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Traditional Medicine and Healing among the Dagomba of Ghana

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ABSTRACT

Traditional medicine and healing (TMH) is a major contributor to the healthcare needs of citizens of many countries, especially in developing countries and among the rural poor. This study of traditional medicine and healing among the Dagomba of Ghana seeks to answer the following questions: How is traditional medicine and healing practiced among the Dagomba of Ghana? What influences people to choose traditional medicine and healing? And how do different actors think traditional medicine and healing can be included in the formal Ghanaian health system? Through in-depth individual interviews, focus group discussions and the use of a qualitative questionnaire and personal observation, the study reveals that traditional healing among Dagomba is largely influenced by their culture and health philosophies. They theorize that *doro* (illness) has both internal and external dimensions with multiple causal factors and that *alaafee* (good health) is having *suhudoo* (peace of mind) and a balanced relationship with: oneself, others, the environment and the spiritual world. People's choice for traditional healing is based on the nature of the illness, its perceived cause and other socio-cultural factors. "Secrecy" is used both as a psychological and political tool by healers to protect their intellectual property rights and to promote *suhudoo* among patients. Finally, the study finds that to ensure the inclusion of traditional medicine and healers in the formal health system, there must be a very strong collaboration between practitioners of both health systems and a shared understanding of traditional healing practices among western medical practitioners and secondly, a framework for mutual referral of patients should be established as the most viable option for inclusion of TMH.

Key Words: Traditional medicine, traditional healing, inclusion, Dagomba, Ghana

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AGG	Assemblies of God Ghana
AIDS	Acquired Immune Deficiency Syndrome
CHS	Consumer of Healthcare Services
CSIR	Centre for Scientific and Industrial Research
CSRPM	Centre for Scientific Research into Plant Medicine
GHAFTRAM	Ghana Federation of Traditional Medicine Practitioners' Association
GHS	Ghana Health Service
GSS	Ghana Statistical Services
ILO	International Labour Organization
MOH	Ministry of Health
PWM	Practitioner of Western Medicine
TAMD	Traditional and Alternative Medicine Directorate
TBA	Traditional Birth Attendant
TM	Traditional Medicine
TMH	Traditional Medicine and Healing
TMP	Traditional Medical Practitioner
TMPA	Traditional Medicine Practice Act
TMPC	Traditional Medicine Practice Council
TMS	Traditional Medical System
WHO	World Health Organization
WMS	Western Medical System

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DEDICATION

To my wife and children

CHAPTER 1

INTRODUCTION

While waiting patiently outside the house of one of the Dagomba traditional practitioners during the summer of 2015 at Yendi, my assistant and I could see a pile of herbs in one of the unfurnished rooms. Some herbs were on the floor while others were packed in jute sacks. We could also see already used herbs lying on the verandah, ready to be thrown away. It wasn't long when the healer finally joined us to have a conversation on the topic as scheduled. We sat on a long bench under a shady tree in front of the house. We talked about a number of issues relating to how he practices traditional medicine and healing as well as, his source of knowledge and perspectives on health and illness. Then the topic of working within the formal health system of Ghana came up and how he might feel about it. In expressing his opinion on the topic, the following narrative was produced:

> We know that illnesses come from different directions. Some are caused by nature and others through spiritual sources. For the natural ones we can combine two or three herbs to treat it. Like *chua* and *kpaʔ'ʒiɛʔʊ*. But illnesses such as *sambu, dihili* and *yukurli* are caused by spiritual means. These can't be treated in the hospital. For these illnesses, when you take them to the hospital, finally they'll tell you to seek home treatment for the hospital specialists can't treat them. They don't know about these ones except the ones in whose families there is something like that. Yes, some of them also come from traditional homes, you see; but the hospital people think this isn't right. And the problem is that you can't take *tisablim* to the hospital. Even sometimes the doctors get angry when they know that a patient went to *Dagbandoo* (a traditional healer) before coming to them (TMP1 at his residency in Yendi, 20/06/2015).

Narratives of this nature kept surfacing during our interactions with other practitioners on the topic of working with the formal health system or how members of the formal health system may perceive their work. This study is therefore about the complexities surrounding the practice of traditional healing and medicine among the Dagomba and how the inclusion of the traditional medical systems and its services in the Ghanaian formal health system may look like.

1.1 Background to the study

Traditional medicine (also known in other contexts as complementary/alternative medicine) has now gained a wider discussion not only in the academia but also among policy experts, health advocates and politician since the last three to four decades. The World Health Organization's (WHO) 1978 Declaration of Alma-Ata called upon governments, especially those in developing countries, to examine the role of traditional medicine in providing primary healthcare. Since

then, some efforts have been made by different countries towards developing their traditional medical systems (TMS). The concepts of tradition and traditional knowledge as they relate to traditional medicine are complex in nature. According to a Ghanaian sociologist Nukunya (1992:3-5), tradition may be seen as a set of beliefs and practices which express the value and purpose of society and help it to organize its basic essential resources. Follwing from this, traditional knowledge could be seen as a set of ideas, values and norms which are dynamic in a society and passed on from generation to generation. Hence the concepts of tradition and traditional knowledge connote native, indigenous and non-foreign but also dynamic and unfrozen practices among a cultural society and its people.

The World Health Organization (WHO 2000:1) defined traditional medicine as:

> the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in prevention, diagnosis, improvement or treatment of physical, mental, [spiritual and social] illnesses (my inclusion).

These knowledge and practices which involve the use of both organic (plant and animal) and inorganic sources to treat and heal illnesses have been a common, but cultural specific, practice among societies throughout time and space. Traditional medicine and healing (TMH) is thus one of the major aspects of indigenous knowledge systems that has provided and continues to provide healthcare services to larger populations, especially among the rural communities in many developing countries. This healthcare system involves a holistic approach to healthcare by considering not only the physical aspects of patients but also their emotional, spiritual, psychological and social realities. While traditional medicine is often perceived as a unitary system of healthcare, many studies have found that there are areas of specialization such as herbalist, spiritual healers, bone setters and traditional birth attendance (TBAs) (Homsy et al 2004; Gyasi et al. 2011; Barimah 2013; Asante and Avornyo 2013) within that field, although the categorization of practitioners into spiritual and non-spiritual based healers, at some points, is very blurred.

According to WHO (2002), about two-thirds of the global population relies on TMH for their health care needs with up to 80 percent of the populations of Africa depending on this health system. TMH has also been noted to provide healthcare services to the larger populations of many African countries including Nigeria, Kenya, South Africa and Ghana (Asante and Avornyo

2013:259). Whereas WHO (2002:2) found that in Ghana, Kenya and Mali, research shows that it costs less to use herbal medicine for treating malaria, in which cases, payment may even be in kind, which is in contrast to Western medicine, Ofosu-Amaah (2005:113) asserts that in Ghana, Mali, Nigeria and Zambia, the first option for treatment of 60 percent of children with malaria induced high fever is the use of herbal medicine.

In Ghana, even though the accessibility to the Western healthcare system has improved due to the introduction of the National Health Insurance Scheme in 2003, the availability of both healthcare facilities and health personnel, especially in rural areas, is still a major challenge. This is where TMH features most prominently to provide healthcare to the majority of the populations living within rural communities. In terms of doctor-patient ratios, Ofosu-Amaah (2005:112) found that in Ghana, there is 1: 400 healer-patient ratio as compared to that of 1: 10,000 doctor-patient ratio. In line with improving the performance of the TMS, Ghana passed the Traditional Medicine Practice Act (TMPA, Act 575) in 2000, as a move towards making TMH services more available, safe and with improved standards, to which many Ghanaians saw as a positive development by the government. Following this, the Traditional Medicine Practice Council (TMPC) was established in 2010 as per the provisions of Act 575 to oversee the activities of the system. Despite the huge contributions TMH is making to healthcare delivery in the country and the serious efforts governments have made towards it, this system of healthcare has still not seen that much improvement. The purpose of this study is therefore to document the Dagomba knowledge and practices of traditional medicine and healing and to examine what influences people choice for traditional healing and the possibility of including this healthcare system in the formal Ghanaian health system.

1.2 Problem statement

Globally, the health and well being of the citizens of many countries seem to be a priority of most governments. While TMH has been a historical and dynamic knowledge and practice among many cultures and societies to which many nations are making greater use of today, some countries are still relying largely on the modern Western forms of medical practices to provide healthcare services to their populations. It has, however, become apparent within the past few

decades that in order to provide the needed healthcare services to the rapidly growing populations, countries have to turn their attention as well to their TMS as alternative healthcare service provider. To this end, countries such as China, India, the Republic of Korea, and others have taken the lead (Ofosu-Amaah 2005:116).

In Ghana, access to Western healthcare services is not only expensive but there are also wider disparities both in healthcare facilities and personnel between the rural and urban communities. Relative to this, Ofosu-Amaah (2005:203-211) claims that "it is quite evident that there is gross disparities in the distribution of health personnel in Ghana". The author further notes that Ghana has a poor coverage of health care services, with less than half of the population having ready access to healthcare and that people might even be constrained because of costs. Despite the fact that TMH provides healthcare services to over 80 percent of the populations and being available, accessible and affordable. Many efforts to develop the TMS have, however, been targeted only at developing herbal medicine through researches and clinical examinations conducted by National and University research centers but not so much into the improvement of the TMS to which herbal medicine is a part.

Twumasi (1975:129) argued that certainly, any endeavor to use the services of traditional healers should be preceded by research. A similar call has been made by Ofosu-Amaah (2005:197) when he asserts that, more information and understanding is desirable about traditional medical practices and that "research will be needed to clarify many issues about the whole system and the effectiveness of Traditional Medicine". However, some studies conducted on TMH in Ghana such as (Insoll 2011; Kankpeyeng, Nkumbaa and Insoll 2011; Asante and Avornyo 2013; Barimah 2013) have some limitations. There are few studies that try to examine TMH from a specific socio-cultural group as well as on attitudes and perceptions towards the TMS from practitioners of both healthcare systems and consumers of healthcare services altogether. This study, therefore, identifies that there is a gab in the literature and based on that, the study aims at documenting the Dagomba traditional knowledge of herbal medicine and healing practices, the perceptions people have about TMH and what infleunce their choices for traditional healing and also how different actors think the TMS can be included in the formal health system of Ghana.

1.3 Research aims and objectives

This study has two broad aims. The first is to provide an understanding as well as information about the Dagomba traditional medical practices, and the perceptions and attitudes people have about TMH. The second will be to find out how different people think this medical system and its services can be included in the formal health system of Ghana. The following are, therefore, the specific objectives to help me achieve these two broad aims.

- To document Dagomba traditional medical knowledge and healing practices.
- To examine what influences people choice for traditional medicine and healing.
- To discuss how different actors think traditional medicine and healing can be included in the formal health system of Ghana.

1.4 Research questions

In order to achieve the above research aims and objectives, the following are the questions this study seeks to answer.

- How is traditional medicine and healing practiced among Dagomba?
- What influences people to go for traditional medicine and healing?
- How do different actors (traditional healers, practitioners of western medicine and consumers of health services) think traditional medicine and healing can be included in the formal health system in Ghana?

1.5 Rationale for the Study

The motivation to carry out this study stems from several sources. These factors are both from within me and the health situation within the Ghanaian context. The most propelling ones include the following:

From a personal level, one of the motivations for this study has been my experience and family background. My late father was a well-known healer. I used to see people come to him for herbal medicine. Perhaps, growing up and becoming a Muslim had influenced my interest in his field or perhaps it was my disconnection from the community which had caused it, I am not certain. After my postsecondary education and upon becoming a professional teacher, I moved away from my home town to stay at Yendi, where I was posted to, and where I currently live. My late father used to ask me to come to the village to document the names of people he had treated with snake bites and the names of other herbal roots used in the treatment of some common illnesses since he was growing very old. However, I became more interested in TMH during my nine year stay at Yendi. I have witnessed cases where relatives of patients would go for a traditional healer to come and look at their patient at the hospital and make recommendations for them, or where patients are asked by medical professionals to go home and seek for local healing for their illnesses, since no pathological condition could be found. Most of these cases involved spiritual illnesses which, are said, to only be treated using spiritual therapy. My desire to know more about how the system works aroused my curiosity and deepened my interest in TMH. Upon gaining admission into the masters in Indigenous Studies program, this was what came to mind when we were told to present our research topics. I decided to conduct this qualitative research into TMH among Dagomba in order to understand the philosophies and theories that underlie this healthcare system and why many people would still need the help of a healer even when they are in the hospital seeking medical care. For me, this research is a way of connecting to the people and the tradition to which I share a family history with and to document and help preserve the Dagomba traditional knowledge and socio-cultural practices of traditional medicine.

Added to this personal interest are the numerous health challenges in Ghana. Prior to 2003, the Ghanaian formal health system was run by what was popularly known as the ‘cash- and- carry’ system. Patients seeking healthcare were to pay, the cost of treatment in full, before they are attended to. Due to poverty and the high cost of treatment, many healthcare seekers either resulted to self-treatment or go for traditional healing. More so, there are disparities in the distribution of both healthcare facilities and professionals between the urban and rural communities in Ghana (Ofosu-Amaah 2005:203,211). This may explain why the majority of the consumers of TMH are within rural communities.

The third motivation is the fact that *Pag'do?sa tohindiba* (generally known as Traditional Birth Attendants –TBAs) have already been included in the formal health system in Ghana. TBAs are mostly women, who due to their age, wisdom and experiences, have accumulated knowledge of delivering babies, mother care and how to manage infants and their growth related problems. Hence, as pointed out by Ofosu-Amaah (2005:198), these women were identified and trained by the Ministry of Health (MOH) in Ghana and have been part of the Maternal and Child Health Division of the Ministry of Health. These TBAs have helped so much in the area of maternal and child health. Argueably, the services of practitioners of TMH can also be included.

Accordingly, these are some major factors which have motivated me to undertake this study. A better understanding of the; theories, philosophies and knowledge and practices of traditional healers and traditional medicine when documented could help to improve that health system. Also when healers are recognized and their medical services included in the formal health system it would be credible since the TMS provides healthcare services to the larger Ghanaian populations.

1.6 Relevance of the study

The relevance of this study lies in three areas: in socio-cultural domain, in health policy and in the academia. Socio-culturally, this study, as shown in the rationale section, will help to document, explain and preserve the Dagomba indigenous knowledge of TMH. This study will help to provide an account of the Dagomba theories and practices relating to health and illness. Their perceptions and understanding of reality and the meaning they give to that in the area of health and illness representation. This has the potential of preserving parts of the Dagomba culture and specific traditional knowledge and practices. From the indigenous studies perspective (as advocated by Smith 2012; Kovach 2009; Blair 2015), the purpose of research should be to help indigenous and minority peoples to reclaim their histories, restore their identities and values and give space to their voices and realities. This, thus has the role of giving space to the Dagomba voices, our perceptions of realities and ways of knowing as well as preserving our knowledge systems in relation to health.

Secondly, findings in this study could also have the potential of influencing policy in the area of health. As shown in the research questions, one of the aims of this study is to examine how and whether the services of the TMS and traditional healers can be included in the formal health system based on the voices of the healers, consumers of health services and members of the Western healthcare system. Since one of the underlying objectives is to provide information about Dagomba traditional medical practices and their understanding of health and illnesses. Based on the views of the actors identified, recommendations could be made to inform both policy and further research on how best or whether to include traditional healers and their healthcare services in the formal healthcare system.

Lastly, in the field of academia, this study can contribute to knowledge, from a localized context, both in theory building and serving also as literature. The Dagomba theories of health and illness, their perception of illness causation and treatment options and how the different medical systems operate in Dagbon when studied could add to knowledge both in indigenous studies and in medical anthropology. Thus, the cultural specific understanding of health and illness, healing and treatment practices and the theories and epistemic traditions which inform them, when documented, will contribute to the larger academic discourse on how society, health and culture are interconnected.

1.7 Insider/Outsider perspectives

Positioning oneself in research or the relationship researchers have or create with the community and the knowledge bearers can have some influences on the data gathering process as well as the kind of data that is obtained. Positioning does not only tell who the researcher is but it also shows how s/he negotiates identities, processes and events in the research encounter. Based on this, I position myself below.

I am a native Dagomba. I was born at Gbungbaliga, a traditional community 5km South of Yendi in Northern Ghana. I was born into a traditional family and in a community where TMH has been a common age-old but dynamic practice. Perhaps, as a growing child, I had used herbal medicine and gone through some traditional healing practices since my family had some connections with TMH as pointed out earlier.

Therefore, as a native Dagomba, I place myself both as an insider and outsider in this study. I share the same ethnic, cultural and linguistic background with the participants I interacted with. My family and community have histories of TMH practices and I have lived in Dagbon all my life. This can position me as an insider. However, with regard to the communities I visited, I was an outsider. I am a male, a Muslim and graduate student from the University of Tromso. I visited families, communities and interacted with individuals some of whom I have never interacted with before. This also positioned me as an outsider. However, the medical anthropologist, Bodil Blix (2015:179) observes that "issues regarding the interviewer's [researcher's] identies as an insider and an outsider are not easily settled. [They] are continuously negotiated, unfinalized, and open-ended". Hence, my dual positioning meant that I had to continously negotiate the multiple identies I assumed. This also meant that I had a huge responsibility towards myself, the data, the participants, their communities and all relationships that I encountered.

1.8 Definition of key terms

For the purpose of clarity, conciseness and better understanding of discussion in this study, it is very important that certain key terms are defined and operationalized. The concepts of *tradition*, *traditional knowledge* and *traditional medicine* have already been defined in the background section. However, I will make some comments on the concept of traditional medicine (TM) as defined by WHO (2000:1) in the background section.

This definition though recognizes the fact that the practice of TM is cultural specific and based on the people theories, beliefs and experiences, it is important to note that the TMS and its healing or treatment practices go beyond the physical and mental aspects of human existence to include the spiritual and social dimensions of illnesses. Hence, in this study, the definition of traditional medicine shall be based on the expanded definition provided by WHO with my inclusion of spiritual and social aspects of illnesses.

Related to the practices of TM is the use of *herbs*. The WHO (2000:3) defines herbs as:

> Crude plant material such as leaves, flowers, fruits, seeds, stems, wood, bark, roots, rhizomes, or other plant parts, which may be entire, fragmented or powdered. [And that] herbal material include, in addition to herbs, fresh juice, gums, fixed oil, essential oil, resins and dry powders of herbs.

Even though this definition is relevant, it is very narrow in the sense that it restricted herbs and herbal materials to only plant products. Nevertheless, many TMH practices involved the use of both organic (plant and animal) and inorganic materials as herbs for preparing medicines. In this study, *herbs* shall be seen as any product, be it plant, animal or mineral resource, used as medicine in the TMS for the treatment, management and healing of illnesses. *Traditional Healing* as a practice in TM shall be seen as any process or activity performed under the TMS to cure, treat, manage, improve or prevent illness and to restore a state of balance (good health) within the patient. Accordingly, TMH is dynamic, experiential, relational and holistic in its approach to health and illness.

Practitioners of the TMS in this study shall be designated as *traditional healers* (TRH) or *traditional medical practitioners* (TMP). Accordingly, a TMP[1] is a person:

> who is recognized by the community in which he lives as competent to provide healthcare by using vegetables [plants], animal and mineral substances, and certain other methods based on the social, cultural and religious background as well as on the knowledge, attitude and beliefs that are prevalent in the community regarding physical, mental and social well-being, and the causation of disease and inability (Evans-Anfom 1986 in Barimah 2013:203).

Since this study also relates to the Ghanaian formal health system which practices are based largely, but not exclusively, on Western science and with their medicine variously called biomedicine, orthodox or western medicine, a few concepts needs to be clarified here as well. In this study, practitioners within the Ghanaian formal health system shall be referred to as *practitioners of western medicine* (PWM) and reference to their medical products shall be termed *western medicine* while the medical system shall be known as the *western medical system (*WMS*).* However, the term *medicine* when used alone without reference to *traditional* or *western*, shall serve as a generic term to refer to all kind of medicines, both traditional and western. This is relevant in the sense that, a translation of the Dagomba native term *tim* means medicine whether it relates to western medicine or traditional medicine. And since interview transcripts will be part of the text, this general term becomes very useful.

[1] It is however, important to note that these persons may be referred to by different names and terms in the cultural communities in which they exist. Hence, within the body of this study, I shall from time to time, use the Dagomba native terms for specific categories of traditional healers that operate within Dagbon (the geographical traditional region for Dagomba in Ghana).

Lastly, the term *illness,* defined as the "social subjective feeling and perception of *dis-ease"* (Bowling 2009:21) which is different from the medical concept of disease shall be used to stand for both sickness and disease. This term is broader in scope since it relates not only to the notion of pain, pathological disorder or recognized malfunctioning of body parts but also the social and cultural conceptions of disease.

1.9 Delimitation of the study

This study of TMH is limited to the Dagomba of Ghana. It is further limited to Dagomba within the Yendi Municipal Assembly though certain traditional practices and cultural philosophies may be general to all Dagomba. Largely, the study is concerned with medical systems, with particular attention however, given to the traditional medical and western medical systems. Analysis of findings shall also be based on individual participants' experiences, practices and theories within the medical systems. However, emergent general patterns shall also be noted. Finally, this study is not about a documentation of medicinal plants and their efficacy as used in the TMS but rather it is about traditional medical practices. Nevertheless, if there is any need to mention some herbal plants that are used in the treatment of some illnesses, I shall do that.

1.10 Structure of the thesis

This study consists of seven chapters. Chapter 1 serves as the introduction to the entire thesis. It discusses the background to the study and the problem statement. The aims and objectives of the study, the research questions, the rationale, relevance of the study and my position are all highlighted in Chapter 1. Chapter 2 covers the historical background of the study. In that chapter, the country background, the historical background of Dagomba and that of the development of herbal medicine in Ghana are discussed. Other specific issues in the chapter include the influence of Islam and Christianity in Dagbon and the indigeneity status of Dagomba. This last point helps to argue why the study is being placed under the master of Indigenous Studies program. Chapter 3 then discusses the methodology used and the processes of gathering primary data for the study. In that chapter, issues of research ethics, reflexivity and the data gathering tools and processes are presented. How the data was managed or analyzed to identify the major themes, concepts and

topics, which form the main arguments of the study in Chapters 4, 5 and 6, are also discussed in this chapter. Chapter 4 will cover the theoretical foundation of the study and a review of related literature. In this chapter, the Dagomba theories of health and illness and the theory of medical pluralism in Dagbon, which are both derived from the data, are thoroughly examined and discussed in relation to the literature. Chapters 5 and 6 will cover the analysis and discussions of the main findings of the study. In these chapters, the themes, concepts and topic derived from the data are analyzed and discussed. Major issues relating to how TMH is practiced among Dagomba, why people choose TMH and other attitudes expressed towards that medical system by both consumers and PWMs, as well as how TMS can be included in the Ghanaian formal health system are analyzed and discussed in these chapters. The final chapter, Chapter 7, then presents the summary of findings and conclusions reached as answers to the research questions in Chapter 1. Then recommendations for further research and policy options are made. Limitations of the study are also highlighted in this chapter. In addition to these main chapter divisions, there are appendixes made up of the list of research participants, list of common illnesses, sample interview guides and questionnaires and other documents.

CHAPTER 2

HISTORICAL BACKGROUND

The practice of TMH among Dagomba and with many other cultural groups in Ghana has been in existence before our contact with Europeans and the establishment of Western medicine and other forms of healing. Issues relating to the development of herbal medicine and traditional healing will be the focus of this Chapter. The chapter will also present some background information about Ghana and the Dagomba. In particular, how both Islam and Christianity entered the Dagbon society, the indigeneity status of Dagomba, as well as the institutionalization processes of herbal and traditional medicine in Ghana are discussed. Some basic health statistics about Ghana will also be highlighted.

