern health care facilities or health personnel in rural and remote areas. Often they are non-existent in such places; therefore, drug peddlers and particularly traditional healers become the first point of contact for the majority of the rural population. The majority of the population, who indulge in self-medications, obtains these drugs from drug vendors (some illegally selling these drugs) and either use modern drugs or herbal medicine exclusively, or use them simultaneously.

Similarly, the growing demand for herbal medicine also has triggered an increase in illegal and quack drug providers, who have invaded the traditional healthcare system, practicing illegally to enrich themselves. This has resulted in drug abuse, inappropriate use of medication and inaccurate dissemination of medical information, among other
factors. With an unhealthy environment, these pervasive practices invoke negative or dangerous consequences on the health status of citizens. For instance, Dr Martin Dung, at the Tema General hospital, indicated that students are increasingly using herbal concoctions as drug abuse; and this has resulted in many reports of chronic liver and kidney complications (abcnews, 2007). With ill-managed law enforcing structures and vague policy boundaries, it is not surprising that many are now abusing herbal medicine and products and in turn undermining traditional healthcare giving. Without any legal framework governing the traditional healthcare delivery system it is difficult to differentiate between the fake and the authentic healers or to prevent an individual from establishing themselves as a healer. This increases malpractice and professional misconduct in the country, putting the over 70% population who access and use traditional health care system at risk.

Although the government set up the Directorate for Herbal Medicine, under the Ministry of Health in 1991, to regulate and monitor traditional health practices, malpractice and professional misconduct among traditional healers have not ceased (MoH, 2007). Traditional healers were still able to do whatever they want because the law lacked effective implementation instrument to restrict them from doing so. With the WHO recognizing traditional medicine as a significant alternative health care system in meeting the primary health care needs in the 21st century, it is no longer a question of neglecting this system as many people depend on it. WHO (2003b) asserted that traditional healthcare system “has maintained its popularity in all regions of the developing world and its use is rapidly spreading in industrialized countries. The global
market for herbal medicines currently stands at over US $60 billion annually and is growing steadily” (np). For that reason, WHO has advocated through the launching of its first comprehensive traditional medicine strategy in 2002, that countries must use scientific evidence to enhance the safety, efficacy and quality of herbal medicine, products and practices, as well as to protect biodiversity and traditional knowledge (WHO, 2003b). The strategy was designed to help countries to 1) develop national policies to evaluate and regulate traditional medicinal practices; 2) create a stronger evidence base on the safety, efficacy, and quality of traditional medicine products and practices; 3) ensure availability and affordability of necessary herbal medicines; 4) promote the therapeutically sound use of all medicinal treatments; and 5) document traditional medicines and remedies (WHO, 2003b).

Therefore, in response to WHO and AU requirements, the Ministry of Health has facilitated the development of safe, efficacious and quality traditional and herbal medicine in the country. As a result, in 1992, PDNC Law 305 was enacted in 1992 under the Food and Drugs Board (FDB) law (PNDC Law 305, 1996). As a corollary, the FDB implemented regulatory measures to ensure that all drugs and foods, including herbal medicine that they register and market are of high standards, in terms of safety, efficacy and quality.

Also, the Kuffour administration advocated for traditional practitioners to send their products to the Centre for Scientific Research into Plant Medicine for proper certification. A manual of harmonized procedures was designed as guidelines for assessing the safety, efficacy and quality of herbal medicine in the country and for
providing local scientists with recommendations (The Ghanaian Times, 2007). This was made possible through the Danish International Development Agency (DANIDA) supporting the Traditional and Alternative Medicine Directorate (TAMD) in a survey.

Furthermore, in 1999, through the effort of the government, all traditional healthcare associations were merged into the Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM) to enhance capability building and the sharing of information. The Traditional Medicine Practice Act 595 was formulated by traditional healers and passed in Parliament in 2000, mandating the establishment of a council to regulate and to set standards for the practice of traditional healthcare, to register and license traditional healers in the country, and to regulate the preparation and sales of herbal medicines and products (WHO, 2001b). Accordingly, a Traditional Medicine Practice Council (TMPC) was established. Through the Council, a list of herbal drugs was included in the essential drug list used in the prescription and dispensing of drugs under the National Health Insurance Scheme (NHIS) in hospitals and clinics (WHO, 2001b; MoH, 2004). Additionally, for the ever first time, in 2004, traditional healers through the GHAFTRAM assisted the Ministry of Health in developing the traditional healthcare system’s code of ethics (GNA, 2004).

Indeed, herbal health facilities, such as the Natural Healing Centre (established in 1999) and the Amen scientific Herbal Hospital (established in 1996), are now using indigenous knowledge, herbal medicine and modern scientific technologies to treat various diseases such as breast, cervical and prostrate cancers, stroke, diabetes, hypertension, arthritis, epilepsy, typhoid, infertility (men and women), erectile
dysfunctions, cardiovascular disorders and managing HIV cases (Amen scientific Herbal Hospital website; Natural Healing Centre website). The traditional healthcare system, which was once frowned upon, with time has become the backbone for many patients’ healthcare needs. Patients from Britain, Germany, Holland and the U.S. are accessing traditional healthcare system from facilities such as the Natural Healing Centre (Natural Healing Centre website). Also, the Amen scientific Herbal Hospital, with fourteen branches in Ghana and three others in West African countries, is working and training “a number of orthodox medical practitioners who could not find treatment at orthodox medical facilities but were treated” at the Amen scientific Herbal Hospital on herbal medicine and traditional mode of treatments (Amen scientific Herbal Hospital website).

Moreover, to promote the study and practice of herbal medicine in the country, the government established a program at the Faulty of Pharmacy in the Kwame Nkrumah University of Science and Technology, to train those interested in herbal medicine. As a result, the Amen scientific Herbal Hospital with the aim of developing and promoting safe and efficacious herbal medicine practices is providing vacation training for students of the Department of Herbal Medicine at the Kwame Nkrumah University of Science and Technology in Kumasi and the Alternative Medicine Institute at Juabeng (Amen scientific Herbal Hospital website).

Indeed, there is no doubt that the traditional healthcare system has progressed in the 21st century, but the fact still remains that fake herbal medicine and practitioners are mounting as demand for herbal medicine continues to increase. Also, many traditional healers are still practicing in secrecy and are not subjecting their products to under
scientific testing. This has occurred because, now traditional healthcare practices has essentially become the preserve of the knowledgeable and the modern scholars, marginalizing the actual healers whose knowledge once sustained this industry.

Policies/Programs in Place

In an effort to enhance health care delivery the previous government reformed and implemented certain policies and programs, however, most of the enhancement and advancement occurred within the confines of the modern healthcare system. Policies were implemented to facilitate better accessibility, improve availability, and adequate utilization of the health care systems. Programs were established to increase the supply of health care personnel, improve the distribution of health service, and to provide adequate and proper usage of drugs.

Drugs Finance and the National Health Insurance Scheme (NHIS)

WHO (2003c) emphasized that medicines are a “human right” as they are a significant resource to health development; hence access to them should be improved to ensure that no one is denied this right. A major challenge to improving and sustaining health care is that of finance. Evidently, “the availability of finance for the procurement of drugs is the lifeline to the whole system of drug management” (MoH, 2004a, p.13). With drugs constituting about 60 to 80% of the costs of health care (MoH, 2004a), it is most unlikely that as a relatively low-income country like Ghana, will be able to adequately supply drugs amid other health care needs. With limited healthcare capital and the high cost of modern drugs, which is frequently escalating, the country runs the risk of importing cheap and ineffective drugs. One of the reasons for advocating for a
comprehensive integration is to develop herbal medicine and products at an efficient and safe ways so accessibility, availability and utilization of health care will not be an issue. However, drug financing in mainly geared towards imported drugs, which is unaffordable for many Ghanaians, given the fact that 35% of the population lives in extreme poverty and 44.8% live on less than US $1 a day (IMF, 2005). This makes it relatively impossible for citizens to purchase drugs if they are being sold at unaffordable rates. Consequently, some imported drugs remain underutilized or expire over time because people are unable afford them. In this respect, investors in those imported drugs run into deficits (WHO, 2006c).

Similarly, Section 7.3.5 of the drug policy indicates that “the government shall grant compulsory licensing (e.g. local manufacture and generic version of patented products) to promote competition and access to drugs when the health of the public is at stake,” yet, little funds are allocated to promoting the production of herbal medicine (MoH, 2004, p.21). Puzzling, policies persistently insist on more research and development into indigenous health care systems, yet the previous government failed to take any major steps toward comprehensive integration.

Furthermore, in an effort to increase economic accessibility to healthcare and to reduce the excessive financial burden on patients and the state, the Kuffour administration passed the National Health Insurance Act (NHIA) in 2003. Unlike the user fees system, the National Health Insurance Scheme (NHIS), which was implemented in 2005, aims at providing universal coverage to all Ghanaian citizens, regardless of their ability to pay (Sulzbach, Garshong & Owusu-Banahene, 2005). In other words, the
scheme was established to replace the user fee system which had negative impact on many Ghanaians. It enables enrolled Ghanaians to obtain the basic health care services such as prescription drugs under the NHIS drug lists, emergencies services, cervical and breast cancer treatments, eye services, maternity care including prenatal, postnatal and delivery services, without paying out front.

The concept of “universal coverage for all” is contentious and ambiguous because the traditional health care system for instance has not been fully tapped into. Besides, some districts or areas lack health care facilities and/or resources including health care personnel. Despite the obvious reasons for NHIS implementation, what the state and the new scheme do not explain is how the health insurance can encourage all Ghanaians to seek care when poor quality of care and the shortage of health professionals have triggered a loss of confidence in modern health care system. The introduction of the new healthcare scheme has not put an end to the sporadic strikes by physicians and other health personnel. These, coupled with delays in reimbursement of physicians and health facilities for services render has negatively impacted the sustainability of the scheme. The NHIS owes many health institutions millions of Cedis and this has adversely affected the quality of care given. For instance, the NHIS owes the Bawku Municipal Mutual Health Insurance Scheme (BMMHIS) a sum of GH₵100,000.00 for only July. As the Administrator of Quality Health Centre, Mr Awudu opined, “anytime they submit claims, they are paid 40% while vetting is underway” (Nkunu, 2008, n.p.). Indeed, hospitals and other health care facilities cannot provide adequate quality care without the funds to purchase enough drugs, medical technologies or to hire health personnel. This leads to
cases where by medical professionals have to turn down patients because NHIS reimbursement have not been paid for previous months. The biggest problem with the NHIS, thus, is adequate financing.

Besides, NHIS does not operate on the national level. In fact, enrollees from Accra for instance, cannot use their insurance in the north. Therefore, for individuals to access free medical care in the north they might make multiple registrations and payments. This makes accessibility very difficult. Irrespective of wherever one is, one should be able to access healthcare under the NHIS, either than that it is merely a process of having “currency without a marketplace to shop at” (NACHC, 2007, n.p.).

Also, Ghanaians’ unpleasant experiences in the past with health care reforms and policies are definitely a hindrance delaying enrollment into the new health scheme. Both the drug policy and the NHIS do not favor or promote traditional health care services, which has been the back-bone of health care giving in the country. And in cases where attention has been given traditional healthcare, all attention has focused on herbal medicines. This is due to the fact that the market and the capitalist demands have placed more emphasis on the scientific justification of medicine, hence have shifted attention from non-scientific traditional spiritual therapy to the herbalists, whose products can be easily justified scientifically. The question that needs to be answered is how the Food and Drugs Board intend to include spiritual healers as providers under NHIS, when the efficacy of this form of care cannot be scientifically verified, since they are mostly based on divine powers.
The NHIS have been argued as another neo-liberal mechanism for profit maximization that favors modern health care arrangements. Although contributions vary from district to district and disease coverage is more specific to each district, the average NHIS premium is set at GH₵ 7.20 (an equivalent of $7) and this put a lot of pressure on the people making a $1 or less a day (Sulzbach et al., 2005). Already, findings from Sulzbach et al suggest that there is a potential problem with affordability of the NHIS premiums in some districts. They note that, for example, “nearly half of uninsured Nkoranza households were formerly insured, citing [expensive] premiums as the reason for ending their enrollment” (2005, p.8). This example goes to show that poor communities and households cannot afford the new health premium and might turn to self-treatment. In fact, many could only afford GH₵2.50 (about $2) per adult per annum (Sulzbach et al., 2005) yet herbal medicines which are cheaper, affordable and have been used by the people for centuries are excluded, all in the name of not meeting “standards” that are based on modern health care ideologies.

Sadly, some district mutual health insurance schemes are charging more, in some cases as much as twice or triple that of the initial premium which is set at GH₵ 7.20 ($5.94). For instance, the Bawku Municipal Mutual health Insurance Scheme (BMMHIS) is charging GH₵9.60 ($7.92), which is extremely high given the fact that the majority of the Bawku population are poor and their “health facilities do not have qualified medical professionals” (Nkunu, 2008, n.p.). As a result, the NHIS which was created to improve the access to health care has in turn become a significant deterrent to health care accessibility. Without a doubt, high premium will led to under utilization of health care
services since the majority of the poor population will not be able to afford it, which in turn creates unequal accessibility to formal health care.

Moreover, there are many health care services that are excluded from the new health insurance scheme. This implies that those who have health conditions not covered under NHIS must pay before care is administered. Thus, the NHIS to replace the cash and carry system has not fully eliminated the old system. What’s more, many enrollees have to wait on an average of 3 months before they receive their membership cards. In effect, a registered NHIS member cannot access free health care and might pay before treatment is given during this period of wait—a cash and carry system. Besides, with the NHIS differently arranged in the various regions, there is no guarantee for individuals who re-register and pay premiums in other regions that their health conditions will be covered. It is therefore not surprising that many people have not registered because the health conditions for which they are seeking medical help are not necessarily covered under NHIS (Nkunu, 2008).

Furthermore, many traditional services, which are affordable, are not covered under the NHIS premium; and yet the Kuffour’s government campaigned for all citizens to be registered under the NHIS. In other words, this government through the health insurance scheme discouraged the people from utilizing and access traditional healthcare system.

**Quality Assurance**

The criteria used to guide the selection of drugs listed as part of the Essential Medicine List (EML) and the Standard Treatment Guidelines (STG) are bias. As MoH
(2004b) stated, the selection of drugs “… were dependent on those used for the selection of medicines for the World Health Organization Model List of Essential Medicines” (viii). This to some extent favors biomedicine at the expense of herbal medicine. Unlike most modern medicine, herbal medicine’s safety and effectiveness are hard to prove scientifically, especially those used by spiritual healers, as mentioned earlier. Of course, standard western methods of evaluating both traditional and modern health care services will certainly promote the use of the modern health care system. This makes these standards inappropriate for assuring the quality of herbal medicine traditional medicines. This also limits the development of certain herbal medicine and products that may be useful for the treatment or prevention of diseases.

**Local Drugs and Herbal Medicine Manufacturing**

The drug policy asserts as its prime objective “to provide needed drugs to adequately treat and control such diseases, and also make other resources available where there are special needs” (MoH, 2004, p.22). Indeed, there is an increase in the supply of essential drugs, but most of these drugs are imported from European countries and North America. Although the past government claims to get a “good price” for the imported drugs, the public are still unable to afford them. Moreover these imported drugs are much more expensive compared to local drugs. In spite of this, state continues to invest largely in imported drugs, draining the country of needed revenue to enhance health development (MoH, 2004).

Of course, the continuing dependence on imported drugs is in itself a barrier to local manufacturing, particularly that of herbal medicine and products. Inevitably, this
prolongs the development of local pharmaceutical companies and herbal medicines. It is conceivable to assume that the previous administration, to some extent, does not trust its own pharmaceutical companies and locally produced medicine. This may be due to the fact that, in comparison to the exportation of raw herbal plants, development of herbal medicine does not present immediate gains to the state. In effect, little attention is given to local drugs and herbal medicine production that are effective and less expensive to produce than imported drugs. In addition, overexploitation of raw herbal plants has led to scarcity of some herbal plants, an important part of traditional health care system. This affects the capacity of local manufacturers to meet demands, advance their products and compete on the international market.

Additionally, the politics of disease control also put local drugs and herbal medicine manufacturing at risk. For instance, section 5.3.2 of the drug policy states, “only drugs conforming to nationally accepted and/or internationally recognized quality standards shall be permitted to be manufactured and distributed in the country” (p.16). The question remains, what is “national” when almost all the rules and regulations are based on international concept of acceptance? Clearly, some international rules and regulations affect and prevent the development of local drugs and herbal medicine. It also affects the autonomy of traditional practices because international organizations dictate how, why, what, where and when herbal medicine should be used. For instance the notion of only purchasing drugs that are prescribed by physicians as acknowledged in the drug policy is problematic. It discourages the use of most drugs prescribed by traditional healers. In essence traditional healers would not be able to prescribe drugs because they
are not viewed as doctors. In DeJong’s (1991) analysis, modernization affects the way traditional practitioners operate. She argues that as a result of increasing competition with modern health care providers, for traditional practitioners to survive they “have begun to adopt many of the practices of modern health care, such as prescribing antibiotics, dressing in white coats, and operating from modern clinical facilities” (p.8). Basically, integration of indigenous health practices is geared toward cosmeticizing traditional health care services rather than considering a deeper, more rooted integration effort.

Importance of Herbal Medicine to Healthcare Development

Previous governments have done a lot to improve the health care system. Policies and programs have been adopted to enhance access to health services, improve efficiency of service delivery and increase health personnel, however, basic health care needs have not been met. The health situation is still characterized by inadequate access to quality health care, shortage of health personnel, and depleting health infrastructure. The reality is that with increasing growth in population, the nature of Ghana’s import and export market, an inheritance of unhealthy health culture, depleting health infrastructure, and deteriorating trust in modern health care, have demobilized any progress made in the health sector.

In terms of availability, undoubtedly, there are more traditional practitioners than modern health practitioners. It was estimated that there are approximately one physician for every 12,000 people, as compared to traditional healers where there is one traditional healer for every 400 people (African Health Monitor, 2003; Akosah-Sarpong, 2008). This implies that traditional healers are evenly distributed across the country and are within
the reach of most citizens. This makes them more accessible (WHO, 2007c). Indeed, any additional loss of modern health personnel has serious implications to the health of citizens. However, despite the availability of many more traditional health practitioners, their services are not being used efficiently.

