Use of traditional healers and modern medicine in Ghana

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**Purpose:** To gain understanding of the use of traditional and modern medicine among the people in Ghana, West Africa.

**Methods:** Data were collected from nine participants using a semi-structured questionnaire developed by the researchers based on review of the literature.

**Findings:** Data analysis was performed manually using reduction methodology to develop broad themes. Findings indicated that choices in healthcare modalities by literate Ghanaians included either traditional or modern medicine, or blending of both. Strong influences on these choices were the level of education and related themes, influence of family and friends, and spiritual/religious beliefs.

**Implications:** Findings indicate that traditional and modern medicines will always be part of Ghanaian healthcare delivery and efforts should be made to integrate traditional practitioners into the national healthcare delivery system.

**Keywords:** Ghana, Healer, Modern Medicine, Religion, Traditional Medicine

**Introduction**

Like other developing countries, Ghana continues to search for a more effective, appropriate and efficient means of meeting the health needs of its growing population. Ghana is located in west Africa along the coast of the Gulf of Guinea and borders Cote d’Ivoire to the west and Togo to the east (Owusu-Ansah 1994; Tabi & Frimpong 2003). Ghana’s population is reported as 20.1 million (Engenderhealth 2003). English is the official language. Compared to more developed countries, the health status of Ghanaians remains poor. Life expectancy is below 60 years compared to 75 years in developed countries (Engenderhealth 2003; WHO 2004).

Approximately 33% of all reported deaths are attributed to infectious and parasitic diseases that are preventable (Tabi 1994). Lack of access to medical facilities, particularly those in rural areas, poor roads and infrastructure, malnutrition, infectious diseases including HIV and AIDS contribute to almost half of all deaths reported in Ghana (World Bank 2002; World Development Indicators Database 2003). The HIV prevalence rate is 3.6 of the adult population in Ghana (Avert 2001) compared to countries in the southern sphere of the continent with more than 20% of the adult population infected with HIV (Tabi & Frimpong 2003).

Traditional as well as modern medicine is integral components of the healthcare delivery system in Ghana. In a country of scarce medical resources and transitioning cultural traditions and beliefs, approach to health care is based on a personal understanding of one’s health, life and being (Hevi 1989; Van Eeden 1993).
The study and significance
The objective of this study was to conduct qualitative interviews with a small number of Ghanaians to determine personal perspective when choosing healers, particularly, Western or traditional medicine, or blending of both, for health care. The cultural, family, educational and religious influences on these choices were of particular interest.

Research questions:
1. What factors influence Ghanaian’s choice of healing for traditional, Western, or blending of both modalities?
2. What criteria do Ghanaians use to determine the effectiveness of a specific modality?
3. What are the social, educational, cultural and spiritual factors that affect these choices?

The study is significant due to a dearth in qualitative documentation of personal preference and rationale for healthcare choices in countries with viable traditional and modern medical systems. The results are important when considering the emphasis on Western medicine for solutions to health problems in developing countries.

Review of literature

Healthcare delivery systems in Ghana
Healthcare delivery in Ghana is pluralistic consisting of traditional and modern medicine (Anyinam 1989; Hevi 1989). The individual’s interaction with other sectors of health care depends on how the health problem perceived or sanctioned by the sick person, and most importantly, by relatives and close friends (Hevi 1989). Depending on prevalent symptoms of illness, a person may choose to disregard an illness or health problem, use treatment modalities known to the individual, friends or family, or make a decision to use services of a traditional healer or modern medical practitioner.

Ghana is administratively divided into 10 regions, each with a regional hospital. Accessibility to health care is defined as living within 3–5 miles of a health service (Tabi 1994). Approximately 70% of the population lives in a rural area where accessibility to health service is a problem. In Ghana, the ratio of medical doctors to population is 1 : 20,000 and the ratio of traditional healers to population is 1 : 200 (Patterson 2001; Tabi & Frimpong 2003). Often, for the rural and urban poor, traditional healers provide the only affordable and accessible form of health care (Cocks & Moller 2002; Sodi 1996; Tabi 1994). The majority of the time, they are the first line of contact in the healthcare system in rural areas.