2.1 Country background

Ghana[2] is located in West Africa and has a total land area of 238,533km^2. It is bordered to the North by Burkina Faso, East by Togo, West by La Cote d'Ivoire and to the South by the Gulf of Guinea. The country has a tropical climate and vegetation with decreasing intensities of both vegetation cover and rainfall amounts towards the inland Northern territories. Most parts of Southern Ghana experience double maxima rainfall regimes with Axim area recording the highest annually (over 2000mm). The Northern parts of the country, however, experience single maxima rainfall with areas around the Upper regions receiving less than 1000mm annually. The entire country is drained by the Volta River and its tributaries and other minor rivers. According

[2] Historically, Ghana was called the Gold Coast because Gold was found in abundance which the Portuguese and other Europeans traded in around the 15thcentury. Cape Coast was the capital city of Ghana by then. Later in the early 19th century, the British took over from all the other European groups and established control over Ghana as a colony. After World War II, nationalism intensified and in 1957, Ghana gained independence from the British under the leadership of Dr Kwame Nkrumah as the first country south of the Sahara in Africa to gain independence. After independence, the name Ghana (a name of once powerful ancient empire that was occupied by the Malinke and Mande people under the leadership of Sundiata in the 13th century) was adopted to reflect the country's power and abundance of gold.

to the 2010 Population and Housing Census, Ghana has a population of 24,658,823 with an annual growth rate of 2.5 percent (Ghana Statistical Services [GSS] 2013a:50).

Currently, Ghana is a multi-party democratic state with 10 administrative regions with Accra being the capital city. Ghana is predominantly an agricultural country producing major food crops such as maize, yam, cassava and plantain. Major cash and export commodities include; cocoa, gold, crude oil, timber, palm oil and hydro-electric power. Agriculture provides employment to over 60 percent of the population who are largely based in the rural areas.

Socio-culturally, the country has very complex and varied cultural practices, based on the large number of ethnic groups it has. There are over 60 linguistic groups in Ghana with the major ones being the Akan, Mole-Dagbani, Ga-Adangbe, Ewe, and Guan language groups. There are 9 regional dominant languages; Ashanti Twi, Fante, Ga, Ewe, Dagbani, Nzema, Gonja, Dagare and Mampruli, belonging to the 5 major regional dominant languages. However, English language is our official language. Officially, Ghana is dominated by three major religious groups. These are Christianity (71.2 percent), Islam (17.6 percent) and Traditional Religions (5.2 percent) (GSS 2013a:63). The country is also endowed with numerous tourists and mythical cites, prominent among them being, the castles and forts along the coast (Cape Coast Castle, Elmina Castle, Osu Castle), national parks, mass graves, ancient mosques and waterfalls.

In addition, Ghana has a plural medical system based on the Western modern health system and TMH. Largely, over 70 percent of the population depends on TMH for their healthcare needs (WHO 2012 in Nimoh 2014:91). Although some efforts have been made to improve the use of herbal medicine in Ghana, that, and traditional healing in general have not seen much improvement, despite the number of people who access their health needs through it. Figure 2.1 below shows the map of Ghana with its international boundaries and administrative regions while that of figure 2.2 shows the map of the Northern region and its districts.

Available health and demographic statistics shows that Ghana has a fertility rate of 4.0, life expectancy around 60 years for both sexes, maternal mortality rate of 144, doctor population ratio of 1: 9043 and that of nurse population ratio of 1: less than 1000 (GSS, Ghana Health Service [GHS], and ICF International 2015; MOH 2015; GHS 2010). In Ghana, the top 7 causes of morbidity, hospital admissions and death in all ages include malaria, anaemia, hypertension,

injuries, diarrheal diseases, pregnancy and related complications and upper respiratory tract infections. Generally, the price of western medicine in Ghana is very high, with treatment for upper respiratory tract infections noted to be simply unaffordable (MOH 2009; GHS 2010).

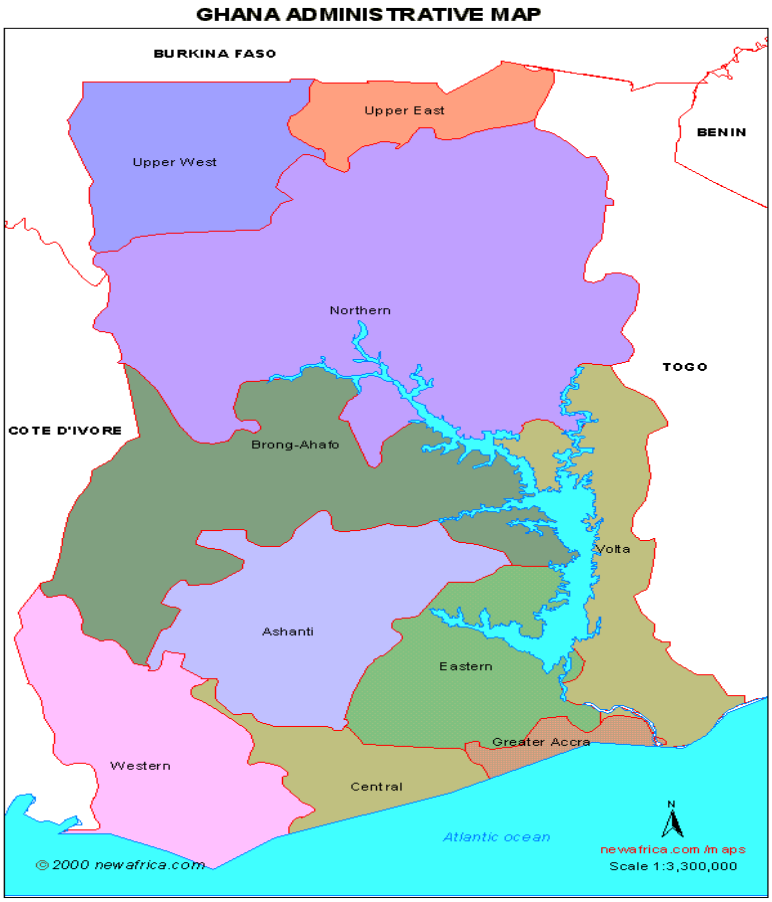

Figure 2.1: Map of Ghana showing its international boundaries and administrative regions

Source: Adopted from newafrica.com maps

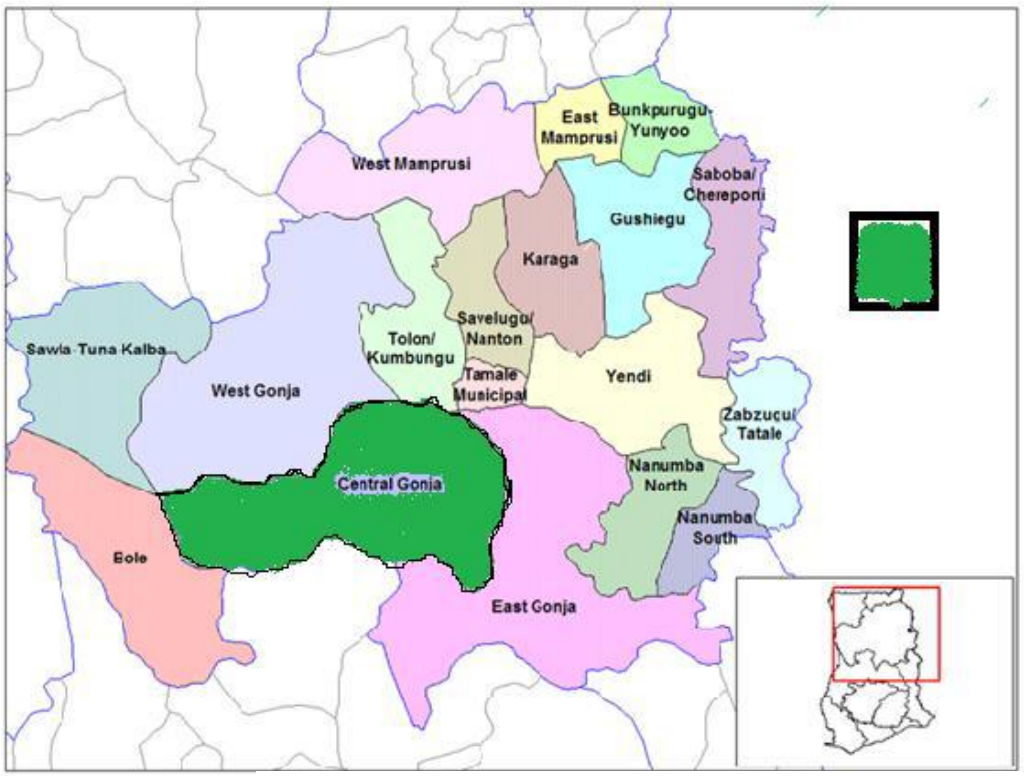

Figure 2.2: Map of Northern region and its districts

Source: Adopted from the 2010 Population and Housing Census Report: Northern Regional Analysis Report (2013:1)

2.2 The Dagomba of Ghana

The Dagomba (or Dagbamba as the natives call themselves) are an ethnic group found in Ghana. They are predominantly found in the Northern region of Ghana, where their traditional area called Dagbon is located. The region is the largest in Ghana covering about one-third (29.5 percent) of the total land area and it is ranked as number 4 in terms of population (GSS 2013a:50-53). Dagbon, which is the traditional territory for the Dagomba, comprises the Karaga, Gushegu, Tolon/Kumbungu, Savelugu/Nanton, Tamale, Yendi and Zabzugu/Tatale districts as shown in figure 2.2 above and delineated into Western Dagbon and Eastern Dagbon[3].The

[3] The partition of Dagbon into Eastern and Western has its history under colonialism. In 1899, the Germans and the British divided Dagbon up with Eastern Dagbon becoming part of German-Togo under the Germans and Western Dagbon being part of the Northern Protectorate under the British (Iliasu 1975:132-133; Staniland 1975 in Pul 2003:55).

vegetation and climatic conditions are that of the Guinea Savanna type, which is generally grassland and scattered woodland vegetation. Dagomba belong to the Mole-Dagbani[4] linguistic group and share a common ancestry with the Mamprusi, Nanumba and Mossi (who are presently living in Burkina Faso). Dagomba constitute the largest member of this linguistic group as well as the largest ethnic group in the Northern region, with a population of about 2million people according to the Northern Regional Report (GSS 2013b:4). The language of the Dagomba is Dagbani (or Dagbanli as the natives call it).The paramount King of the Dagomba is the *Ya-Na* (translated as 'King of Absolute Power') and the traditional capital is Yendi located in Eastern Dagbon.

Socio-culturally, Dagomba practice patrilineal system of inheritance. They have a centralized system of governance like some other ethnic groups in Ghana. Until recently, oral traditional, woven around drum and other musical instruments, has been their major source of history and transmission of knowledge and culture. Agriculture is the main occupation for the majority of the Dagomba though, other forms of occupations are practiced. They cultivate food crops such as yam, maize, millet, cassava and rice on subsistence basis. Economic trees in Dagbon include the shea tree, baobab, dawadawa, neem and mango. Animals reared are; cattle, goat sheep and other domestic fowls. Horses are kept and used for cultural purposes especially among chiefs. Islam, Christianity and Traditional religions have been the major forms of religion practiced by the Dagomba but with the majority being Muslims (about 60 percent) (GSS 2013b). Accordingly, the culture of Dagomba has been heavily influenced by Islam. Major festivals celebrated by Dagomba include Damba, Bugum and the two Eid festivals of the Islamic religion. Some of the traditional dance forms that Dagomba perform include the; Baamaaya, Jara, Tora, Simpa and Bawuna.

[4] The Mole-Dagbani linguistic group to which the Dagomba belong, like some other ethnic groups in Ghana (Ewe and Gonja for instance), are said to have migrated from somewhere to Ghana under the leadership of *Tohizie* (translated as the 'red hunter'). They entered Ghana and first settled at Pusiga, a town now in the Upper East region of Ghana. After the death of *Tohizie*, his elder son, Gbewaa established the Mole-Dagbon kingdom. The membership of the larger Mole-Dagbon Kingdom which includes the Dagomba, Mamprusi and Nanumba ethnic groups now exist as separate kingdoms in Ghana (Abdul-Hamid 2010).

2.2.1 Islam in Dagbon

The influence of Islam both in Ghana and on Dagbon predates the European explorations and contacts with the country. Wilks (1963: 412, 1965)[5] believes that it was the Wangara and Hausa traders who brought Islam into Ghana and Dagbon. He argues that the Wangara and Huasa traders had established contacts with the centralized States of Gonja in 1585, Dagomba and Ashantis in the 18th century.

Na Zanjina (the 16th ruler of Dagbon) is said to be the first Muslim King of Dagbon (Wilks 1963, 1965:89; Abdul-Hamid, 2010) and that it was the Hausa Islamic scholar Malam Mahama (Sabali Yarna) who brought Islamic civilization to Dagbon and was also the one to convert Na Zanjina to Islam. The early known Muslim settlements in Dagbon were, Sabali and Kamshegu (Wilks 1965). After Na Zanjina conversion into Islam, Islamic scribes and scholars were made part of the King's court. Abdul-Hamid (2010) contends that Dagomba easily accepted Islam because they revered their kings, and also perhaps because of their belief in the powers of the God of the Muslims. Also, some of their cultural practices were already in line with Islamic practices (for example polygamy). Islamic influences in the culture of Dagomba can thus be found in some areas of their festivals (Kpini, Chimsi, Konyuri Chugu) and in other customary practices such as in marriage, funeral rites, inheritance and many aspects of Dagbon social life.

Wilks (1965:91) observed that a majority of the Dagomba both in towns and the countryside now profess the Muslim faith. Also many Islamic based traditional healers known as *mallams* are common in Dagbon and other parts of Ghana. Bierlich (2000) also noted that part of the Dagomba TMH is largely influenced by Islam. With their knowledge of the Quran, these healers treat both natural and spiritual illnesses, either by using verses of the Quran or in combination

[5] As Wilks argued, the movement of Wangara groups into Ghana, into what is virtually the Volta Basin, appears to have begun, or at least to have gathered momentum, in the late 14th century. It was but one aspect of the greater Malinke dispersion which probably commenced during the reign of Mansa Sulayman of Mali in the mid- fourteenth century. The Hausa people, on the other hand, began to have contacts with Ghana in the late 15th century with the development of the kola nut trade. Both the Wangara and the Hausa merchants wanted to participate fully in the gold and kola nut trades respectively through the trans-Saharan caravan trade routes. The Wangara traders, as observed by Wilks had penetrated Ghana even up to the coast in the Elmina-Shaman region and elsewhere and were well established along the coast before the Portuguese traders first arrived in 1471. However, the Wangara contacts were later concentrated around Wa (now the Upper West regional capital) and other parts of the present North-western regions of Ghana. The Hausa traders on the other hand, had most of their influence on Ghana around the 18th century (1963: 410-414).

with herbs. Accordingly, it is worth stating that the historical contacts of the Wangara and Hausa traders, and their introduction of Islam into Ghana concentrating largely within the Northern parts of the country, could possibly be responsible for the larger concentration of Muslims in the Northern region.

2.2.2 Christianity in Dagbon

The advent of Christianity in Ghana and in Dagbon can be attributed to our contact with Western Europeans. The Portuguese explorers and missionaries were the first to make contact with the coast of Ghana, then the Dutch, Danes and finally the British joined in. They came as traders and as missionaries, propagating the Gospel of Christ. Through the missionary activities, schools were built and clinics with Western medicine and forms of healing introduced. These first concentrated within Southern Ghana and then later spread to the Northern regions as well. This has been noted by Tabi, Powell and Hodnicki (2006:54) when they assert that, "Christian missionaries and missionary societies were the first to bring modern medicine to Ghana in the 19^{th} century".

Presently, there are many different Christian denominational churches in Dagbon but with many of them concentrated in the regional and district capitals. However, the early known churches in Dagbon were the Assemblies of God church and the Presbyterian Church. The Presbyterian mission (The Basil mission) was established in 1913 under Rev. Hans Huppernbauer while the Assemblies of God church was established in 1931, by Rev. Lloyd and Margaret Shirer, Missionaries from Assemblies of God USA (website reports). Between 1913 and 1916, the Bible was translated into Dagbani and a mission school was built in Yendi (Northern Presbyterian Mission website report). The Assemblies of God Mission also built clinics and Bible schools; translated the Bible into Dagbani and worked to reduce poverty, illiteracy, hunger and diseases.

At the present, other churches in Dagbon, that have a lot of influence include; the Adventist church, the Evangelical Presbyterian church and the Church of Christ. The Adventist church has a regional hospital in Tamale and the Church of Christ has a well-functioning clinic in Yendi. These early Christian missions despised Dagomba traditional practices, especially those relating to traditional healing and other forms of worship. This resulted in most Dagomba refusing to be

converted into the religion until much later periods. Hampshire and Owusu (2013:251) also observe that the growing Pentecostal and Charismatic churches in Ghana despise traditional medicine; seeing it as diabolic. Perhaps, this could be due to the fact that they also do faith healing.

2.3 Traditional medicine and healing among Dagomba

The use of TMH among Dagomba existed many years before our contact with Islam and later with Western medicine. This phenomenon is true for many other ethnic groups in Ghana such as the Akans, Ashantis and Ewes (Abel and Busia 2005; Tsey 1997). Traditional medicine was the sole medical system, through which traditional healers treated various illnesses among all age groups, using herbs and other spiritual means based on their African traditional beliefs. Since the introduction of Western medicine into the country, the Dagomba now combine TMH with modern Western medicine in the treatment of their illnesses.

Among Dagomba, knowledge of TMH is transmitted through oral means and direct observation of the healing processes, by the learner. For many healers, their knowledge of healing is acquired through the family, where practicing parents or grandparents teach the apprentice the names of herbs and the diseases they are used to treat, as well as the practices involved and customs/norms to observe, in the treatment process. Others get the powers for healing through spiritual calling or possession and visions in their dreams. The acquisition of the knowledge of healing through this means is often, but not exclusively, associated with a traditional shrine where supernatural beings instruct the learner through a traditional priest. Names of illnesses, their modes of healing and herbs involved, are recounted to the apprentice by the deities through the priest. Another means through which healing knowledge is acquired among Dagomba is through afflictions, that a man or his family has gone through and in order to find cures for these afflictions, a person learns so much about herbs and their uses that with time he begins to treat others. Again, through Islam, and based on ones knowledge of the Quran, others learn to treat people by using verses in the Quran or with herbs to cure illnesses (sometimes with spiritual foundations). Some healers in Dagbon generally known as *mallams* acquire their healing knowledge and powers through this

means. They treat people with spiritual illnesses by using their Quranic knowledge. This type of healers, Addy (n.d :3) argues are many in the Northern region.

Even though different healers acquired their knowledge of TMH through different means, the most common category of healers in Dagbon include; bonesetters, herbalists, spiritual healers and *pag'doʔsa tohindiba* (TBAs). However, many scholars in Ghana and elsewhere (Addy [n.d]; Abel and Busia 2005; Tsey 1997; Barimah and Akotia 2015)[6] have grouped these categories of traditional healers into herbal based non-spiritual healers and spiritual healers. Nonetheless, it is very difficult in practice to put traditional healers into strict sets of spiritual healers and non-spiritual healers, since even healers who treat diseases largely by the use of herbs, do admit the spiritual dimension of illnesses, and may even give patients some restrictions to observe during treatment, which have spiritual connotations.

Dagomba traditional healers base their knowledge of medicine and healing on their beliefs in the African traditional religions and also with the influence of Islam. Diagnoses and treatments are based on their philosophies and theories about; human nature, the natural environment, the spiritual world and illness causation in general. Most of these concepts will be examined more in Chapters 4, 5 and 6 of this study. As Dagomba are aware of these distinctive but interconnected parts of reality, their approach to treatment takes into account the holistic nature of these complex systems of human-nature-spirit connections.

This perspective is shown linguistically by the existence of only one word *doro* in the language to stand for 'sickness, illness and disease'. Also, expressions such as *Doro n-gbaai ma* (translated as 'illness has come to or caught me') or *N doro n-yiʔisi* (translated as 'my illness has stood up') are used to signify that illness from the outside has attacked me or an internal illness has been triggered, hence making distinction between the external and internal dimensions of the human-illness-environment relationship.

[6] Even though Tsey (1997:1068) falls into the group of scholars who make this strict categorization, he acknowledges that, actually, there is no a clear cut separation between spiritual healers and non-spiritual healers. An opinion expressed also by Hampshire and Owusu (2013).

2.4 The indigeneity status of the Dagomba

The concepts of indigenous and indigenous peoples are complex and have acquired different conceptualizations across time and space and in different discourse domains (legal, political and socio-cultural). They become even more complicated when applied in the context of Africa. From the adjectival usage, Saugestad (2001:302) contends that the term indigenous means 'native, local and non-European' which she asserts is non problematic especially when used in areas such as agriculture, knowledge systems, plants and by extension indigenous medicine and healing. However, the terms indigenous and indigenous peoples when used in the political sense and in relation to the rights of groups of peoples, it could be, and it is often, problematic. Prior to the criteria now used within the United Nations (UN) system. The concept of indigenous peoples, as was first conceived in the Americas and during the first political meeting leading to the development of the global indigenous movement in 1974, was defined as "people with prior occupation of a place and lack control over the national government" (Sissons 2005:521). Sissons (2005) noted that no mention was made to 'minority status, tribal identity or closeness to nature'. This historical development indicates that the whole idea of indigenousness and indigenous peoples were largely confined to the settler states of America or in Scandinavia, since the Sami also had a representation in the first meeting and subsequent developments leading to the formation of the global indigenous movements.

From the UN/ILO C169 and Cobo (1989) perspectives, the term indigenous peoples refer to a group of people who are defined by the following criteria (Saugestad 2001:305):

- Were the first to occupy their territory (priority in time at a place).
- Wish to have the voluntary perpetuity of their cultural distinctiveness.
- Have experiences of subjugation, marginalization and dispossession.
- Have self identified themselves and by the state and other groups as distinctive.

Given the above criteria, many people can claim indigeneity status depending on their location on the surface of the earth and in relation to other groups of people. For example when put in the context of Africa and in relation to European colonization, all black Africans are considered indigenous due to their prior occupation of their territories before colonial contacts. However, when the gauge is tilted towards the political economic landscape and the moral responsibility of

nation states towards humanity or towards people's closeness to nature, which Sissons (2005) termed 'eco-indigeneity', only the hunter-gatherer and pastoral peoples in Africa are seen to be indigenous peoples. This makes it more difficult to clearly say who is or who is not an indigenous group in Africa though the criterion of self identification stands prominent.

Now to examine the status of Dagomba as being an indigenous group or non-indigenous, the following will be my argument. From the point of view of colonialism, all Africans including Dagomba are considered indigenous peoples of Africa. They were in occupation of their territories (prior occupation in time) before Western European colonizers came to Africa, colonizing and subjecting many groups to subjugation, marginalizing their culture and lifestyles and dispossessing them of their lands. Dagomba have their distinctive cultures which they wished to transmit to their future generations. Hence, Dagomba with their ties to their land (Dagbon) and based on colonization, are an indigenous peoples in Africa.

On the other hand, based on the internal ethnic history of Ghana, many of the major ethnic groups such as Dagomba, Ewe, Gonjas, Mamprusi, Nanumba, among others, are said to have migrated somewhere into Ghana long ago before colonialism. Thus, in terms of prior territorial occupation in time relative to other ethnic groups in Ghana, Dagomba and many other major ethnic groups will be considered migrants before the formation of the present nation state of Ghana. This particular factor is believed by Pul (2003) to be one of the major causes of ethnic wars over land rights and ownership in Ghana, especially between the Konkomba on the one hand, and the Gonja, Nanumba, Dagomba, and Biboba, on the other, since the 1980's up to 1994/5. Again in terms of self identification, Dagomba have not self-identified to be indigenous peoples based on the political sense of the term 'indigenous peoples' nor has the state of Ghana identified or recognized them as indigenous peoples like, the Masai, San, Endorois and other indigenous groups in Eastern and Southern Africa who have been recognized by their nation states. However, any online Google or Wikipedia search for the expression 'indigenous people in Ghana' or 'indigenous ethnic groups in Ghana' will produce hits that include Dagomba as an indigenous group in Ghana.