The continuous migration of physicians, nurses, midwives, and pharmacists mean that the ratio of health professionals to 1,000 people as estimated by the World Bank will deteriorate over a period of time. In contrast, there are “approximately 45,000 traditional healers, most of who are recognized and licensed through various associations that fall under the nationally mandated Ghana Federation of Traditional Medicine Practitioners’ Association,” (Akosah-Sarpong, 2008, n.p.). This is enough to assist and sustain the health care sector. Presently, traditional healers provide services to about 75% of the population, particularly those in rural and remote areas. Many more people are turning to traditional healers because of the scarcity of health personnel among others factors. In some remote and rural areas, traditional healers are the only source of care for the people. Recognizing the importance of traditional health services, many researchers view traditional health care systems as a better option to improving basic health care.

It is often argued that remittances from health personnel overseas is geared towards the development of Ghana, however, remittances alone cannot compensate for the investment lost in their personnel, especially when the country is in dire need health workers (Eastwood, 2005). One should recognize that the training of modern health personnel is a long process, involving considerably large funds from the state. Nonetheless, these personnel depart from the country without investing into the health
sector. Therefore, country ends up recruiting health personnel from overseas, costing it more money (Dovlo & Nyonator, 1999). From Van der Geest’s (1997) perspective, the gap in the shortage of health personnel can be bridged by training traditional practitioners, which is cheaper and quicker. According to DeJoug (1991), this is particularly necessary for enhancing health manpower development and service expansion. Integrating traditional healers into healthcare system ensures the sustainability of the system because these workers are more likely to stay in the country since they are unlikely to trade their beliefs and methods for biomedicine.

In terms of cost, “traditional health care are more easily met” (DeJong, 1991, p.4). This is because, compared to the modern health care, traditional healers are more willing to accept delayed payment, payment in kind such as gifts or in some cases patients can negotiate the amount (DeJong, 1991). The flexibility is payment plan, make the traditional system more accessible. In many case, if effectively managed, it could supplement inadequate care provided by the modern health system.

As underscored by DeJong (1991) and Van der Geest (1997), the cultural affinity between traditional healers and their patients is unique, which an additional benefit in healthcare giving. For Swantz (1972 cited from Good 1979), not only are indigenous healers concerned with therapeutic issues, but also the patient’s traditional values and beliefs. The traditional healers because they normally reside in the community are more familiar with the social context and the community in general and hence can easily to figure out how, when and why certain disease outbreaks occur in that community (DeJong, 1991). In his own words, Van der Geest states “the fact that healers and patients
share ideas about the origin, meaning and preferable treatment of illness enhances the efficacy of treatment” (p.907). Besides traditional healers spend more time with their patients, they are respected, and many believe they are tolerant compared to modern health professionals who often are unsympathetic and unresponsive to the needs and concerns of their patients (Diesfeld 1974).

Of course, traditional health services do not have the answers to all of the health problems in Ghana and as Yeboah (2000) aptly pointed out, they cannot substitute biomedicine. He also argued that herbal medicine provides more effective treatments to certain health problems, thus, both modern and traditional health care systems provide specific therapeutic services. DeJong (1991) acknowledged that by not integrating the two distinct health systems the health care sector is losing out as exchange of information between the two structures are limited.

It is often noted that the diversity in therapeutic services provided by traditional health care makes it difficult for the government to integrate them into the national health care system. Moreover, concerns are constantly been raised by government officials, health authorities, international organizations, and researchers about traditional health care system’s reliability and safety (WHO, 2001a). The quality of herbal medicine and products and qualifications of traditional healers are sometimes questioned (WHO, 2001a). This may be true, however, traditional health services are “…unlikely to disappear, particularly if the quality of and access to modern health care service is not improve significantly” (DeJong, 1991, n.p.). For DeJong (1991), ignoring to regulate and to recognize traditional health care prevent effective supervision of the care they provide
to people. If government officials and health authorities withhold official integration of traditional heath care, “…they reduce their opportunities for learning about its pharmacopeia, and thus for discouraging the use of those substances which are harmful anti promoting those that are valuable” (Dejong, 1991, p.9). Accordingly, comprehensive integration of traditional health care system into the mainstream health care system will help control herbal medicine and products usage and improve traditional health services’ safety and reliability.

Indeed, traditional health care system, especially herbal products and drugs have developmental implications. Typically, herbal medicine preparations are highly effective in disease treatment. By incorporating traditional health care system the country stand a better chance of strengthening its safety, efficacy and quality as well as developing traditional pharmaceutical companies that will legally sell these products. In effect, by developing effective traditional health system, the country becomes more self-reliant (Van der Geest, 1997), therefore reducing its dependence on imported drugs that are expensive and not afforded.

Also, there will be sufficient drug supplies at an affordable price, if full integration is achieved. What’s more, this will generate revenue for the country, thus, boosting economic development and improving living conditions. In the Declaration of Alma Ata on primary health care, governments are suppose to utilize existing resources completely (DeJong, 1991), which traditional health care system seem to provide. In other words, traditional healers and their medicines are part of available resources which the government must utilize fully.
Examples of Integrative Efforts in Africa

*Traditional and Modern Health Practitioners Together Against AIDS and Other Diseases (THETA) - Uganda*

With traditional healers being the main and, in most cases, the first contact of care for the majority of HIV/AIDS patients in rural Uganda, it became urgent and necessary to equip traditional healers with the knowledge in HIV/AIDS. Focusing on improving access, cost and quality of health care for vulnerable communities, THETA’s main goal is to collaborate with both modern and traditional healthcare practitioners to prevent, control and treat HIV/AIDS and other sexually transmitted diseases (World Bank, 2009). According to a World Bank report, THETA has comprehensively trained more than 5000 traditional healers in 17 districts of Uganda in basic knowledge of HIV/AIDS treatment, presentation and care. For instance, traditional healers in Uganda are counseling, educating, promoting safe-sex and distributing condoms to local communities.

Collaboration between modern and traditional healthcare practitioners has also led to the successful development of medicinal plants for the treatment of oral thrush, Herpes zoster, dermatitis (Skin infections), and persistent cough in HIV/AIDS patients (World Bank, 2009). In some cases, the developed herbal medicines were found to be “more efficacious than some of the available allopathic medicines (Herpes Zoster and skin rash in HIV/AIDS in particular)” (World Bank, 2006, np.).

Indeed, not all HIV/AIDS patients can access Anti-retroviral (ARV) drugs needed to improve their health and life expectancy. This is mainly due to the fact that only patients with CD4 cell counts below 200 qualify for ARV treatment. In essence, patients
with CD4 cell counts of between 200 and 500 are more likely to die because they cannot access ARVs. However, this collaborative effort has resulted in the validation of numerous efficacious herbal medicines with immuno-boosting properties, which has helped patients not eligible for ARV treatment to have access to treatment, gain their immune systems and appetites, and reduced their risks to infections related to HIV/AIDS (World Bank, 2009). In addition, some herbal medicines have helped ARVs patients to better manage side effects such as, nausea, anorexia, and vomiting from taking anti-retroviral drugs (World Bank, 2009). THETA’s approach has generally helped improve traditional health care practices in health care industry, especially for communities without access to modern health care services.

The Culture and Health Program (CHAPS) - Kenya

PATH is an international non-governmental organization that has established itself as leader in implementing cultural sensitive program that promote health in Africa. One example of PATH initiative is the Culture and Health Program (CHAPS), which is currently working on health projects in four African countries – Kenya, Nigeria, Egypt and South Africa. Grants from CHAPS have enable communities to integrate certain cultural practices that affect their health into health care programs. For instance, in Kenya, the ancient Kaya Forest which is home to the Digo community has a large number of rare medicinal plants and has been used for centuries for prayers and traditional ceremonies (PATH, 2007). Indirectly, this customs has helped conserve rare medical plants species and the traditional healing practices. However, the gradual destruction of the Kaya Forest for construction projects, farming and the provision of
space for tourism, has destroyed some of the rare species (PAH, 2007). In order to save
the forest and the cultural identity of the Digo community, some traditional healers
formed the Kaya Kinondo Self Help Group, and have collaborated with the Coastal
Forest Conservation Unit of the National Museums of Kenya. With grant from CHAPS,
the group built a traditional healing center and trained three young members for a year,
on how to prepare and use traditional medicine—in fact this process included ways of
identifying medical plants and their uses (PATH, 2007). The trainees are now working in
their local communities, increasing awareness and access to traditional health care
system.

Also, the group, through their involvement in the community they have
established herbal farm and tree nursery projects, and are always increasingly engaged in
training community members on how to grow different types of plants and practice
traditional healing measures. As a result, almost 300 different medical plants and trees
have been identified and grown, and used by the clinic to help treat various illness in the
country (PATH, 2007). As part of their activities, the Kaya Kinondo group collected
information on the role of traditional medicine and its significance to the Digo cultural
practices. This was made available at schools, cultural awareness forums, and even places
of worship (PATH, 2007). The group is working with other healers across the country,
sharing their experiences with them.
CHAPTER 3: METHODOLOGY

Research Design

The purpose of this research is to analyze and evaluate the benefits of full integration of traditional healthcare into the national healthcare system. This assessment will examine ways in which such integration could maximize public access and use of health services in Ghana. The nature of this study is such that it seeks to explore the perceptions of Ghanaians on the benefits of integration as an opportunity for a comprehensive health care giving, hence justifying the use of qualitative research approach. Qualitative methods provide a deeper analysis and allow for a richer and an in-depth understanding of how people make meaning of their situation or interpret phenomena (Denzin & Lincoln, 1994; Merriam, 1998). The rationale for using qualitative research is to understand how the different stakeholders—government officials and traditional healers view the implications of the integration process as means to expanding and maximizing health care giving.

While quantitative study is based on causal inference and the use of standardized measures to produce quantified data that can be statistically analyze, discovering thick description data that may be comparable and transferable to other situations is best understood using qualitative study (Patton, 2002). Given that traditional health care system is deeply rooted in the socio-cultural contexts and practices varies from community to community, qualitative research becomes an effective tool for understanding “the way in which respondents view their worlds and create meaning from diverse life experiences” (Padgett, 1998, p.8-9). In this regard, the research is immersed
in the culture of the people, which places the data within the rich unified milieu of social
life.

Qualitative research is appropriate for this study because this is relatively an
unexplored topic in Ghana. As Strauss and Corbin (1990) state, qualitative methods are
useful to unveil knowledge and to facilitate our understanding on phenomenon that little
is known about.

Furthermore, Bailey et al (1999) stated that since validity is an essential element,
the researcher should attempt to accurately represent findings. According to Patton
(2002), this depends on credibility, which can be enhanced through triangulation of data.
To this end, different data sources were employed by the researcher to check consistency
of what people say and thus the necessity to expand the data pool to include three
different groups of participants—focus group, individuals and informants.

Research Site

The study was conducted in the country of Ghana. No specific geographical
location was relied on for data collection from key informant. Focal locations for data
collection were at the workplaces of key informants, which are situated in the capital
city-Accra, Mampong in Eastern region and Temale in the northern region of the country.

Conversely, given the nature of this research, in that, it seeks public perceptions
on the integration of traditional health care into the current national health care structure,
the research site for individuals and focus group participants was restricted to Tema
Municipal District, a city in the Greater Accra region.
Tema Municipal District is a coastal city located 25 kilometers east of Accra, in the nation’s capital. With the Greenwich Meridian (00 Longitude) passing through the city and recording about 790mm rainfall annually, Tema Municipality is the driest part of southern Ghana. Tema Municipal District was chosen because of its demographic nature. Tema municipality is known as the heart of the country’s development and as an industrial center. The Tema Port is the largest seaport in the country and one of the most important maritime on the west coast of Africa. There are “over 250 factories in the municipality engaged in eight major areas: chemicals, textiles, food [and fish] processing, engineering, paint, fish cold stores, printing and wood working” (Ghanadistrict.com, 2006, np). This notwithstanding, the municipality’s domestic economy still revolves around agriculture. Fishing is the predominant agricultural activity mainly in the southern coastal part, with the remaining parts more involved in crop farming activities, including exotic vegetables and fruits (Ghanadistrict.com, 2006). Although over 80% of the population enjoy electricity supply and have access to potable water (ModernGhana.com), some part of the Tema municipality, particularly rural areas have no formal water systems in place, and hence depend on water from streams, rivers and boreholes (Ghanadistrict.com, 2006). Indeed, Tema Municipal District is an urban city, yet, with rural characteristics in many of its communities; this makes it appropriate for this study, as it mimics the nature of the country.

Moreover, Tema municipality was chosen because there are several health institutions, including private health institutions and traditional healthcare facilities. However, residents in both the urban and rural communities of the municipality largely
rely on traditional health care system (Agyepong et al., 2004). On average, the distance to the nearest traditional health facilities is within less than 5 kilometers and a hospital within 25 kilometers in most Tema municipal areas (Modernghana.com). Given the fact that the Greater Accra region has more doctors than most regions—of the 1082 doctors in the region, only 83 (7.7%) are in the Tema municipality—the population of Tema Municipal District as a whole have a shortage of modern health care personnel. The district is more likely to face the same set of potential health care challenges as other places in the country. This, therefore, allows the study rich authenticity to explore in depth how health service integration can help resolve the inadequate care crippling the nation.

Tema municipality has a population of 141,479 (Ghana Statistical Service (GSS), 2000), grouped into twenty-six communities. Given that the researcher has limited resources and time, focusing on all these communities is practically impossible. In Patton’s (2002) words, “No rule of thumb exists to tell a researcher precisely how to focus a study. The extent to which, a research or evaluation study is broad or narrow depends on the purpose, the resources available, the interests of those involved” (p.228). In this sense, I purposefully selected participants from a pool of volunteers from three different communities. Community 10, Sakumono (Community 13) and Ashiaman were chosen because of their unique geographic characteristics—portraying characteristics of Tema Municipal District. Community 10 is a well developed and affluent community with traits of an urban area. Sakumono, originally a small fishing village on a lagoon, is now quite developed and is popularly known as a middle-class suburb. Ashiaman, on the
other hand, is a populated underdeveloped community, with large slum areas consisting of shacks (Ghanadistrict.com, 2006). It is a deprived and marginalized community with serious socio-economic problems.

Selection of Participants

Key Informant Participants

Thirty-three participants were selected to participate in this study. Three groups of participants were used for the study; namely key informants, individuals and focus groups. This helps to generate a trustworthy answer to the research questions, which strengthens and enhances the quality of the research. Key informant participants were selected through the snowball sampling technique. By using the snowball technique I utilized well informed individuals to identify key informants with great deal of information about traditional health care system and the integration process. In other words, the snowball approach is a technique for finding research subjects, as one subject recommends another subject, who in turn refers another subject and so on (Vogt, 1999). With government officials influencing health policy and traditional healers having an impact on health care giving, this technique becomes an essential tool to identify and accumulate critical issues associated with the integration process.

According to Salganik and Heckathorn (2004) the main value of snowball sampling is its ability to obtain respondents from the desired sample that is not easily accessible, are few in numbers or where some degree of trust is required to initiate contact. In this study, the snowball technique seemed to be particularly useful because trust was developed as referrals were made by acquaintances or peers, allowing the
researcher an entry to interview respondents with rare and unique characteristics not shared by the wider population, those who are extremely difficult to locate, and impenetrable and reluctant to take part in studies. This technique was appropriate for the study because these government officials and traditional healers have the ability to shape and influence policy decisions in the integration process and also in health policies and programs, but without recommendation from somebody who personally know them, they are practically inaccessible.

Most key informant participants (80%) were recruited through word-of-mouth, through direct contact by informal network of friends and other key informants who participated in the study. Often, key informants were mentioned multiple times. The rest were recruited through substantial list of names of potential participants. I had initially proposed to using only government officials involved in the integration of traditional health care as my key informants, but I ended up expanding this pool to accommodate traditional healers who were initially to be included as a focus group. This was due to the fact that it was difficult to find and organize traditional healers. There was no time that was suitable for all the prospective participants since many of the traditional healers were not willing to take time off their practices for the interview. Besides, those willing to participate were not enough to be considered as a focus group. Judging from this, and considering the limited time available for the study, I decided to include them as key informants.

While this technique is cost-effective, it comes at the expense of introducing bias because the researcher is dependent on the subjective choices of the respondents who are
likely to share some common characteristics (Griffiths et al, 1993). In order to avoid selection bias, key informants were purposively selected based on their interest, work experience, knowledge about the integration process, and research or policy involvement in both modern and traditional health care. Selection bias was unlikely to have occurred because both government officials and traditional healers were all dealing with different aspect of health care or the integration process and had different personal views and experiences.

*Individual and Focus Group Participants*

Although individual participants were recruited from the three selected research site, focus group participants were recruited from Community 10 and Ashiaman due to certain recruitment barriers, which will be discussed later on. For the selection of individual and focus group participants, convenience sampling technique was employed. In convenience sampling approach, potential respondents were asked, upon first meeting, if they were interested in participating in such a study. Thus, participants were easy to recruit and the researcher was able to gather information without incurring cost or time. Researcher visited places of social gathering and as the opportunity presents itself, approached potential interviewers. Time of visit to these places of gathering was random so that interviewer did not target any specific time when specific group of people may be gathering at these centers. The aim was to discourage one sided group views on the research questions. As Krueger and Patton (1988) noted, “qualitative procedures like focus groups or individual interviews enable the researcher to get in tune with the respondent and discover how that person sees reality” (p.39). In light of this concern,
individual and focus group participants were selected to discuss issues of integration as they are in the best position to identify and decide characteristics that best relate to their healthcare needs. Besides, they are the people who would be most affected by issues or proposed changes in the health care system, making them suitable for this study.

Furthermore, one useful technique to gather rich information is what is known as focus group interviewing or discussion. As noted by Krueger and Patton (1988), focus group interview is a “socially oriented research procedure”, and people are “social creatures who interact with others” (p.44). Thus, focus group interview places a group of people in a natural, real-life situation environment, where they influence and are being influenced by comments of others, and tend to make decisions after listening to the advice and counsel of people around them (Krueger & Patton, 1988; Kleiber, 2004). In this light, I recruited and organized groups of participants with common characteristics to engage in free discussion on the research topic. Although I intended to interview focus group respondents from the elderly, women, traditional healers, the youth and the unemployed population, I was unable to recruit enough participants. Therefore, I ended up with only two focus groups—women and the youth. This was due to limited number of volunteers and difficulties in locating certain groups, especially the unemployed and traditional healers.