The traditional medical system
Traditional medicine consists of health practices, approaches, knowledge and beliefs incorporating animal- or mineral-based medicines and spiritual therapies, either used singularly or in combination to treat, diagnose and prevent illness to maintain well-being (Craffert 1997; Du Toit 1998; WHO 2004). Approximately, 80% of the population in Africa uses traditional medicine for health care (Patterson 2001; WHO 2004). Traditional medicine has been part of the Ghanaian culture. The traditional medicine system includes not only herbal remedies for specific diseases, but also folk knowledge, traditions and values, health behaviour rules and patterns, and identified personnel and structures for delivery and restorative therapy (Hevi 1989). There are many types of practitioners available in Ghana, each with a distinctive approach to diagnosis and therapy. There are secular healers often referred to as ‘traditional pharmacists’ who use herbal medicine prepared from selected leaves, roots or other parts of plants and animals. There are also plant drug peddlers who travel to towns and villages, as well as sell herbal medicines at workplaces, bus stops and in the streets.

Health and religious influence
Predominant religions in Ghana are Christianity 63%, followed by Islam 16% and Traditionalist 21% (Care International 2003).
Although the Christian religion is practised by a greater percentage of the population, traditional religion is significant and represents a value system and social order intrinsic to the cultural history of Ghana.

Christian missionaries and missionary societies were the first to bring modern medicine to Ghana in the 19th century. They were 'almost the sole providers of modern medicine until after World War I’ (Owusu-Ansah 1994, p. 110). Today the Ministry of Health supervises the medical system, as well as control of drugs, narcotics, scientific research, and professional qualifications of medical personnel. Warren et al. (1982) attribute modern and traditional systems with a common goal of protection and preservation of health in Ghana, but observe that, 'the predominant attitude between them has been mutual disregard' (p. 1873).

Factors contributing to use of traditional and modern medicine healers
The existence of a dual healthcare delivery system and the use of either or both traditional and/or modern medical systems have had a significant effect on Ghanaian health practices. In addition, the Ghanaian history of strong family and religious bonds has impacted the choices made by individuals seeking healthcare services. Finally, external limitations imposed by terrain and economics have isolated a majority of the Ghanaian people from access to adequate services.

Influence of locale
Bonsi (1980) cites attainment of formal education, acquisition of new skills, rapid economic development and improved job markets as reasons to move to more populated areas. His observations reveal that people are removed from the influence of the traditional village system and begin to act independently of traditional values. Thus, a person begins to adopt values and norms of others within close proximity and leave the village way of life.

Economic and financial factors
The World Health Organization acknowledged the need for inexpensive and effective treatment for common diseases in low-income countries. Most traditional medicine practitioners live and work in the community level, which makes such treatment available and affordable to most of the population (WHO 2002). The ability of traditional healers to alleviate financial burden is accentuated by Oppong (1989) with his observation of a Nigerian traditional birth attendant (TBA). Many of her patients lived within a short walking distance and generally she received very little for her services. Patients often paid for her services using a chicken or piece of cloth following delivery as a token of their appreciation (Oppong 1989).

Methods
This qualitative study investigated Ghanaians’ use of healers to manage illness. The purpose of the study is to gain understanding of the use of modern medicine and traditional medicine, or blending of both modalities among the people of Ghana. The study was conducted in June 2000 in Cape Coast, a central region of Ghana. Data collection began after approval was obtained from the investigator’s institutional review board and from the community leaders in the locale where the study was conducted. Recruitment of sample was by word of mouth; purposive sampling was used as a result of time constraint and lack of extensive contacts in the area. A contact person in the Department of Religion at the University of Cape Coast assisted with recruitment of subjects. Participants were given an equivalent of $10 for partial compensation of their time in the study. Certain criteria for inclusion in the study were identified as essential to obtain relevant, reliable and comprehensible information: male or female; 21 years of age or older; ability to speak, read and write in English; willingness to participate and ability to understand the concept of the study. Participation in the study was voluntary and informed consent was obtained from all participants.