Therefore, to avoid complexities and confusions in relation to the indigeneity status of the Dagomba, I prefer to treat them in this study as an ethnic group in Ghana or better put, as an indigenous (a native) ethnic group in Ghana. I will also state that I have placed my study in the

context of Indigenous Studies, in the sense that TMH has been a traditional practice among Dagomba, even before their contacts with Islam and Western Europeans, hence, making their knowledge in TMH an indigenous and dynamic one. Their theories and philosophies on illness causation, knowledge of herbal medicine and healing approaches as well as the transmission of these knowledges and practices through generations, arguably, constitute their indigenous knowledges.

2.5 The development of herbal medicine in Ghana

Senah (2001) observes that the introduction of the 1878 Native Custom Regulation Ordinance in Ghana by the colonial administration outlawed traditional healing and all other indigenous practices, compelling Ghanaians to depend on only the colonial medical officers for their health needs. She noted further that the early Ghanaian Christian converts were often threatened with ex-communication whenever they consulted traditional healers (in Barimah and Akotia 2015:101). Despite these colonial threats, traditional medical practices continued even till now, and different governments have seen the need to promote it, so that people can enjoy more of the benefits that the health system is contributing to the healthcare needs of Ghanaians. In line with this, several developments have occurred in Ghana, after independence, towards the development of both herbal medicine and traditional healing, which I will highlight briefly in the following headings.

2.5.1 Traditional medical practitioners in Ghana

Prior to the early 1960's, the various individual traditional healers, practicing within their respective fields of specialization in their societies or communities, worked as individuals even though practitioners who were closer to each other and knew each other very well, could exchange ideas and herbs. However, in the late 1960s, the Ghana Psychic and Traditional Healers' Association (GPTHA)[7] was formed by the Nkrumah's government to help promote and

[7] It has been noted, however, that this association at the time did not include traditional spiritual healers (priest and priestess) until in 1973 (Warren et al. 1982). Also, the overall responsibilities of the Association as noted by Warren et al (1982) were to help promote and encourage the study of TH, to support and protect the interest of healers, to

respect the organization and common purpose of herbalists (Nimoh 2014; Addy [n.d]; Warren et al. 1982). This association, however, did not last for long. But in order to strengthen the work of traditional healers and to promote TMH in the country, efforts were made by the Ministry of Health (MOH) which led to the formation of the Ghana Federation of Traditional Medicine Practitioners' Associations (GHAFTRAM) in the late 1990's. This was to function as the mother association to all regional and local associations (Nimoh 2014; Asante and Avornyo 2013). This Association currently is in charge of promoting the interest of all traditional healers in Ghana, collaborating with other research centers and institutions that work on herbal medicine and also serving as a link between healers and the government of Ghana. However, how this association operates or its effectiveness as a traditional healers' association falls outside the focus of this study. Added to this was the Ministry's move in the late 1990's to train[8] and absorb the TBAs into the Maternal and Child Healthcare unit of the Ghana Health Service to continue their work in assisting women to deliver at the rural areas and to recommend the transfer of women in critical labor conditions to main health centers. Finally, Ghana instituted an annual event for the celebration of TM (called the Traditional Medicine Week) which started in 2000 and has now been made to coincide with the African Traditional Medicine Day the first of which was celebrated in 2003 (Addy [n.d]:6).

The worrying aspect is, despite, that theTMS provides health needs to a large proportion of the population, with herbal medicine undergoing progressive development, TMPs, with their medicine and healing knowledge, have not been formally recognized and included in the health system in Ghana.

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provide a platform for research into TM and to establish clinics throughout the regions for the treatment of illnesses that orthodox medicine at the time had no cures for and also to treat other common illnesses alongside orthodox practitioners.

[8] It has also been noted that there was some training done on a pilot basis under the Primary Health Training for Indigenous Healers Program (PRHETIH) in Ghana at Techiman District in the Brong Ahafo region. The purpose of the training was to facilitate the cooperation and understanding between traditional healers and western healthcare practitioners (Warren et al. 1982).

2.5.2 The Center for Scientific Research into Plant Medicine (CSRPM)

The Center for Scientific Research into Plant Medicine, which was established in 1975 came as a result of individuals' collective efforts along with the government of Ghana's willingness to develop a broad based herbal medicine in the country. The often mentioned individual behind the establishment of CSRPM is Dr. Oku Ampofo[9], who was a renowned allopathic medical practitioner and had some experiences of herbal medicine from his father and other TMPs in the community. The CSRPM was established at Mampong-Akwapim in the Eastern region of Ghana in 1975 by an NRC Degree 344.

The Center performs many functions, among which include to conduct and promote scientific research into plant medicine; to promote a high quality standard of drugs extracted from plants. It is also to establish and manage botanical gardens for medicinal plants, where necessary to cooperate with the national traditional healers associations and research institutions such as the Noguchi Memorial Institute for Medical Research (NMIMR). Finally, it is to undertake the publication and dissemination of research findings and other useful technical information about herbal medicine as well as cooperate with other commercial organizations globally that deals with plant medicine.

This Center also has a clinic that operates an Out Patient Department (OPD) where, herbal medicines are developed and produced by the Center, are prescribed to patients. It also has a clinical laboratory and dispensary, which are managed by medical personnel. In addition, the Center also has a herbarium with over 80 percent of specimens of Ghanaian medicinal plants and an electronic database of information on both Ghanaian and non-Ghanaian medicinal plants. It has an Arboretum of a 750 acre arboreta located at different vegetation zones within the Eastern region of Ghana with both in-situ and ex-situ conservation programs going on to protect useful medicinal plants.

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[9] However, Addy ([n.d]:8) noted that at the time Dr. Oku was busy organizing and testing the therapeutic values of a collection of some herbal plants, the then Ghana Academy of Science also supported the establishment of an Alkaloid Unit within the Department of Pharmacy in the then Kumasi College of Technology under the leadership of Professor A. N. Tackie where a large number of plants were also collected and screened for their therapeutic properties. Professor F.G.O Torto and J.K Quartey both of the University of Ghana's Chemistry Department then collaborated with Dr. Oku with their research findings and in 1971 sent a memorandum to the Government of Ghana recommending the establishment of a herbal center to facilitate the coordination of research works into plant medicine which then led to the establishment of the Center.

Apart from the CSRPM and its role towards herbal medicine in Ghana, Asante and Avornyo (2013:261-263) found that there are other educational institutions and research institutes that are also making greater efforts towards the development of herbal medicine in Ghana[10]. They noted that the College of Pharmacy at the Kwame Nkrumah University of Science and Technology has, since 2001/2002 academic year, instituted a four year Bachelor of Science degree program in Herbal Medicine, to train students has produced graduates, who are now working at various private clinics and at the Herbal Medicine Department of the University. They also observed that the University of Ghana's Faculty of Science, especially the Department of Botany, in collaboration with the Center for Scientific and Industrial Research (CSIR), undertook a project known as 'Herbs of Ghana' to study and document the taxonomic inventory of herbaceous species of plants in Ghana.

2.6 The Traditional Medicine Practice Act (Act 575) of 2000

Despite the fact that TMPs and TMH have not formally been made part of the Ghanaian healthcare system, there are a number of regulations and regulatory bodies that control the activities of TMPs and their healing and medical practices. One such regulation in Ghana was the introduction of the Traditional Medicine Practice Act (TMPA), Act 575 in 2000. This Act mandated the establishment of a traditional medicine council, known in the Act as the Council, to be responsible for the regulation of the practice of TM, the registration of TMPs, licensing of their practices, regulating the preparation and sales of traditional herbs and medicine and to act in all other matters relating to TMH in the country.

The Council is composed of 12 members, 5 of whom are nominated from traditional healers associations, 2 from the ministry of health, 2 from universities, 1 from food and drugs board and 1 from the CSRPM. The Council is also mandated to establish offices in the regional capitals, and if necessary in other districts, to help in the performance of its functions. Registration of

[10] However, it is important to note that the activities of these Research Centers and educational institutions are mainly to identify the scientific efficacy of the herbal medicinal plants they work with but not largely the knowledge traditional healers have about these plants or how TMPs herbal knowledge are being used in the treatment of various illnesses as part of the healing practices.

practitioners, issuing of licenses and certificates to practitioners, setting standards for traditional medical practices and enforcing the code of ethics for traditional medicine practice, promoting and supporting training in TM and collaborating with other institutions and research centers are some of the major functions of the Council. Nonetheless, I wish to point out that despite the fact that this Act was passed in 2000, the secretariate of the Council was only set up in 2004 and the Council itself was constituted and inaugurated in April 9, 2010. This indicates the slow attitude and inertia of governments of Ghana towards making traditional healing an integral part of the formal health system.

Other regulatory bodies of TM and practitioners in Ghana include the Traditional and Alternative Medicine Directorate (TAMD) of the Ministry of Health which was established in 1991. The mission of this body was to make available to the people of Ghana, a well defined, recognized complementary system of health, based on excellence in traditional and alternative medical knowledge, and to coordinate and monitor all activities relating to traditional medicine. Also, Ghana Food and Drugs Board (now Food and Drugs Authority) established by a PNDC Law 305B is another regulatory body in Ghana to both manufactured foods and drugs including traditional medical products. This body is responsible for testing all medicines and food imported or manufactured in Ghana to ensure that they are safe for consumption by the public. It has the power to conduct periodic unannounced visits to markets and other pharmaceutical shops to randomly pick drugs and package food for inspection and testing.

Arguably, one challenge, with all these regulatory bodies and TMPs in one instance, has to do with how to manage the socio-cultural perceptions of these healers, in relation to illness causation and treatment or healing processes at the practical levels. For there to be any successful inclusion of TMPs and their healing knowledge to the formal health system of the country, there is the need to understand the philosophical and theoretical perspectives these healers have. This will help inform the kind of regulation and monitoring as well as training programs that should be instituted to target different healers and cultural groups at different locations in the country. Also, there is the need to conduct studies to thoroughly understand the attitudes and perceptions of both TMPs and the modern PWMs so as to help address certain perceptional challenges relating to these different health systems. An understanding of the philosophies and theories that each system works with will help to reduce some stereotypical attitudes between practitioners of

these health systems thereby creating the needed conducive atmosphere for successful collaboration.

Having given this background information about Ghana, the Dagomba and their basic traditional medical practices and that of herbal medicine development and regulation in the Country, the next chapter will present the methods used in gathering primary data as well as how the data was managed to obtain the findings discussed in later chapters.

CHAPTER 3

DATA GATHERING PROCESSES AND EXPERIENCES

Data is an essential component of any research process. It is what enables researchers to investigate their topic of research and to come out with findings thereafter. Data helps to explain the meanings people attach to events, their perception of reality and how they produce knowledge. It is gathered through rigorous processes by the use of different methods and tools. These methods and procedures are the means through which the central problem of the research is addressed. They are the tools used for gathering data and as such are an integral and important part of the methodology of research (Chilisa 2012:162). This chapter will present the ethics, reflexivity and the data gathering processes I went through as well as the methods that were used in the process. Ethics and reflexivity are discussed first, because they are the underlying principles, which influence and guide every research data collection process. How participants were drawn upon, the data gathering tools used and how the data was managed and the findings that were made, will then follow.

3.1 Ethics

The concept of ethics is always central in every research endeavor. Although ethics tries to examine what is good, right or virtuous conduct, during the research process (Punch 2014:36), it is difficult to define, and harder to work with, but which every social researcher must reflect upon and make decisions about (Seale 2012). Research ethics require that researchers do no only observe institutional ethical rules, but also individual and collectives rights, issues of power, community and cultural protocols as well as being responsible to all relationships they encounter in the research process. Research ethics that is guided by relational accountability will guide researchers not only during the data gathering process but throughout every stage of the research. The researcher must act appropriately and responsibly towards others, in a way that ensures a state of harmony between the self, the other, the community, and the environment (Chilisa 2012;

Blair 2015). One general misconception about research ethics, as Seale (2012:59) asserts, is that they are sometimes seen as prescriptive codes of procedures, which when followed makes research practices authomatically ethical. I give a narrative of what happened during my data gathering process to illustrate how ethics in research and in knwoledge production can be taken for granted by others.

My first experience began when we met one of the healers, a well known healer in Yendi. My assistant and I met him in his residence, presented him with some kola nuts, as a way of observing tradition and cultural protocols, and to ask for his free and informed consent to help us with information on the topic. He agreed and said he could even teach us how to heal some common illnesses using herbs. I then showed my voice recorder to him and explanined that in order for us to have a way of referring to the conversation and getting what we missed during the interview session, we would like to record the conversation when we come back for the interview. He became skeptical and decided to share a story with us, to explain to us why. He said:

> Ah, I don't want you to record me. You can write all you want but not recording. You educated people can put others into trouble. You will just start it and later when I'm deep into it, you'll put me into a stage where I can't escape. Once I visited the hospital to see a patient. She was brought from Zabzugu and was suffering from a mild stroke. The doctors wanted to inject her and I told them not to do it. …. They said then they'll give the patient to me to heal her. The doctor said it'll be my responsibility if the patient survived or died. I agreed and took her to my house. I went to the forest, collected the herbs I needed and commenced treatment. Two days later, some nurses came to my house. They saw that the lady could move her leg and arm and could walk a little. She was seating outside when they came. Those nurses went back to their work and later, the doctor also came. He recorded things in his book and left. Some days later the lady was healed. I have been invited to both the Yendi and Tamale hospitals to look at patients and to describe their conditions. Students do also come to me to document information and go away. Doctors have done the same. Two days after I treated her, a police officer knocked at my door. I had just returned from the mosque at dawn by then. He said I was being invited to the charge office (the police station). When we got there, there were three doctors already seated. The police officer told me it was the doctors who came to them asking for me. The doctors told me that they were taking me to Tamale. They said government was calling me at Tamale. But I told them I wasn't going since I didn't commit any crime. They said it was in relation to the lady I treated. I told them well, if it was my knowledge, then I didn't want my knowledge again. But they said since it was a government invitation, I couldn't refuse that. But I had no intention of going anywhere since it was early in the morning. I wasn't even prepared. So the police commander told them to take me back home so that I could prepare and go with them to Tamale. They did that and we left for Tamale. When we got there, they took me to the Tamale hospital. I think they wanted to test my knowledge. They had assembled 5 patients and said they wanted me to examine them and tell their illnesses.

> One of them wasn't actually sick. So I told them only 4 were real patients. The doctors were surprised. One of them held my hand and hugged me. They then asked about those 4 patients. I described the patients' conditions and how they could be treated. There were four doctors. They all agreed to my diagnoses and took me round the other wards. Before the doctors could let me come back to Yendi, it was around 3pm. So you see, you educated people can hold our wrist and we can't free our hands (Narrated by TMP1 during fieldwork at Yendi on June 24, 2015).

When he told us this, I was very worried at that moment but I understood his situation. Couldn't the doctors have met him in his home, explained why they wanted him and asked for his consent? This story illustrates the idea of power, neglect for human rights and an unethical quest for knowledge. At the core of ethics in research is that researchers need to interact with participants and their communities in a way that no harm of any kind is caused. This is where research ethics and reflexivity merges together. Because, wherever in the research process the researcher needs to reflect upon means that there is an ethical consideration to make as well.

3.2 Reflexivity

Reflexivity is part of ethical considerations in research. It is not only part of ethics, but it also tells us who we are and our relationship to the research topic, participants and the knowledge production process as well as how we arrived at the conclusions that we make. Reflexivity in the context of researching on indigenous peoples or issues, in the view of Chilisa (2012:168) "refers to the assessment of the influence of the researcher's background and ways of perceiving reality, perceptions, experiences, ideological biases, and interest during the research". She asserts further that since the researcher is the main instrument of data collection and who analyzes, interprets and writes the findings, it is very necessary that his/her subjective feelings, thoughts, frustrations, fears, concerns, problems and ideas are recorded and made known throughout the study.

Therefore, to conduct the research in an ethical and responsible manner, I first had to, as part of the institutional ethical requirements, register my fieldwork with the Norwegian Data Services (NSD) and obtain their recommendations, in addition to that of the University of Tromso's ethical guides. Also, unlike among the First Nations and Native American communities, who have their own written ethical guides, the Dagomba of Ghana do not. Instead, community ethics are the cultural protocols, taboos and norms that people must observe as members of the society.

It involves following the right procedures of how things are done, in most cases the elders, opinion leaders, Assembly members and chiefs, have to be contacted in order to gain access to communities, thus making the issue of rapport building and free informed consent among research participants not an individual affair. As Chilisa (2012:196) reveals, in the African perspectives, consent could take the form of individual, community, group or collective, where togetherness, connectedness, social justice, harmony and responsibilities are shared between and among everyone. Given that people have strong feelings attached to their personal stories and narratives, or that stories contains the worldviews and peoples understanding of realities, since it connects them to the land and other people (Wilson 2008), the need for rapport building was very essential. Wilson (2008) further argues that, conducting research is about building closer relationships with people, things and ideas in order to ensure a responsible representation of the multiple realities one encounters.

With my kola nuts in hand and being aware of the cultural norms, taboos and protocols to observe, my assistants and I went from community to community, family to family and from home to home to interact with the paticipants and to ask for their individual and collective free and informed consent to participate in the research. The kola nut was a central cultural element used in seeking consent and in establishing trust and building rapport between us and most of the participants, once the purpose of this study was explained to them. In many African contexts and as noted by Achebe (1958) in his book, *Things Fall Apart*, he who brings kola brings life. And once these relationships were established, the ground was then prepared for the actual data gathering tools to be used, through constant negotiations as I moved through the multiple identities and spaces to get connected to people and places.

3.3 Getting participants

Getting participants or respondents to participate in one's research is not always a simple task. Because for one to be able to generalize, or not to generalize the findings in his or her research, requires that research participants are selected in a certain way. Issues of validity and reliability, resources available and the amount of time that a researcher has to a certain degree influence the kind of participants a researcher engages with. Therefore, in order to obtain very rich and

relevant data for this study, I used a non-probability sampling frame, such as purposive sampling. Purposive sampling is a deliberate sampling technique where the researcher selects participants based on a purpose in mind such as the purpose of the study, the information required to answer the research questions, the amount of knowledge the participants have on the topic and their willingness to participate in the research process. Purposive sampling helps us to select information rich cases, based on their accessibility, availability and willingness (Chilisa 2012:170; Punch 2014:162; Tagoe, 2009:55). Denzin and Lincoln (1994:202) also assert that purposive sampling helps us to seek out groups, settings and individuals where the phenomenon being studied has the highest rate of occuring (cited in Silverman 2010:141).

In all, 34 participants were purposively selected for this study. Ten (10) of them were TMPs from 5 different communities – Yendi, Sunsong, Gukpegu, Pelaaya and Paansiya – within the Yendi Municipal Assembly. These participants were selected because they are the known traditional healers in those communities. Ten (10) PWMs were also selcected from Yendi's main hospital, from different units and wards. My initial plan to contact only medical doctors for the study did not work out, because there was only one medical doctor in the hospital at the time of my fieldwork. Hence, I had to include medical assistants (MAs), senior and experienced nurses and midwives, and other specialized practitioners from the theatre, emergency, pharmacy, laboratory and out-patients department (OPD). This mix helped to give varied and rich data on the topic, since these were individuals from different departments of the formal health system who had different; experiences, attitudes and knowledge about traditonal medicine, healing and healers. The remaining 14 participants were consumers of TMH and other health services. A sample size of 34 participants were drawn because in many qualitative studies generalization is not the norm. Accordingly, large sample sizes are not often used.

3.4 Data gathering tools

Having selected the participants for the study, different data gathering tools were used to collect the primary data. Semi-structured interviews, focus group discussions, qualitative questionnaires and field notes were the principal data gathering tools employed in this study.

In-depth individual interviews are a form of communication between a researcher and a research participant, in a setting where they both engage in face-to-face conversation, with the aim of constructing knowledge together. It is the most widely used data collection tool in qualitative research, where the researcher accesses people's perceptions of reality, meanings and definitions of situations (Punch 2014:144). As claimed by Chilisa (2012), the indigenous interview processes emerge into a ceremony where rituals and symbolism come to play with the researcher giving voice to the participants and getting connected to them in the knowledge creation process. The researcher and the participant are in a ceremonial state where both individual and collective values, beliefs and cultural protocols are relevant and must be respected in a relational way throughout the interview process (for more on this see Chilisa 2012:204-222). Thus, we conducted 18 semi-structured individual intervews with the traditional healers. We used an interview guide that contained open-ended questons. For each of the participants, we met them in their homes and they determined where they wanted us to sit for the interview. For some, we sat in their seating rooms, in the compound or outside the house under a shade. Since most of them were already contacted before the actual interviews, they already knew the topic and the purpose of the research to which they had consented to participate in. Participants were asked to tell us about themselves and how they learn to heal. They had the time to share their stories, narratives, knowledge and personal experiences with us as healers as we went through the interview questions. The shortest interview lasted for 32 minutes and the longest lasting 1 hour 25 minutes. All interviews were recorded on a voice recorder. In order to ensure the reliability and validity of the data obtained, first interviews were transcribed and read out to participants during the second interview, for confirmation of what has been said. Follow-up questions were then discussed during the second interview. Where we met a participant only once, we tried to relate his/her responses to other participants, to cross-check the information given, especially on illnesses and their causation.

In addition to interviews, we also organized focus group discussions with consumers of TMH. It has been noted that focus group interviews not only provide individual perspectives to issues but they also show certain group dynamics and can function as a place for validation and rejection of facts and ideas. Scholars (Chilisa 2012:212-213; Bowling 2009:424-425) believe that focus group interviews are more applicable with real life interactions of people in natural settings,

where social problems are usually discussed and solved and where members can challenge participants on their opinions leading to more realistic views. This perspective is likened to a situation in communities where people meet at the village/town-square to discuss issues and come up with suggested solutions to their problems. The accuracy of information can be checked and many topics can be covered. Focus group discussions offer us the opportunity of exploring cultural values and beliefs, especially about health and diseases when used in health research (Bowling 2009). Hence, two focus group interviews were conducted with consumers of healthcare services in two different communities. In order to ensure that participants had the freedom to express their individual opinions and to contribute in the group discussion, we conducted separate focus group interviews for women and for men. The first consisted of 7 women whose ages ranged from 21 to 90 and the second consisted of 7 men, with ages ranging from 34 to 75. In each case, these groups were organized through the help of a community member. The reason that inspired us to have separate focus group discussion for men and women was informed by the concept of power and who has a voice in Dagbon traditions and culture. So in order to give the women the freedom to express their views we had to have separate meetings with each gender. Nevertheless, before the discussion in each group started, we had to remind participants the purpose of the research and together with them establish some rules to guide our interaction. Issues such as respect for one another's opinions, arguing in a non-violent manner, providing constructive criticisms, or rejecting others' ideas and taking turns to speak, for as much as possible, were all discussed before we commenced. An interview guide with open-ended questions was used in each of the focus group discussions.

The third data-gathering tool was a qualitative questionnaire. Even though questionnaires are particularly related to quantitative research, especially in surveys where a standardized set of questions, with pre-coded responses are provided for participants to respond to (Punch 2014), questionnaires are also often used in qualitative studies. This kind of questionnaire, usually involves questions that are designed to find out the; meanings, attitudes, definitions, emotions and experiences people have about a social phenomenon. They allow for people to provide their individual and subjective opinions to questions; to describe how they perceive reality and the meanings they give to events and happenings.