Indeed, piggyback or on-location recruiting strategy was used to locate participants. According to Krueger and King (1998), on-location recruiting strategy is used “when participants are gathered together for a different, unrelated purpose and you ask them to join you in a focus group” (p.55). In the same vein, the youth focus group participants
were recruited after a soccer event, whiles the women focus group respondents were recruited and interviewed after a women’s empowerment leadership conference. The youth’s focus group interview took place at the YMCA Recreational Centre at Tema. Focus groups participants did not know each other. Each focus group interview lasted approximately one to one-and-half hours.

Also, in his study of self-disclosure, Jourard (1964), found out that those with something in common realize that they are alike and tend to “disclose more about themselves to people who resembled them in various ways than to people who differ from them” (p. 15). Apart from the fact that participants in the women focus group were females, they were all mothers and the main decision makers in their children’s health care needs. Also, regardless of demographic and socioeconomic factors that affects health care accessibility and usage for this group, common health issues and concerns of this group included chronic health problems, pregnancy and disability among others. Given that young people are excluded from family planning, reproductive health care and prevention services or tend not to use certain existing health services, make them vulnerable to certain diseases, a common shared viewpoint of the youth in the study.

Participants of the Study

The final sample included a total of thirty-five (33) participants, which consisted of 12 individuals, 8 key informants and 2 focus groups (6 women and 7 youth). The study targeted only respondents above the age of 18 years who are Ghanaian citizens and have knowledge and/or access to both traditional and modern health care systems. Moreover, apart from key informants, participants who have not lived in the Tema Municipality area
for at least 2 years were excluded from this study. This approach was taken in order to ensure that the participants are well immersed in the social, political, economic and cultural lives of Tema, hence able to articulate authentic concerns affect this community.

Instruments of Research

The main instruments used were open-ended interviews, developed by me, the researcher and validated by my committee. Many scholars have argued that this approach is an effective way of obtaining good descriptive substance and more conceptual ideas. It also makes interviewees more comfortable since it allows them to feel part of the study; it establishes participants as experts on the subject and encourages them not only to tell their story but also to share their ideas, observations and concerns (Padgett, 1998; Gall, Gall & Borg, 2007).

Additionally, to ensure a systematic interview process, a semi-structured interview protocol (see appendices 2 & 3) was used in collecting data for this study. An “interview guide approach” proposed by Patton (2002) was created by the researcher to answer the research questions. According to Padgett (1998), an interview guide contains an initial set of questions that are to be discussed during the interview. Given that this study employs multiple sites and groups, interview guide helped to maintain consistency in data collection and enhanced comparability of responses between the groups--individuals, key informants and focus groups.

Data Collection Procedure

Before the conducting fieldwork for this study, permission was obtained from the Institutional Review Board (IRB) of Ohio University in Athens, Ohio, since any study
involving human subjects must be approved by IRB so as to protect participants against unethical procedures.

The instrument for the study was pre-tested on 8 participants (6 individuals, 2 key informants) in Dansoman, a suburb in Accra. Pre-testing of the instrument helps in assessing whether questions are clear and understandable by identifying ambiguous or difficult to comprehend questions and questions that although are understood by the respondent are interpreted differently than what the investigator intended (Reis & Judd, 2000). Participation was entirely voluntarily. Participants were informed that the information they provided will only be used to test the appropriateness of the questions.

Also, the cognitive interviewing process was used during the pre-testing by asking respondents to provide a concurrent “think a loud” response, verbalizing their thoughts or interpretations of the questions (Reis & Judd, 2000). For instance, the word traditional medicine in the context of my research became immediately inappropriate in the Ghanaian concept of traditional health care system. According to the pre-test interviewees, in Ghana, traditional medicine is used in the context that invokes the idea of alternative medicines, whiles herbal medicine projects the use of plant medicine in the maintenance, control, treatment and the prevention of health-related conditions. Also, question on how government support or discourage public reliance on traditional health care was split into two questions after concerns of complication were raised by the pre-test respondents. After their review, wording and design, the interview guide was revised prior to the actual data collection phase of the study.
Interviews were conducted over a three-week period. For the government official participants, the interview was conducted at their offices. The research site for individual participants varied and participants were met in places which they proposed. I met with some participants in their homes; others at their workplace, drug stores, local market center, barbering/beauty shops, internet cafés and restaurants. As mentioned earlier on, interviews with focus groups took place after a soccer event and a conference. Prior to the interviews, I arranged with individual and key informant participants as to where they felt comfortable for the interview to be held. The rationale behind this was to ensure that participants are relaxed and comfortable, while giving them a high sense of confidentiality that will boost honest responses to interview questions. Interested potential participants were asked preliminary questions to ascertain their qualification for the study. I described and read the aims and purpose of the research to potential participants, addressed all questions and concerns and obtained informed consent forms, prior to the interview. Also, throughout the interview, participants were assured of anonymity and confidentiality and it was made clear to them that only pseudonyms would be used in the final research study. In the case of key informants, permission was sought from qualified key informants before their names were used in the study. I personally found key informants, with the exception of one, eager for the researcher to mention their names in the study.

Participants were interviewed using in-depth open-ended interviews in a face to face setting. In order to avoid bias and not to affect the answers that I obtained from participants, I asked the questions on the interview guide as it was written, instances
where it was necessary to probe or ask specific questions, questions were asked in a non-directive way. Also, I recorded the interview using digital tape recorder and I obtained informed consent from all participants prior to each audio taping. In some cases, I both tape recorded and took field notes.

The interview was conducted in English, Twi, Fante and Dagbani, lasting from 20 to two hours depending on which group of participants being interviewed.

The Researcher

The fact that I am a Ghanaian puts me in a better position as the principal researcher to conduct this study. I was in a strong position to gather information from participants because I do speak and understand majority of the languages and cultures in Tema and generally in Ghana. Besides, I grew up in Tema and went to school in Ghana, hence, putting me in a position to easily obtain potential participants, as well as making participants comfortable enough to voice out their ideas and opinions. Additionally, as a Ghanaian, I had access to potential key informant participants through a network of friends and my father in the country. As a researcher, I played the role of the interviewer, moderator and listener.

Holliday (2002) and Glesne (2006) emphasize on the importance of elucidating the researcher’s reflexivity in relation to his/her motivations for the study. In this direction, my motivations for this study derive from my experiences growing up in Ghana during a time when traditional health care service was rarely an open practice and the main source of health care was that of modern health care. This brings to mind my childhood memory of my cousin who died from uncomplicated malaria. My cousin was
taken to the neighboring hospital in the Kete-Krachi district in the northern part of the Volta region of Ghana. The absence of a hospital or the services of doctors in our village meant that my cousin must seek healthcare outside our village, in Motoka, also in the northern part of the Volta region. After the long journey to the hospital and the hour and half wait, he was attended to by an untrained nurse, because the only doctor in the district had traveled to another district to work. I later realized that this was a common trend in healthcare services in most parts of the country. My cousin’s illness got worse and he was rushed back to the hospital only to be told that the doctor had traveled abroad to seek “greener pasture”. It was then that I realized the gravity of the healthcare shortage. This was the sixth time that the hospital had lost its physician to healthcare facilities abroad. A week later my cousin died from malaria, which is easily treatable; yet in his case, he had no chance to survive. It never occurred to me as a fourteen-year-old child that I would witness the death of a close loved one. The pain of his death has gradually faded, but the memory of it is indelibly imprinted in my mind.

Indeed, due to my experiences I am deeply aware of the gravity of delayed national health care integration efforts. Therefore, as the sole interviewer of the study, while my biases may have influenced the direction of this study, it equally gives it that authentic urgency needed for advocating the development of a comprehensive integrative health care system.

Data Analysis

Bogdan and Biklen defined qualitative data analysis as “working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns,
discovering what is important and what is to be learned, and deciding what you will tell others” (1982, p.145). Albeit, tape recording all the interviews, I took field notes when conducting the interviews, noting down any remarks and/or reflections. As soon as possible, after getting to my residence, I transcribed each interviews and read through each field notes, making comments on them. However, during the latter days in the third week, I was unable to transcribe each interview. The remaining interviews were transcribed and typewritten using word processing program once the fieldwork was completed and I had returned to the U.S-Athens, Ohio. This made it easier to develop multi-dimensional categories. The researcher did several reading of field notes, interviews and comments and re-examined the categories, and then, allocated colors to each participant’s responses to the interview questions, noting similarities and differences. This was mainly done at the library or in my residence. The goal was to create different concepts and to determine how they are linked. This, then, made it easier to trace the source of each response and quotes, which forms the preliminary framework for analyzing the data. I also did cross case analysis of the interview, noting similarities and differences across participants’ responses to the interview protocol. I, then, developed themes derived from the data and analyze them within the framework of the literature.

Limitation of Study

The time and resources were a limitation to this study. I proposed content analysis of available health policies; however government officials were skeptical about giving out policies or any written information on health policies. The researcher was advice to
contact the Assembly Press, but due to the Christmas season they were closed. Consent forms were not enough to conduct interview with most government officials under the Ministry of Health. In most cases, an additional letter was required before interview was granted. An additional limitation is that one government official recommended by most government official participants to have vital information on both the integration process and traditional health care practices was reluctant to provide enough information. Also, being the sole researcher, coupled with my motivations for this study, may have affected the interpretation and analysis of the research findings.

Reflection from the Field

The participants in this study did not see me, the researcher as an outsider. In fact most of them, including government officials and traditional healers were willing to share their experiences and personal challenges with me. Individuals in both focus groups had independent views and they were not intimidated to share their stories. During the course of the interviews, there was a tendency for the individual participants to give me, recipes and instructions on how to treat different diseases, ranging from a mere headache to more fatal diseases like malaria and cancer. In fact, Dr. Taimako, a herbalist, gave me samples of herbal medications she prescribe to patients with high blood pressure, hypertension, jaundice and diabetes. Initially, I had an interview with a spiritualist however, the wife of the spiritualist (also a spiritualist but with higher ranking than the husband) was eager to share her stories and voice out her opinions on the topic. Therefore, I ended up interviewing two spiritualists, usually a hard-to-reach population. The snowball sampling technique was very useful in data collection. Through referrals, I was able to gather
information that under normal circumstances were difficult to obtain. Therefore, key informants were more open and willing to talk in-depth about both the positive and negative issues associated with the integration process as trust was established, especially since traditional healers are still secretive and will not give out information easily. Some key informants went as far as providing extra information that they thought will be useful in the integration process.
CHAPTER 4: DISCUSSION AND ANALYSIS OF FINDINGS

Introduction

This chapter will discuss the findings from the data collected and analysis the results. The background characteristics of the participants interviewed for this study is discussed in the first section. The second section examines the presentation of the findings which was collected and organized into themes. The last section analyzes the research question, with the literature review as the basis for discussion in this section.

Background of Participants

A total of 33 respondents were interviewed, which consisted of 12 individuals, 8 key informants and 2 focus groups (7 youth and 6 women). The individual participants were from Tema municipality, 7 were women and 5 were men, representing various employment sectors of the country’s labor force, with the exception of 3 participants—a housewife and two female students who were unemployed at the time of the interview. Of the 12 individuals interviewed, 3 participants (2 females, 1 male) were from Ashiaman, 4 participants (3 females, 1 male) from Sakumono and 5 participants (2 females, 3 males) from Community 10. Most participants have lived in the Tema municipality for a long time, ranging from 8 years to 35 years. All the individual participants use and have knowledge about the traditional health care system.

Two focus groups were interviewed, which consisted of a youth focus group and women focus group. Seven young people from Community 10 were interviewed in the youth focus group, 5 were men and 2 women, of which 4 were students and the rest were employed in a variety of jobs. Three of them use and have knowledge about traditional
healthcare system, three uses traditional health care and one has knowledge about traditional healthcare services but does not use it. There were 6 participants in the women focus group, all were mothers with children and have lived in the Ashiaman community, ranging from 2 years to 19 years, as well as represent different sectors of the country’s labor force. Four of them use and have knowledge about traditional health care, one has knowledge about traditional health care and the other uses traditional health care services.

Of the key informants interviewed, 4 were government officials (all men) and 4 were traditional healers (2 men and 2 women), all of them use and have knowledge about traditional health care services. Many of the key informant participants have lived in the country since birth and the others have been in the country ranging from 30 years to 70 years. The list of government officials interviewed included the Minister of Health, the Director of Traditional and Alternative Medicine, the head of the herbal medicine unit at the Food and Drugs Board (FDB) and a senior research officer from the Centre for Scientific Research into Plant Medicine. With the exception of one traditional healer, the other healers interviewed have other jobs aside practicing medicine. Of the four traditional healers I interviewed, one is an herbalist, two (husband and wife) are spiritualists and the other combines traditional healthcare practices with Islamic teachings.

I would like to give a brief description of the key informants who allowed me to use their names in this study.

**Major (rtd) Courage Quashigah**
Honorable Quashigah is the Minister of Health. He has been a military officer for most of his time and is now a politician, a minister of state. For decades the Ministry of Health, under successive governments, is responsible for providing health care services to the people of Ghana. Under the old government administration—the Kufuor’s administration—the Ministry of Health approached politics from a new paradigm. This approach was a bypartisan effort built between both the minority and majority parties who have equal vested interest in improving public health care. Under the supervision of the Minister of Health, the Ministry initiated the implementation of policies and initiatives to promote preventive care.

**Sumaila Abu**

Sumaila is the head of the herbal medicine unit at the Food and Drugs Board (FDB). He is a pharmacist by profession. Presently, the herbal medicine unit of FDB evaluates the efficacy of herbal drugs and products. It also registers and regulates the sale and distribution of herbal drugs and products in the country.

**Dr. Yaw Ameyaw**

Dr. Ameyaw is a senior research officer from the Centre for Scientific Research into Plant Medicine. Presently, the Centre for Scientific Research into Plant Medicine screens all herbal drugs and products before they are dispense to the public. The centre also set up botanical garden of medicinal plants wherever they are found, research into medicinal plants, and develop their own herbal medicine and products.

**Dr. Hajia Salamatu Ibrahim Taimako**
Dr. Taimako is a prominent herbalist, environmentalist, and entrepreneur. She is now the regional chairperson of the Ghana Federation of Traditional Medical Practitioners. She is highly respected nationally and internationally. Dr. Taimako uses herbal plants to treat various ailments, and provides supplementary health care services to patients at the Tamale Regional Hospital. She also offers training to farmers and students into tree nurseries, agro-forest plantations, and herbal practices. She is also a supplier of over 10,000 assorted seedlings to individuals and organizations. She has received several awards and honors, including an Honorary Doctorate degree for her contribution towards the development of herbal medicine in Ghana.

**Abubrakari Iddirisu**

Abubrakari, also known as Afa Abukari is a traditional practitioner. He combines traditional therapeutic practices with the Islamic teaching to treat various ailments. He is also an Arabic teacher at the Arabic school in Tamale. He is an opinion leader, well-respected in his community.

**Yepalsi-naa Alahassan & Adisah Alahassan**

Yepalsi-naa is a traditional spiritualist. Adisah is a wife to Yepalsi-naa and also a spiritualist, but she is more advancein spiritual healing than the husband. They consults their gods on causes and sources of illness, and for guidance on how to treatment the sick. Among other treatments, they specialize in mental, emotional and other psychosocial problems. Their views and ideas are highly respected and accepted by the people in their community. In fact, before my interview, I observed as people came to great them before going to do their chores. Apart from Yepalsi-naa is a farmer. His wife, Adisah helps him
on the farm during harvest time. She processes Shea nuts into Shea butter, which she sells in the market.

Presentation of Findings

Perceptions on Accessibility of Traditional Healthcare System

Individuals’ Perceptions

One hundred percent of the individual participants expressed the opinion that in comparison to modern health care system, traditional health care services were more accessible. Many of the views expressed by the individual interviewees spoke of the costly services and products of modern health care, which they said obviate them from accessing the modern health care system. Some of the participants, including the high earner participants noted that high cost is depleting their capital, causing them to access more of the traditional health care services.

The individual participants’ perceptions of accessibility of traditional health care system were that because traditional health care is part of the environment they can access it freely and “no-one will charge you or do anything to you,” stated one security officer. Participants noted that, even if one access or buy herbal medicine from drugstores or market places, traditional health care system is still cheaper than the modern health care. Some participants pointed to the complex registration process one has to go through before consulting a doctor, laboratory tests and the long procedures of getting medications as restrictions which make modern health care system less desirable and therefore less accessible.
Many of the individual participants mentioned that local knowledge in traditional health care makes it more accessible in comparison to modern health care system. They noted that having knowledge about herbal plants makes it easy to access herbal medicine available in their environment anytime, especially in the nights when the drugstores are closed. Some participants mentioned that there is always someone in the neighborhood who is knowledgeable about herbal medicine, therefore traditional health care system is more accessible than modern health care system.

One participant, a security officer noted that individuals’ educational status may be a barrier to biomedicine accessibility. He noted that the inability of some Ghanaians to read the instructions on western packaged medicine or remember how to take the medication has caused them to rely and access herbal medicine. In this regard, he states,

Not everybody has been to school and even those who have been to school they are ignorant about the chemical content of biomedicine. So if you tell them to take one tablet twice daily, they may two or three. This makes it difficult for them to access orthodox medicine. Rather, the illiterate who knows about traditional medicine can use it more effectively.

One interviewee, a trader mentioned that although traditional health care system is more accessible, depending on the ailment, biomedicine may be more accessible than herbal medicine. To this end, she noted that while modern drugs are ready for one to use, herbal medicine, especially those made of stems, requires one to purchase it first, and then process it (grinding and/or boiling) before care can be administered. Therefore, she noted that this takes time and causing a delay in treatment.

*Key informants’ Perceptions*

This was something that 100% of the key informant participants agreed upon. They all were of the opinion that the traditional health care system is more accessible
than modern health care. In conversations with these participants, many of them, like individual respondents, pointed to the inexpensiveness of traditional health care as the reason why they perceived traditional health care as more accessible. They noted that those who usually access traditional health care services are mostly the poor in society, often unable to afford modern health care services. They also noted that due to the current economic crisis, coupled with high cost of biomedicine, even individuals who are able to access modern health care services are increasingly unable to pay for their prescribed medications. They argued that unlike modern health care system, traditional health care system is cheap, and in most cases cost nothing since it is part of the environment.

Interestingly enough, honorable Quashigah, the Minister of Health gave a vivid picture of the high cost of biomedicine and why he thought traditional health care system was cheaper. He criticized the pharmaceutical companies under the modern health care system, perceiving them as a ‘business’ mainly concerned with recovering their investments and in making profits. To this effect, he argued that the drug companies on average spend “$802 million to research, develop, package and market one type of drug, which requires some sick people somewhere to pay for it” stated the Minister of Health. Adjunct to the above, all the traditional healers and the Minister argued that unlike biomedicine, traditional health care system is more concerned with the well-being of the society and therefore provide humanitarian services to the communities (something that has being in existence pre-colonial era). Malaam Abubrakari Iddirisu, a healer who combines the traditional health care practices with the Islamic teachings stated:
For us we don’t treat and expect money. Our reason for treating patients is not to make money. It’s to make sure that the person gets better and that is where we derive our satisfaction from.