Data collection
A semi-structured interview guide (Table 1) developed by the investigators to probe specifics of personal experience was used. Each interview was tape-recorded and numbered with additional identifying information of age and occupation to protect anonymity. Data analysis was generated manually; reduction methodology developed broad, consistent themes. Investigator triangulation improved transcription comprehension and limited investigator bias. The three researchers (two experienced in qualitative analysis) reviewed the data and agreed upon the themes generated from the analysis. Themes were assigned to specific categories: modern medicine, traditional medicine, and choice of modern or traditional, defence of modern and traditional, power of modern and traditional, and educational, religious and spiritual elements. Relationships within the data were identified.

Findings
Findings were extrapolated from the responses of nine middle-class subjects who originated from a variety of backgrounds. Some grew up in larger towns or cities, some in villages. Some still lived in their village of family origin, while others had moved to larger towns or cities when they became adults. Religious affiliation also varied: some were Muslim, some Christian, and some had more traditional roots than others. However, common themes emerged from seemingly different origins.
Demographic characteristics
Study participants included five Ghanaian men and four women ranging in age from 25 to 60 years. All had either sought traditional healing at some time in their lives or had known someone who had been treated with traditional medicine. Some had parents or grandparents who had been traditional healers or herbalists. Anecdotal responses indicated that some of the participants also perceived of themselves as healers.

Seven of the nine participants were married and two were unmarried. All except the two unmarried participants had children. Education and employment demographics included two university students of religion; one male participant with middle school and technical school education employed in public relations at the local university; another male participant with middle school certification employed as a technician in public relations at the local university; a male participant with technical school certification employed as a government clerk; one female clerk participant with secondary school education; another clerk participant with two-year post-vocational training; a Roman Catholic priest with a bachelor’s education; and a professor with doctor-of-philosophy education.

Description of findings
Data were identified according to contextual influences of either external or internal origin. Subheadings were developed according to themes. External controls were identified as decisions made according to influence of education and religion, input from friends or caregivers, employer requirements, or influence of locale. Internal influences were described as belief of problem origin, e.g. spiritual or non-spiritual, and previous history of success with specific therapeutic modality, modern or traditional, and the power associated with each method.

External contextual influence
Six of the participants discussed the influence of family, friends and employers as significant to their decision-making process. These influences covered both ends of the spectrum, from over-riding parental beliefs in traditional medicine to employers who would accept a work excuse only from a modern medicine practitioner. Four participants offered insights about influence of locale and economics. Opinions indicated rural areas had more poverty creating a hardship to travel the distance to modern medical facilities. If service could be accessed, the high cost of treatment would make it unaffordable. This same isolation served to create a bond between villagers and their local, familiar healers that increased their faith in traditional healing.

Education, religion and culture
Participants mentioned education as a contributing influence when choosing a healing modality. For example, some participants mentioned concern for hygiene; some thought accepting information from a traditional healer with lesser education was demeaning. One participant mentioned that he was born in a village and knew only traditional ways until he went to school, where he learned ‘herbal concoctions are unhygienic.’ Two different perspectives were offered regarding the effect of education on the patronage of traditional healers. One man described education as a barrier to the acceptance of information, when the healer is not educated in a formal sense, or not as educated as the person receiving healing. Another spoke of Western education as ‘brain washing, that everything African is bad. So the educated, the elite, would not like to take traditional medicine, the herbs’.

Some participants, especially those of Christian or Muslim faith, associated demonic influences with traditional medicine and thus preferred to use modern medicine. Others felt cultural
aspects were influential, citing pressure from families and friends to use traditional medicine.