As a result, in order to find out the attitudes, perceptions and understandings that PWMs have about traditional healers, medicine and healing, we used qualitative questionnaires to get their perspectives on TMH. To do this in an ethical and responsible manner, I submitted an application for permission to the hospital management. Attached to the application letter was a sample of the questionnaire, a letter from my supervisor as well as a letter from the Center for Sami Studies. Since the hospital is a formal institution I also needed to follow their institutional protocols and guidelines. Three days after I submitted the documents, I was invited by the Medical Superintendent and later referred to the hospital Administrator. A permission letter was handed to me and access to the hospital granted. Nonetheless, I needed to contact individual personnel in order to seek their free and informed consent. I went round the various wards with the Administrative Secretary to meet the participants I needed to respond to the questionnaire. I introduced myself, explained the purpose of my research and asked for their consent to participate. Those who agreed to help me in the research gave me their names and contact details. The following day, I handed the questionnaires to them. The questionnaires contained open-ended questions covering the areas of respondents' demographic data, professional practices, attitudes towards traditional medicine, TMPs, traditional healing, and options for including TMH in the formal health system. Although some of the participants had misplaced their copies, 10 copies were returned to me in the end.

Finally, field notes were also made. The field notes I made were largely information based on my personal observations and notes taken during the interview sessions. For example: The interview settings, dates, participants' names, keys points, non-verbal expressions produced by participants and knowledge shared with us were all documented in the field notes. Some of these were done to serve as an explanation to the information in the recorded audio, while others were to be used to assist us in coming up with follow-up questions in subsequent interviews, either with the same participant or with other participants, as a way of cross checking the information provided. It also contained information on cancelled schedules, reasons behind those cancellations and other personal experiences shared with us by some PWM's with whom I had given the questionnaires to. Photos were also taken to capture data about the tools and the materials used in traditional healing. I took pictures of herbal products, healing aids such as X-ray pictures, bandages, the local mat (in the case of a fracture healing) and different forms of prepared traditional medicine.

Other pictures were taken of the natural setting and the environment and other spiritual healing items. These pictures were to serve as visual data, to back up the observational data, as well as what has been said by participants. Also I had the opportunity to observe fracture healing, how Islamic spiritual healing is performed on patients that were possessed by jinn and how some forms of herbal medicine were prepared.

3.5 Challenges and successes

From the preceding topic, one can realize that some successes were made during the data gathering process. My assistant and I were able to organize 20 successful interviews (18 in-depth individual interviews and 2 focus group interviews), 10 qualitative questionnaires were returned from the PWMs and detailed field notes were produced. Experiences, knowledge, stories and secrets were shared, relationships created and trust built between us. Thus, every individual had made a substantial contribution to the data produced.

However, things were never smooth or without rough edges. The Islamic month of Ramadan (a month of fasting) put stress on both my assistant and I, as we are Muslims who were also observing the fast. It affected both the length of the interviews as well as how it was scheduled with the participants. In most cases, it led to the cancellation of some interview sessions and so rescheduling became a normal process. There were also interruptions during the interview sessions, especially with the TMPs, by patients and other users of TM. Another challenge was that we had to move between five different communities to meet the different participants for each of the interviews. This also affected the timing for interviews, since for some of the communities we had to cover not less than 8km distance on a motorbike. We also had to always restate the purpose of the study to participants and to assure them of their safety and the confidentiality of experiences shared with us, in order for them to be very open with us. Because at times, I thought participants were not very open with us and most importantly, I had to always ensure participants, that the recorded conversation was going to be used purposely for this study. Lastly, because the interviews were semi-structured with open-ended questions, respondents had the opportunity to tell their own stories which led to large volumes of information being

produced. Transcribing the recorded interviews and coding them, which I will discuss in the data management section, were thus, never an easy task.

3.6 Data analysis and management

As it is often the case, for any data to make meaningful contributions in research, it has to be organized and managed. Data management in a qualitative study becomes the process of organizing the data, such that meanings, interpretations and descriptions can be derived from the data. Even though Lacey and Luff (2007:6) assert that "there are no 'quick fix' techniques in qualitative analysis", they have identified grounded theory and framework analysis, as some of the approaches that can influence qualitative data analysis with; transcription, organizing data in retrivable forms, familiarization, coding and themes identification, being the major steps to go through in managing qualitative data. Other techniques identified by scholars include coding, memoing, abstracting and comparing, developing categories and themes, and creating concept maps (Punch 2014; Seale 2012). Tagoe (2009:61) also states that in analyzing data for ethnographic research, one must do coding, summarizing the coded data and seeking for themes and patterns. It is also noted that qualitative data analysis does not only involve managing and organizing the data, but working with it, to enhance the credibility, validity and reliability of the findings thereafter. In relation to this, Chilisa (2012:164-168) identifies peer debriefing, doing negative case analysis, member checks, triangulation and being reflexive as some of the various ways researchers can use to ensure that their data and findings are credible and dependable.

Accordingly, to manage the data we gathered effectively, the first recorded interviews were transcribed and read to participants during our subsequent meetings, for validation of the information received. This helped us to ask follow-up questions and to cross check key emerging concepts and issues with other participants. The purpose for doing this was to ensure the credibility of the data through member checks as noted by Chilisa. The transcribed interview scripts were then, together with the questionnaires and field notes, subjected to content analysis and manually coded (for details on manual coding see Bowling 2009:420). There were constant cross comparisons with other participants' scripts to identify both commonalities and differences. Again, to ensure rigour, credibility and dependability of the codes obtained, my assistant had to

go through the transcipts and compare his findings with mine. Where there were differences, we discussed and then agreed on a common label to use. Narratives and stories shared were also noted, some of which are already in use in this chapter. Other participant responses' which contradicted certain general notions (negative cases) were noted. Data from the multiple sources were constantly compared (trinagulation of data sources) to ensure that findings made were grounded in the data. Peer reviews in class, during chapter seminars, was another method used to ensure that findings were credible. What follows in the next section are the major themes, topics and concepts identified from the coded data

3.7 Findings

As described above, the following themes, topics and concepts emerged from the coded data. They include: participants demographic characteristics, theorizing illness and good health, common illnesses, common herbs used, acquisition of healing knowledge, causation of illnesses, secrecy in healing, diagnosing illnesses, the choice of a healthcare system, attitudes towards TMH, TMPs working with the formal health system, illnesses and injection, rituals in healing, gender in healing, emerging trends in TMH, referrals of patients, psychology in healing and the art of healing. Most of these will form the major sections to be analyzed and discussed in Chapters 4, 5 and 6. However, some of them will be discussed under other broader topics.

Based on these data gathering processes, experiences and findings, the next chapter will examine two of the major findings on how the Dagomba theorize health and illness as well as how patients within Dagbon negotiate within the medical systems that are available to them.

CHAPTER 4

THEORY AND REVIEW OF RELEVANT LITERATURE

This chapter will discuss the Dagomba theories of health and illness and how the different medical systems in Dagbon are used. I will try to describe how the Dagomba perceive health and illness and how the meanings, values and knowledge which constitute Dagomba realities are constructed in relation to health and illness as shown in the data. Hence, I will first present the two theories derived from the data and then discuss them in relation to the wider contexts and the available literature, particularly that of the medical anthropologist's Helman (2007) and Kleinman (1980) and their models of Lay theories of health and medical pluralism.

4.1 Theoretical perspectives

Theories are explanatory models or descriptive tools that help us to understand peoples' perception of reality and the meanings they make out of it or attribute to it. Accordingly, Punch (2014) believes that experience is the foundation or source of knowledge based on our observations and other sense data, and forms our reality to which theory either tries to explain or describe. Hence, whereas some studies begin with theory and use it to understand data, others allow theory to emerge from the data. This particular study takes the latter stance. The theories, which are presented below, were what largely helped to explain and describe the participants realities. Thus, they emerged from the data to account for how the people make meanings and understandings of their realities in relation to illnesses, their causation and healing.

4.1.1 Grounded theory

Grounded theory is a framework that takes various philosophical and methodological positions in research endeavors. Punch (2014:131) argues that grounded theory is not a theory per se but a

research strategy or approach whose purpose is to generate theory from data to help us understand social phenomena. Grounded theory, as a research framework, has its origins in the seminal works of Glaser and Straus in the 1960's. However, other contributions to the development of grounded theory include that of Straus and Corbin (1990, 1994, 1998), Charmaz (1995, 2000, 2006), and Bryant and Charmaz (2007) (Birks and Mills 2011; Punch 2014). Birks and Mills (2011) concur that grounded theory consists of both methodological diversity and methods (strategies and techiniques) of conducting research which aims at generating theory from data. In grounded theory research, priority is given to the concurrent occurrence of data gathering and data analysis. This study is thus inspired by grounded theory methods, as demonstrated during the data generation and collection processes in Chapter 3, and in this particular chapter as I try to explain how Dagomba theorizes health and illness.

4.1.2 Dagomba theories of health and illness

Good health and ill health (or broadly seen as health and illness) have different representations in different cultures or societies and among different people, even within the same culture to which different theories are used to explain. Among the Dagomba of Ghana, illness and good health are said to be on a continnum. *Alaafee* (good health) is a discourse and to some extend a metaphor. It is a state of balance between the self, the other, the society and the environment (including the spiritual world) in general. *Alaafee* is within the language and used to indicate a relational inter-connectedness. Hence, good health is never seen as the absence of illness, since people are born with some innate illnesses, which can be triggered by both internal and external forces within and around the individual. *Alaafee* is thus seen as a state of having *suhudoo* (peace of mind) within the self and in relation to others and the society. Accordingly, *doro* (illness, sickness and disease) is seen as a state of imbalance within a person or the society. People are born with illnesses, which come and go and are part of growing up . As the anthropologist Bernhard Bierlich (2000:707) argues, the "Dagomba see many illnesses as inescapable facts of living and growing up. They demand no explanation. They are part of people's everyday experiences".

Dogomba theorize that people are born with *kpaʔa, chua* and *dirigu*[11]. These illnesses are said to be part of our creation. They are innate to us. They only become illness when they are triggered by either intenal or external forces or both. Hence, a person's age, blood quality, 'head' and individual self as well as the external natural, social and spiritual forces are the sources of illnesses as well as what determines individuals suceptibility to illnesses and the success of their healing.

Based on these theories of health and illness, Dagomba postulate that illnesses have multicausal factors and sources. They argue that the food we eat, the natural environment, ones family background, the spiritual forces around and other social factors (poverty, witchcraft, sorcery) constitute the sources of illnesses. They also contend that humans, spirits, ancestors, God, jinn, and physical forces constitute the causal elements of illnesses among people. The Dagomba theories of health and illness and the sources and causes of illnesses is thus illustrated in figure 4.1 below.

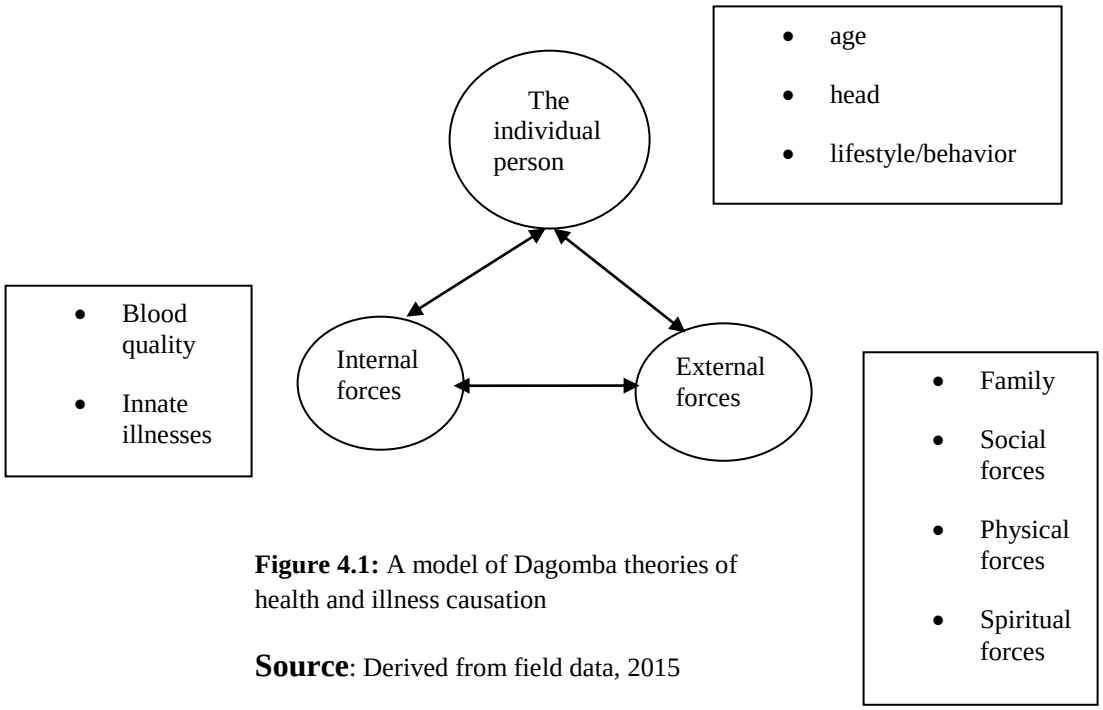

Figure 4.1: A model of Dagomba theories of health and illness causation

Source: Derived from field data, 2015

[11] These are the native names for the innate illnesses people are born with. These illnesses do not have exact translation in the modern western medical terminology. However, their near descriptions are provided in Appendix C under the list of common illnesses within the TMS.

The model in figure 4.1 above per Dagomba theories indicates that illness can come from within the individual based on his/her *nama* (creation, internal forces or physiological makeup) since people are born with certain innate illnesses (*kpaʔa, chua* and *dirigu)*. These illnesses when triggered by forces, either within or outside the body, the native expression used to indicate that is often: *N doro n-yiʔsi* (translated as 'my illness has stand up') which presupposes that an internal illness has been triggered (see Bierlich 1995, 2000 for further discussion of Dagomba notions of illness and health). It is also noted that some of these innate illnesses, when absent in a person's system, could lead to his/her inability to procreate. *Dirigu* and *kpaʔ'piɛlga* (a form of the generic *kpaʔa*) do affect both matured males and females reproductive systems and thus can influence their child bearing abilities when they are very high or very low in a person. In essence, these innate illnesses may not be illnesses at all. They become illnesses when triggered by external forces. Blood as an internal force has dual relationship to illnesses. The family constitute a source of illness since certain illnesses (such as *kpilinkpihi* 'epilepsy', *darmihi* 'sickle cell', *nina doro* 'eye disorder', *yukurɨli* 'old wound/sore' and many others) are known to be family related illnesses, thus, they are heredity in nature. The model also indicates that people get illnesses from the external environments (the family, society, physical and spiritual forces). These consitute the social (through human relations and envy, witchcraft, sorcery), physical (natural forces through the weather, animals, insects, injuries, accidents and other natural body system malfunctioning) and spiritual forces (spirits, gods, ancestors, jinn, ghost) within the universe through which many health systems attribute illness causations to.

The model thus shows that illnesses come from multiple sources and caused by multiple factors as well. The individual and his/her lifestyle is a source of illness. His/her age, head and blood quality (either hot or cold and sweet or bitter) determines how easy or difficult he/she can become ill. Though many illnesses are common to all age groups, some illnesses (*daʔʊ, talga, tahiga*,) affect only children while others affect only matured people and the aged. This is how age comes into play in the Dagomba model of illness representation. However, age and blood quality are interconnected since adults are said to have *ʒitulli* (hot blood) and are more resistant to illness, while children and the aged have *ʒimahili* (cold blood) which makes them less resistant to illness. Also, a person could have *zuʔ'kpiong* (hard head) and so not easily affected by illness (both natural and spirtual) or *zuʔ'gbanvalinga* (soft head) and as such easily affected

by illness. The Dagomba theories of illness are thus complex, interconnected and broadbased. It does not only explain illness causation in a relational manner (where social, cultural, natural and spirtitual forces constitute the domains of illness) but also places the individual at the center stage. The individual, therefore, is not a passive being whose health and illhealth is dictated to by socio-cultural, physical and spiritual forces, but also he/she is an active being whose lifestyle and behaviour (the food eaten, alcoholism, excessive sexuality and relations to others which are considered very crucial among Dagomba) contribute much to his/her health status.

4.1.3 Dagomba theories in the wider contexts

Lay theories of health and illness are thus broader explanatory models that are used to explain the origins of misfortune or causation of illness based on peoples beliefs about the structure, functioning and malfunctioning of the body (Helman 2007:134-139; Bowling 2009:22-24). Earlier scholars such as Foster and Anderson (1978) and Young (1983) noted that lay explanations of illness causation, in relation to the functioning of the body, were largely in personalistic/naturalistic and externalizing/internalizing terms respectively (Bowling 2009:23; Helman 2007:139-140). Foster and Anderson's (1978) model, places agents such as supernatural beings, god, ancestral spirits and humans (through witchcraft and sorcery) as causes of illness under the personalistic causal factors while impersonal factors through natural forces (such as heat and cold, winds, and others) are placed under the naturalistic perspective. On the other hand, Young's (1983) model of externalizing and internalizing, postulates that forces outside the patients' body, but largely within the social world through human relations and interactions (witchcraft and sorcery, jealousy), constitute illness causal factors under the externalizing divide while forces within the patient's body (largely physiological changes and forces) constitute sources of illness among people under the internalizing divide. The Dagomba theories may correlate with Foster and Anderson's (1978) personalistic and naturalistic model of illness representation, as it shows that illness causation is explained both in what we might frame as spiritual/social (human) and natural terms. Also it communicates with Young's (1983) externalizing and internalizing model, since certain illnesses among Dagomba are said to be innate and also based on the individual blood quality and other internal forces within the body system while others are external to the body systems.

An expanded explanation of lay theories of illness, however, is that of Helman (2007:134) where lay explanations of illness causation are placed in four (4) different but interacting worlds. These are; the individual world, the natural world, the social world and the supernatural world. Comparatively, Helman's model of lay theories of illness representation is broadbase with wider analytical power than those of Foster and Anderson (1978) and Young (1983). Though the Dagomba theories of illness, as shown in figure 4.1 recognizes these four interconnected worlds postulted by Helman (2007), it is somehow different. Structurally, Helman's (2007:134-139) model consists of concentric circles in a hierarchical manner to represent the four different but interconnected worlds, which rather subsumes the individual within the other worlds. His model seems to indicate that the individual is but a passive being whose health status is under the dictates of the social, physical and spiritual worlds. The model also sort to portray the universe as an ordered system where the physical, the social and the spiritual worlds are in a hierarchy. This however, may be difficult to comprehend in real life and everyday activities of people, where these worlds are unbounded, fluid and in constant interaction, perhaps, in the sense of the Dagomba perspectives. Also, Helman's broad generalization that (though he acknowledges that it is problematic) explanations of illness causation within non-industrialized communities are largely attributed to, what he calls, the social and supernatural worlds, while within that of the industrialized communities, are attributed to the individual and natural forces seems to suggest that there is cultural homogeneity within the non-industrialized and industrialized worlds. Also, Helman's model is more general as compared to that of the Dagomba's perspective where the age, head and blood quality of the individual have significant influences on a person's relation to illness.

Generally, the Dagomba theories of health and illness causation, like other lay theories are broader in scope and have stronger analytical perspective to explanations of ill health. These theories do not only recognize the responsibility of individuals actions and natural phenomena in illness causation, but they also acknowledge that social factors, as well as supernatural forces, such as spirits, gods, ancestors and God are sources of ill health. Lay theories of illness recognize the multiple dimensions of reality as it advocates multicausality of illness. These theories also recognize that people's culture, traditions, norms, values and economic modes all have influences on how they perceive illness and by extension how good health should be approached.

The multicausal understanding of illness as well as which health system to approach when seeking for healing in Dagbon led to the emergence and discussion of healthcare pluralism in Dagbon.

4.1.4 Medical systems in Dagbon

Societies, both large and small, through time and space, do have different dynamic ways of managing their ill health. Several options could be used to ensure balance in health within the individual self, the society and the community. Given the above perspectives of health and illness among Dagomba, the data shows that different healthcare systems with different healing approaches exist within Dagbon to which people turn to, for their healthcare needs. The data shows that three complex and interdependent healthcare systems exist in Dagbon. These healthcare systems are the Household healthcare system, the Traditional healthcare system and the Western healthcare system. These healthcare systems and their interconnections are shown in figure 4.2 below.

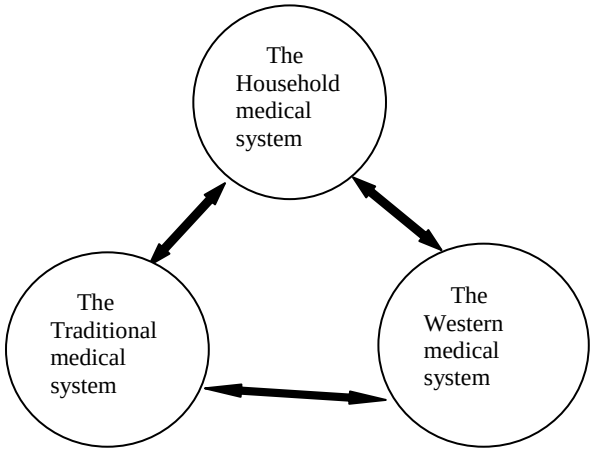

Figure 4.2: A model of medical systems in Dagbon

Sorurce: Derived from field data, 2015

The household medical system in figure 4.2 constitutes the basic medical system in Dagbon. It is the domain where most health decisions are made concerning access to healthcare in the other medical systems. This medical system is made up of family members (with mothers having extensive roles in the health concerns of their children) (Dove 2010), friends, other relatives,

drug peddlers (they sell either traditional medicine or western medicine on bicycles, motorbikes or in cars), traditional birth attendants (TBAs) who are also now part of the formal health system in Ghana, both licensed and unlicensed pharmaceutical shops and other mini private clinics operated by some members of the western medical system. Medical knowledge of some of these members is based on the past experiences they have had in treating themselves of some illnesses. Some of the operators of the pharmaceutical stores or drug stores may have some formal/western education in pharmacy, while others base their knowledge on experience of working as a drug seller. The point is that both traditional medicine and western medicine are used within this medical system. Medicines are freely sold over the counter in drug stores and pharmaceutical shops or in the open market. People can buy them with or without a medical prescription. Self medication seemed a common practice under this system. Most illnesses treated under this system are the common illnesses. As Bierlich (1994) observed, the treatment of minor sicknesses takes place in the home where herbal medicine and western pharmaceuticals are deemed sufficient (in Bierlich 1995:504). Also some homes have *dunoli tia* (family traditional medicine which is usually for spiritual protection of the family members) which they invoke from time to time to heal members of the family suffering from certain illnesses. This has also been noted by Bierlich (1995:504) as he found that among Dagomba, people who are away from home are prone to illness because they have left the medicine protection that their homes provide. The household medical system thus occupies an important position in the healthcare needs of people within Dagbon. It is complex and involves disparate groups of people with varying levels of medical knowledge. For detailed discussions of home remedies for children and pregnant women or how the household system, the use of money and western pharmaceuticals operate in Dagbon see (Dove 2010; Bierlich 1999).

The Traditional medical system (which is the main focus of this study) consists of traditional healers of various kinds. Practitioners within this medical system include bone specialists, snake bite specialists, herbal and spiritual specialists, traditional circumcizers (*Wanzamanima*), Islamic based specalists (*Mallams*) and many others. Most of them acquire their knowledge through long term training from either within their families or outside the family (details of this will be discussed in Chater 5). Healing and treatment services are provided to all kings of ilnesses by using herbal medicine, spiritual medicine or both, and through rituals and ceremonies. As

indicated earlier, the decision to seek for healthcare services under this medical system or the western medical system is taken under the Household medical system based on the nature of the illness and its perceived cause, among other factors. Medical professionals under this system may be specialized in a particular illness or provide healing to several different illnesses caused by natural, spiritual and social forces. Members may practice at their homes or under traditional shrines. Most healing and treatment services provided by practitioners are based on relationships and observance of cultural norms and in many cases, with less involvement of money since some healers claimed that selling TM or charging people for providing healing services kills the medicine or the healers powers.