Besides, as argued by some key informants, resources for the preparation of most herbal medicine and products are less costly in comparison to that of modern health care. One herbalist, Dr. Taimako, however, argued that, although accessibility of herbal medicine is much easier in comparison to biomedicine, bad practices mostly triggered by economic development are causing the scarcity of medicinal plants. Presently, many traditional practitioners have to travel long distance to access certain medicinal plants that used to be within walking distance.

Some key informant participants also made a link between local knowledge and the accessibility of traditional health care. As noted by the director of Traditional and Alternative Medicine, even when people have no knowledge of traditional health care system they know people in their communities who are knowledgeable. Also, most healers pass on some of their knowledge and practices to patients and other healers. When I enquired about this trend, with some of the participants, they pointed to the hospitality and brotherly love that exist among Ghanaians, stating that they cannot watch a “brother” suffer when they can assist them get better.

For some participants, the availability of traditional healers, especially in the rural areas, is what they think make traditional health care system more accessible than modern health care system. Some noted that in some case, even the healers come in search of the sick. As one traditional spiritualist, Adisah noted:
It is accessible in the sense that when the spirit tells me to do this, exactly what I am going to do. If there is a sick person in this area and I am asked to go and contact the person then I’ll have to do it.

**Focus Groups’ Perceptions**

The perceptions and views on accessibility of participants varied across both focus groups, and consequently, while some groups spoke of traditional health care being more accessible, others repudiated that claim. In a conversation with these interviewees, 5 out of 6 of the women focus group, and 6 out of 7 of the youth focus group said traditional health care is more accessible.

The issue of cost was mentioned by some interviewees as the reason why traditional health care is more accessible. They mentioned that most western drugs are available, but unaffordable. In this regard, one participant, a houseboy from the youth focus group stated:

> Modern health care is about money, without money you cannot access the hospitals or buy the prescribed drugs but with traditional health care, you can access the herbal plants easily and prepare the medicine yourself.

The focus group participants, similar to both the individual and key informant participants, made mentioned of local knowledge of traditional health care system. They noted that knowledge in traditional medical practices or knowing someone—a family member, friend or neighbor who knows about traditional health care practices makes it easy to access herbal medicine in one’s vicinity.

While some participants perceived the time of access as a trait to accessing herbal medicine, others mentioned time as the reason why biomedicine is more accessible. For some interviewees, biomedicine is readily made and available for one to access. They
noted that herbal medicine is often inaccessible at certain times. In this regards, a student from the youth focus group explained:

It is easy to access modern medicine anytime but with traditional medicine is very difficult and unsafe to go to the bush or the forest to access herbal plants in the nighttime, around 12pm. In addition, if you live in the big city that mean you have to travel all the way to the village to access certain herbal medicines maybe from your grandmother.

Conversely, one participant also a student from the youth focus group argued that similarly, biomedicine are inaccessible at certain times, especially when pharmacies are closed (which is usually around 10 o’clock). In the same vein, an alcohol seller from the women focus group stated that because there are a variety of herbal plants in most people’s backyard or surroundings they can access herbal medicine anytime. Therefore, in terms of the time of accessibility, depending on the individual, both health systems are accessible.

There was the perception that accessibility to health care is based on one’s location. Most participants from the women focus group and one from the youth focus group stated that traditional health care system is more accessible in the rural areas, in that they have access to more medicinal plants and healers. They also noted that compared to biomedicine, not all herbal medicine are available in the urban, and some requires the individual to travel to rural areas in order to access it. Based on what these participants said, another youth participant mentioned that location was not an issue when it comes to herbal medicine, because, just like western medicine, herbal medicine are available in most drugstores.
Perceptions on Availability of Traditional Healthcare System

Individuals’ Perceptions

Compared to modern health care system, traditional health care system is easily available, which was revealed through the responses I got from the interview questions I posed to individual participants. When asked what they thought made traditional health care system more available 100% of individual participants mentioned their environment as the reason for the easy availability. In conversations with these participants, they pointed to the conduciveness of their surroundings to medicinal plants and made a link between this and the availability of traditional health care, especially herbal medicine. They noted that many of the medicinal plants used for treating various ailments are available all year round, partly because they are naturally grown or cultivated on many gardens and farms. These participants were familiar with herbal plants around their surroundings, and argued that most herbal medicine is within walking distance from their houses. There was also the perception that plants around them are part of God’s creation, made for mankind to treat their diseases.

All of the individual participants pointed to the presence of medicinal plants in their backyard as one reason why herbal medicine is more easily available than biomedicine. Participants did mention that because they have medicinal plants in their backyard all they have to do is to access the type of herbal plants they need, anytime of the day, when necessary.

The availability of women herbal medicine sellers and healers in market places in market places was also mentioned as a reason why traditional health care services, in
comparison, are more available than the modern health care services. They noted that one can easily access traditional health care system when one is shopping, which they noted, was more convenience.

**Key Informants’ Perceptions**

One hundred percent of the key informant participants mentioned the environment as the reason why traditional health care system is more available than modern health care system. These participants also pointed to the naturally grown medicinal plants in their environment, and clearly made the link between the conduciveness of most environments and the copious existence of medicinal plants in the country. There was also the perception that God has equipped each environment with needed medicinal plants for society’s health problems, and hence the availability of certain species of herbal plants in certain areas.

One participant from the Traditional and Alternative Medicine department noted that traditional health care system is more available because of its long existence, before biomedicine came into being. Dr. Hajia Taimako, also agreed to this view, but instead commented that because of excessive modernization and exploitation of the environment aimed by economic development most vital herbal plants effortlessly reachable within walking distance are increasingly become scarce. She further noted that even when herbal plants are found, bad agricultural practices such as the application of fertilizers on crops, makes herbal plants lose their potency, and therefore one does not get the expected outcomes.
There was an implicit suggestion that the availability of herbal plants in people’s backyard made traditional health care much more available. Similarly, some of the key informants also linked the easy availability of herbal medicine to the cultivation of medicinal plants, which are not only used for the treatment of diseases, but also for food consumption. The Minister of Health repeatedly indicated the tremendous contributions of the Moringa tree (a drought-resistant tree commonly grown in the country) to healthcare giving. His estimation of the contributions of the Moringa tree among others is summarized below:

Moringa, is used as spices in food, as nutritional supplement, for purifying water and also used in the preparation of some medicine. Today Moringa has become a huge thing but we have been growing Moringa almost in every house and we didn’t know much about its therapeutic values. Kontonmire and most of the things we grow in our gardens has all kinds of medicinal components.

Dr. Yaw Ameyaw from the Centre for Scientific Research into Plant Medicine was also of the view that there are more traditional healers compared to modern health personnel. Therefore, there is always a traditional healer within the reach of the people. He also made mentioned that the availability of traditional healers in most drugstores, which he said were close to the people than doctors. Interestingly enough, Dr. Taimako again noted, although this is true, availability of traditional health care services has decreased as many healers are dying without sharing their knowledge with others. To this end, she pleaded with the past government to speed up the integration process in order to preserve the knowledge. The participant from the department of Traditional and Alternative Medicine, further said that large-scale production and the approval of many
herbal medicine and products has increased the availability of traditional health care system to the public.

**Focus Groups’ Perceptions**

Participants from both focus groups, similar to the individual and key informant interviewees, mentioned the conduciveness of their environment to the availability of a wide range of medicinal plants as the reason why they thought traditional health care is more available than modern health care. Interestingly enough, two participants, one from each focus group argued that both health systems are easily available in the urban areas, but in the rural areas, traditional health care system is more available in comparison to modern health care system.

When asked what they thought were some of the reasons for the much more availability of traditional health care system in rural areas, the participant from the women focus group pointed to the clearing of lands for economic activities such as the buildings of houses as the reason why there is a limited number of herbal plants in her area (Ashiaman).

In conversations with these participants, many of them mentioned the availability of herbal medicine in market places. Similarly, some were of the opinion that the certification of healers and some herbal medicine and products by the government has promoted the selling of herbal medicine in market places. However, they noted that both herbal and modern drugs are equally available in most drug stores.
Perceptions on Experience of Traditional Healthcare System

Individuals’ Perceptions

Many participants said they access both the modern and traditional health care services. They noted that both systems are useful and effective for treating different diseases. Biomedicine was said to be effective in treating heart problems, cough and fever, while stomach pains, menstrual pains, malaria, typhoid and “old age illness” for instance, were curable using herbal medicine. Some participants noted that they often access modern health care services before accessing traditional health care services. When asked what the reason behind this was, they noted that diagnosis of diseases is much accurate because of the availability of high-tech medical technology and of medical information. According to the participants this enable them to know precisely what is wrong with them, before they access herbal medicine to treat the diagnosed disease. However, all the participants said they preferred to use and access traditional health care system.

The perceptions and views of participants as to why they access traditional health care varied among participants. Some participants said that the availability of medicinal plants in their environment made it easier for them to access herbal medicine. While 3 out of the 12 participants mentioned the issue of money, noting that compared to modern health care system, traditional health care system often cost them little or no money. For many participants, money was not an issue, instead, they pointed to the effectiveness of herbal medicine as the reason why they access traditional health care system. These interviewees noted that not only does herbal medicine work better but also traditional
health care services are less stressful and simple. Most of the individual participants argued that more often than not, there is a long waiting time and some modern health personnel are unprofessional, which they stated adds to the stress of the already anxious patient. One participant, a security officer noted that most Ghanaians are afraid of surgery procedures because of the risk and complications associated with it. He argued, traditional health care system barely deals with “cutting” of any sort. He also had this to say:

Some time ago, my sister went to the hospital and she was given chloroquine. The doctor wrote that she should take 4 in the morning, afternoon and night time, which is 12 tablets daily. She collapsed after taking the medication and was rushed to the hospital. The doctor was angry with the nurses because she almost died, because the nurses gave her the wrong dosage.

Another interviewee, a female student stated:

I was admitted at the hospital because I was having a severe stomach ache. The doctor prescribed a medicine I was allergic too and I notified the nurse but she forcefully gave it to me and I had severe side effects to it, but with the traditional ones since I am not allergic to it I can use it and I wouldn’t experience any complications.

In the same vein, some participants noted that none of their family members, friends or people they know who had one time in their lives accessed traditional health care services were harmed by it, or experienced any problems. Most of the participants noted that since they are knowledgeable about herbal medicine they have not experienced any problems with the traditional healers or products they access. To them, traditional health care system is safe and cheap.

During the course of the interviews, there was a tendency for individual participants to compare their traditional healthcare experiences to that of modern health
care. When I questioned the individual participants about their experience with traditional health care system, 12 out of the 12 stated the efficacy of traditional health care, particularly that of herbal medicine and products. Participants described their experiences with traditional health care as good, stating that while some modern drugs may weaken or suppress the immune system, herbal medicine address the underlying causes of diseases and deal with health imbalances in the body. They also mentioned that, in cases where diseases are incurable, herbal medicine serve as a long term care for those patients. They elucidated that modern medicine are more of a “first aid,” a temporary relief for many diseases, which in most cases are ineffective. In this regard, a security guard stated:

If I have a headache or cold I use F-pac, which is western medicine. Within an hour or two I’ll be feeling sick again because it just a temporary relief, it does not cure the sickness permanently but with the traditional medicine it is stronger and it cures my headache or cold.

Interestingly enough, three of the individual participants were of the opinion that herbal medicine prolong one’s life expectancy than biomedicine. Out of these 3 participants, two were over the ages of 50 years and looked very healthy and strong. One participant (over 60 years) argued that, although many citizens in the urban areas have access to modern health care services, many do not live to the age of 50. Another participant (54 years) compared herself to foreigners she knew who are of the same age group, describing herself fit and healthier than most of them. The other participant (who is 37 years old) said she had witnessed her grandmother live to 120 years, noting that her grandmother only used herbal medicine and she was very strong and fit.

While many participants stated that they have used traditional health care system since childhood, as taught to them by their parents or grandparents, other participants
noted that they have used it for many years. In response to my questions as to how often they use or access traditional health care, almost all of the participants stated that they access traditional health care services when they are sick, and said, when they use herbal medicine they hardly fall sick.

This researcher noticed that whereas the majority of Ghanaians access and use traditional health care, there is this perspective that it is dangerous. When I enquire about this perception, individual participants made mentioned that both health systems can be dangerous if not used appropriately or if fake ones are obtained. Some interviewees said they trusted traditional health care system, pointing to the historically entrenched of traditional health care system. To this end, these participants noted that traditional health care system has been in existence since the creation of human beings and of course before the introduction of modern health care system. They stated that traditional health care system has been passed on from generations to generations, and used with rarely any side effects. They argued that, although time has passed and more diseases are emerging, traditional health care still continues to play a major role in healthcare giving in the country.

These participants seemed pretty aware of the fact that the traditional health care system were being perpetuated as dangerous, pointing to the issue of packaging. They noted that previously, there was no measurements involved with herbal medicine and preparation procedures were unhygienic. They noted that although this has changed, the educated and elites especially, still perceive herbal medicine as dangerous. Some participants also noted that those who are ignorant and yet practice self-medication may
access fake herbal or modern products, putting their health at risk. When asked what is causing the wrong dosage of medications in the country, some participants pointed to the fact that pharmacists are not checking doctors’ orders to ensure that written dosage are right. They also noted that, because the uneducated is unable to read they may take more or less drugs than what the doctor has prescribed for them. In the case of herbal medicine, some noted that, some people are not following instructions; often times when people want to be cured quicker they tend to over dose prescribed medication. One participant, service personnel, noted that diabolism is still associated with traditional health care system, causing some people to perceive traditional health care system as evil and dangerous. Pointing to himself, he argued that the traditional health care he uses “has no diabolic effect.”

Others made mention of biomedicine personnel and some governmental officials who view some herbal medicine, especially as dangerous because they have not been scientifically proven as safe and/or effective. They noted that due to the holistic nature of traditional health care system, certain practices, products and achievements using modern scientific standards may be difficult prove or challenge. They noted that biomedicine instructs that there are no cures for certain health conditions such as cancer, HIV/AIDS and diabetes (or least cure cannot be found using the traditional approaches). Some argued that they have directly or indirectly witnessed persons being cured for the same diseases that are claimed to be incurable using herbal medicines that according to biomedicine concepts have no scientific proof.
Focus Group’s Perception

Similarly, most of the focus groups participants said they access both health systems, but preferred to access the traditional health care system. One out of the 7 youth focus group participants said he rarely access traditional health care, and noted that he did not trust it. He noted that medicinal plants were inaccessible during the night time, stating that there is no assurance that a healer will return from the bush or forest since it is a dangerous place to visit at night. He seemed not to know that herbal medicine are accessible anytime, but another participant from the youth focus group noted, herbal medicine are easily available in powder, leaf, stem, liquid and capsule form and readily available in drugstore to the healers and patients.

Participants noted that herbal medicine are available for all kinds of diseases, for both uncomplicated and complex diseases such as constipation, malaria, fever, boil, henna and piles. They also noted that certain diseases such as whole in the heart are effectively treatable with modern health care. Focus groups participants, likewise, said they access modern health care services first before accessing traditional health care system, and pointed to the importance of advanced medical technology to early diagnoses, preventions and treatments.

When asked why they access traditional health care services, most made mentioned of the effectiveness of herbal medicine in treating their ailments as the reason. They noted that herbal medicine work better and faster than modern medicine. Two out of the 7 youth focus group participants and 1 out of the 6 participants from the women focus group stated that traditional health care system are more affordable giving the fact
that it is part of their environment and can be easily accessed from friends or families without paying. Ultimately, these interviewees noted that there is a patient-healer relationship in comparison to modern health care system. One interviewee from the youth focus group noted:

Sometimes when you go to the hospital, it takes time before the doctor sees you and he doesn’t even have time to examine you properly compared to the healer who has time and treat each of his patients special. The nurses too can be very rude.

Participants from both focus groups also expressed the view that biomedicine is more of a temporary relief and does not treat diseases permanently. They also noted that in some cases traditional health care system is the only known method of treatment for certain diseases, such as boil and Anansi. Participants noted that even in cases when biomedicine work and cure their ailments, they experienced side effects.

For participants who access traditional health care, they noted that they access it when modern health care has failed to treat, prevent or control their diseases. Similarly, they also noted that often times when they use herbal medicine they hardly fall sick.

In response to my questions as to why traditional health care system is viewed as dangerous, the focus group participants also stressed that both health systems can be dangerous if used inappropriate. Also, they said, effectiveness of herbal medicine coupled with the high demands has triggered the emergence of fake healers and products. They all pointed to the mounting rates of expired, fake modern drugs, and noted that sometimes both herbal and modern drugs do not have expiration dates on them. This they stated is a concern, yet in their view the past government did not doing much to control the growing trend. However, some participants noted that because they grew up with certain medical
plant or medicine they can tell the fake from the genuine. As one participant from the women focus group narrated:

Our grand fathers that we grew up with make herbal medicine so we know how they look like. Some of them the color is brown and sour, but today because of greed they don’t mind roasting sugar and adding water to it and pass them as the ones that are brown and sour. When we meet sellers, we test their products and based on what we know we can say this is not the genuine one. Those who have no clue are the ones who fall victims to these fake healers

Likewise, many of the focus groups participants said that because modern health care personnel have not been able to use science to prove the efficacy of some herbal medicine they have concluded that those medicines are not good for the public. Many of the views advanced by the participants spoke to the trust in the traditional health care system. In this stead, they argued that traditional health care system has been part of the Ghanaian cultural heritage and its knowledge has been taught and shared among societies for generations. Many argued that the fact that they grew up with it and has not experienced any difficulties or side effects indicate that it is effective. In this regard, they argued that the western procedures of testing and screening herbal medicines to classify them as scientifically good for the public may not always be an appropriate standard to test herbal medicines.