Choice of healing modalities
Several participants believed in the use of modern medicine as preferred choice of healing modality and described the importance of laboratory and radiology results to identify the cause of illness. One man mentioned the necessity of tangible parameters ‘because we are living in a scientific age’. He went on to state, ‘If the doctor is unable to cure your sickness, then I will tell you to see an herbalist’. This participant explained how he had treated a previous personal illness of ‘swelling in the neck and not feeling well’. He stated that findings from hospital laboratory indicated, ‘There was nothing to show that I was sick’. He then sought a traditional healer who told him he had a spiritual illness brought about by jealousy of other family members toward him. He was given a ‘potion to drink’, and told by the traditional healer ‘the spirits have been removed’. The subject verified that he was not bothered by the problem again.

Another participant also identified hygiene as a stumbling block in the use of traditional medicine, ‘Because the herbalists often do not use hygiene in preparing their medicines, people think they are not good. But we make it locally which we just don’t test it like and measure and say if one teaspoon or a tablespoonful is needed, we just drink it like that [the way it is given to us]’. He identified modern concepts of hygiene and the importance of accurate dosage measurement as influential when choosing between modalities.

Situational factors
Another determinant when choosing traditional or modern medical healers is the influence of others, such as relatives, friends and employers. One participant stated public servants in government institutions often are required to seek treatment in a hospital. She stated ‘The problem is if you work in a government institution, you have to go to the doctor first to do some tests and later to the herbalist. The herbalist cannot give you security’. One participant remembered her father’s concern with her first pregnancy. There was a family history of death in childbirth. He urged her to seek protection from a fetish priest. She stated, ‘In fact it was not my intention to use a traditional healer, I usually go to the hospital’. She combined the traditional healing with modern medicine and sought prenatal treatment with a medical officer. Her rationale for seeking modern medicine was: ‘I know the doctor, and I wanted to make sure in case there is an operation needed (caesarian-section), the doctor can do the operation than [not] the fetish priest. I did go to the laboratory for tests, because the fetish priest cannot do any tests’.

Accessibility and affordability of health care
Locality and high cost of medicine seem to be intertwined concepts in choice of healthcare modalities. Familiarity with the local provider is identified as another factor associated with physical circumstances. One participant pointed to poverty in rural areas as a deterrent to the use of modern medicine in Ghana.

You see I feel that they [Ghanaians] use more of herbal medicine because many of them particularly in rural areas are poor, so they cannot go to or come visit the hospitals. Poverty prevents treatment in hospitals because drugs are very expensive and hospitals are not easily accessible without adequate transportation. Sometimes you have to give money to the nurses and the doctor himself to receive treatment, and the medicine is very expensive, also. There are many people who cannot pay and so they rely on traditional medicine, herbs. Even for children, they use herbs.

Internal contextual influence
Internal contextual influences encompassed the concept of illness of spiritual or non-spiritual sources. The belief was that spiritual illness could only be cured with traditional medicine. Those experiencing non-spiritual illness might choose either traditional or modern medicine; frequently the choice was made according to faith related to successful past experience with a specific modality. The perception of personal power vested within a healer, especially in traditional medicine, played a significant part in determining choice. Some felt this personal power was essential to the healing process; others feared the source of the personal power was demonic and synonymous with evil.

Spiritual illness
Some participants perceived spiritual illness as a reason to seek traditional care. One participant spoke of a cousin who was cured of epilepsy by a herbalist. Her personal family experience led her to believe that there were diseases that required a spiritualist. According to the participant, ‘Somebody may want to destroy your life and a spiritualist may help to protect you. Most of these people have powers’.