The third medical system (the western medical system) as shown in figure 4.2 is the formal health system in Ghana. This medical system is generally represented by teaching hospitals, general hospitals, clinics and community based health posts (CHPS) run either by the government, Christian or Islamic missions or by private individuals. Included in this system is also licensed chemical or pharmaceutical companies and stores. Practitioners within this medical system have some amount of formal education and training. They include doctors, nurses, physicians, chemists and other paramedical staff. Medicine used under this medical system is largely western medicine though many private clinics do use other herbal medicines produced in Ghana. Within the Yendi municipality, patients can either access healthcare under this medical system by going to the government hospital in Yendi, or other clinics both within Yendi town and in some other surrounding communities.

Despite the fact that these medical systems have some fundamental differences in philosophies and theories about health and illness, and that they have different structural orientations and medical practices, they interact in very complex ways. For instance, some members of the TMS as well as that of the WMS can sell traditional medicine or western medicine in the open market, hence making them part of the household medical system. Practitioners within these medical systems also refer patients to one another, though the TMS does that more than the WMS (more discussion is done on patient referral in Chapter 5). Some traditional practitioners also use many medicines and other medical equipment conventionally used under the WMS. It is also important to note that interactions between these medical systems is also often marked with conflicts and power struggles (over ideas, medical practices, patients satisfaction and practitioners

professsional orientations). The model is thus to be seen as a system with subsystems (plural medical systems) and should be read as an interactive medical systems to which patients or healthcare seekers in Dagbon make use of.

4.1.5 Dagbon medical pluralism in the wider contexts

Based on the above data, the idea of theory of Medical pluralism became clear. This theory postulates that different societies have different healthcare systems, which in most cases cannot be studied in isolation from other aspects of the society, such as; the peoples culture, religion, political and economic institutions (Helman 2007:90). The various social institutions and the culture itself of every society are the major influencing components of every healthcare system. Healthcare pluralism thus means the existence of different healthcare systems that may belong to different cultures, with different philosophies and foundations towards reality and about illnesses but coexisting in a society to which patients can access singularly or in combination.

Kleinman (1980:50-60) has identified three overlapping and interconnected healthcare sectors. These are the popular, folk and professional sectors which any complex society has. Kleinman noted that "in every culture; illness, the response to it, individuals experiencing it, treating it and the social institutions relating to it are all systematically interconnected" (pp, 24). Elaborating more on each sector Helman (2007:81-95) argues that the popular sector is the lay, non-professional and non-specialist area of the society, where the family is the main arena of healthcare. Here, the author notes that self-treamenet/self-medication, advice from relatives, friends and neighbours and consultation with other lay persons, form the main sources of healthcare information as well as healing practices. Experience is the main source of knowledge among members belonging to this sector. The folk sector consists of individuals who are specialized in some forms of sacred or secular or both healing practices but who do not form part of the formal medical system. Members of this sector may include herbalists, snake specialists, bone specialists, spiritual healers, traditional birth attendants and many others. These categories of healers, in most cases, are members of the society and share the same culture as the rest of the larger socety. They are common and base their heathcare services on their beliefs and realities about illness and its causation. Helman notes that, in recent times, some countries are making

this sector as formally recognized as the professional sector. The professional sector, on the other hand, is the legally recognized and organized sector of healthcare where medical practices are governed by codes of ethics and conducts. Members of this sector enjoyed some prestigue. They include nurses, doctors and all other paramedical professionals. Largely, this sector is often based on the Western scientific medicine known as biomedicine. Practitioners under this sector operate with computers and complex equipment. Again, Helman asserts that this sector in most societies, is elevated to a higher status than the others and it is also funded by state resources.

Though some of the characteristics about the folk sector and the professional sector are true to some extent, many others are problematic and over generalized. The notion that one sector is professional with medical practices governed by a code of ethics seems to suggest that practitioners within the folk sector (the traditional medical system) are not professionals and by extension do not have authentic knowledge about their field. It also seem to suggest that they practice without any code of ethics (which could even include moral standards). Additionally, traditional healers also enjoy prestige and a higher social status in communities in which they exist.

Despite the few issues pointed out, Kleinmen (1980) and Helman (2007) pluralistic understanding of healthcare systems intersects well into the Dagbon context (and the wider Ghanaian contexts). All three sectors identified under the theory of healthcare pluralism (Kleinman 1980; Helman 2007) may be said to exist in Ghana and within Dagbon, my study area. The study population access all these three sectors of healthcare systems. Consumers of healthcare services, however, in addition to using these two systems also use the HMS as documented by Bierlich (1999). I will therefore argue that Dagbon society operates plural healthcare systems with the decision to seek healthcare from these sectors based on the Dagomba theories of health and illnesses (their nature and causation), the availability, accessibility and affordability of the services of each healthcare systems as well as other socio-cultural factors and individual lifestyles.

4.2 Review of relevant literature

This part of the chapter will present a review of the relevant literature and an analysis of their impact on this study. But as claimed by Punch (2014:95-97), a literature review can be emperical or theoretical where either the findings, evidence and content of previous studies are analyzed in the case of emperical review or the fit of theory and methods of investigation (where both substantive and methodological theories of a research) are reviewed in the case of a theoretical literature review. This study takes a synthesized position in its review of related literature. Both the findings or evidence in previous studies and their methodological approaches will be examined and how they relate to this particular study. I will also like to point out that my review of literature here, is done according to the research qustions the study seeks to address on the topic of TMH and also from specific to broader contexts.

4.2.1 Philosophies, theories and practices of TMH

Traditional medicine and healing is one of the healthcare systems in Dagbon. It is part of the plural healthcare systems in the region. This sector consist of practitioners whose medical practices are based largely on their culture, traditions and theories about illnesses, their causation and the functioning of the human body. Even though similar practices may be known across different domains, medical knowledge and healing practices are generally cultural specific, dynamic and experience based.

In his study among Dagomba, Bierlich (1995, 2000) found that the Dagomba's representation of illness is broad based. Their understanding of illness and its causation are largely influenced by their beliefs and cultural practices. Bierlich observed that Dagomba make no distinction between the biomedical notion of disease and the personal subjective feeling of pain or discomfort (illness). The Dagomba have only one word in their language *doro* to stand for disease, sickness and illness. In his (Bierlich 2000) study, he also notes that among Dagomba, some illnesses are said to be innate. People are born with those illnesses. The author stated *kpaʔa* and *yoʔu* illnesses as among the innate illnesses. According to Bierlich, Dagomba do not only based their traditional medical practices on their culture and beliefs, but they also know which illnesses to take to hospitals for injection or to avoid being injected. Given these findings by Bierlich on the

Dagomba, it presupposes that their knowledge of herbal medicine and traditional medical practices are generally influenced by their theories of health and illness as well as their perceptions of reality and the meanings they make and ascribe to everyday events. However, Bierlich (2000:710) makes a mistake by classifying *yoʔu* illness among the innate illnesses which are part of people's creation. As he asserts, "*yoʔu* is an illness caused by an insect [usually called *nantoo*] in the bush". The urine (or whatever fluid it is) is said to be very infectious. Hence, when the insect urinates on grasses and other plants and humans or animals come into contact with that fluid, they will be infected by the *yoʔu* illness. Also when humans eat the meat of an infected animal, they can still get the illness that way. It is therefore, clear that *yoʔu* illness is an external illness which comes to the body through contact with the urine of the *nantoo.* It therefore does not form part of the innate illnesses people are born with.

In another study on Dagomba, Bierlich (1999) noted that among Dagomba, requesting TMH is based on relationship building where the use of money is frowned upon. Patients or people seeking TM just need to meet the traditional healer, greet him or her and makes their request (usually by offering kola nut as a sign of respect). This perception is based on the belief that money kills the medicine (thus selling traditional medicine weakens the potency of the medicine as well as the healing powers of the healer). In his study, however, the author makes an over generalization about the concept of *tim* (Dagomba medicine) where he claims that the term *tim* is derived from the word *tia* (tree). This presupposes that all Dagomba medicine is derived from plant sources. However, the term *tim* is a polysemous noun which broadly refers to both TM (either for treating natural or spiritual illnesses as well as for malevolent purposes) and western medicine. It takes different adjectives and contexts to make its meaning clear and straightaway from its ambiguous nominal sense. The author even recognizes this broader meaning of the term *tim* when he discusses the discourse surrounding the word *tim* in Dagbon society.

Similarly, within the Ghanaian context, Insoll (2011), Kankpeyeng, Nkumbaa and Insoll (2011) in their archaeological analyses of traditional shrine healing and medical practices in Ghana both assert that TMH in these shrines is deeply rooted in the African religions where theories of illness are very broad. These studies both found that healing requires the identification of the cause of illness before the application of medicine which is based both on plant and non-plant origins. Even though both studies are based on archaeological study of traditional shrines and

their medical healing practices, they are differed in content. While Kankpeyeng, Nkumbaa and Insoll (2011) assert that TMPs have a dual task of understanding the disease and the patients with healing practices based on extablishing a balance between human and spirit that of Insoll (2011) which focuses more on how traditional medicine is prapared or healing is practiced and the various forms the herbal medicines are administered. Also, the study of Kankpeyeng, Nkumbaa and Insoll (2011) is largely based on the interpretation of past medicinal practices within the shrine as opposed to actual practices shown in Insoll (2011) study. These studies though provide meaningful insights into how TMH practices are done in some shrines in Ghana, they are methodologically different from this study. They are largely based on archaeological analysis. Also, whereas Insoll found that rituals and gendered practices were visible at the Talensi shrine he failed to investigate why those difference in rituals between healing men and women as well as the use of sacrificial animals were practiced.

In other studies conducted in Nigeria, Isola (2013) examines the relevance of the African traditional medicine to healthcare delivery system while Omonzejele (2008) looks at the African concepts of health, disease, and treatment. Isola (2013) claims that the African Traditional Medicine is based on the material world, the sociological environment and the metaphysical forces of the universe. The author notes that TM in Africa provides primary healthcare, maternity as well as preventive services to the people in multiple cases such as fracture healing, snake bites and in both antenatal and postnatal services among others. Isola discusses in detail how healing knowledge is acquired, diagnoses and healing practices are done and how varieties of illnesses are treated. However, his conception of this medical system as the African Traditional medicine sort of portrays a singular TMS for the entire African region. This kind of conception is problematic since there are variations in cultures, traditions and belief systems across the continent to which most TMSs are based. On the other hand, Omonzejele (2008) postulates that African conception of health is embracing, it does not only look at the proper functioning of body organs, but also look at the mental, physical, spiritual and emotional stability of the self, family and community. The author observes that the African conception of health through TMH is broadbased with healing and treatment based on the use of herbs, making sacrifices and conducting divination, thus, linking illness causation to human, spiritual and physical means. Omonzejele's (2008) study acknowledges the fact that TMH is based on people's personal

perspectives and cultural practices about illnesses, the functioning of the body and the interconnected nature of things in the universe. Hence, it gives an in-depth analysis and conception of health, disease and healing practices in Africa than that of Isola, although both are studies based on Nigeria.

4.2.2 Attitudes, perception and the choice for a healthcare system

Several studies have made different findings on how different sectors of the society perceive TMH as well as the practitioners of the TMS. A few of such studies are reviewed here. But since one of the research questions of this study is to discuss how different actors think TMH can be included in the formal health system, more emphasis will be placed here on studies that have Ghanaian context.

Some interesting studies on TMH conducted in Ghana are that of Barimah (2013) and Nimoh (2014). Barimah (2013) discusses the non-inclusion of traditional healers as healthcare service providers in the Ghanaian health insurance scheme, despite their valuable contribution to healthcare service delivery in the country. As the author identifies several illnesses that traditional healers provide healthcare services for and the effectiveness of their treatment, he also acknowledges that there are certain challenges within that healthcare sector. Issues such as; the lack of cordination and cooperation between healers, lack of formal training or incomplete education among them, lack of proper storage facilities, inadequate documentation and more importantly, secrecy in their practice. On the other hand, Nimoh (2014) compares TMH to Western medicine and healing in order to draw upon their commonalities and differences. He argues that though both systems have a mission of diagnosing and providing treatment to illnesses, they are markedly different in terms of their cost of treatment, use of technology, philosophical foundations and modes of treatment.

Despite that both studies have the aim of assessing the relevance of TMH and the challenges the traditional sector faces, Nimoh (2014:85) makes an important observation about why some healers hold their knowledge in secrecy. He argues that the “current attempts to tap into, analyse and systematize traditional medicine have not involved much input from traditional healers”. The relevance of these studies lie, not only in their analysis of how TMH is important, but how it is

perceived and compared with Western medicine and also the different understandings of the concept of secrecy within the system, by these scholars, since this has been noted differently by other scholars. The relevance of the concept of secrecy will, however, be discussed later in Chapter 5.

Adding to the above, Asante and Avornyo (2013) in their study on *Enhancing Healthcare System in Ghana*, assert that TM is affordable, accessbile and available to which a large part of the population use for their healthcare needs. However, they found that mainstream medical practitioners do not appear to have very good attitudes to TMH, since 44 percent of the respondents in their study did not show any interest in any traditional medical practices. Some of them even remarked; "what can an educated person learn from an uneducated one?" (pp, 267). This confirms the claim that Helman (2007:89) makes about relationship between healers and doctors. Another remarkable study on the choices people make about which healthcare system to use in Ghana is that of Tabi, Powell and Hodnicki (2006). In their study, the authors found that the choice of which healthcare system to adopt, by most Ghanaians is based on several factors such as; beliefs about source of illness, pressure from family, friends and employer, poverty, source of healers' power and accessibility of the healthcare system. This study is relevant in that it recognizes the pluralistic nature of the Ghanaian healthcare systems as well as the influence of culture and beliefs about illness causation in seeking for health. However, the study participants were all educated making its findings limited to the views of the literate Ghanaian society. It is possible that different perspective could have emerged had the study involved both literate and non-literate participants.

Similarly, Hampshire and Owusu (2013: 258-259) found that in Ghana, some TMPs and consumers of TMH services both have ambivalent attitudes and perceptions towards TMH. They found that although the TMPs in their study obtained their knowledge of healing through their families, the healers have different opinions regarding the spiritual aspect of TMH. Whereas some acknowledge its existence in the medical system, they down play its significance and see it as not being scientific. Again the authors found that consumers also have ambivalent perceptions. Some insist on getting the 'pure' TM, which according to them, heals faster than orthodox medicines while others want a moderninzed version of TM, which they believe, is 'more scientific, more refined and more hygienic,' from the practitioners. This finding shows

how people have differing attitudes and perceptions about TMH including practitioners of the medical system. Similarly, Gyasi et al (2011:43-45) argue that most Ghanaians have mix feelings about TM. They observe that people claim that TMH is readily available, accessible and effective in treating many illnesses but also contend that it is less safe, has low efficacy and is also unhygienic.

Ofosu-Amaah (2005) in his book on *Health and Disease in Ghana* raises some serious concerns about the traditional health sector. Issues such as safety, biodiversity loss, inadequate international laws to protect traditional knowledge and the need for the Ghanaian health professional to study and understand the traditional systems of medical practice are some. He acknowledges that he himself has little knowledge on Ghanaian traditional medical practices. Also, in making a comparison with ancient Egyptian TMPs, the author posts questions about the Ghanaian traditional practitioners' knowledge of the body structure and system, their willingness to share their knowledge, the notion of TM treating many disparate conditions at the same time and lastly on practitioners lack of consensus on disease causation with rational or scientific justification[12]. The author failed to recognize that traditional medical practices are cultural specific and based on the people's belief systems, philosohpies, theories and perceptions of reality, with healing practices taking a holistic approach. Therefore, to talk about the scientific justification of traditional medical practices rather than verification of the efficacy of the medicinal plants they use will be to impose the Western notions of scientific rationality and medical practices on the traditional ones.

Similarly, Helman (2007:88-89) in comparing folk healers to biomedical doctors in their mode of healthcare practices and perceptions claims that folk healers explain ill health in wider and more familiar cultural terms than PWMs. In relation to attitudes and perception, Helman (2007) again observes that there has been mutual distrust and suspicion between healers and the formal medical professionals. The author observes that "most doctors have tended to view folk healers as quacks, charlatans, witch doctors or medicine men who pose danger to their patients' health". Even though this notion may be true in terms of the relationship between TMPs and PWMs, the

[12] My comment on this goes back to the authors own remarks; the lack of knowledge and understanding among both scholars and the formal health professional about TMH as well as the inadequate international legal protection for their knowledge are possibly what causes these concerns.

labels and characterization of TMPs as ‘folk healers’ and PWMs as ‘medical doctors’ seem to be biased in the sense that these practitioners are all professionals and highly revered in their own healthcare systems.

4.2.3 Including TMH in the formal health system

On the aspect of including TMH in the national healthcare systems, studies conducted in different countries have demonstrated various strategies and available options to adopt when planning to include TMH in the formal healthcare sector. In most such studies, references are being made to the success stories of China, India, Vietnam, the Republic of Korea and the Democratic People’s Republic of Korea (Ofosu-Amaah 2005; Isola 2013; WHO 2002). A few of these studies and reports will be reviewed here on the various strategies and options to adopt when proposing for inclusion of TMH in national health systems.

In Ghana, a study that discusses the possible ways of including TMH in the Ghanaian mainstream health system is that of Asante and Avornyo (2013). This study found that while medical practitioners of the formal healthcare system supported the idea of including TM in the formal healthcare system, they did not want to work in healthcare institutions with traditional healers. This is very important, given the fact that it unvails the attitudes of some medical professionals towards the issue of inclusion of TM. However, the weakness of their study is that it only used medical practitioners from the formal health system, hence, limiting its findings. The opinions of TMPs and some members of the public (consumers of healthcare services) were not considered since this was a study targetted at only PWMs.

Also, in a study on the relevance of African traditional medicine to healthcare delivery in Nigeria, Isola (2013) draws from other countries such as China, India and Ghana on how TM is regulated as a way of integrating TM into the Nigerian health systems. The author advocates for the institutionalization of TM by establishing centers of scientific research into plant medicine, large gardens of herbal plants, a research hospital for TM and university training programs in TM. One particular challenge in relation to Isola’s proposals with these institutionalization or professionalization of TMH practices advocated by many other scholars and national health policy analysts is that, it is more targeted at developing herbal medicine rather than TMH as a

medical system. Also, as observed by Hampshire and Owusu (2013), it could also make the TMH very expensive and also devalue lay knowledge. Added to this is also the fact that some TMPs are less or uneducated in the Western system of education and there is also a lack of systematic intellectual property rights for traditional knowledge systems. Hence, it could be a threat to the TMS without proper involvement of traditional healers or an understanding of their practices and theories of health and illness. The good will and intensions that many have towards the TMS could, however, lead to the gradual breakdown of it, should this institutionalization advocacy, with a complete lack of knowledge and understanding about the traditional system, be pursued.

Furthermore, other options and different integration systems have been identified by the WHO (2002:8-9) in different countries. The three major existing forms of recognizing TMH within formal health systems identified by the WHO (2002) strategy document include: integrative system, inclusive system and tolerant system. Integrative systems involves the recognition of TMH in the state national health and drug policies. Traditional healthcare providers and products are registered and made available in both public and private hospitals and covered by health insurance. There is also education and relevant research in TMH. On the other hand, the inclusive system only recognizes TMH but does not fully include it in the national healthcare policies and eudcational system. It is rarely included in the health insurance programs and there is minimal regulation of the service providers and their products. However, with the tolerant system, only certain practices of TMH are tolerated by national laws. Under this system, the entire healthcare system is largely based on allophonic medicine. The WHO (2002) report noted that only China, Vietnam, Republic of Korea and the Democratic People's Republic of Korea practice integrative system with most developing countries including Ghana, either practicing inclusive or tolerant national medical systems.

Similarly, in examining the relationship between national healthcare and indigenous health systems, Cunningham (2013:176-180) also identifies monocultural health systems, multicultural health systems (pluricultural) and intercultural systems as some of the common systems that

exist around the world[13]. The author believes that promoting intercultural health systems has more advantages, in most contexts, than the other two. Because, intercultural systems, which relates so much to the integration of different health systems do take different forms. It can either be in the form of; promoting the use of medicinal plants, establishing joint delivery of official and TM in the same health facilities or adopting the complementary approach between traditional and official health systems, where both healthcare systems maintain their authonomy but have coordinated referral and counter-referral agreements. Even though Cunningham's (2013) study deals with indigenous peoples and their healthcare system's needs and challenges, it has a similar focus on how TM can be integrated, as demonstrated in other studies.

To make a general conclusion on the review of relevant literature, I wish to make the following few statements. First, it is important to note that I have chosen these literatures because they have varied content and contexts on the subject matter of TMH, thus creating a wider picture about the philosophies, theories and practices within the system which underscores the cultural specific nature of that health system. Different attitudes and perceptions have also been noted about TMH among scholars and members of the formal healthcare system and some reasons about why many consumers of healthcare services do go for TM, healing or treatment. However, these studies differ from this current study. In some cases, some of them are archaeological based studies (Insoll 2011; Kankpeyeng, Nkumbaa and Insoll 2011), or have different backgrounds (Isola 2013; Omonzejele 2008) or are based on one side of the plural healthcare systems (Asante and Avornyo 2013; Nimoh 2014). This current study examines the perspectives of practitioners in both systems and healthcare service consumers. Most importantly, this study focuses on a paritcular cultural group, the Dagomba of Ghana.

The next chapter will present the discussion and analysis of the various medical practices within the TMS among Dagomba. How the Dagomba theories of health and illness and that of medical pluralism infleunce their medical practices or are influenced will be looked at in the next chapter.

[13] These categorizations by Cunningham (2013), however, are in relation to national health systems recognition of other cultures and their health practices. This and the WHO (2002) analysis of integrating healthcare systems are both based on wider and varied contexts which could be studied and narrowed to ones own local context.

CHAPTER 5

TRADITIONAL MEDICINE AND HEALING PRACTICES

This Chapter will present the empirical findings stated in Chapter 3. Here, I will do both analysis and discussion of these findings in relation to the practices of TMH among Dagomba based on their theories of health and illness and the medical systems available to them. The thematic issues and concepts covered in this chapter are descriptions of the practices of TMH within Dagbon. It also presents the challenges found in the TMS as well as attitudes and perceptions people have towards traditional healing. Finally, I will also relate the analysis and discussion in this Chapter to other findings on the topic of TMH in other studies.

5.1 Participants profile

Thirty-four (34) participants consisting of 11 females and 23 males took part in this study. The youngest participant was 20 years old while the oldest was 89 years. The average age of all the participants was 53 years. Two of them were widows, another 2 divorced with the rest being married. On the basis of their religious affiliations, 5 were Christians, 1 Traditionalist and the rest being Muslims. The majority of them (20) had no formal education, 3 had primary education while 11 had tertiary education. With the exception of all the PWMs and one of the TMPs who had formal jobs, the rest of the participants were farmers (14), petty traders (4), food vendor (1), primary school cook (1), healing (3) or a combination of farming and trading or farming and healing. With regard to the TMPs, none of them practice under an established traditional shrine. Additionally, with the exception of a few of the PWMs, the rest of the participants were all Dagomba. Details of the demographic characteristics of all the participants are attached in Appendix A.

5.2 The art of healing

The practice of TMH among Dagomba is complex and interrelated in varied ways. The ability of a healer to successfully treat and heal patients depends on several factors and processes. These are what give legitimacy and recognition to a healer as a revered one in his/her community. Some of the processes and practices involved in healing among Dagomba are presented below.

5.2.1 Traditional healers and their knowledge acquisition

Among Dagomba, how a person becomes a healer and through what sources vary. Based on the data, four different means of acquiring healing knowledge are identified. These are through the family, a search for it outside the family, spiritual calling, and lastly based on the search for treatment for oneself and then learning the art of healing afterwards.

The data showed that four of the traditional healers (TMP2, TMP3, TMP4 and TMP6) acquired their knowledge through their families. As TMP4 observes:

> Our father was a bone setter. We started learning it when we're young. Whenever our father was healing someone he'll allow us to observe and sometimes we'll also attend to simple cases. Our younger brothers are also learning from us. It's a family medicine. The three of us are all healing. When they bring a patient anyone of us who is around attends to that.