Key Informants’ Perceptions

This research, did not ask the key informants about their experience, instead, key informants were asked about the past and current experiences of traditional health care system. In conversations with these participants, many of them seemed to discuss the similarities and changes that have occurred with traditional health practices. Government official participants made mention of traditional health care services as the only health
care accessed prior to colonization, noting that the abolishment of traditional health care services during the colonial era is undoubtedly the reason why, even today, traditional healers practice in secrecy. For the traditional healers, changes have occurred in some aspects of their practices, especially with preparation and packaging of herbal medicine and products. However, Yepalsi-naa and his wife, Adisah, both spiritualists, noted that they still access medicinal plants in the same manner; praying and seeking treatment from their gods before the commencement of any treatment. They argued that with the emergency of many new, yet similar diseases one might seek guidance from the gods.

There is an implicit suggestion that the people of Ghana trust the traditional health care system. Also, there was no questioning of its longitude as during the course of interview with key informant participants, there was the constant implication that traditional health care system is part of the Ghanaian legacy, and thus no intentions of precluding it practice.

Some participants tended to compare both health care systems and mentioned traditional health care system as more effective in preventing, treating and controlling a wide range of diseases. They noted that most modern drugs have failed to treat most tropical diseases and increasingly many physicians are unable to diagnose many diseases. Accordingly, many doctors are referring cases to traditional healers. To this end, traditional healers have gained lots of respect from those who under normal circumstances will not access their service. The government official interviewees made mention that both health systems are relying on each other to maximum healthcare giving in the country. Responding to this, Dr. Taimako remarked:
It is believed that traditional healers and doctors are supposed to work hand in hand but that is not really the case. The traditional healer may refer the person to orthodox medicine but when the referrals are made we rather get insulted. The patient too gets frustrated because physicians blame them saying they shouldn’t have gone to the traditional healer to start with. It is like they just discourage people from accessing our services.

The traditional healers, similar to the individual respondents, pointed to the complications of surgery and noted that some of their patients were afraid of accessing the modern health care system for fatal diseases because of the tendency of them being operated on.

Similarly, key informants argued that although traditional health care system can treat most tropical diseases, both health systems can treat specific ailments more effectively. They noted that herbal medicine deal with complicated diseases such as HIV/AIDS, white cough (similar to HIV/AIDS), evil spirit related problems, mental illness, psychological problems, stroke, and fractures more effectively. To this end, the healers noted that whereas doctors will not access their services, they sometimes access modern health care system because certain health problems are more effectively treatable with biomedicine.

The pervasive belief that traditional health care is dangerous was shared by the participants in the study although reasons given varied. Most participants noted that both modern and herbal medicine can be dangerous if not used appropriately. They noted that people react to medications differently, which does not mean that those medicines are ineffective. Three out of the 7 key informants agreed that compared to biomedicine, herbal medicine are safer, with little side effects, because unlike modern drugs which
contain a lot of chemicals, herbal medicine and products are made only from herbal plants. Key informants were of the opinion that the bad reputation of traditional health care system stem from its long history of some healers using unclean water to process the herbs or dispensing herbal medicine in 20 litter containers has caused this belief. They noted that with education and research, packaging and preparation has improved and there are not many reported cases of side effects. Government officials argued that most reported cases are associated with improper administration, a rising issue in the country. These interviewees stated that there are lots of fake practitioners and fake medicine in the country. The traditional healers stated that they are in associations, whereby they criticize each other’s practices and bring fake healers or those involved in false or bad practices to justice. The traditional healers and some government officials also pointed to the lack of preservation of most herbal medicine, noting that medical information and directions on preparation of certain medicine may be given to patients, especially if it is long term care. However, some patients may take overdose so as to recover sooner. They noted that many healers are poor and even have second jobs in order to sustain their family and may not live in a clean environment, therefore people may conclude that their products are unhygienic and harmful. Dr. Ameyaw alluded to the idea that because one herbal medicine is said to cure various diseases, it may be viewed by some as dangerous. However, he argued that many scientifically tested medicinal plants contained more than one component.

The traditional healers also argued that scientists and some modern healthcare personnel have criticized their products, often arguing that just because people have
claimed them to be effective does not mean they are since they have not been able to prove it scientifically. In this stead, the herbalist, Dr. Taimako, noted that although some traditional practitioners like her have earned good reputation nationally and internationally, and are known to have healed patients with difficult cases, especially those with mental illness, their medicines once tested under the scientific system are immediately pronounced inefficacious. This, she recounted:

I was among the first people to go to Mampong for this testing. After I had prepared the medicine I asked for the results and what they told me and the others was that the concentration of the drugs was very strong, that we should reduce the potency, the preparation. All they told us was that there was no scientific proof for our medicines. We found that to be very interesting since we have been using the same medicines for decades to treat patients and they have worked and evidences are there to prove this. We were treated as if we had no idea about what we have been doing for years and about medical concepts.

In addition, the spiritualists, Yepalsi-naa and Adisah Alahassan made mentioned that the holistic approach of traditional health care system makes it difficult to scientifically prove their standard of care giving as efficacious, especially as most of their medications are as a result of what their “gods” have recommended to be given to their patients. In fact, they argued that modern health care personnel view their practices as culturally significance but with less medical base, and this impedes the development of their care. They further noted that when they ask these modern healthcare personnel to explain why people are being cured through spiritual means, they were told by the modern healthcare personnel that the spirit healing was more of a psychological manipulation than scientific breakthrough, and that what their patients experienced was the placebo effect.
Perception on Current Policy Impact

Individuals’ Perceptions

Rather consistently, all the participants recognized the tremendous efforts by the past political administrations as improving health care in the country. For the individual participants, the past governments were able establish and effectively use research facilities such as the Noguchi Memorial Institute for Medical Research (NMIMR) to research and develop herbal medicine and products. They noted that through media channels, especially the radio, they have been informed about current safety issues with herbal medicine and products.

When I questioned the individual participants, 6 out of the 12, stated that although the government is making an effort, past experiences continue to influence the integration process. Some participants expressed the view that, historically, the government has exploited the healers, and is still, presently, not been honest with the healers about the integration process. They made mention for instance, that the government is asking healers to take their products to the Centre for Scientific Research into Plant Medicine for testing, verification and approval, but then, is unwilling to assist these traditional healers to get their products to the supposed places. They stated that most healers in the rural or remote areas do not have the money to travel to the center, a hindrance to herbal medicine production and supply as well as the integration process.

Participants expressed the view that some healers still perceived the integration as a way for the state to exploit them, noting that regardless, the state will continue to give doctors the upper-hand in decision-making and policy formulation. Therefore, they noted,
some healers are unwilling to cooperate with any government institution or to come forward. Some interviewees pointed to the colonial period where traditional health care system was perceived as barbaric and satanic, arguing that this, in some way, tied to the continual reluctance of some physicians and western educated policy makers to accept traditional healthcare practices as effective and safe. They also noted that some physicians are aware of the efficacy of herbal medicine and the high public demand for it; however, they are afraid that integration will decrease access, availability and use of modern health care system. Therefore, they are suppressing any attempt to integrate it.

Focus Groups’ Perceptions

The focus groups participants also agreed that the government has made efforts to integrate traditional health care system into the current health care system. Some participants made mention of the establishment of manufacturing facilities in Tema municipality, which they noted has increased the availability of effective herbal medicine in hospitals and clinics.

Startlingly, the participants from both focus groups tended to be passive on the subject of the delay in the integration process. In fact, only one participant from the youth focus group said that poor implementation is what is causing the delay.

Key Informants’ Perceptions

The ideological structure of the integration has evolved over time and what has been done about it was revealed through the responses to the interview questions I posed to key informants. Mr. Abu from FDB said that compared to before when herbal medicine were mainly in liquid form, through research and development the Centre for
Scientific Research into Plant Medicine is now able to make herbal medicine in capsule forms. He also talked about the FDB and how they are monitoring herbal medicine and products they have certified to ensure their continuous safety and quality. Most of the participants stated that the government has put in place complaint centers for citizens to make complaints and report fake healers and medicine, and technical advice committees who investigate complaints received and alert the public of any problems. Participants also noted that the government has organized seminars, symposiums, and workshops for traditional healers, those interested in herbal medicine and researchers across Africa. The government has encouraged traditional healers and researchers to form associations such as PROMITRA and ONE PURSE (networks of West African natural product researchers), so as to exchange ideas on practices and herbal plants, and to influence policies on health. Some participants also made mention of the government taking traditional healers through lots of good practices, including sending herbalist and research scientists to India and China to study traditional medicine and practices.

Some participants noted that the government has established herbal medicine programs at the university levels, stating that the second batch has graduated and working at the Center for Scientific Research into Plants Medicine, FDB or with physicians. They noted that this has resulted in some doctors adding herbal medicine to their practices and using herbal medicine to treat patients, for instance, those with malaria and prostate cancer.

There was the tendency for key informants to discuss future programs and plans. Dr. Ameyaw at the Center for Scientific Research into Plants Medicine made mentioned
that the center is working on the documentation of all 35 herbal medicines currently under research as this will make it easier to identify herbal plants and their components. Mr. Abu from FDB stated that the government is planning herbal medicine fund, to increase research and development into traditional health care system. According to the director of Traditional and Alternative Medicine (TAMD), they intend to establish post graduate programs into herbal medicine. The Minister of Health, made mention that they were concentrating on certain herbal medicine practitioners and considering on including other types of healers such as the spiritualists into the integration process. He noted that a policy proposal is in the process of being presented to the Cabinet for approval.

Six out o the 7 key informants agreed that there are guidelines in place to support public reliance on traditional health care system. They were of the view that the government engaged the media, occasionally broadcasting traditional healthcare practices to facilitate public interest and to promote positive perceptions. For some of the traditional healers, the fact that they are allowed to operate and physicians are referring patients to them shows that the government supported their existence. Dr. Taimako stated that, some healers, like her have been recognized by the government. Participants noted that the government only discourages public reliance on traditional health care delivery when certain products or services have been proven to be harmful to the public. One of the participants however, disagreed with the notion that the past administration had been anything but supportive since by allocating more funds only to modern health care development and refusing to assist the traditional system, indirectly it prevents its progress.
When asked what they thought were some of the reasons for the delay in the integration process, insufficient funds was mentioned by government officials as their number one problem. For the TAMD, integration is a long process, requiring cautious planning before any implementation, which therefore has prolonged the process than intended. The spiritualists noted that they are reluctant to the integration process because their spiritual leaders have not given them the go ahead and therefore they cannot come forward. The government official participants argued that traditional healers are skeptical about the integration process because they think the government will exploit them for their own benefit, and this they noted, has resulted in the lack of enthusiasm on the part of traditional healers towards the integration. To this, two of the traditional healers responded that, they had witnessed firsthand exploitation or knew a healer whom the government or an international organization exploited. The traditional healers discussed that the lack of intellectual property rights has made them reluctant to disclose their practices and skeptical of integration of any sort. As the herbalist, Dr. Hajia Taimako opined:

At one of our meetings there was an elderly man who wept throughout our meeting. He said he has been robbed of all his secrets. There was a boy who was bitten by a snake and this old man picked some leaves grinded it, applied it and the boy was healed. So they heard of this, the Mampong people heard of this and they approach the man. The man said no I don’t sell my herbs; I don’t give it out for free. Not knowing they have talked to the teacher in the village. They were doing to go into partnership with him so if he could actually get the man to give them the preparations, the herbs. So the teacher, whom everybody in the village trust was able to convince the old man telling him that the people will assist him to establish his business. The man gave out the preparation, which is now available on the market but he has never seen any of them since then and he was not paid a pesewa and his secret is gone. So things like this frustrate healers and we will never disclose our herbal preparations.
The traditional healer interviewees were all of the view that the past governments were to be blamed for the delay for integration. For these traditional healers, there were lots of talks about integration but little is done to sustain the process. These participants discussed at length how they were encouraged to treat patients and to be open about their practices since they are the backbone of primary healthcare, but were denied assistance. One traditional healer participant made mention of the past government’s refusal to give an old, deserted hospital to traditional healers to practice and do research, but wanted them to assist the physicians with mental health problems when that same hospital was later converted into a psychiatric district hospital. They also noted that most awareness programs, announcements or information are in English or Twi (a local language), which most of them, the healers in the northern part of Ghana cannot speak or understand. They argued that this makes it difficult for them to voice out or put their forth their petitions. They noted that even when they have a representative they are not sure the right information is being communicated to the government and vice versa. This, they stated hinders the development of traditional health care system and the integration process.

Traditional healers also stated that the state was not employing grassroots approaches. They argued that without starting at the local level more false practitioners will continue to operate in the country. To this end, the herbalist, who was recognized and honored by the state, stated that, she is yet to be invited and involved in data collection or in decision making. There was this perception among some of these
traditional healers that because they were uneducated, the state still viewed their contributions or ideas as irrelevant.

In terms of challenges, government official participants stated that there was no questioning of the efficacy of certified medicine; however, they noted that further investigation have shown that some false practitioners are duplicating and faking certified herbal medicine and products. They further noted that this has hindered some citizens’ reliability and accessibility on traditional health care services. Another challenge they pointed out was the lack of directory to indicate the names, practices and locations of healers in the country.

In response to my questions as to what they were doing to ensure that successful integration precede, the traditional healers made mention of a model garden, which they in Tamale, northern Ghana had developed. They noted that they had collected and planted different medicinal plants and educated each other on the importance of preserving and sustaining medicinal plants. They also noted that younger generations in the community are being encouraged to adopt plant and to learn its features. They said that they are trying to build their own small clinics at their homes.

During the course of conversations with key informant interviewees, there was the constant implication that the modern health personnel perceived traditional healers as a threat to their existence in the country. They all were of the opinion that most modern health professionals are doing everything in their power to prevent the integration. They argued that physicians viewed traditional healers as competitors, who when given the chance will take their patients, income as well as their earned respect from them. They all
noted that modern health personnel still doubt the efficacy of traditional products and practices especially claims of finding a cure for HIV/AIDS when those products are not scientifically proven.

The lack of trust in traditional health care system continues to be an impediment in the integration process. The traditional healer participants mentioned that when they are assisting doctors administer care, especially to mentally ill patients, more than not the doctors want to dictate to them what to do. They noted that they want a place they too can operate just like physicians without any interference. The key informants expressed similar sentiment to the individual participants, stating that the colonial perception of traditional healers as witches and devil worshippers is still manifested in the current views of traditional healers. The key informant interviewees noted that, health care delivery in Ghana is all politics, mostly controlled by modern health personnel and western educated elites, who already have negative image about traditional health care system.

Perception on Policy Direction

Individuals’ Perceptions

When asked how integration will help them, most of the individual participants said that a comprehensive traditional health care system will not only benefit them but also benefit all Ghanaians. Many of these participants mentioned that, personally, integration would help them to access traditional health care much freely. One participant, a female student at the university, mean more herbal medicine added to the NHIS drug plan, and 4 other individual participants agreed that, hence certain herbal
medicine rarely available in the Tema municipality would be easily available. They also made a link between integration and safety use of traditional health care system, noting that fake practitioners and products can be reduced and controlled when the government integrates traditional health care system into the mainstream healthcare system.

For many of these participants, with a comprehensive health care system, they can fully access the benefits of both health systems. They argued that the quality of healthcare giving will improve since more research into traditional healthcare system would enhance therapeutic effects. This integration, they argued, presents an opportunity to improve the health status of the people and to maintain high health standards in the country. Again, there was the tendency to compare cost of traditional health care services with that of modern health care. Participants expressed the view that giving the generous availability of herbal medicine and products and healers, integration will make health care less costly.

In terms of the economy, participants pointed to the copious and the readily available herbal plants, and noted that it is cheaper to develop herbal medicine than to import drugs. To this end, participants noted that the government would generate income from exporting herbal medicine and save money by purchasing fewer imported drugs. One individual participant, a service personnel, made mention of the integration goals, which he said was in line with the government’s health and poverty alleviation programs under the Millennium Development Goals. He noted that, for example, the NHIS has helped reduced poverty and if integration is successful more people can access healthcare, consequently there would be healthier workforce to develop the country.
Also, the development of herbal medicine and services would create job opportunities, consequently improving standards of living conditions.

In response to my questions as to what they want the government to do about the current situation with the delay in integrating traditional health care system into the formal health care delivery, 11 out of the 12 participants alluded to the idea that for the integration to be successful, the government, traditional healers and modern health personnel must understand the importance of improving healthcare giving in the country. They were all of the opinion that government should educate more traditional healers and involve them in research, clinical work and allow medical students to also study some aspect of traditional health care. The lack of research into medicinal plants and herbal medicine was pointed to as one reason why the integration of traditional health care system has delayed. They noted that for the integration process to be quicker and successful, the government should research more into machineries and better technologies for producing and packaging of traditional products. Some interviewees agreed that the government must ensure proper certification procedures in certifying healers as well as funding and assisting these certified workers establish their own facilities or improve their services.

Some participants stated that the government usually involves the public on matters concerning the nation; however, it has not involved them in this integration process. Implicit in the concept of public involvement, they proposed that the government should open community forums, provide communities with suggestion boxes or employ
individuals to seek public opinion about the integration of traditional health care system.

As pointed by one service personnel:

There is something in the Ghanaian governance system called “Meet the Assembly” where the president moves from the castle to the door steps of the people and he listens to the grievances of some citizens. I think the government should use this system to find out what the people want so that he can put pressure on the stakeholders to do the right thing.

Focus groups’ Perceptions

Although participants in both focus groups did not spoke of how integration would benefit the economy, most importantly, these interviewees were of the opinion that integration will help them and other citizens. These participants expressed similar sentiments to the individual participants. Some participants from the women focus group talked about how integration would enhance availability and accessibility of herbal medicine in urban areas. Therefore, they will not have to travel to the rural areas just to access certain rare herbal medicine.

The focus group participants similarly alluded to the idea that there are many modern drugs that are ineffective, noting that integration will enhance drug supply and availability, thus, reducing mortality rates and untreated diseases in the country as more herbal drugs would be added to the essential drug list plan. Participants noted that integration will enhance health care quality and promote utilization of both health systems. They also noted that once traditional health care system is integrated it becomes government’s responsibility to regulate and control its practices. They noted this will reduce the availability of fake products and practitioners, as well as enhance hygienic preparation of herbal medicine, dosage and packaging. Some of the participants from
both focus groups were of the opinion that integration would make health care more affordable, especially for poor citizens.

The focus group participants, similar to the individual participants, mentioned the need for public involvement in the process. One hundred percent of the participants from the women focus group agreed that the government should provide better, hygienic places, similar to modern health care facilities, for traditional healers to operate from. In the perceptions of the youth focus group, the government should invest more into research and development of herbal medicine.