Another female participant stated she would ‘seek all other results with modern medicine, and then seek the herbalist. When there is no way out you definitely have to use the herbalist’. When asked for more descriptive information she stated,

Sometimes there is the belief that some of the illnesses are caused by spirits, or spiritual illness. If taken to the modern medicine healer, they will treat you based on the physical signs, like if you’re having pain. But the herbalist, I know they read and they are revealed certain things to do.
Personal belief/fait in healing

Some of the participants described illness that they identified in modern medical terminology. Their approaches varied in the use of modern medicine, traditional medicine or a combination. A middle-aged male participant with a family history of hypertension treated his own hypertension with modern medication from a medical officer. He had never seen a herbalist for his hypertension. He stated, ‘I take my medication when my pressure is high, and I stop when the pressure is okay.’ For him symptoms of headache and fatigue were indicators to take his medication.

A female participant diagnosed with rheumatoid arthritis and sickle cell disease by laboratory analysis first chose modern medicine for treatment of leg pain. According to the participant, modern medicine did not relieve her pain causing her to seek relief from a herbalist. When asked why traditional medicine worked for her, she stated,

I don’t have any motive about the spiritual powers. I believe in the medicine. It is only by faith. You see using a certain medicine you have to believe that the medicine that you are using will cure you. If you do not believe that and have no faith in it, it will not work.

Source of healer’s power

Several participants shared thoughts on different aspects of the power of traditional medicine and healers. Three participants believed that traditional powers of healing are passed from one generation to the next. One male participant expressed it as ‘wise by experience’. He stated, ‘Herbal medicine is something the people know, is handed over the years.’ Other participants feared the power of some traditional healers, because they were unsure of the source of power. Powers considered to be from a Supreme Being or God, were perceived to be safe origins of healing. Some considered powers derived from lesser deities, also called intermediaries, as demonic power.

A participant in touch with the spiritual life of Ghanaians offered an alternative perspective:

Our people do not think that [lesser deities have demonic power]. Now, the hierarchy, the hierarchical structure of the worshipping lives of our people, they see the Supreme Being, they see the intermediaries, and then the human beings. Our people do not see these deities, minor gods, small gods as devilish or demonic. People living in villages see traditional healers for illness, birth, bone setting, and psychological problems. And so, if there is any help, if they need any help from the minor deities or gods, you know, they feel they represent God.

Discussion

The findings of this study suggest a complex process involved in making healthcare decisions. This process is responsive to a combination of forces coming together to develop individual and personal choices of these Ghanaians. The forces of traditional culture, religion (Traditional African, Christian and Muslim), finance and economics, education, advice of family and friends, and introduction of Western systems (educational, medical and cultural) all have shaped the healthcare choices.

The strength of this study lies in the homogeneity of the subjects, but conversely this is also its weakness. This investigation was conducted with a small number of participants. The similar backgrounds, experiences and general profiles of the participants make it possible to extrapolate theories of perception related to the influencing forces mentioned above. However, a study conducted with people who have lived in traditional villages in close contact with traditional healers all of their lives would be expected to produce different responses. It cannot be concluded that the findings obtained in this investigation represent the attitudes of a majority of Ghanaians. However, the participants do represent a cross section of the population who have influenced by education, religion and Western systems.

Conclusion

Healthcare systems originate and develop on the basis of health views. At the core of people’s health views are culturally determined beliefs and values. Through experience and socialization, people demonstrate health behaviours reflective of personal development. Perceptions of health and disease, expression and interpretation of symptoms, and types of health care available guide these health behaviours. Globally most cultures, including the people of Ghana, retain indigenous health beliefs. Even though people in Ghana may accept modern scientific medicine, they retain traditional concepts to give meaning to their health experience.

Practice implications

Implications of the study findings indicate that traditional and modern medicines will always be part of Ghanaian healthcare delivery and efforts should be made to integrate traditional practitioners into the national healthcare delivery system. The challenge for nurses and nurse–midwives is to help people identify and use the positive elements of traditional health resources. With integration of modern and traditional medicine, facilitated by introducing each modality to the benefits of the other, goals of global improvement in health conditions and realization of personal abilities may be achieved. A good understanding of traditional preventative issues by nurses and policy makers could have enormous public health benefits.
References