The two bone specialists, *tuʔɨlinima* (TMPs 3 & 4), and the other two herbal and spiritual specialists, *kpamba* (*kpema*, singular) (TMPs 2 & 6) even though they specialize in different areas, their knowledge acquisition was through the family. Their parents were healers and taught them how to heal through observation, tutoring, demonstrations and guided practicing.

Another source of acquiring healing knowledge besides the family is through the search for medicine to cure one's own illness and thereafter learning how to heal. One of the renowned healers (TMP1) acquired his knowledge through this means as he narrated:

> I was very sick. There were times they had to take me out to bath me. Sometimes they had to force open my mouth and put food in. One day, they took me out, bathed me and leaned me against the mortar in our compound. My father came to me. He called me three times and I responded. He asked me to leave town and search for healing for myself. I asked him: 'if I leave town who will be farming for you'. He said that was a childish question because if I go and treat myself, I could still come back to him, but if I die that ends it. I listened to him, left town and search for healing. Afterwards, I contacted many kpamba (healers) to learn both

> herbal and spiritual healing. This is why today I'm a known healer. I listened to my father; search for healing for myself and now I'm benefiting from his advice.

The third means of gaining healing knowledge is by learning to heal from others outside the family. This appeared to be similar to the second, but the difference is that, in the second case the person is pushed by illness and in the process of healing oneself, he/she learns the art of healing. But in this particular form, however, the learner contacts as many specialists as he can, to learn how to heal different illnesses. TMPs 7 & 8 acquired their healing knowledge through this means as explained by TMP7:

> Before 1994, snake bites used to be a serious issue in this village. Many people used to die of snake bites. So I went and learn how to heal that. But during the 1994-5 War, fire burnt the *wa?'zuli* (the spiritual cow tail possessing the powers of healing snake bites). So when we returned after the War, I had to make sacrifices to reignite it. I've been healing again since 1995.

The fourth means identified in this study is through spiritual calling. These healers specialize in healing spiritual illness of varied kinds. They get their knowledge in dreams, in the form of inspirations or direct communication with the spirit beings. Three of the healers in this study acquired their healing knowledge through spiritual calling. They are TMP5, TMP9 and TMP10. TMP10 uses only Quranic knowledge for healing people whose bodies have been inhabited by jinn. He recites verses in the Quran and other forms of Islamic prayer for his patients to cast away the spirits that are responsible for the patient's illness. However, TMP9 uses herbs prescribed to her by the spirit beings while TMP5 used both herbs and Quranic knowledge in healing both spiritual illnesses and other natural illnesses. TMP9 narrates to us how she acquired her healing knowledge:

> I've jinn with me. I was born with them. I'm told when I was born those spirits beings were always making noises around me. The spirit beings are those who always inform me whether to take a patient or not. They also tell me which herbs to use. They speak to me directly and I hear what they say. I only treat mental illnesses caused by natural spirits. I don't treat wee or drugs madness or *sambu* (human spiritual caused) madness.

These are some of the means through which many healers acquire their knowledge. I also observe that some healers combine these different sources to expand their repertoire of healing knowledge. Some of these and other different means of acquiring healing knowledge have been reported by other scholars, among other groups both in Ghana and elsewhere. Dove (2010:824) found that in the Northern part of Ghana, a child may acquire the knowledge through the family,

spiritual calling by a shrine or if he/she shows predilection for interest in herbs. Also, Tsey (1997:1067) notes that healing knowledge among the Ewes can be acquired through learning from a close family member, through formal apprenticeship under an established practitioner or through spiritual calling while Addy ([n.d]:5) identifies the family through parents and grandparents and spiritual calling through dreams and visions as some of the major routes to becoming a healer. Even though similar means of acquiring healing knowledge has been reported among other groups, the division of healers into herhal based and spiritual based healers was rejected by the traditional healers in this study. They acknolwdged that there are natural as well as spiritual causes of illnesses but indicated that every healer is a spiritualist. Some of them even rejected the idea that some illnesses can be treated based purely on herbal knowledge.

5.2.2 Illness causation

From the perspectives of PWMs, illnesses are caused by bacteria, viruses, fungi, chemicals, stress, poor nutrition, poverty, environmental degradation, family line, poor personal hygiene and sanitation, drugs and alcohol abuse. Generally, these causes can be grouped into lifestyle (personal hygiene, drug and alcohol abuse, stress and sanitation), genetics/heredity (family line), micro organisms (bacteria, fungi, viruses and other germs), chemicals and food, and finally social causes (poverty, illiteracy, and ignorance). All these sources of illnesses per the PWMs' perspectives seem to belong largely to the natural and social causes of illnesses. Thus, this limits healing and treatment of illnesses to the physical and psychlogical aspects of the human body's functions.

Relative to the Dagomba theories and based on both the traditional healers and consumers of health services, illnesses are caused by natural forces, the food we eat, jinn, gods, ancestors, human beings (witchcraft and sorcery), insects, snakes, poverty, stress, substance abuse, alcoholism, family line, poor hygiene (both personal and environmental), and finally those we are born with (the innate illnesses). It is also observed that the quality of a person's blood, his/her age and 'head' determine the rate and resistance level of the individual to illnesses. These causal factors thus can be put into natural causes, social causes, spiritual causes, family line or heredity, individual lifestyle, *nama* (ones creation and internal body status), and cultural norms (curse and

blessings). This perspective is similar to what the anthropologist, David Westerlund (2006) found in his analysis of religion and disease causation among the San, Masaai, Sukuma, Kongo and Yoruba people of Africa. He notes that diseases are caused by supra-human spiritits (God, gods, deities, ancestors), humans (witches and sorcerers through witchcraft, curses and blessings) and natural means (insects, germs, snakes, weather, food). Also, whereas Nkosi (2012), Liddell, Barrett and Bydawell (2005) both found that witchcraft and sorcery, ancestor spirits and other supernatural beings are the causes of illnesses, the latter also argue that pollutants (through semen, blood, menstrual discharge) which originate from people bodies also constitute sources of illnesses.

Accordingly, the Dagomba notions of illness causation is elaborate, complex and interrelated since there is always some amount of spiritual inclination to many illnesses, as observed by some participants. For instance, a 'snake bite can be natural (*chang cherigi*) or spiritually sent (*waʔ'bɛʔʊ*)'. 'A fracture or dislocation can be caused by a natural accident as in a motor accident or through human spiritual manipulation'. This emphasis on the duality of forces (natural and spiritual) behind every illness could possibly be the reason why most of the healers contend that traditional healing among Dagomba is largely spiritual based and that every healer is a spiritualist since natural illnesses could still have spiritualism attached to them.

It was also observed that some participants attributed the emergence of new illnesses to the food we eat. They argued that the rampant use of agrochemicals in the cultivation of most crops and vegetables could be the cause of some of the current widespread chronic illnesses (cancers, heart illnesses, ulcers, and diabetes). Additionally, they noted that illnesses which used to be age-specific illnesses (for instance, joint pains for the aged) now affect even the youth. The impact of agrochemicals on our health has also been observed by de Graft Aikins et al (2012:62-63) as they found that many illnesses in Ghana are linked to "toxic staple foods" as a result of the use of chemicals to induce faster growth in crops or in fishing.

5.2.3 Diagnosing illnesses in traditional healing

Finding out the kind of illness a person is suffering from and what causes it, is the beginning of the healing and treatment process in most medical systems. This is what determines the kind of

healing to perform and also whether or not to refer the patient to another healer or to a different health system.

Among the traditional healers, it also determines the status of a healer as either being powerful and genuine healer or a fake one. The four major questions that are asked during diagnosis among traditional healers in Dagbon include the following: What illness is the person suffering from? What is the cause of the illness? Why the person? Can I heal the illness successfully? And lastly, which of my medicines do I have to use in healing the illness? These questions seem to be ordered since healing cannot possibly commence without the healer knowing what illness the patient has. Also the cause of the illness has to be ascertained and why the person before questions relating to whether or not the healer will be successful in healing the illness are addressed. Both traditional healers and consumers of TMH know that healing also involves luck. This explains why a healer will need to find out if the patient has luck with him. The luck part of healing is expressed as: *O tilaa be N-sani* (translated as 'he/she has herb – healing – with me') or *O tilaa ka N-sani* (translated as 'he/she has no herb – healing – with me').

Comparatively, however, there seems to be different ways of diagnosing illnesses between the TMS and the WMS. When responding to the question: By what methods do you identify the particular disease a person is suffering from? PWM6 stated that 'illnesses are diagnosed through clinical presentations, physical examination, laboratory investigation, and radiological and CT scans'. Other methods listed by other PWMs included; 'anamnesis (medical history of patient), assessment of the patient, patient complains, and signs and symptoms presented by the patient. These methods seem to be uniform and common practices among many PWMs.

In relation to the traditional healers, however, other diagnostic approaches are employed although some of them are similar to those mentioned by the PWMs. Such common ways of diagnosing illnesses included; 'patients' narratives, physical signs and symptoms, body colouration, and internal movements and sounds within the body. This common means of diagnosing illnesses supports Nimoh's (2014:88) claim that traditional healers perform body examination "for skin color changes, joint movements, abnormal shapes, vomitus, stature and posture, and unfamiliar body sounds" in diagnosing illnesses.

Nonetheless, they are other individual diagnostic approaches based on their knowledge and powers as well as their lay understanding of illnesses. For TMP5, he notes:

> I can just look into your palm and tell your illness. My diagnosis is no longer based on bihigu gmebu (Islamic divination). Allah has blessed me with the gift and I can just look into your palm or into your eyes and tell your illness. Even if it's a stomach illness, I can tell that by holding your hand.

Other specialized ways of diagnosing illnesses among some traditional healers was explained by TMP1 in the following statement: 'when you come to me for healing, I'm not going to base my healing on what you tell me. I'll look into your blood first then I'll know what you're suffering from'. This method of diagnosing appears to be spiritual in nature just like TMP5 indicated. Similarly, other healers have charms they use for diagnosing illnesses as TMP2 indicates:

> When a patient is brought before me, what I've is like a belt. We'll tie it around the person and examine the body by touching around to detect the nature of the illness. Also, we've something we can place on the person. We'll know that his/her illness is this or that and who has caused it. This sickness is not natural, it's human caused.

These forms of spiritual diagnoses have been found to be the distinguishing features that mark out some traditional healers among their colleagues. As noted by (Evans-Anfom 1986, Barimah and van Teijlingen 2008 cited in Barimah 2013:204) "most Ghanaians prefer healers who have a 'third eye', the baility to foretell the future or make accurate predictions". Accordingly, having spiritual powers and the ability to diagnose illnesses spiritually is an important feature for being a powerful healer which also makes most healer in Dagbon spiritualists.

Finally, other means of diagnosing illnesses is through divination and consultation with deviners and soothsayers as TMP8 said:

> When someone comes to me for healing, I've to first consult. I tell him/her to give me some time to sleep over it. I'll then go to do consultation to find out what it is, what has cause it and whether or not I can heal it. I've to do all that before I start the healing process. If I know I can't heal the illness then I'll ask him/her to see another healer.

Usually, healers who do not have certain powers to tell the nature of illnesses and what has caused them are those who go to diviners for consultation. This has been noted by Kankpeyeng, Nkumbaan and Insoll (2011) when they assert that healing requires the identification/diagnosis of the cause of illness before the prescription of medicine and thus divination becomes very important. Diagnosing illnesses among Dagomba healers has very important roles it performs.

Apart from influencing the referals of patients, it also makes healers emphasize on the, what and why parts, of illness treament (what is the illness and its cause and why the person) before questions on, how it will be treated, are looked at.

5.2.4 Common illnesses

Traditional healers and the TMS handle a myriad of illnesses. These illnesses are common[14] in the sense that they form the majority of illnesses patients do take to traditional healers or in conjunction with the other medical systems. However, four major categories emerged within this collection of illnesses. These are gender and reproductive related illnesses, age specific illnesses, spiritual related illnesses and lastly other illnesses (which may somehow be seen as everyday common illnesses). Illnesses under the last category are usually those that some Dagomba will see as part of life and growing; they come and go.

5.2.5 Rituals in traditional healing

Like most other medical systems, healing and treatment practices under the TMS are generally rich with rituals and ceremonies, most of which either have spiritual meanings or are used to foster culture and relationship building. Also, some of the rituals and ceremonies have symbolic functions as well as gender dimensions. Beginning with the gender dimensions of rituals, it has been noted how men and women are treated varies during certain healing processes. As TMP7 pointed out, 'when healing a snake bite, we've to shave the patient on the third day if it's a male or on the fourth day if it's a female'. Another gendered dimension in healing was observed as TMP1 relates:

> When I'm healing *pa?'kohingu* (an illness caused when a man or a woman coughs during sexual intercourse. This is believed to have similar effects as HIV/AIDS among some Dagomba), I've to apply the medicine three times on the entrance to their room for the man to lick it and four times for the woman to also lick it.

[14] A list of most of these common illnesses, their native and modern names and causations identified in the data are attached as Appendix B. However, the names of some of these illnesses may not fit well into the western/modern medical labels.

Other instances of this difference, in the number of times men and women have to perform some rituals during healing, was also noticed by the bone specialists. Both TMPs 3 and 4 explained that when healing a patient, there are some foods and other things the patient is not allowed to eat or do. Hence, certain final rituals have to be performed after the patient is healed before he/she can begin to eat those foods again. This ritual however involves payment of some money in the following manner: 'for males they have to *pay kobɨsita ni pihita naata* (333) (equivalent to GHS 6.63 in Ghana cedis) and females *kobɨsinahi ni pihinahi naanahi* (444) (GHS 8.84)'.

Even though these gendered differences exist in the healing process, most healers indicated that there is no difference in healing males and females when they both have the same illness. The exception is only in relating to their reproductive systems since men and women have different biological features. And also, under fracture healing since men and women have different bone structures and strengths. What appeared to be the reason for these differences in rituals was observed to be the impact of the Dagomba culture on their healing practices. The healers claimed that; it is part of the culture, which they have grown up to meet. Others also stated that, this was how their fathers did it, as TMP7 explained in the following narrative:

> It's a tradition; for females their things are always done in 4s and males in 3s. Even when a woman dies and we are doing the funeral rites we do it on the 4th day and the prayer money is often kobɨsinahi (400) (GHS 8.00) or *kobɨga ni pihinahi naanahi* (144) (GHS 2.84) and for a man, it's on the 3rd day and the money is *kobɨga ni pihita naata* (133) (GHS 2.63).

Despite this cultural reason for some differences in healing practices between women/men, the two healers (TMPs 5 & 10), who practice Islamic healing either solely or with herbs, did claim that to them the difference in healing men and women is based on Islamic principles of modesty and other norms. They said Islam prohibits touching or seeing certain parts of a woman, therefore, during healing, women may be treated differently from men. Healing practices that involves massaging certain body parts or making incisions to apply medicine may not be done unto women. They are either allowed to take the medicine home, to apply it themselves or have their husbands or parents apply it to them. These gendered dimensions in healing have also been noted by Insoll (2011:194) in his archaeological study of the Talensi medicine shrine and its medical practices in Ghana. The author observed that in the Talensi shrine, medicinal substances were heavily engendered in the numerical evidence shown in both the preparation and

administration of medicine where the number three (3) was associated with males and four (4) with females.

Another important ritual dimension in healing practices relates to the use of the sacrificial animal and its colour. Many of the healers recounted that in healing this or that illness, the patient will have to provide either a red cock, black hen, white sheep or mixed coloured goat. What this means is that different animals with different colours are used in many sacrifices during healing depending on the nature of the illness and its cause. However, it was noted that most of the illnesses that involve making sacrifices during healing are spiritual in nature. This notion was inferred from TMP2 in the quote below:

> for most of the common illnesses, if we ask for a hen or a cock, we're are just doing it to make you feel that what we're giving you is serious. Other than that, the herbs are enough for it. But you see, some people just feel that if you don't slaughter a fowl, it seems like a joke.

But what is the reason for using different animals with different colours in making sacrifices during traditional healing? Two reasons were provided for this: The first reason was to make a sacrifice to the ancestors and those who were the owners of the medicine the healer is using in healing particular illnesses or to make prayers to Allah for guidance and support in the case of the Islamic based healing. This reason for sacrificing resonates what TMP8 stated: 'Sometimes we've to make sacrifice to our ancestors to ask for their support and guidance in healing the patient'. The second reason related to the spirit beings within the healing medicine. These spirit beings will feed on the blood of the sacrificed animal as its food and then work to remove the illness in the patient. This idea was made clear when TMP6 narrated this:

> The colour of the fowl I use, depends on the nature of the illness and the medicine I'm going to use to heal it. I sacrifice a hen or cock to the spirits within the medicine. That is what they need to do their work. They use the blood to work with. Then we use the meat of the animal to prepare the part of the medicine the patient will eat. The medicines are different and so are the sacrificial animals.

Related to the above was another instance of sacrificing to the spirit beings even when harvesting some herbs. TMP3 explained that for certain plants, before you can take its parts as herbs, you need to sacrifice a hen or an egg to it because they are spirits inhabiting the tree. So, you need to ask for permision from them before you cut the tree. This notion of sacrificing to ancestors or other spirits and gods in the TMS shows that traditional healers recognize the existence of the

spiritual world and the links human have with it. It shows the interrelationship humans have with plants, animals and spirits. This relatedness of humans and spirits could possibly explain why healing under the TMS is diverse and targets many aspects of the human existence. Though different interpretations and reasons are given to the colour of the sacrificed animal in healing, Insoll (2011:195) found that the colour of the animal offered during healing can be significant.

Another instance of ceremony or ritual noted in healing, especially in fracture healing is the practice of breaking parts of a cock to correspond with the part of the patient's body parts that is fractured. That is if the fracture is on the arm, the wing of the cock is broken and if it is the leg, the leg of the cock is broken. Then healing is provided for both the cock and the patient. Whatever medicine is applied to the patient, the same is given to the cock. The belief with this ritual is that when the cock heals, the patient heals too. It is also believed that this cock is never sacrificed nor stolen. Anyone who steals such a cock will have a fracture and will reveal his/her identity since he/she will be brought for healing. Also, when the cock dies, another one is provided until the patient is fully healed. Apart from these beliefs and practices associated with that ritual, there was no particular reason given as to why that is done other than that it is a tradition passed down to them by their fathers. However, the bone specialist (TMP4) said that they no longer break part of the cock. But they still take the cock and keep it around. So the patient must provide that cock since it is part of the healing process per their practices.

5.2.6 Spiritual healing

Tisablim, a term which can be translated as spiritual healing among Dagomba, is a major component of the TMS. Perhaps, practices under this domain may be what add to the uniqueness and cultural specific nature of the TMS. Spiritual healing involves providing cure, treatment or management of illnesses, which are believed to have spiritual causal origins. It tries to provide a balance in the patient's physical and social world with the spiritual one. These illnesses could be caused by human spiritual involvement, or other superhuman beings such as jinn, ancestor spirits and gods. As a departure from other illnesses, spiritual illnesses require some special diagnoses which may not base so much on presenting physical symptoms of the illness. As observed in the data, most spiritual healing practices, though not exclusive, involve rituals, cleansing and

ceremonies, as noted in the immediate previous section (5.2.5) above. In a sense, spiritual healing is a way of acknowledging the spiritual dimensions of nature and how humans, through their social and physical interactions, must ensure a balance or be in harmony with it. This has been recognized by the MOH (2003:3) code of ethics as it observed that disease causation in TM has both spiritual and physical (psychosomatic) dimensions.

Thus, spiritual healing may go beyond the human self to include the entire society as in pacifying gods during drought for the rain to fall, or families sacrificing to their dead relatives or family spiritual medicine for the protection of the entire family. Among Dagomba, some of the common illnesses that are treated through spiritual healing include *sambu, dihili* (spiritual food poisoning), *paʔ'kohingu, daʔɨri doro, yinyahili* (mental health or madness), *yukurɨli* (old wounds/sores), *kpilinkpihi* (epilepsy), and many others. However, it is also important to note that there is still spiritual involvement in the treatment of other common illnesses, since some of the healers believed that traditional healing is more spiritually based than knowledge based, although others agreed to the existence of both. Apparently, this is also an area which constitutes a source of conflict between TMPs and PWMs as I will show later. The relevance of spiritual healing has also been observed by Tabi, Powell and Hodnicki (2006:56).They claimed that when an illness is caused by spiritual agents then it has to be treated spritually. Similarly, Darko (2009:16) argues that spirituality cannot be separated from TM because of the vital role spirits play in the life of some Ghanaians.

5.3 Patient referrals in traditional healing

Based on the existence of medical pluralism in Dagbon society and also based on the fact that these medical systems have different theories on health and illness causation, different treatment and healing options, different philosophical foundations, and different effectiveness and cost of treatment, patient referrals seem a common phenomenon. There is cross referral of patients within the three medical systems shown in figure 4.2 in Chapter 4. Within the WMS, patients are often referred from one hospital or clinic to another of higher status with both superior medical equipment and personnel. Also, within the same hospital, patients could be referred from one department to another for purposes of consultations, medical test or for medication. However,

referral of patients from the WMS to the household system or the TMS rather comes with complications and worries. Due to the fact that TM, healing and traditional healers are not fully recognized in the Ghanaian formal health system, there seem to be no formal referrals of patients to that system. Some circumstances under which referrals are made from the hospital was explained by PWM8 in the following quote:

> When there is no physiological basis for patients medical conditions under the modern (western) system we ask them to go home and seek home treatment. Illness such as possession by jinn is an example of such illness or non-surgical management of fracture. I know one healer but it's not formal. Clinicians have even invited him for some information.

Another practitioner (PWM1) noted that when the medical condition of a patient requires very high cost for treatment and they know that the patient cannot afford it, they will ask him/her to seek home treatment. All these point to the worrying nature of patient referrals from the WMS to the household or the TMS. The general observation is that patients who go from the hospital to traditional healers do so under the influence of family members, or on minimal cases, by western practitioners telling them to go to particular healers they know about in an informal way.

On the contrary, referrals from the TMS, both within it or across it to the WMS, are influenced by several factors, some of which are similar to those under the western system (cost and effectiveness) while others are complex and spiritually informed. Three reasons were given to account for why patients are referred to the WMS. One such reason was the need for water or blood transfusion as reported by TMP2:

> We ask patients to go to hospital because we don't have control over water and blood. When you are healing a person and notice that the illness is no longer active but the patient seems not to be fit, it could be that he/she is short of water or blood. So we've to ask him/her to go to the hospital for check up. In most cases, it does happen that they're in short of blood.

A second reason why patients are referred to the hospital for treatment is due to the need for surgical operation or for open cuts to be stitched. Especially, in fracture healing, TMP3 noted that when a patient is brought to them, they will examine the fracture and if it is complicated they have to ask the patient to go to the hospital so that he can be operated on for the broken pieces of the bone to be fixed and open cuts stitched then he/she can come back for healing. A third reason though closely related to the second has to do with referring patients with some common illnesses that can be effectively treated in the hospital. Patients with simple *kpaʔʒiɛʔʊ* (malaria or fever) or *kpaʔa* that has accumulated at a particular point on the body are usually

referred to the hospital for treatment or operation. Also patients who are interested in the hospital system or whose family is interested in the hospital system are referred to the hospital. As TMP1 observed, 'if a patient's family is interested in going to the hospital then I've to allow them to because if I don't and something goes wrong, they'll be blaming me or the patient'.

Based on these narratives, it appeared that traditional healers do more referral of patients to the WMS (represented here by the hospital) than PWMs do to the TMS; a similar finding has been made by Gyasi et al (2011:44-45). The reason for this could be based on policy lapse in the sense that TMH and healers have not been fully recognized by the law in Ghana though some of their practices are tolerated.