*Key Informants’ Perceptions*

For the key informant participants, integration is beneficial to all including the individual, community and the country as a whole. However, for TAMD, depending on how the integration process is done will determine the possible benefit. There was an implicit suggestion that the integration of traditional health care system into the mainstream health care system will solve some of the health problems in the country as there will be more efficacious drugs available, many diseases would be diagnosed, treated or controlled with fewer side effects, and affordable for all. They stated that proper regulation of the traditional health care system would reduce the number of fake healers and drugs, malpractice and drug abuse in the country, and they noted that proper administration of medication would enhance the quality of care giving. Participants also noted that integration will lead to the provision a coordinated healthcare, giving the patient a privilege to access an alternative health care system whenever the need arise. The Minister of Health, made mentioned of some medical doctors and traditional healers
operating side by side, and noted that already the quality and proper utilization of health care has improved. Some participants discussed the importance of herbal medicine and healers to the healthcare delivery system, making mention of how the recognition of healers has increased dramatically trust in traditional health care system. To this end, 3 out of the 7 key informants expressed the view that integration will facilitate trust in traditional health care system, especially from those who doubt its efficacy.

Participants compared the development of the traditional health care system to government’s spending on imported drugs and on recruiting modern health personnel, and noted that researching and developing of herbal medicine is more cost-effective. They also compared the availability of copious herbal plants used biomedicine, which they argued in most cases were unavailable or ineffective. They made mention of how investment and research into traditional health care system will generate income for the development of the economy. One participant noted that there is consultation going on with the FDB on ways to export the 35 herbal products approved to be efficacious. Two of the traditional healers noted that through integration the government will be able to generate income from healers through taxation. This, they noted will enhance development of herbal medicine, which in turn will improve health status of individuals, making them more healthy and fit people to work and amplify economic growth in the country. As a result, increased employment rates would reduce poverty rates in the country. Mr. Abu also stated that integration will improve the distribution of medical practitioners across the country.
On the issue of what government can do to speed up the integration process, Mr. Abu stated that for integration to be successful and effective there need to be commitment from both the government and the people. In this regard, he noted that there is the need for a stronger regulatory agency to regulate and monitor the integration process and the formulation of a traditional health care council to influence and help shape policy areas. Similarly, Malaam Iddirisu pointed to the importance of having proper and adequate strategic plan, talking at length about the mal-functioning procedures and the ineptitude of the present structures. For Dr. Taimako, more healers must be recognized and acknowledged if government wants them to participate in the process. She also noted that traditional health care services cannot progress if traditional healers continue to operate from their small houses with no assistance. Therefore, suggested that the government should put infrastructure in place or assist recognized healers financially, to allow them operate more efficiently and hygienically. Not so, some of the graduate students of herbal medicine should be giving the internship of assisting healers with their practices.

Analysis of Findings and Conclusions

This study assumes that with the formal recognition of traditional health care system the gap between accessibility, availability and utilization in the current health care system can be bridged. In this stead, this study examines public perceptions to understand how citizens’ health care consumption behaviors could inform policy. Also, this research work seeks to ascertain the implications of using traditional health care in the mainstream health care system. That the government can maximize health care giving through full integration of traditional health system into the mainstream health care structure is
exemplified by other writers and the participants. The analysis of the research findings draws attention to the similarities of the perceptions of the people of Tema Municipal District (individuals and focus groups) and key informant participants in Ghana. This section analyzes the research questions, with the literature review as the basis for discussion in this section.

Research Question One

What are the perceptions on the current conditions of traditional health care’s accessibility and availability?

The study found out that the people of Tema municipality have access to both health care systems than most places in Ghana. Even so, participants, including key informants agreed that traditional health care system is more accessible and available than modern health care system. The population per healer for Greater Accra, for which Tema municipality is part of, is 2,407, compared to the population per doctor of 2,686, which is much higher than the national average of 953 to one healer and national average of 9418 to one doctor (modernghana.com; ghanadistricts.com, 2006). Notwithstanding, modern health care services do not reach far enough in most Tema municipal areas. In fact, whereas traditional healers are evenly distributed and traditional healthcare facility within less than 5 kilometers, there are only 83 doctors in Tema municipality and a hospital within 25 kilometers in most Tema municipal areas (Modernghana.com). To this end therefore, there is a huge availability of traditional healers bridging the gap in health care giving. Similarly, modern health personnel and facilities in the country have increased over the past years, yet modern health care system has remained unable to cope
with rapid population growth. At the same time, as Anyinam (1987), Amanor (1992) and
Van der Geest (1997) have noted, there are more traditional healers, evenly distributed in
the country than modern health personnel, and the consequent gap in the shortage of
health personnel has led many to access traditional health care system. Unfortunately,
traditional practitioners are gradually dying off, taking with them the knowledge of a
variety of traditional therapeutic methods.

Most parts of Ghana are endowed with vast resources of medicinal plants. So far
over 600 medicinal plants in Ghana have been documented (MoH, 2007x), and according
to Dr. Yaw Ameyaw at the Centre for Scientific and Research into Plant Medicine, an
additional 35 medicinal plants are in the process of being documented. It must, however,
be noted that current economic activities has endangered several medicinal plant species.
In this regard, Dr. Taimako remarked, modernization and urbanization such as excessive
construction of road and houses, hydro-electric power generation, extraction of timber,
and bad agricultural practices destroy natural habitat of medicinal plants. In the olden
days, traditional laws on the environment such as it was a taboo to farm in certain sacred
areas or restrictions on the number of trees and plants one can harvest or fell within a had
led to the conservation and the sustainability of not only herbal plants but also
biodiversity in Ghana (Abbiw et al., 2002). Consequently, Ghana has lost roughly 25% of
its forest cover, which is approximately 1.7% per year between 1990 and 2000; and
“there is hardly any intact virgin forest left outside the constituted Forest Reserves
besides sacred groves” (Abbiw et al., 2002, p.4; FAO, 2005; WDI, 2005). According to
Conservation International (2006), Ghana is known as having one of the most fragmented
ecosystems in the world. On one hand, high demands for herbal plants have resulted in indiscriminate harvesting and over-exploitation for export. This, in effect has led to near extinct and extinction of certain species of medicinal plants. For instance, “some important medicinal plants such as *Cassia sieberiana*, *Trema orientalis*, *Treculia Africana*, *Trichillia monadelpha* and *Antiaris Africana* have all disappeared around Konkonuru” in a village in Aburi, Eastern region of Ghana (Abbiw et al., 2002, p.9).

Given that modern healthcare has failed to address many of the tropical diseases affecting Ghanaians, Dr. Taimako, a traditional herbalist participant in this study is concerned about the availability of certain species of medicinal plants and the limited rate of custodians of certain medicinal knowledge. The reduction in knowledge of traditional health practices definitely has serious impact on the conservation of biodiversity as many species known to those healers may never be documented. Similarly, the extinction of several medical plants before they are documented affect future treatments of health problems as one cannot predict those species importance in future healthcare giving.

With the majority of Ghanaians relying heavily of traditional healthcare system, such loss affects the availability and accessibility of health care in the Ghana. Indeed, knowledge of traditional health practices certainly plays a significant role in today’s healthcare delivery in Ghana; and yet its status in future potential health development will remain vulnerable if medical plant species continue to be endangered, with some becoming extinct. Just like in Kenya (discussed in Chapter 2), economic activities is affecting the existence of some rare species of medical plants. As discussed in Chapter 2, Kenya has been able to preserve and improve on its traditional health care practices in the context of
its rare culture, a model that can be adopted. Indeed the establishment of herbal farm and tree nursery projects can ensure the availability of medicinal plants for the treatment of diseases in the country when needed as was the case with the PATH program in Kenya.

In the Tema municipality and certainly in Ghana, traditional health care system is perceived as part of the society, making it easily available and access at most times. Many herbal plant species used in treating various diseases have been part of the environment and have used over the centuries for the sustainability and wellbeing of Ghanaians. Participants in this study perceived traditional healthcare system as a system which has adapted to changes--bridging political, economical, social and cultural challenges in the past, present and obviously that of the future.

Most herbal plants are part of the daily dietary system of most Ghanaians, mostly used as nutrient supplements and flavors in most sauces and soups. Most medicinal plants used in the Tema municipal areas are commonly found in the communities and have been used for decades. Of course most medicinal plants found in Tema municipal areas and in most part of Ghana are naturally or wildly grown. Like most place in Ghana, Tema municipality surroundings are conduciveness to many medicinal plants, therefore many herbal plants are easily cultivated. Herbal plants can be found behind household’s backyards, in gardens or on farmlands, mostly within walking distances. Besides, most herbal medicine are manufactured in the Tema municipal areas; coupled with that, the certification of traditional products and healers to sell and operate in marketplaces and drugstores was argued as what made traditional health care services readily available to the public. Traditional health care services are easily accessible because most traditional
healers travel within communities (which they perceived as an important cultural role to their communities), administering care to those who need it. Given their relatively high number, they are easily able to do this. To this end, herbal medicines are easily available and accessible to users most times of the day or year.

Given the current economic crisis, coupled with the increasingly escalating cost of the formal health care system has made modern health care system impossible for many Ghanaians to afford. As noted earlier in Chapter 2, many citizens are unable to obtain the most basic health services, as a direct product of high costs of modern health care. In this stead, more healthcare problems are accumulated as patients forgo need prescribed drugs or divert funds needed for essential things such as food towards needed medications. At the same time, even if patients are able to extract funds from other expenses towards their healthcare needs, it deprives them of attaining other essential wealth in society such as improving their living conditions. On the other hand, not only is traditional health care system available, accessible and safe but also it is affordable, more often than not, within the means of most people. In most cases, because it is part of the environment, most people do not pay for it—it is entirely free; even if they do, it is comparatively cheaper than modern health care. What DeJong (1991) states about payments in traditional health care system are applicable to the perceptions of participants gathered in this study. DeJong stated that compared to physicians, traditional healers are more willing to delayed payment, negotiate the amount or accept payment in kind.

Key informants in this study tended to argue that, the fact that modern health care is expensive impose barriers to its accessibility, causing the poor in the society and even
high income citizens to turn to traditional health care services, an affordable health care.
The plight of the people of Tema municipality is that cost of prescription drugs are high and escalating, squeezing every pesewa out of them. That pharmaceutical companies charge more for their products in developing countries than they do charge developed countries is not to be denied (Madeley, 1999).

The peculiar nature of free trade and globalization, which as noted by Madeley (1999) promotes the free movement of pharmaceutical companies and their drugs, allows drug companies to enjoy less restrictive policies from government and to set prices for their products, with little or no negotiation from government or patients. Participants in this study argued that as a result a huge chunk of health care expenditure go towards purchasing imported drugs, which remains prohibitively costly, and affecting other health care needs of the country. In essence, modern health care does not meet some of their health care needs, making its services less desirable, and hence less utilized by the people. This discovery is a reflection of findings from WHO (2002) and MoH (2004a) as discussed in Chapter 2, whereby government funds to the health care sector is insufficient to address the health challenges in the country. To this end, therefore the country loses its human capital and modern health care facilities continue to deteriorate, affecting how the people access and use it.

The issue of cost is not always the case for accessibility of traditional health service delivery, but the access and use of herbal medicine was related to the availability, accessibility and quality of modern health service delivery as emphasized by participants in this study. Traditional health care system is easily available and accessible because
there is local knowledge and long history of its use. Many citizens are taught how to access and prepare herbal medicine for various diseases by their family members at an early age. In fact, every household has some knowledge of herbal medicine for the prevention, treatment and control of minor diseases such as headache, fever, cough and stomach pains. With this comes the argument that the knowledge is passed on from generation to generation and has been the culture of the people even before the colonial times, therefore their efficacy is trusted. It is often stated that hardly any household is without a person knowledgeable in traditional healthcare. Therefore, in Tema municipal areas and in Ghana, the discourse is that there is shared knowledge in traditional health care and even when individuals are ignorant, there is always a friend or someone in the community who can administer care or teach them on traditional health care practices. In this stead, one does not have to be educated or pay for such knowledge, making it use simple, less stressful, and its access less restrictive to the locals, which in some ways preclude the accessibility of modern health care.

In this regard, Madeley (1999) states the medium of instruction on how to use modern medicine is strictly in foreign language and this restrict access to use by speakers of local language. To this end, one of the individual participants in this study noted that a majority of Ghanaians are illiterate and hence cannot read instructions on packets, forcing them to rely on and access herbal medicine, a system which educational status of the people is not a factor in its access.

There was a sense of trustworthiness which these participants perceived about traditional health care system. In this study, herbal plants or plants in general were
portrayed as are part of God’s creation, purposefully made for each environment to be used for the environment’s need. In this stead, medicinal plants in Tema municipality and in Ghana are readily acceptable to the body, and hence less harmful to the body and good enough to treat various diseases in the country.

Within the context of Tema municipality, the influx of fake drugs and counterfeit biomedicine on the Ghanaian market is a major concern. Many expressed the opinion that it is difficult to detect authentic medicine from counterfeit ones. Many writers and reports have alleged that the drug companies are selling medicine that have been withdrawn from developed countries in developing countries including Ghana. For instance, in August 2002 fake GSK paediatric anti-malarial syrup halofantrine (Halfan) were found in Ghana and said to contain “two potentially harmful sulphonamide drugs, but no halofantrine” (Cockburn et al., 2005, np). Cockburn et al. stated that a report had found out the GSK Medicine Research Centre had analyzed fake halofantrine syrups, but noted that GSK did not release any information in Africa. However, according to GSK, fake Halfan were only present in Nigeria and Sierra Leone and both countries were informed. Yet, “the Pharmaceutical Board of Sierra Leone, which handles fake drug cases, was not informed by GSK of any discoveries of fake GSK Halfan syrup” (Cockburn et al., 2005, np). Cockburn et al. (2005) stated that “the Ghana incident needs to be viewed in the context of the wider illegal trade in fake Halfan syrup identified in West Africa, and GSK’s reluctance to give us details about this trade” (np). Consequently, people are more apprehensive to use western drugs. Besides, authentic
western drugs are ineffective and the people are gradually getting fed-up, thus turning to herbal medicine.

In terms of herbal medicine, because of local knowledge the majority of the populations who are knowledgeable about it are able to easily detect fake herbal medicine and products from genuine ones. Herbal medicine, while many have argued that its use and toxicity level cannot to be scientifically proven, therefore as discussed in the literature review, its efficacy is dubious, but yet, within the Ghanaian society there is more trust in it than modern medicine. Traditional health care system has been in existence in the Ghanaian community for a long time and perceived to be part of the Ghanaian heritage; and while there could be negative recuperation, from the research conducted, this study there was no tangible serious health conditions that could be associated with herbal medicine. In this stead, traditional health care system in Tema municipality and in Ghana is readily acceptable and utilized, which is reflected in its continuous demand. As a disclaimer, I am not suggesting that because people haven’t seen negative side effects with herbal medicine it is necessarily good, but this is a step in the right direction in that the government can control it and invest more in its development. In the modern health care precedent, concerns have been raised about the continuous side effects of many medications, consequential development of chronic diseases from certain drugs and the ineffectiveness of many western drugs to treat tropical diseases. Therefore, people tend to access traditional health care services more since they trust it, a culture embedded in their daily activities.
Moreover, in Tema municipality the discourse is that, there are particular tropical diseases such as *Anansi*, certain boils and “White Cough” that modern health care system have not found cure for, but many express the opinion that there are herbal medicine available and it is used to treat such diseases. Indeed, modern health care system is not concerned with treating “spiritual illness,” hence traditional health care system becomes the only known practice with therapeutic medicine for such diseases. In fact, it is the only health system that deals with the restoration of wholeness—that is physical, psychological, spiritual and social moral restoration of an individual. This has influenced the ways in which people in the Tema Municipal District access and use traditional health care services and modern health care system.

**Research Question Two**

*What have been the experiences with the use of traditional health care services?*

Practices and belief about traditional health care services have not changed that much. There is still the belief that traditional healthcare is part of the Ghanaian culture, dietary system, a heritage passed on from generation to generation before biomedicine came into being, and thus cannot be parted with. Unlike modern medicine which synthetic chemicals are added, herbal plants continues to be the only components of all herbal medicine produced in the country. Services of traditional healers are still perceived as humanitarian act to the community, and hence traditional healers are more interested in the physical, mental, social and moral wellbeing of the patient the than in making money from patients. The study found out that oftentimes healers would feed patients before treatment commencement as well as teach patients on how to have a holistic lifestyle or
lead healthy lifestyles. What Swantz (1972 cited in Good 1979) states about traditional healers being concerned not only with administering care to patients but also with the patients’ traditional values and beliefs are applicable to the perceptions about traditional healers. This is similar to studies done by DeJong (1991) whereby he concluded that compared to modern health care services traditional healers are more willing to accept a delay payment.

Spiritualists still consults their gods before administering any treatment, regardless of the disease. They consult their gods to ensure that they render the maximum appropriate care to the patient. What has changed is that, before, traditional healers will give out information on herbs, how to get herbal plants, prepare them and administer care, but now due to fake practitioners and lack of intellectual property rights, most healers are careful about information they disclose to their patients and others, including researchers. With the herbal medicine now in different forms, often, healers only give information on dosage intake and side effects. Previously, many herbal medicine and products were poorly prepared, in unhygienic environment, poorly packaged and sold on public bus. Recently, many herbal medicine and products are prepared in hygienic places, better packaged with some in capsules forms, preserved properly and sold in many certified drugstores across the country. More hygienic and safe herbal medicine and products have increased reliability and usage; many more citizens have gain confidence and trust in the traditional health care system.

In this study, traditional health care delivery system is portrayed as safe, effective and cheaper than modern health care system. This finding is not different from other
studies. Giving the natural ingredients that are used in the preparation of herbal medicine and herbal plants as part of the people’s dietary system, therefore it is clear that most herbal medicine and products are safe. Herbal drugs are effective in treating most tropical diseases, in many cases it gets to the core of the disease. Of course, herbal medicine work better than modern medicine. Discourse with participants from Tema municipality and key informants demonstrated that herbal medicine treat most diseases permanently, whiles biomedicine are perceived as “first aid”, relieving patients of their sufferings temporarily. Therefore, it is clear that, diseases surface after a while when patients use modern medicine. This research found out that those who use herbal medicine hardly fall ill. Thus, in Tema municipality, those who enjoyed prolong life expectancy were the ones who used herbal plants on a daily basis. In fact, the findings reveal that herbal plants help with imbalances in the body. The natural components of herbal medicine and the fact that it is from the Ghanaian environment makes it more designed for the Ghanaian genes than biomedicine and hence, are readily acceptable to the body. This discourse is in line with Allen Roses’ (worldwide vice-president of genetics at GlaxoSmithKline) views that because western drugs are often made for the genetics of Europeans for instance, “fewer than half of the patients prescribed some of the most expensive drugs actually derived any benefit from them. … the vast majority of [western] drugs – more than 90 per cent – only work in 30 or 50 per cent of the people” (Connor, 2003, np). Indeed, based on Dr. Roses examination it can be argued that many western drugs available on the Ghanaian market are ineffective in curing diseases, and has the tendency of adding new diseases to the patient given the genetics of Ghanaians. In the Tema municipality context, and
illustrated by the findings on key informant participants, there are various types of herbal medicine and medicinal plants available in the country, which are effective in preventing, treating and controlling various diseases that modern medicine have failed to treat or in instances where there are unknown western drugs for those diseases as mentioned earlier. Herbal medicine used by traditional healers have been discovered to be effective in cases of white cough, Anansi, hypertension, high blood pressure, snake bites, malaria, impotence, fractures, and piles just to mention a few.

Besides, the nature of traditional health care system, in that, it is part of the environment, as a humanitarian service and shared local knowledge, makes it far cheaper than the modern health care system. Notwithstanding, traditional health care system has simple procedures and the fact that there are rarely any surgeries involve in its practices makes it more attractive to the locals. Thus, in Tema municipality, one of the less attractive things about modern health care is its complex procedures, including complications and risk of surgery with no guarantee that the surgery will be successful.

The majority of the rural population relies solely on traditional health care system. Interestingly enough, although the Tema municipality participants in this study said they access traditional health care system, this research also found that most of these participants utilize the services of traditional health care as a second choice. The people of Tema Municipal District opt for modern health care system for diagnosis purpose, and then use herbal medicine as the source of treatment or when herbal medicine has failed to meet their healthcare expectation. However, both health systems are used concurrent depending on the individual and the disease for which the individual seek treatment.
Despite the increased use of herbal medicines, there are demands by Ministry of Health for herbal medicines to be scientifically proven. Traditional practitioners have to subject their products to screening and testing to check the toxicity level of their products before they are certified as efficacious enough for public use. Traditional practitioners have a different standard of testing the efficacy of herbal medicines. With modernization effort, the government obliges that traditional practices and products be aligned to the control and tastings of traditional medicines by modern health care standards. However, most techniques and methods developed over the time and even now are designed for biomedicine, and hence they are extremely unfavorable to the testing of most herbal medicines. For instance, in 2007 traditional practitioners working with Dr. Nicholas Kofi Antwi, of the Ashanti Region-based Chronic Disease and HIV/AIDS Treatment Centre, proclaimed that they have found cure for HIV/AIDS. However, the Ghana AIDS Commission and government officials of the Ministry of Health refuse to listen or work with them, for to them “traditional medicine cannot claim that HIV/AIDS is curable and therefore the public should not mind traditional medicine – where is the scientific proof that there is a cure for the disease” (Akosah-Sarpong, 2007, n.p). Furthermore, Akosah-Sarpong (2007) stated, “Dr. Antwi and his outfit were warned against their claim since the World Health Organization, the global health watcher said there is no cure for HIV/AIDS yet” (n.p).

It is not surprising that most herbal medicines cannot be verified scientifically as efficacious. The development of new drugs often based on clinical trials takes a long process, on average it takes about 15 years before they are scientifically
proven to be efficacious. Therefore, what makes government officials, policymakers and international organizations to think that the efficacy of herbal medicine can be proven within a short period of time? Indeed, just as it has taken considerable time for biomedicine to improve the quality of their products so also, I believe, should traditional medicine be given the necessary time and encouragement to mature. Besides, most successful and well-known western medicines originated from medicinal plants. For example, winged yam (*Dioscorea alata* L.) mostly found in tropical Africa and Asia which is used by traditional practitioners as analgesic, rejuvenative tonic, diuretic, and aphrodisiac, is a source of steroid diogenin used in birth pills (Masterson, 2007). Also, Artemisinin drugs are made from a plant, which has been used for generation by Chinese traditional practitioners to cure fever and malaria. Besides, as discussed in Chapter 2, countries like Uganda, through collaboration between modern and traditional healthcare practitioners has successful develop medicinal plants for the treatment of oral thrush, Herpes, dermatitis, and persistent cough in HIV/AIDS patients (World Bank, 2009). Even some of these new developed herbal medicines for Herpes and skin rash in HIV/AIDS patients are said to be more efficacious than some available biomedicines (World Bank, 2006). Indeed, Ghana can reduce HIV/AIDS patients’ risks to infection and provide alternative medicine for those who do not have access to medication and reduce the impact of the disease on the country by following the THETA model in Uganda, instead of the government and modern health personnel rebuffing claims about cures for HIV/AIDS.
Research Question Three

*What are the socio-economic implications for fully integration both health systems?*

The ideological structure of the integration has evolved over time and government’s efforts to successfully integrate traditional healthcare into the modern health care system is not to be denied. Historical data prove that after independence attempts were made by the Late President Kwame Nkrumah (the first President of the republic of Ghana after independence) and succeeding governments to integrate the secretly kept practices of traditional health care services into the mainstream health care system, a way of developing a comprehensive health care system which President Nkrumah had earlier on preached about. In this stead, the Noguchi Memorial Institute for Medical Research (NMIMR) which is located at the Legon campus of the University of Ghana was established and presently is the leading biomedical research institute for Africa.

At the same time, as Twumasi and Warren (1986) has noted, this led to the Acheampong military regime’s establishment of the Centre for Scientific Research into Plant Medicine in 1974 at Akwapim Mampong in the Eastern region of Ghana. In Tema municipality and definitely in Ghana, the discourse is that, the center not only conducts research into plant medicine, but also, develops herbal medicine and products in the country. To this end, the center has developed better dosage and packaging of herbal products and medicine, including the development of capsules for herbal medicine perceived only to be in liquid form. The centre test the purity and toxicity of the plants, screen all herbal medicine and products and block non-efficacious products before they
are dispensed to the public. Also, the researchers at the center are working with traditional healers including psychic healers to establish botanical garden of medicinal plants. In this light, presently in Tamale (Northern region of Ghana), healers have model garden, whereby all sort of medicinal plants known are cultivated and the young people are encouraged to adopt a plant. Consequently, the healers educate and exchange ideas on herbal plants and medicine. This is said to encourage and facilitate the interest of traditional health care system in the youth and as a way of enhancing the knowledge. Moreover, the government encouraged traditional healers to come forward with their products for testing, verification and approval. As a result, more traditional healers have come forward and hence more herbal medicine and products are being produced and made available in hospitals and drugstores across the country.

Many of the perceptions of the participants from the Tema municipality and key informants is that, whereas there were no talks on the safety of traditional health care, the development of the Herbal Medicine Units under the Food and Drugs Board and several laws has safeguard public health. In this stead, a law was passed in 1992 to protect the safe use of herbal medicine by the public and Act 575 was also was passed in 2000 to regulate the activities of healers. Under the Food and Drugs Board, herbal medicine and products are tested, registered and verified. This has ensured that herbal medicine and products meet good manufacturing practices and appropriate standards of quality, safety and efficacy before they are manufactured on a large scale and distributed to the public, as discussed in chapter two. To this end, therefore, the Herbal Medicine Units evaluate the acute and chronic toxicity and chemical properties information that the Centre for
Scientific research into Plant Medicine, NMIMR and other research facilities have submitted. Certified products and medicine are then registered, issuing each product with a registration number. Some of the approved registered medicine has been added to the essential drug list plan under the National Health Insurance Scheme. Therefore, the discourse is that with the creation of the Herbal Medicine Units, the state established different manufacturing facilities in Tema Municipal District to promote the production of herbal medicine and products in the country, making drugs available in most drugstores, marketplaces, and hospitals. Besides, a technical advice committee was developed to investigate alerts and complaints from the public, coupled with that, the public is informed through media channels such as radio, about new researched drugs, approved medicine and issues relating to safety of both modern and herbal medicine in the country. In this stead, the state is able to limit, control and prevent the use of unsafe and counterfeit drugs in the country.

As have been stated in Chapter 2, the then government facilitated the study of herbal medicine at the tertiary level. To date, the two graduated batches are working at the Center for Scientific Research into Plant Medicine and the Food and Drugs Board or working with doctors across the country. This therefore, has led to some physicians learning and including herbal medicine to their practices. In addition, as discussed in Chapter 2, the training of traditional birth attendants (TBAs) to assist the Ministry of Health to expand its primary health care services to rural areas and remote places has helped provide delivery, antenatal, postnatal, family planning services and education on HIV/AIDS to all the ten regions of Ghana. Indeed, in most rural communities TBAs are
“the first point of contact for pregnant women,” as such to help them function properly within their communities, workshops are being organized to “upgrade the skills of the TBAs…and to provide them with the necessary working accoutrements” (Bayor, 2007, np).

The historical trajectory of traditional healthcare’s oppression has created mistrust and hesitant in some aspects of traditional health care services provided in the country. Coupled with better packaging, the state has encouraged good practices of traditional health care services by recognizing the good works of some traditional healers. This has enhanced the image of traditional health care system. Previously, those who have no choice were said to access and use traditional health care services, but perceptions about safety and quality have changed and increasingly the rich and the educated are accepting the traditional health care system. This finding reflected how the colonial legacies have transcended into current Ghanaian health care practices, as discussed in Chapter 2, whereby the church denigrated traditional healthcare system as evil and backward and perceived orthodox healthcare as appropriate for the people.

Moreover, the state is increasingly sending herbal medicine practitioners and research scientists to India and China, to study the successful integration of traditional health care into their health care systems. The state organized seminars, symposiums, and workshops for traditional healers, researchers and those who are interested in herbal medicine from other Africa countries. In addition, the state established and encouraged healers and researchers to form networks, to exchange ideas on traditional health care practices so as to be able to influence health policies. This facilitates the way forward for
integration of traditional health care system not only in Ghana but also other African countries. In this regard, networks of West African natural product researchers such as PROMITRA and ONE PURSE have been established. Also, in Koforidua (Eastern region), traditional healers have formed an association, and are working on malaria issues.

At present, the Centre for Scientific Research into Plant Medicine is working on documenting all 35 herbal medicine which are currently being researched into. Giving that not all herbal plants are medicinal and that non-medicinal plants are similar to herbal plants, the documentation of the 35 herbal medicine is a step towards enhancing identification and knowledge of herbal plants and medicine in the country. The past government also planned on establishing herbal medicine development fund to increase research and development into herbal medicine, services and products. Efforts are also being made to develop a Traditional Health Practitioners Bill, which will consist of a code of ethics for traditional healers as discussed by Dr. Yaw Ameyaw from the Centre for Scientific Research into Plant Medicine. Also, proposal has been made to establish post graduate programs into herbal medicine. Besides, the Minister of Health has developed a policy proposal to be presented to the cabinet for the approval of involving spiritualists into the integration process.

Indeed, integration of traditional health care system into the current health care system is a step in the right direction and there are efforts made to decentralize the healthcare system; however there is the tendency that current efforts will fail. The study found out the terms of the integration was mainly controlled by medical doctors, who of course, have negative views of traditional health care system. Within the context of Tema
municipality and key informants, integration of traditional health care system will be ineffective if it is from the modern health care viewpoint. However, what modern health personnel fail to realize is that, within the modern system of care giving the integration process to some degree has already taken place. For instance, faith based healers can be found in most hospitals and clinics in Ghana, such as priest to administer prayers (a form of healing therapeutic) to patients (and despite the fact that these faith base practices cannot be scientifically proven, there are enough evidence to prove that these healing practices work for some people, hence the need to integrate such approaches). In this stead, modern health care system is not a stranger to the integration process of unscientific approaches.

Consequently, commitment from the past government, modern healthcare personnel, traditional healers and the public are necessary to spearhead and pace the process and hence more traditional healers and the public should be involved in the process. In this stead, grassroots approach should be employed. Participants in this study noted that the government should employ individuals or leaders in communities to research more into the public’s perceptions on the integration process. They noted this will make the implementation phase of the integration more appropriate to their needs if the government knows exactly what the people want. They also noted that upcoming medical students should be educated on the philosophy of traditional health care services, as a way of carving a positive perception of traditional health care system.

One of the major challenges that the Centre for Scientific Research into Plant Medicine faces is scientifically proving the efficacy of most herbal medicine used in the
country. This discourse is in line with Sofowora’s (1996) views, that not only do most herbs lack scientific proof, but also most aspects of traditional health care practices in Africa “cannot be verified scientifically and therefore are regarded with suspicion by Western doctors” (p.366). Most herbal plants and medicine have been used for decades, and although cannot be scientifically proven has is efficacious. What was clear from the perceptions of many participants in this study is that, some traditional healers have found a cure for HIV/AIDS and it works; however, western researchers and physicians have claimed the medicine lacks scientific evidence for its efficacy. Rather, Akosah-Sarpong’s (2007) argued that “Koankro” (the found cure for HIV/AIDS) was tested scientifically by the Biochemistry and Biotechnology Department of the Kwame Nkrumah University of Science and Technology and found credible. Akosah-Sarpong noted that the state has not investigated further to these claims and warning these healers to stop this claim. To this, therefore, he stated

The situation reflects the on-going schism between neo-liberal and traditional Ghana in the development process … The World Health Organization, the global health watcher, said there is no cure for HIV/AIDS yet. [Therefore, the public is advice to ignore claims made by these healers]. Once again, the orthodox, blinded more by arrogance than scientific thinking and open-mindedness, is not trying to understand the traditional, and in the ensuing struggles, undermining many a traditional medicine’s attempts to open up the doors for sober at how it can help solve the HIV/AIDS problem.

The practices of traditional healthcare are part of the Ghanaians heritage and as DeJong (1991) and then Van der Geest (1997) stated, it is culturally accepted and used by the majority of the people. Indeed, as Yeboah (2000) discussed in Chapter 2, it works and is the backbone of primary health care in Ghana. Despite this on-going schism between herbal medicine and “scientifically proof” of herbal medicine, it appears that the majority
of the people still believe and rely on the invaluable spiritual and practices of the traditional health care system, which is reflected in the increase in demand for its services. Even so, continuous research into medicinal plants has led to scientifically proof of some herbal medicine, testimonies that more research can help improve and provide some credibility of safety and quality to many herbal medicine and products. As noted by some participants in this study, there is the need for more research to be done on medicinal plants before “scientifically proof” can be feasibly applied to herbal medicine. In this regard, more traditional healers, researchers, resources, better and appropriate machineries and technologies must be employed.

Indeed, dosage and packaging of herbal medicine has improved dramatically, but incessantly, quake practitioners are faking products and medicine that have been authorized by the Food and Drugs Board. Rather, the allocation of codes and/or numbers and labeling of certified herbal products and medicine to reduce fake herbal medicine in the country has produced easy duplication for bogus practitioners, which is explained by Twumasi (1988) and Oppong & Williamson (1996) as “Itinerant Drug Vendors.” To this end, therefore, a stricter regulatory agency to overlook the herbal industry was advocated.

The data collected in this study found that the government has not provided funds or put in place the necessary structures to assist the traditional healers to open up their practices, and hence the delay in the integration process. In this regard, many traditional healers have two jobs to supplement their income or are unable to take time off their busy schedule, and therefore are unable to travel to the Mampong, where the Centre for Scientific Research into Plant Medicine is, to have their products tested. Besides,
evidence from participants in this research states that structures provided are malfunctioning and incompetence. Advertisements of approved herbal products and medicine, and/or asking traditional healers to bring their products for testing fail to provide this information in local languages. Some announcements are in Twi, a local language; even so, not every citizen understands it, especially those in the Northern part of the country (which has a vast number of traditional healers). In other words, advertisement should be in the nine government-sponsored languages if most traditional healers are to be informed about the integration process. Many traditional healers have been recognized without the government assisting them with the needed resources to advance. There was the implicit suggestion that, for recognized healers to progress, the government should establish facilities similar to modern health care facilities or assist healers financially to allow them operate more efficiently and hygienically. As part of their internship, not only should graduates of herbal medicine be places in modern health care services or research centers but also should be working with recognized traditional healers, was what some participants in this study proposed. Besides, government should recognize more healers and this, as argued by the participants in this research, will facilitate the formation of a traditional health care council to influence and shape policies not only on the integration process but also on general health issues.

Once policy opens up, the state must put money, research, expertise and resources into research and development into the commercialization of traditional health care system. More research into the development of herbal medicine will increase the quality and safety of many herbal medicine and products, which in turn will increase the
availability of drug supply in many health care facilities. In this regards, many diseases would be diagnosed, treated or controlled with fewer side effects, and affordable for most citizens. The quality of health care giving will improve, and health care giving will be faster, safer, effective and efficient. In effect, the trust in traditional health care system will increase and thus, there will be proper utilization of healthcare giving in the country. Besides, with appropriate regulation of the traditional health care system, malpractice, fake healers and counterfeit medicine will be at a reduced rate. What’s more, healthcare workers will be evenly distributed making health care services accessible for all. A holistic approach to health care will move health care giving more in the direction of prevention management and promote self-care among citizens.

Researching more into traditional health care services, coupled with its integration into the formal health care system will generate funds, which tends to be particularly potent for the development of the healthcare sector and the country as a whole. To this end, therefore, gains will not be replicated to other countries as profit will remain in the country to develop it. Less government’s spending on imported drugs and on recruiting more health care professionals for the current health care system mean money will be channeled into the research and development of traditional health care system. Also, traditional healers will be taxed, drugs can be exported to other countries and thus the money channeled into other development. While there is economic hegemony in traditional health care there is the need for the government to protect the local knowledge and the environment from exploitation. Therefore, government should consult the people on the different aspect of traditional health care including how herbal plants are grown
and harvested. As a result, more citizens will not only be involved in the process but also will be employed in the various aspects of traditional healthcare and empowered, hence providing funds for the people.
CHAPTER FIVE: SUMMARY, CONCLUSION AND SUGGESTIONS

This chapter presents summary, major findings and concluding thoughts. It also puts forward some areas for future research.

Summary

Ghana, like most developing countries, has a pluralistic health care system, whereby modern health care system co-exists with the traditional one. However, like many other developing countries, because of the heavy reliance on the modern system, it continually struggles to provide a comprehensive health care for its people. This study embraces the notion that Ghana can maximize health care giving by fully integrating traditional health service into the current health care structure. Literature surveyed in this stead indicate that for a long time there has been a structural neglect in the processes of fully integrating and maximizing health care giving. While modern health care system is relatively a new phenomenon, and also a colonial artifact; in Ghana, it is the formal and the most government-sponsored healthcare structure in the country.