Referrals within the TMS, however, are informed by some factors. The most common reason for referring patients from one healer to another was reported to be the lack of healing medicine for a particular illness by a healer. This particular idea on patient referral within the TMS was explained by TMP2 in this narrative:

> When a patient is brought to us, first we tell him to go home and give us some time to find out about the illness. I refer patients on two grounds. When I do my consultations and they come back. I can tell them: *O tilaa ka N-sani* (translated as 'he/she has no healing with me'). This could mean that I have no medicine for that illness so I'll ask them to see another healer who has that medicine. I can direct them to a particular healer I know who can heal it or I just tell them to find another healer.

The second factor is that when the healer knows that he/she cannot successfully heal the patients then he will refer them to another healer. He/she could also commence treatment and later refer the patient to another healer or invite that other healer to come and assist him/her. This point was the second meaning given to the expressions: *O tilaa ka N-sani* (he/she has no healing with me) or *O daliri ka N-sani* (he/she has no luck with me) as TMP2 elaborated in his narrative:

> When I say; *O daliri ka N-sani*, it may not necessarily mean that I don't have medicine for the illness. It could also mean that I won't be successful in healing the illness. You know, sometimes healing goes with luck. So I can tell them to see another healer after doing my consultations.

This perspective points to the 'head' (luck) part of the individual person under the Dagomba theories of health and illness. The 'head' of a person does not only influence his/her level of susceptibility to illnesses but also his/her chances of getting healing from a particular TMP.

The third reason for referring patients within the TMS, which was observed to be highly confidential and relates so much to secrecy in traditional healing, was the notion of a patient surviving an illness. For most of the healers, when they diagnose a patient and know that the patient will not survive the illness, then they have to either refer the patient to another healer or give him/her medicine and ask the family members to take the patient back home even if the illness had required that the patient be kept at the healer's place. This reasoning was inferred from the following statement by TMP5:

> As a healer, it's not good to have patients dying under you. Even medical doctors don't like that too. It spoils your records. So as Dagomba healer or medical doctor you should have *Nɛli* (a spiritual means) to identify illnesses fast. So that if it's something you can't heal then you can ask the patient to go elsewhere to avoid the patient dying under you.

Based on these explanations, it is clear that patient referrals within the TMS are not only due to the lack of medicine for the patient's illness but also due to whether or not the patient has the luck of the healer or will survive the illness. Most of these reasons are however concealed, especially the last one, when doing the actual referral of patients among healers. It is usually expressed in a neutral way within the language as either simply: *O tilaa ka N-sani* or *O daliri ka N-sani.*

5.4 The concept of secrecy in traditional healing

Secrecy in its diverse ways is seen to be an important human phenomenon. Whereas in some instances, it is used as a means of communications, in others it is used to conceal information or identity. Within the medical field, however, secrecy has often been interpreted differently in the WMS and the TMS. In the WMS, secrecy has often been seen as confidentiality, a professional practice which is held in high esteem. Western medical practitioners are supposed to hold the medical conditions of their patients in secret both from other patients and from the public. When they are able to do this, they are trusted, praised and thought to have observed medical professional standards and codes of ethics.

The same perception about secrecy has not, however, been given in the TMS. Some members of the academia and the WMS do have a very pejorative and shallow interpretation of secrecy as used in the TMS. The common interpretation given to it is that traditional healers practice in

secret occultism or hold their knowledge in secrecy without disclosing it for public benefit (Barimah 2013). But secrecy performs several important roles in the TMS as it has been established in this study.

In the first instance, secrecy in traditional healing has been found to perform a similar function as patent which traditional healers use to protect their intellectual property right as observed among some of the traditional healers:

> When you don't trust someone you don't give him your healing knowledge or powers. They can go and sell it in the open market and that can kill the medicine. And you know, *Dagban tim* (Dagomba traditional medicine) should not be sold.

The practice then among most healers is to withhold information about one particular herb or the healing process to someone they don't trust very much. This idea of protecting their herbal and other traditional knowledges even came up during some of my interviews with the traditional healers. Some of them wanted to know if I was doing the study for doctors or if some doctors had sent me to find out from them. This shows how curious some of the traditional practitioners can be when it comes to guarding and protecting their knowledge. Other studies have found this role, that secrecy performs in traditional healing or in protecting traditional and indigenous knowledge, as Ofosu-Amaah (2005) believes that the requirements for protection under international standards for patent law as well as national conventional paten laws are inadequate to protect traditional knowledge and biodiversity. Similarly, Cunningham (2013:177) asserts that though there is a growing tendency to legalize the use of medicinal plants, and by extension traditional medical knowledge, laws often fail to recognize the property rights of indigenous and traditional knolwdge and those who hold that. The author further notes that these people often become reduced to marginal actors in the implementation of norms relating to their knowldges, a view similar to that of Nimoh (2014:85) when he claims that the "attempts to tap into, analyse and systematize traditional medicine have not included adequate inputs from traditional healers". Hence, the reluctance of traditional healers to release their knowledge as complained by some researchers. This points to the fact that traditional healers do not only lack adequate laws to protect their knowledge but they are also often excluded from decision making processes that deal with the use of their knowledge and other traditional practices deemed valuable to society. This could possibly explained why they practice and hold their knolwdge in secrecy.

Another role that secrecy performs is for the protection of patients during traditional healing. Some illnesses are known to be very complicated or dangerous among the Dagomba. Hence, when such illnesses are diagnosed in a patient, it could have serious psychological effects on the patient. This function of secrecy as it applied in traditional healing was explained by TMP2 thus:

> When patients come to me and describe their illnesses, I listen to them. Then I'll do my own consultations. If what I find is different from what they told me I can tell them the actual illness depending on whether it's simple or serious. There are some illnesses even if what they tell me is the same as what I've found I'll never let them know that it's that illness. The reason is that I want the patient to have a sound mind. I don't want him/her to have any heart breaks (suhu damli). It can make healing very difficult. If a patient can't eat or drink then how do you get him to take the medicine? So they need to have peace of mind in order to eat and drink. Then healing can go well. This is why we don't tell our patient some illnesses they're suffering from. We keep it secret and continue the healing process.

This role of secrecy performs a psychological function which is equivalent to counseling within the WMS since sometimes patients are given counseling before the results of their medical tests, conditions or diagnoses are made known to them. It is also pragmatic in the sense that healers know that patients though under illness, still need some peace of mind in order to be able to eat and drink well, because one of the most common means of administrating medicine within the TMS is through oral ingestion.

Related to the above, is the idea that secrecy is used to protect the potency of spiritual healing medicine and the healers' track records. Most of the traditional healers observed that spiritual illnesses which are caused by human beings (through witchcraft and sorcery) are very difficult to heal since the one behind the illness can fight the healer, the medicine or both. Therefore, in healing most human-caused spiritual related illnesses, the process is done in secrecy to protect the potency of the medicine. Similarly, secrecy is also used to protect traditional healers' records. As I pointed out in **Section 5.3** under referrals of patients, it has been noted that when patients will not survive their illnesses, many healers will refer them to other healers or give the patient medicine and ask their caretakers to take him/her home. This is done in secrecy because the healer will never tell the patient that he/she will die out of the illness. Also, most traditional healing processes involve making sacrifices, rituals and performing other ceremonies. Per the Dagomba beliefs and cultural norms, these things must be done in secrecy (*ashili*), hence, the notion that traditional healing is *ashili* within Dagbon.

Based on these observations, the concept of secrecy has more dynamic functions in traditional healing and among traditional healers than just being an occult practice or a way of keeping their knowledge to themselves. Members of academia and western medical practitioners should therefore see secrecy in TMH in this broader perspective and work cooperatively with them if they so wish to understand how things are done within that medical system. Benefit sharing could also be discussed with them as recognition of their property rights and co-owners of whatever knowledge or result is co-produced with them.

5.5 The choice of a health system

With references to the opening quote in Chapter 1 and that of the model of medical pluralism in Dagbon in Chapter 4, choosing a health system for one's illness has several factors influencing that. Also, many health decisions, whether to seek healing and treatment from the WMS or the TMS or both, are rather taken within the household system. Practitioners within these medical systems all have some amount of knowledge about which illnesses are taken to which health systems or what illnesses to refer to which health system based on some interrelated factors.

One of the influencing factors in choosing which health system to attend to during ill health is the nature of the illness. For most of the healthcare consumers who took part in this study, some illnesses are for the 'hospital system' (the western medical system) while others are for the TMS. When asked to list illnesses which are 'hospital illnesses' or illnesses for traditional healing, these were some of the responses provided. Participant CHS4, during the first focus group interview noted that:

> Illnesses such as malaria, headache, operation illnesses, stomach pains, and open deep cuts are hospital illnesses. Epilepsy (*kpilinkpihi*), sickle cell (*darmihi*), spiritual food poisoning (*dihili*), *sambu*, *yoʔʊ*, *kpaʔ'piɛliga*, and lordosis (*waʔ'gurugu*) are illnesses for traditional healers.

Participants claim that for some of these illnesses, they are easily treated either in the hospital or by traditional healers. Particularly, illnesses that require surgical operations, blood transfusion, drips or stitching are generally sent to the hospital for treatment.

Related to the nature of the illness is also the belief about the cause of the illness. Based on Dagomba perspectives on illness and health, some Dagomba argue that illnesses have multi-causal factors but their explanation can be dualistic. There is both natural and spiritual explanation to most illnesses and some natural illnesses could even have spiritual inclination. However, the general opinion was that most illnesses which are belief to be spiritually caused are sent to traditional healers. Some of such illnesses include; jinn inhabitation, *sambu*, spiritual poisoning (*dihili* and *sambu*), spiritual madness, *yoʔʊ*, boils (*morlim, bingohi, bintora*), epilepsy (*kpilinkpihi),* sickle cell (*darmihi*) and others. For these illnesses, the belief is that even if they are sent to the hospital, they may not be any physiological basis for them and so the patient may be told to seek for home treatment. Or even when they are diagnosed in the hospital, they may not respond to treatment. This finding confirmed what de Graft Aikins et al (2012) found in their study of lay representations of chronic diseases in Ghana. They observe that though epilepsy, sickle cell and diabetes were listed as heredity (linked to family) illnesses, they were believed to be spiritually caused and thus required expert spiritual treamtment. Citing Twumasi (2005), the authors further note that "spiritual causal theories of illness are an important part of Ghanaian cultural health beliefs" (p,65). This supports the idea that both consumers of healthcare services and healthcare practitioners know which illnesses are taken to which health systems for healing or treatment even if some PWMs have different opinions about some of such beliefs. Also, the *yoʔu* illness has been found to be intolerant to injection (Bierlich 2000), hence, patients with *yoʔu* illness can only seek for treatment from the TMS. Although the nature of an illness and belief about its cause are influencing factors, they can also be generally linked with family pressure, since in most cases it may be a family member, who based on the nature of the illness and its cause, influence the patient, to seek for healthcare in a particular medical system.

Other important factors that influence people's choice for a health system include the availability, accessbility, effectiveness and affordability of the healthcare system and its services. Most healthcare consumers use the TMS for some illnesses because they assert that traditional healers are available (perhaps live in the same community with them) and their services are accessible, effective and affordable. Many traditional healthcare services are said to be less costly and or could even be paid for in kind. Apart from these, the system is also known to be effective for treating certain illness (*yoʔu*, mental health illnesses, and other spiritual illnesses

such as *sambu* and *dihili*). Asante and Avornyo (2013:260) agree with this when they assert that TMH is accessible, available, efferctive and affordable and provides healthcare services to over 70 percent of the popualtions in Ghana and Africa. On the other hand, healthcare consumers use the WMS because their services are effective for illness that require blood and water transfusion, surgical operation, for stitching open cuts and other new and complex illnesses.

Finally, it is also found that some socio-economic factors such as poverty, religious belief systems, level of education and the status of the individual also influence people's choice for the various healthcare systems available. For instance, poverty, among Dagomba, is seen as an illness (often called *fara doro*). As one CHS said; *fara nyala doro* ('poverty is sickness'). Hence, many people go for traditional healing because they cannot afford the cost of accessing western medical services. Even though the National Health Insurance Scheme cover a number of illnesses and diseases, a lot more are not covered by this scheme. Accordingly, patients whose illnesses are not covered by health insurance have to bear the cost of treatment. Moreover, not everyone is able to pay the premium in order to be covered by the national health insurance. This finding is similar to those of (Nimoh 2014:91; Tsey 1997:1072; Asante and Avornyo 2013:259-260). Whereas Asante and Avornyo (2013) found that traditional medicine and healing is effective, affordable, accessible and available, Tsey (1997) noted that some healers take some patients because they know that the patient cannot afford the cost of hospital treatment which some PWMs also know as remarked by a doctor; "they only come to the hospital as a last resort … I don't blame them, it is the astronomical costs of drugs that is preventing them". Again some Christians and Muslims may not access some traditional healing practices (rituals, ceremonies, sacrificies and divination) because they may see that to be against their beliefs and hence sinful or Satanic. People level of education can also influence the choice of the medical system they attend to for their health needs. Many of these factors have also been noted by (Tabi, Powell and Hodnicki 2006; Hampshire and Owusu 2013).

Despite these categorization of illnesses for healthcare systems, the general observation is that most patients combine the services of these medical systems in diverse ways when seeking for health. Some patients may start with the WMS and end with the traditional one and the vice versa or that they use both medical systems concurently though these practices among patients

do constitute a source of conflict between them and some PWMs as shown in the opening quote and also observed by Tsey (1997:1072).

5.6 Emerging trends in traditional healing

The TMS is dynamic and in constant exploration to create new practices as well as incorporating other practices from other medical systems into its domain. A number of certain developments were identified as new and emerging practices within the medical system. Some of such practices are discussed below.

To begin with, transmission of medical knowledge within the TMS used to be done through oral means. By this method, learners of TMH are told illnesses, their causation and symptoms as well as their modes of healing. The medicinal plants and other herbs used in treating them as well as the healing procedures are all narrated to them. Learners thus observe healing practices and also carry out guided healing services under the watch of their teachers. This was made clear when TMP6 said this: "I learned everything from my father by committing them into memory including names of herbs and illnesses they're used to treat". However, an important new practice has emerged where traditional practitioners now begin to document their knowledge in the native language. Many of the traditional healers who took part in this study indicated that they now have their knowledge being documented either by their younger brothers, children or grandsons who are learning under them as TMP8 stated:

> I've someone learning under me. I've even asked them to document it. I won't fail to do that because I know I'm going to die someday. I was only 2 years old when my father passed away. It was my elder brother who took care of me until I was grown. So I won't let my knowledge go to waste when I die. I've given them a book to document all the knowledge I've so that in future they can use it.

Besides this, another important new practice within the medical system is the incorporation of some western medical equipment and techniques into traditional healing practices. Among the bone specialists, X-ray pictures, bandages, cotton and crutches are used as part of their healing practices. The traditional bone specialists stated that they use X-ray pictures to help them assess the nature of new fractures which are complicated or old fractures that need re-examination when patients are referred to them for treatment. Also crutches are now used instead of a stick to

support patients who had leg fracture and need to start walking again during the healing process. Also, some western medicines and medical services such as blood and water transfusions are also used by some traditional healers alongside their traditional medicines in the healing process. The bone specialists reported that they use azole, gloves, bandages, penicillin powder, cotton and gauze for washing and dressing of their patients' wounds or sores. Similarly, TMP6 also stated that he gives paracetamol, amoxicillin capsules and other 'western pain killers' to his patients during the healing and treatment process and that he also often calls upon some nurses to give his patients drips or blood. These trends confirmed what Hampshire and Owusu (2013) found in their study of four traditional doctors in Southern Ghana. They found that the four doctors use post cards, radio broadcast, white coats, and other modern techonology in their practices, thus mediating between the traditional and modern medical practices.

These innovations within the traditional medical system, not only indicates how dynamic the system is, but also show how interactive it is with other medical systems, as illustrated in figure 4.2 in Chapter 4. However, it is important to state that the use of nurses (for water and blood transfusion or for other services including injections) by TMPs is based on local arrangements with the healers and those PWMs in the study context. But where the need for X-ray pictures or for stitching open cuts are concerned, then patients have to be referred to the hospital for that.

5.7 Challenges in traditional medicine and healing

The TMS, like most other medical systems have certain challenges it faces. Whereas some relate to the resources used in the system, others relate to its medical practices. The challenges observed in this medical system can also vary when examined from the perspectives of the practitioners, healthcare service consumers or by practitioners of other medical systems. In most cases, however, some of the challenges could converge.

There were five major challenges identified in this study. They include the lack of access to some herbal or medical plants due to the depletion of the vegetation. Others were the problem of accommodation for patients whose illnesses required that they are kept at the healer's place as well as the cost of buying other herbal materials from the market., A means of transportation to

harvest herbs and lastly spiritual attacks from perceived inflictors of spiritual illnesses (through sorcery and witchcraft) were also noted.

Through the narratives of some traditional practitioners, it was noted that most of the common herbal plants they used to collect at a walking distance from their homes can now only be harvested by cycling to distant locations for them or that those plants have disappeared completely within their locations. As TMP5 observed; 'for a herb like *jerigɨli,* you can't easily get it now because of deforestation. You can only get it at places that haven't been farmed for at least 2 years'. The depletion of some of these herbs was attributed to deforestation as a result of continuous farming or expansion of settlements. Another challenge relating to herbs is the cost involved in buying some of them. Herbal materials in the form of inorganic substances, some special plant parts or bones of some animals could only be obtained in the market or sent for from other locations, especially when the healers resides in an urban area. This does not only make is costly to obtain such herbal materials but also it makes it difficult to access them as TMP8 explained:

> These days it's hard to get some herbs. For some, you need to buy them and others you have to send for them somewhere. For a herb like nar'gbandi, I've to send for it from Mampurugu land since we don't grow *nara* (a cereal from the millet family) here.

The difficulty in getting some herbs either due to forest depletion, the cost of buying them or lack of means of transportation to harvest them on the part of the healer has some implications for traditional medical practices within the study area. This has the potential of changing the relationships between healers and patients in two instances. First, this could lead to the involvement of money in the process, since patients or their relatives could be asked to buy some of these herbal materials, hence the notion of buying the medicine. But Dagomba traditional healers believed that money kills the medicine and so TM should not be for sale. This can affect the relationship between healers and their patients. Secondly, some patients access TMH because they may not be able to afford western medicine and so these challenges could compel them to make some financial commitments in the process, thus further stressing them out, although some services could be paid for in kind.

The problem of accommodation within the medical system is crucial. It does not only make it difficult for healers to keep patients with them, while treating them but it also relates to issues of

secrecy, protecting the patient and power relations which has some implications for spiritual healing and the inclusion of the medical system into the formal health system in Ghana (more discussion is done in section 6.2). The lack of accommodation facility for healers to keep their patients means that aspects of healing practices that are done in the closed and other practices of spiritual healing are challenged. It also means that healers do not have full control over who visits the patient. The value of having a place to accommodate patients was observed in the following narrative by TMP4:

> We'll want to have our patients stay with us here. When I've to go to the hospital to treat people, there are some things I can't do. Doing it there is like going to the market to sell yourself out. It'll be too open. So I want to have my patients here. Also it's because some patients' illness might be caused by someone. So treating the patient in our own home, we can identify such persons and prevent them from visiting the patient. But in the hospital, you can't have such powers and control over visitors.

Finally, fighting spiritual battles as a healer is also one of the major challenges traditional practitioners may have to go through. In healing spiritual illnesses, some healers observed that, one could be attacked spiritually if such an illness is human caused. They noted that witches, wizards and sorcerers who are behind some spiritual illnesses could attack the healer and his/her medicine as well as the progress of the patients. This particular challenge was noted in expressions such as; 'sometimes you need to prepare yourself spiritually before you can treat some patients', 'we do get spiritual attacks for healing some patients', I'm not that powerful to keep patients here' and many others. Generally, some of these major challenges have been reported by (Darko 2009; WHO 2002:4) such as lack of patent or intellectual property rights for healers' knowledge, no legal recognition of their practices and deforestation/depletion of plant resources.

These challenges, especially those relating to the disappearance of herbal plants, lack of accommodation and means of transportation, as well as the cost of buying some herbal materials, may have a combined effects of increasing the cost of treatment or healing under this medical system. This would have a greater impact on the rural poor and many disadvantaged communities given the fact that there are already high disparities in both the distribution of health facilities and health personnel in the country.

CHAPTER 6

TOWARDS THE INCLUSION OF TMH

This chapter discusses briefly the discourse surrounding the inclusion of TMH in the formal Ghanaian health system by examining some opinions and perspectives from the main actors in this study. It focuses on the perception and attitudes that PWMs have about TMH, how TMPs think about the way PWMs see their work, the possible options for including TMH in the formal health system and some few policy demands and challenges in relation to improving standards among TMPs and their work. In particular, I will point out in this chapter some few implications that the perceptions of PWMs or the standardization policies on TMH may have for integration.

6.1 Attitudes of practitioners of western medicine towards TMH

There appeared to be mix attitudes towards TM and traditional healers and healing by most of the PWMs who took part in this study. Whereas the majority of them (6 out of 10) agreed that TM and traditional healers are effective in treating some illnesses, with the remaining 4 having different opinions, over half of them (6 out of 10) have never recommended their clients for TM or healing. Also 5 out of 10 stated that they will not use or recommend TMH. Those of them who think TM is effective or that traditional healers can treat some illnesses observed that illnesses such as spiritual poisoning, jinn possession, simple fracture, diabetes, sickle cell, stroke, hepatitis, mental illnesses and lordosis are some of such illnesses. A few of these practitioners were also those who indicated that for some of these illnesses, they have recommended home treatment for their clients either because of high cost of treatment or because there was no medical basis for their conditions under the WMS. They again stated that the categories of TMPs they could work with are; bone specialists, herbalists and spiritualists. On the other hand, those WMPs who said TM and healers are not effective were those that stated that they have never and will not recommend TMH for their clients. A summary of these responses are shown in Table 6.1 below.

Table 6.1: Perceptions of PWMs about traditional medicine, healers and healing

Participants	Do you find TM to be effective?	What illnesses is it effective for?	Will you use/ recommend it for your clients and why?	Do you find TMPs to be effective in treating illnesses?	What illness do you find them to be effective in treating?	Have you ever recommended TMH for your clients and why?
PWM1	Yes	stroke, hepatitis, typhoid fever	Yes, when WM fails to work	Yes	stroke, hepatitis, typhoid fever, alcoholism, gonorrhea	Yes, because of high cost of treatment or when no medical basis is established
PWM2	No	None	No	No	None	No
PWM3	Yes	simple fracture	No, its mode of treatment isn't attractive	Yes	simple fracture, mental illnesses	No, they cause more harm than good
PWM4	Yes	fracture	Yes	Yes	fracture	Yes, based on personal reasons
PWM5	At times	Can't best tell	No	Sometimes	Not conversant	No
PWM6	No	None	No, because I have little knowledge about that	No	None	No, don't know much about traditional medicine/healers
PWM7	Yes	malaria, sexual weakness	No	No	I don't know	No
PWM8	Yes	Tropical illnesses, hepatitis	Yes	Yes	diabetes, hypertension, fracture, malaria, jinn possession	Yes, when there is no physiological basis for illness
PWM9	No/Yes	Sickle cell	Yes, sometimes WM is not reliable	Yes	diabetes, fracture, spiritual poisoning, hepatitis	Yes, when illness is not responding to treatment under WMS
PWM10	Yes	lordosis	Yes, they treat many illnesses	Yes	lordosis	No

Source: Field data, 2015

The observed reasons for these mix expression about TMH among PWMs stem from two main factors. The first is that there are no established laws in the country for now that requires that PWMs can confidently refer patients to traditional healers. This explains why though 60 percent of them acknowledged that TM and healers are effective only 40 percent of the practitioners have recommended TMH for their clients or only 50 percent of them are willing to recommend TMH for their clients. It is also important to note that those who have ever recommended it did so informally. The second factor is that some of the PWMs have little knowledge about TMH or about illnesses that traditional healers do treat. As PWM6 indicates; 'I don't use or recommend TMH because I've little knowledge about TM and besides I don't even know the diseases traditional healers actually cure'. However, some of them confuse TM with herbal medicine, when of course herbal medicine is a component of TM. Thus, their lack of knowledge about TM or the work of traditional healers could possibly be an explanation to why they do not recommend its usage.