In spite of these efforts, modern health care giving has failed to meet the needs of the people as the health care status of Ghanaians incessantly remains precarious. The mainstream healthcare delivery system in general is faced with multifaceted challenges. Declining poverty level has made modern health care services expensive and out of the reach of the majority of Ghanaians. In fact, the health of Ghanaians is threatened by the spiraling cost of imported prescription drugs and other fees pertaining to health services. Rising costs of imported drugs has made it very difficult and almost impossible for low income earners, and uninsured in particular, to receive medically necessary drugs, as
modern health care services has increasingly become unavailable and inaccessible. Notwithstanding, increasing growth in national health expenditure predominantly goes into modern health care services, and this funds the training of medical providers (who leave the country after huge government’s investment, to seek greener pastures in foreign lands), drugs importation (some of which are fake) and other essential equipments (which are usually insufficient). Despite state’s commitment to providing increasing funds to support the modern health care system, one witnesses a massive migration of health care personnel both within and across the national border. Inevitably, depleting number of healthcare personnel coupled with inadequate funds that will commensurate with the increasing demands for health care service by the growing population, has led to the closures of many health care facilities and created unequal distribution of healthcare services in the country. In addition, the complexities or failure of modern health care to handle most tropical diseases has led to increased practice of self-medication or the heavy demand for alternative health care services.

Another phenomenon that emerged with the implementation of the Structural Adjustment Program (SAP) was that the government was forced under policy requirements to cut subsidies to all public institutions. In this case, while yearly expenditure show a modest progressive increase of government’s commitments to health care (and yet this increased commitment is inadequate in as long as it does not commensurate with the growing demands for health care services with the growing population), the state has consistently shifted cost to citizens making the cost of health care unbearable and inaccessible.
In the face of high costs and deteriorating health care services, then, the majority of Ghanaians have shifted to an increased use of traditional health care system, which though not formalized nor integrated, has existed for centuries (first the only means of health care giving and now as supplement) within the health care economy. Indeed, the Kuffour administration was determined to deal with the health care problems and also to achieve sustainable economic growth, however, this dream seems very difficult to attain. As long as high health care costs continue to mount, health services deteriorate and modern health care system becomes largely inadequate in meeting the needs of the people. This then will result in adverse affect, not only the health care system, but also the socio-economic milieu that informs economic development.

Hence, the study posed the following questions to ascertain ways in which the central government can ensure the expansion and maximization of health care giving through full integration of traditional health care services as it pertain to the people of Tema municipality area of Ghana:

- What are the perceptions on the current conditions of traditional health care’s accessibility and availability?
- What have been the experiences with the use of traditional health care services?
- What are the socio-economic implications for fully integration both health systems?

Relevant literature reviewed covered both modern and traditional health care systems in Ghana. Chronologically, I discussed in details the development of both healthcare systems during the colonial period till present. How the colonial legacies of
healthcare management and the implementation of the structural adjustment program have aided or affected the modern health care system were also discussed. Additionally, I elaborated on government policies and how they encourage or discourage the accomplishment of a comprehensive health care system. The importance of traditional care system to bridge the gap in the biomedicine was also presented.

This study used a qualitative research methodology with a case study approach. A semi-structured interview guide was used in collecting data from a total of 33 participants, which consisted of 12 individuals (representing the various labor sectors), 8 key informants (government officials and traditional healers) and 2 focus groups (7 youth and 6 women). All of the participants were Ghanaian citizens, above the age of 18 years with knowledge and/or access to both traditional and modern health care systems.

Major Findings

The research found out that there is a huge potential for integration and that the people of Tema municipal areas, especially, clamor for full integration of traditional health care into the current health care system. The following is a summary of the main findings from the study based on the research questions:

When participants were asked how accessible and available traditional health care are, the following findings emerged:

- Accessing traditional health care services are cheaper compared to that of modern health care services. While modern health care is good in some aspects of healthcare giving, it is too costly and hence inaccessible to many people in the Tema municipality. Most herbal medicines are part of the environment making
them easily available and accessible at anytime of the day, without paying for them. Herbal medicines are available in most participants’ backyard and government’s authorized ones are easily found in drugstores or marketplaces.

- Traditional health system affords huge human resource. There are lots of traditional healers than modern healthcare personnel in the area studied and in the country at large. This makes it easy to access traditional health care services. In fact, it is hard to find a community without a traditional healer within every 10 kilometer.

- There is a vast local knowledge system (communally owned and shared) that guards traditional healthcare practices. Participants in this study indicate that usually, there is someone in every family who passes the knowledge of traditional health practices on to the younger generation of that family, and this knowledge is passed onto the next. This has led to the ability of many people to access and use traditional healthcare services without any technical restriction and the processes of usage.

- Traditional health care system is culturally accepted. Giving its long existence and usage, whereby the knowledge is passed from generation to generation, and its rare side-effects, have made the people trust the traditional healthcare system just as much as they trust the modern one.

- There are less restrictions and simple procedures associated with traditional health care usage. One does not need formal education to access traditional health care services or to use herbal medicines. In most cases, instructions and dosage does
not require one to have formal educational status. Modern healthcare on the other hand, requires one to know how to read before one can take prescribed drugs (or at least consult a physician for such services). Also in cases where modern healthcare practices have recommended surgery, traditional health care giving does not require any incisions in the processes of containing and managing ailment. This in many ways make traditional health care more accessed than the modern system, and because most Ghanaians are afraid of the risk and complications of surgeries, the traditional system has over the years encouraged increased use.

- In some cases, the only known and effective treatment for particular diseases, such as boils, White Cough and Anansi are herbal medicines.

Furthermore, regarding the experiences with the use of traditional health care system, the following findings were revealed:

- Not much has changed in the role, application and general popular attitudes to traditional health care system. It is still a major health service provision for the community; in that the first consultative avenue to dealing with any sickness is essentially traditional mediums of health care giving. Also, since the traditional healers are more driven by the capacity and ability (which then become the foundation upon which their practices are judged) to cure the patients rather that the excessive development of capital (a doctrine that modern health care has come to embrace). In fact in some cases, the traditional healer feeds his/her patient before administering treatment or goes to find the sick in the community.
• Unlike modern health care, traditional health services embrace a holistic approach to care giving. Traditional healers are concerned about the socio-cultural environments, physical and emotional symptoms of their patients. In essence, the healer believes there is a link between ones illness and ones environment (both the physical and spiritual). Traditional health care system deals with both the imbalances within the human body and the illness at hand. This is in line with the Kuffour administration’s new paradigm for health, that is, preventive management in health.

• There has been dramatic change in the way herbal medicines are packaged and processes of determining dosage have scientifically improved. Presently, most herbal medicines are prepared with clean water and in very hygienic place. In fact, due to the ability of research centers to test and verify herbal medicines, some herbal medicines have been tested, prepared into capsules and certified for public use.

• Traditional health care practices are perceived as part of the Ghanaian tradition, a heritage passed on for centuries. Traditional health care practices are recognized as something that developed within the local cultures. Traditional health care services are influenced by religious beliefs and in its usage both authentic religious and cultural believes are preserved to pass down to posterity.

• Most medicinal plants used in the preparation of herbal medicines are used on a daily basis in various communities. Herbal medicines are viewed as part of the
Ghanaian dietary system. Some herbs are used as spices in food preparations, whiles others as nutritional supplement or for water purification.

- Traditional health care system is perceived as safe. The fact that herbal plants are the only components of herbal medicines and part of the Ghanaian diet makes herbal medicines in particular safe and readily acceptable by the people. There is the belief that God has created each environment with the necessary needed herbs, and therefore, the people trust herbal medicines to be safe.

- Traditional health care services are considered very effective in treating so many health conditions. Although, most herbal medicines are yet to be scientifically proven as efficacious, they are perceived as safe and effective, and panacea for most health care problems in Ghana. In fact, herbal medicines work and has been successful in treating most illness in the country. Besides, there seemed little doubt in its efficacy by its users. In most places, it is the only available system that the people really use. There are various medicinal plants available and used in treating, preventing and controlling both chronic and infectious diseases. Herbal medicines get to the core of the health problem and in most cases treat diseases permanently. Seldom does one falls ill when they use herbal medicines.

- Traditional health care services are far less costly. Traditional health care practices and products are cheap because of the presents of shared local knowledge and the availability of herbal medicines in ones environment.
On the question of the implications of full integration of traditional health care into the current health care delivery system in Ghana, the major findings were:

- There is a growing emphasis on traditional healthcare system and the past government has made some efforts to ensure that traditional health care system is integrated into the current health care system. Currently, traditional healers across the country and Africa are being educated, and platforms are being created for networking and exchanging of ideas on practices. Through awareness creation, some traditional healers have open up their practices and brought their products for testing, verification and approval, and hence more herbal medicines and products are being produced and available in hospitals, marketplaces and drugstores across the country.

- Integration has delayed and there is the tendency for it to fail. Past attempts at integration continue to influence the current trends for full integration. The past administration failed to put the necessary structures in place to facilitate the process. Traditional healers are skeptical about the integration. They view it as a way for state to exploit their individual creativity, especially where there is no talk of their intellectual property rights.

- There has been the tendency for modern health personnel and some elite in society to treat herbal medicines as a threat to the health of the people. They still perceive traditional health care services as primitive and unsafe as its products lack scientific proof. In fact, because most of these elites are involved in policy reform structures, efforts at full integration have been resisted by these groups.
Integration of traditional health care system will improve the quality of care, giving the patient the freedom to choose and benefit from both health care systems. It will generate economic benefit such as revenue and employment for the people and the nation. For instance, there will be less importation of drugs and recruitment of foreign health personnel. Because medicinal plants abound in large quantities, coupled with the local knowledge, it will be easier to produce herbal medicines on a large scale and if possible to export to other countries.

Recommendations

Indeed, both the Chinese and India traditional health care models has illustrated that it is possible to successfully integrate traditional health services into the healthcare systems; as such this should serve as a role model that Ghana can follow for full integration. There is no question that the past governments have done a lot to ensure the successful integration of traditional health care system into the modern health care system, however, in order to achieve successful integrative health care system, the government, policymakers, stakeholders, modern healthcare personnel, traditional healers and the general public must be involved in each stage of the process of policy formulation, giving each sector a sense of ownership and empowerment in the direction of healthcare giving in the country.

Most importantly, traditional health care practices are an intricate part of the Ghanaian culture and religion, which cannot be ignored or taken away from the traditional health care system. Therefore, it requires the government to seriously consider ways and means to integrate, support, and scientifically enhance the humanitarian aspect
and payment systems of the traditional health care system, so as to make health care giving to the people cost-effective and culturally acceptable.

Already the advantages of combining modern and traditional health workers in the treatment of certain disease have shown the immeasurable benefit of integration. However, mired in modern capitalist requirements and rhetoric, the potency and economic capacities of traditional health care system have been diminished in policy frames, hence associating modern health care giving with civilization. This has triggered a notion of disparagement of traditional health care system, causing modern health personnel and the government to assume that traditional healers have little, if any, to offer the world of biomedicine. Quite to the contrary, traditional health care system has much to contribute to biomedicine and the economy at large, if one pays attention to what is happening in both India and China’s health care systems. Therefore, there is the need for education and awareness to expand the benefit of both systems of health care delivery. Both systems stand to gain in this process, and thus, training and education should be geared towards both traditional and modern healthcare workers.

Modern health personnel and elites leading the integration process raise a red flag, since they have a different strategy and mentality towards traditional healers. This only creates more complications in the integration process, making the traditional healers more skeptical about the process. For successful implementation and integration of traditional health care system into the current health care system, the government should involve more traditional healers and the general public in the deliberation process. Public opinion must be allowed to sway the direction of the integration process. There is a need for
community ownership to the integration process, as such to facilitate community participations, administrative structures must be decentralized such deliberation efforts. Integration should be designed to fit into the socio-cultural nature of the people.

Both professions have their own benefit and ways of administering care. Of course modernization serves a good purpose for the traditional health care services, yet it can also change the whole ideology and ways of traditional practices. Therefore, the government needs to concentrate more on good practices and providing facilities suitable for traditional healers to operate from than this whole idea of white lab attire and things that will jeopardized their practices. Obviously, some herbal medicines and traditional practices have not been “scientifically” proven, whiles some have, but, regardless, integration efforts must take a comprehensive approach, where fair standards (and not necessarily modern scientific standard) should be employed in measuring the efficacy of traditional medicines.

Also, most herbal medicines have proven efficacious in dealing with the health problems in the country. Indeed, the government has encouraged the manufacturing of herbal medicines and products, but most procedures that are presently in place to ensure quality production, seem duplicatable. Similarly, improper production of herbal medicine and products is just as dangerous and harmful to the public’s health as counterfeit and fake drugs, and some chemical modern drugs. Hence, there is the need for the government to divert some of its resources toward the production of quality herbal medicines and products, as well as support and encourage traditional healers to use safer and healthier methods in their practices.
It must be stressed that limitation of resources has a strong influence on the integration process. Clearly if things remain invariably stagnant for the healthcare sector, there will be an increase in disease outbreaks, and deteriorating geographical discrepancy in health institutional setups and health providers’ distribution across the country. The individual, society as well as the economy stand to gain from a comprehensive amalgamation of traditional health practices into the current healthcare system. Indeed, training of individuals into the traditional setups are inexpensive, to compliment the vast resources in medical plants available and the growing number of traditional healers/practitioners in the country. Therefore, the government must invest more into the integration process and the development of its traditional health care system if it intends to see value in the Ghanaian health care system, human development and in its citizens, at large.

Suggestions for Further Research

This research was limited because it was not able to represent all the different types of traditional health care systems available to Ghanaians. A more comprehensive study of the current traditional health systems available in all the ten regions of Ghana, where traditional healthcare services coexist with modern health care system, is, therefore, recommended. Possible benefits to such a study could yield many important results, as government policy (being influenced by this outcome) could begin to reflect such comprehensive provision of health care.

Also, a study into the importance of local knowledge systems that guard the traditional health institution and the intellectual property required to protect this body of
knowledge. Not only will such a study provide government with the necessary tool to protect these institutions, but also local inventors/healers whose medicine prove efficacious stand to profit from royalties of any sale of this medicine. In this approach, many healers will be encouraged to come forward with their medicine, knowing that their intellectual properties will be protected by the government. This study could also anticipate the possible financial and economic opportunities that these provisions could endow the nation, the individual and the society.

A prospective studies following people who claim to have been cured by herbal medicine that are said have no scientifically proof, such as the cure for HIV/AIDS, is important for comparing clinical data with that of new findings and observation. This is important in helping to identify new ways to improve and modify the standards used in testing and monitoring the efficacy of herbal medicine.

Conclusion

Traditional health care system is the most commonly used and access healthcare in Ghana and in most cases it is the only primary healthcare available to the people. Therefore, one cannot address healthcare giving in the country without admitting the importance of traditional health care services to the management of diseases in the country. Integrated traditional health care system into the current health care delivery processes will provide employment for the local people and naturally boost economic development. Since there will be less importation of drugs and recruitment of foreign health personnel, and the raw materials and knowledge for traditional health care is
abundantly available, income derived from traditional services and products will stay in the country, helping to develop the country.

More importantly, because of the availability of local knowledge in traditional healthcare practices not much money will be required to educate the people, saving the government some money. It is apparent that both systems of healthcare have their strengths and weakness, and it is only in full integration that the nation can maximize health care delivery. Indeed, currently both systems are used exclusively, simultaneously or alternatively depending on the available options and socio-cultural background. Therefore, integration could provide intellectual reinforcement for those who believe in the holistic approach. Moreover, integration will help maximize health care giving in the country, making a significant contribution, not only to the health status of the people, but also to the socio-economic development of the nation as well as for government to meet some of its MDGs. Similarly, the prevention aspect of traditional healthcare is in line with the government’s new paradigm for health, which indicates that there is the need for Ghanaians to adopt a healthy lifestyle.


Chavunduka (Eds.), The Professionalisation of African Medicine (pp. 100-130). Manchester: Manchester University Press in association with In.


APPENDIX A: THESIS INTERVIEW PROTOCOL FOR INDIVIDUALS AND FOCUS GROUPS

This is a study to identify and evaluate the importance of full integration of traditional health care system into the mainstream health delivery system.

Neutral Face Sheet Questions
Are you above 18 years?
Are you from Ghana?
Are you a resident of Tema? How long have you lived here/there?
What is your occupation?
What is your income bracket (if the person is willing offer that answer)?
Do you use or have knowledge about traditional health care services?

Probing Questions
1. Compared to modern health care, how accessible is traditional health care system?
2. Why do you access traditional health care?
3. It is popularly argued that traditional health care services are dangerous to use. What do you think about this?
4. How often and how long have you used traditional health care system?
5. What are your experiences with the use of traditional health care?
6. What are your experiences with the use of modern health care?
7. Which one do you prefer and why?
8. In what way do you think fully integration of traditional health care can help you?
9. What do you want government to do about the current situation with the delay in integrating traditional health care into the formal health care delivery?
APPENDIX B: THESIS INTERVIEW PROTOCOL FOR KEY INFORMANTS

This is a study to identify and evaluate the importance of full integration of traditional health care system into the mainstream health delivery system.

Neutral Face Sheet Questions
Are you above 18 years?
Are you from Ghana?
Are you a resident of Tema? How long have you lived here/there?
What is your occupation?
What is your income bracket (if the person is willing offer that answer)?
Do you use or have knowledge about traditional health care services?

Probing Questions
  1. In what way does government support or discourage public reliance on traditional health care?
  2. What are the possible benefits both to the public and the economy of fully integrating traditional healthcare system into health care delivery?
  3. How can traditional health care services help improve the utilization of health care delivery systems.
  4. In your view, what is preventing or prolonging government’s efforts at fully integrating traditional health care system?
  5. What can be done about the current condition with the use of traditional health care?
  6. There is a perception in Ghana that traditional health care is accessible and easily available. What are your views on this?
  7. In what ways do you entertain public perceptions on full integration of traditional health care services?
APPENDIX C: IRB APPROVAL LETTER

A determination has been made that the following research study is exempt from IRB review because it involves:

Category 2 - research involving the use of educational tests, survey procedures, interview procedures or observation of public behavior

Project Title: Health and Development: The Role of the Traditional Health Care System in Ghana

Project Director: Rhodaline Baidoo

Department: Center for International Affairs

Advisor: Francis Godwyll

Robin Stack, C.I.P., Human Subjects Research Coordinator
Office of Research Compliance

Date: 11/27/07

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.