Generally however, despite these mix expressions about TMH or about traditional healers, other comments about the practices of traditional healers were made. Most of the PWMs observed that TMs lack some information about dose and dosages, expiring dates, are prepared under unhygienic conditions; involves the use of a single drug for several diseases or that traditional healers are illiterate; practice in secrecy and spiritual involvement or make false claims about curing diseases which are scientifically proven to be incurable such as HIV/AIDS, sickle cell and hemorrhoids, and finally no documentation of the safety and efficacy of their medicines. Table 6.2 shows the summary of these notions.

Table 6.2: PWMs observations about traditional healers and some of their medical practices

participants	What will make you reject the use of traditional medicine?	What aspects of traditional medicine will you want to be improved?	What challenges do you think TMH has?	What can post as a challenge for integrating TMH into the formal health system?
PWM1	Lack of standard dosage protocols. Treatment is carried out under unhygienic conditions	They should improve on hygiene and the dosage of their medicines	Poor environmental conditions. Inability to prove scientifically the constituents of their medicines	Cultural and religious beliefs of the healers. Their lack of basic education
PWM2	Their lack of knowledge about diseases. They practice in secrecy and spiritualism.	They should open up and share their herbal knowledge and skills	Don't know	Their belief in spiritualism. The lack of understanding about their mode of operation. They lack necessary equipment to ascertain the quality of their products
PWM3	They lack formal training. They don't know the implication of what they do.	How they handle psychiatry cases	Dosage of their drugs. No stated side effects. Unhygienic preparation of their medicines.	Lack of education on healers' part.
PWM4	Because of the hygiene issues of their products and practices.	They should improve on their management of fracture	none	none
PWM5	Because of the quality and quantity of their disposed drugs	The management of bone setting	none	The quality of their drugs
PWM6	Poor dosage. Poor or inadequate education. Use of one medicine for multiple diseases. Safety and efficacy of their drugs not documented. False claims of curing incurable disease.	Improve on health education, dosage of their drugs and document the safety and efficacy of their medicines.	No labs for investigating diseases. No X-rays or scanners to aid diagnosis. Problem of doses and dosage.	The lack of knowledge about TMH among staff of the formal health system
PWM7	Some of their medicines contain a lot of waste. Medicines prepared under	They should reduce spiritualism in their work.	Complications due to misdiagnosing. No scientific research in their treatments and	Because of limited research on TMH. Healers are less educated. Diagnostic approaches are

	substandard conditions. Dosing and treatment durations are erratic. Spiritual involvement. Used of large volumes of medicine	Improve the hygiene of their medicines and environments. The use of one medicine for countless diseases	medicines used. Lack of standards in their practices. Approaches involve spiritualism	challenged
PWM8	Dose/dosage is poor. They use same medicine for different illnesses. Lack of expiring dates for their medicines.	How they prepare their herbal medicines. The dose and dosage of their medicines.	Poor dosages and unhygienic environments	Illiteracy on the part of healers
PWM9	So much belief in spiritualism. Poor doses and dosage	How they manage fracture. The none-seriousness in some of their practices	Healers are illiterate. Financial challenges in their work	Lack of education on the part of healers. Lack of precise information about dose/dosage of their medicines. Safety of their products not well known. Problem of hygiene.
PWM10	Hygiene issues and poor dosage	Improve on their hygiene	Poor dosage	Lack of education on the healers' part. Medical professionals have little knowledge about traditional medical practices.

Source: Field data, 2015

Barimah (2013:205) makes a similar observation when he asserts that lack of formal training or incomplete education, lack of storage and preservation facilities and inadequate documentation of patients records are some of the problems under the TMS. Even though some of the observations by PWMs are true, a comment on others is desirable. The notions that TM lacks dose and dosage and the use of one medicine for treating several illnesses or that traditional healers are illiterate are over emphasized and bias in some sense. The notion that TM has no dose and dosage implies that traditional healers leave their clients to the mercy of God. Observed traditional practices, however, show that traditional healers do tell their patients how many days

to use a particular medicine, how many times a day to use it and in what quantities, whether the medicine is in liquid, ball or in powdered form. They also give differential usage information to their patients based on whether they are children or adults. Accordingly, it will appear that some PWMs are being influenced by their training in the western perspective, hence, their non-recognition of the kinds of doses and dosages used in TMH. Equally, the notion that traditional healers are illiterate may also be biased in the sense that most western medical practitioners feel that traditional healers are not able to read and write in the English language thus limiting literacy to only the English language. On the contrary, some healers can read and write in their native languages or in Arabic in the case of the Islamic based healers and also they have gone through training for many years before beginning to practice as healers. Similarly, Hampshire and Owusu (2013) found that some TMPs are highly literate and also use modern technology in their practices.

Again, it is somewhat a general tendency among some PWMs to see traditional healers as quacks, charlatans, people who know nothing about illnesses but concoct their medicines and hide under the pretence of secrecy to claim medical knowledge. It may be true that some traditional healers are not very knowledgeable about their art but to generalize that traditional healers are quacks who engage in secrecy and occultism may be baseless, simple because a few practitioners have been found to be non-professionals in the art, does not make all of them so. For in most medical systems, including the Ghanaian formal system, people do post as qualified practitioners and even operate in public hospitals or some PWMs engaging in unprofessional practices until they are identified and taken into book.

Consequently, these perceptions about TMH and healer as well as their medical practices, as shown in Tables 6.1 and 6.2 above, have major implications for the inclusion of TMH and healers in the formal health system and the possibility of TMPs and PWMs working in the same healthcare facility as some scholars advocate. It appears that power differentials exist as this was implied in the statement by PWM4; 'if traditional healers will comply with *our regulations* we'll be happy working with them'. I emphasize the expression 'our regulations' because to me it implies some sort of personalized stands instead of institutionalized practices as in 'our medical professional regulations'.

6.2 Options for including TMH in the formal health system

Integrating TM into the Ghanaian national health system has been on governments' health policy agendas for a very long time. Since the establishment of the Centre for Scientific Research into Plant Medicine (CSRPM) in 1975, different governments and the Ministry of Health have created both legal and health policies (such as Act 575 of 2000, Ministry of Health (2003) code of ethics for traditional and alternative practitioners, Ministry of Health (2005, 2007) policies on traditional medicine development, and that of the national health policy) geared towards the development of herbal and traditional medicines. In most cases, however, how the inclusion of this medical system is to be done has not seen so much examination both from government and the ministry of health or within academia, hence, the need to investigate that in this study.

Based on critical examination of the opinions of the different actors who took part in this study on the need to include TMH in the formal health system and the options to adopt, I present below, some general views expressed.

All three actors in this study (traditional healers, western medical practitioners and consumers of healthcare services) agreed that TMH should be included in the formal health system. They also acknowledged that the TMS has some philosophies, theories and assumptions about reality, health and illnesses, and medical practices which are very different from the WMS. Consequently, the approach towards TMH which requires that both PWMs and TMPs work in the same health facility (say in the hospital) may be problematic. Issues of secrecy, having control over visitors and the practice of certain ritual and ceremonies as part of traditional healing were all raised by traditional healers as crucial to their medical system. As stated earlier, what this suggests is that power issues are also at play since both practitioners will want to have control over certain things within their domain. Most PWMs see TMPs to be illiterate whose medical practices and medicines may be non-standardized, unhygienic, lack scientific verification and involve spiritualism. On the other hand, TMPs want to maintain certain practices as secret, have control over who comes to visit their patients, and also think that PWMs lack some knowledge about traditional medicine and its practices. As TMP1 said; 'I won't work at the hospital. They'll use money to deceive me, and you know money kills the medicine'. TMP7 also said; 'working at the hospital is like selling your secrets in the market. I don't want to work

there. If they can send patients to me, fine'. All these dynamics, point to power issues or having control over things. These can affect how both parties will work within the same health facility.

Hence, the majority opinion was that for now, TMPs and PWMs can both work in their separate institutions but have a developed and coordinated referral of patients. Consumers of healthcare services observed that traditional healers could be invited from time to time to look at patients whose conditions do not respond to western medical treatment and make some recommendations. I think these options seemed viable in the sense that most TMPs already have informal links with some PWMs where patients' referrals and the use of some western medical services and equipment are already ongoing. Also due to the lack of knowledge on the part of most PWMs about TM and practices, it makes some sense that the co-referral of patients be practiced. However, there needs to be legal recognition of these in health policies.

Also, participants observed that they should be some collaboration between practitioners of both medical systems, so as to establish some trust among each other and to share basic ideas. This will reduce the mistrust they both have about each other and also offer the PWMs the opportunity to learn about practices within the TMS. Nonetheless, how this is to be done was not explained.

These findings are similar to some observations other scholars have already made. As Ofosu-Amaah (2005:118) observes, "modern scientist should not only work with traditional remedies but should try to understand better the traditional system of medical practices". He added, "we owe it to Ghana to strive to understand what our traditional doctors did and continue to do currently". Again, Asante and Avornyo (2013:269) also state that to be able to integrate TMH into the formal healthcare system and to make it feasible, "there must be regular consultations and regular dialogue between practitioners of both medical system". Also, the Ministry of Health (2005:13) policy document also notes that currently, TMPs and PWMs, though are working separately, have mistrust between each other due to ignorance and lack of both information and education about the role of eachothers' practices. All these point to the fact that there is the need for interaction and knowledge sharing between the practitioners of both medical systems, though issues of power and property rights have to be examined critically.

6.3 Certification and knowledge about traditional healers associations in Ghana

Among the policy directives of the TMPC, the Ministry of Health Code of Ethics 2003 and other policy making bodies on TMH (such as the TAMD) require that traditional healers go through some basic training to upgrade their skills in improving the safety and efficacy of their medicines and medical practices; to be registered and issued certificates as qualified traditional medical practitioners; and to belong to an association of traditional healers in Ghana. All these policy directives and the urge to standardize TM and medical practices are done in order to promote a successful inclusion of TMH in the formal health system.

However, evidence on the ground shows that these moves have not reached, perhaps, many of the TMPs in certain parts of the country. Based on the field data, it was discovered that a majority of the healers did not have any certificate as practitioners. Only one practitioner had a certificate and two others indicated that their fathers, under whom they learned, also had certificates. Also, the data shows that none of these TMPs belongs to, or know about any traditional healers association in Ghana. Within their local communities, they do know about other healers to whom they do refer patients to, but they had no association locally nor belong to any regionally or nationally. Additionally, the healers stated that they have never had any training or discussions with members of TMPC/TAMD or other PWMs on issues relating to the hygienic preparations of their medicines, storage techniques or on basic first aid administration.

This evidence points to issues of policy gaps on the part of the TMPC whose mandate it is to identify qualified TMPs, register and certificate them, as well as provide training for them from time to time to help them improve on their standards of practices. Hence, more work is required on the part of the TMPC.

CHAPTER 7

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The main focus of this study was to document the Dagomba traditional herbal knowledge and medical practices, to examine what influences people choice for TMH and to discuss how the actors in the study think TMH can be included in the formal Ghanaian healthcare system. Having gone through the analysis of the findings in Chapters 4, 5 and 6, this chapter aims at highlighting the main issues raised in the entire study. In this chapter, I intend to summarize the main findings of the study and draw some conclusions to the main questions posed in the introductory chapter. I will also point out some limitations of the study and then make recommendations for further research and policy.

7.1 Summary of findings

A number of substantive findings have been made in this study in relations to the Dagomba traditional medical knowledge and healing practices, what influences people to choose TMH, the attitudes and perceptions PWMs and other consumers of healthcare services have towards or about TMH and how people think TMH can be included in the formal healthcare system in Ghana. The following are summary of the key findings of the study.

- The study found that among Dagomba, both health and illness exist in a continuum. The Dagomba theorized that health (*alaafee*) is not the absence of illness since people are born with some innate illnesses. But it is a relational concept in which a person is in a state of balance within the self, and in relation to others, the society and the physical and spiritual worlds. Illness (*doro*) thus ensues when this state of balance is disrupted either by internal or external forces or both within the individual or in the society. Hence, to have good health is to have *suhudoo* within the self and the larger society. A philosophy well recognized by the Ministry of Health (2003:3) when it states in its code of ethics that

our forefathers developed TM relative to their understanding of nature, the creator, divinities and ancestral spirits with the conception that the well being of man (people) entails harmony between the body, mind, soul and spirits and the maintenance of good relationship with the spiritual world and the external environment.

- Also, the study discovered that the practice of TMH among Dagomba is an art which begins with knowledge acquisition through many years of exposure through observations, oral tutoring, guided practices and experiencing under a master who could either be a family member or outside the family. Progressively, healing and treatment of illnesses are thus based on precise diagnosis and the performance of rituals guided by the principle of secrecy with herbal and spiritual healing being the major components.

- However, the study noted that the principle or concept of secrecy is a powerful tool in TMH. It has both psychological and pragmatic functions in the traditional medical system. It is not only used to protect practitioners' knowledge, records and their patients' health, it also plays an important role in the referral of patients.

- Additionally, the study found that within Dagbon society, there exists a plural medical system each with its own foundations of knowledge, perception of reality and principles of medical practices in relation to how health and illnesses are perceived and treated. These medical systems are the household medical system, the traditional medical system and the western medical system. They interact in various complex ways in terms of the composition of their memberships, illnesses they treat and how they refer patients to one another.

- Despite the fact that patients make use of all these medical systems in different ways, the choice of a particular medical system is found to be influenced by several factors which includes the nature of the illness, the belief about the cause of the illness, the effectiveness, accessibility, availability and affordability of the medical system and its services, the economic and social status of the individual and their families as well as pressure from family members.

- The traditional medical system is dynamic and its practitioners are innovative and progressive. The study found that some practitioners now document their medical knowledge in their native languages; make of use of western medical equipment, medicine and services alongside their herbal medicine and also are creating local collaborations and networks with some practitioners of the western medical system.

- Even though some PWMs agree that TMH and TMPs are effective, the study found that most PWMs have never used or recommend TMH to their clients. Some of the reasons why this trend persist are due to the fact that TMH has not been fully recognized by the laws of the country while other reasons are based on the opinions that TMH is not save, unhygienic, have no doses/dosages or expiring dates and that TMPs are illiterates and have no scientific knowledge about their medical products.

- Again, the study observed that most of the works done by the CSRPM and other research Institutes are basically towards the development of herbal medicine, its efficacy and standardization but not on the development of TMH as a medical system.

- Similarly, the study found that though governments of Ghana and the Ministry of Health have both recognized the need to include TMH in the formal health system, there seem to be some kind of inertia and policy lapses. Apparently, despite the creation of a policy guideline on the development of TM in 2005 by the Ministry of Health, two years later, there were only few policy options and references to TMH in the National Health Policy document in 2007. This lack of seriousness in the implementation of policies in relation to TMH has also been observed by the Ministry of Health (2005:14) policy document.

- To take as a starting point, majority of the actors in this study proposed that due to the difference in the philosophical and theoretical foundations between the TMS and WMS and also coupled with the differential power levels of their practitioners and national recognition, the inclusion of TMH in the formal health system should be based on co-referral of patients but not institutional integration. It was found that there is the need for strong collaboration and interaction between practitioners of the TMS and WMS so as to promote better understanding of medical practices among practitioners of both medical systems. This particular point has also been advocated by the WHO (2002:25) as a way

of giving patients wider therapeutic options to draw upon for their health needs as well as a way of disseminating important health messages since most traditional practitioners are usually the sole providers of health services to most communities.

7.2 Conclusions reached

With reference to the research questions and in relation to the key findings summarized above, the study draws the following conclusions:

- The practice of TMH among the Dagomba of Ghana has been a dynamic established medical system for a very long time. It was the sole provider of healthcare to the people until western medicine was introduced into the country in the 19th Century. The Dagomba practices of TMH are based on their theories and perceptions about health and ill health. They observed that people are bone with some common illnesses such as *kpaʔa, chua* and *dirigu*. These and other common illnesses are seen to be part of life, living and growing up. To Dagomba, being healthy does not mean being free from illness, but having *suhudoo* (a piece of mind) within the self and in relation to every other thing. Other illnesses, however, come to the body and act upon it. These other illnesses are caused by both external and internal forces within the individual or outside his/her body system. The age, blood quality and 'head' of the individual all have an impact on how people react to illnesses. These theories of health and illness among Dagomba are what influence their approach to healing and treatment. Individuals who have gone through some training to become a TMP, based their healing on their knowledge of illness causation and herbal medicine. Spiritualism, precise diagnosis and medical norms, including rituals are central in their art, with secrecy playing a key role in their medical practices.

- People make different choices among the different healthcare systems for their health needs. Whereas the nature of an illness and its perceived cause stand tall among other factors, the availability, accessibility, affordability and the effectiveness of these medical systems also matter. Individuals' socio-economic statuses and or family pressure on them can also influence their choice of a healthcare system for their illnesses. Generally,

however, the different medical systems are combined in different ways to achieve the desired health needs of the patients. Despite the differential attitudes and perceptions, both consumers of healthcare services and some members of the western medical system have towards TMH, a larger proportion of the Ghanaian population depends on it for their health needs. A number of challenges, however, are identified within the medical system. The depletion of forest resources and environmental degradation in general, has now led to the disappearance of certain herbal plants. The cost of buying some herbs, lack of accommodation facilities and means of transportation on the part of TMPs, may make the cost of treatment under the TMS (the once affordable medical system) to rise in the future. Again, issues of doses/dosages, unhygienic nature of some TM and lack of expiring dates have also been some concerns that are preventing some people from using TMH.

- Based on the difference in philosophical foundations about what constitutes reality, different theories of health and illness causation as well as different medical practices between the TMS and the WMS. The options for including TMH in the formal health system have been in favour of establishing a coordinated cross referral of patients between both medical systems. All the participants agreed that there is the need for TMH to be included in the formal health system of the country, though certain practical limitations exist. The majority of participants opted for inclusion through coordination of practices and co-referral of patients but not complete institutional integration. For now, much needs to be learned about TMH among members of the WMS, hence the need for collaboration between practitioners of both medical systems to share knowledge.

7.3 Limitations of the study

This study has some few limitations which I wish to highlight briefly. One of the limitations has to do with the composition of the sample of participants. Since the main sampling frame was purposive sampling, participants were drawn based on their knowledge of the subject matter, their availability, accessibility and willingness to participate in the study. Consequently, the age of participants was skewed in some way. Only two participants were below 30 years. This means

that the opinions and perceptions of people with ages below 30 years have been excluded from the findings made in this study. This can be substantial, considering the fact that it could have been possible to have different views from people within this age range. Another limitation relating to the sampling is the religious background of the participants. There was only one Traditionalist (a believer and practitioner of the African Traditional Religions). This is also a limitation because, if there were a number of participants who are Traditionalists, different perspectives on TMH could have emerged. However, this might not be a strong limitation because Abdul-Hamid (2010) observes that among Dagomba, even those who are traditionalists still participate in most Islamic rituals including the daily prayers. This might convince them to state that they are Muslims since they participate in most Islamic activities.

Finally, the study being a qualitative one, most of the findings can not be generalized over the entire Dagbon region given the fact that there might be different practices of TMH within Eastern and Western Dagbon. Again, findings may not be generalizable for the entire country given the fact that other ethnic groups may have different practices of TMH. However, most of the findings in the study can help us to understand the dynamics of TMH among Dagomba and within Ghana since cerain practices could be similar among other groups and across other regions, espcially those that have similar cultural practices as the Dagomba.

7.4 Recommendations for further research and policy

Based on the findings of this study, the following recommendations are relevant for purposes of policy direction and for further research:

- The TMPC should intensify its operations across the country to ensure that all TMPs know about it, its services in relation to their work and how they can work with it. Also, it should, in collaboration with the MOH, organize in-service training for TMPs to offer them some training on basic skills in hygienic preparation of their herbal medicines and how to properly store them and basic training on how to give first aid. This point has also been advocated for by the WHO (2002:24-26). The mode of training package can take the form organized for the traditional birth attendants (TBAs) before their full inclusion in the main health system.

- The TMPC in collaboration with the TAMD should conduct a national survey to identify and register all known TMPs across the country. This will provide the baseline information for further training and education in standards of practice on how to promote efficacy and effectiveness of their products and services as provided in the TMPA Act 575 of 2000 and that of the MOH (2003) code of ethics.

- Due to the poor interaction between medical practitioners of both the traditional and western medical systems, TMPC and the TAMD should constitute a forum where TMPs and PWMs can meet from time to time to discuss some basic medical practices pertaining to their respective medical systems.

- However, patent and intellectual property rights laws should be put in place to safe-guard the traditional herbal knowledge and medical practices of the TMPs. The TMPC and that of TAMD should call for a national legislative instrument for the protection of Indigenous and Traditional knowledges on medicinal plants, herbal medicine, traditional medicine and traditional medical knowledge about certain illnesses that are effectively treated by TMPs. This will encourage knowledge sharing, collaborative research and clinical trials between PWMs and TMPs.

- Again, there should be courses on cultural sensitivity, lay perspectives of health and illnesses and cultural orientations about health and health seeking behavior in the medical and nursing training schools and colleges where PWMs are trained. This will not only give them basic information and knowledge about the link between culture, health and social interactions, but it will also offer them some knowledge about traditional medical practices. Even though there is Bachelor of Science degree program in Herbal Medicine at the Kwame Nkrumah University of Science and Technology that is not enough. This particular recommendation should be applied to all colleges and medical schools as part of the training programs for all medical and nursing students. This particular point has been noted by (Nimoh 2014:91; Benedict 2014; Asante and Avornyo 2013:270; MOH 2005:5-6; WHO 2002) to be very important towards the development and inclusion of TMH in the Ghanaian health system.

- Additionally, more research needs to be conducted on TMH in general or in specific areas within it, among other ethnic groups in Ghana, so as to get different cultural perspectives to traditional medical practices and illness knowledge base. This will help both in the inclusion process as well as in the design of curricular for medical or nursing training in our institutions of higher learning.

- Finally, the TMPC and TAMD should work closely and take is as their responsibility to co-ordinate all health policies and policy options about TMH as provided in the Ministry of Health (2005, 2007) and the TMPA Act 2000 and work towards the implementation of those policies since the MOH (2005:14) acknowledges that there is inertia on the part of government when it comes to implementing policies on TMH.

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APPENDICES

Appendix A

Table A.1: List of traditional medical practitioners and their demographic features

Serial number	Sex	Age range	Occupation	Religion	Areas of specialization in Healing	Level of formal education	Number of years as a practitioner
TPM1	Male	85-90	F and H	Muslim	Spiritual healing, snake bite and fracture	None	30
TMP2	Male	40-45	F and H	Muslim	Spiritual and Herbal healing	None	25
TMP3	Female	80-85	H	Muslim	Fracture and respiratory illnesses	None	40
TMP4	Male	40-45	F and H	Muslim	Fracture and spiritual healing	None	22
TMP5	Male	35-40	H	Muslim	Spiritual and herbal healing	Primary	14
TMP6	Male	35-40	F and H	Muslim	Spiritual and herbal healing	Primary	15
TMP7	Male	85-90	H	Muslim	Snake bite	None	20
TMP8	Male	75-80	F and H	Traditionalist	Spiritual and herbal healing	None	30
TMP9	Female	80-85	Tr. and H	Muslim	Spiritual healing	None	60
TMP10	Male	35-40	Te and H	Muslim	Spiritual healing	Tertiary	10

F = Farming, H = Healing, Tr. = Petty trading and Te = Teaching

Source: Field data, 2015

Table A.2: List of practitioners of western medicine and their demographic features

Serial number	Sex	Age range	Religion	Areas of specialization	Level of formal education	Number of years as a practitioner
PWM1	Male	35-40	Muslim	SSN and GN	Tertiary	9
PWM2	Male	50-55	Christian	Pediatrics and GS	Tertiary	23
PWM3	Male	35-40	Christian	PA and SNP	Tertiary	15
PWM4	Female	60-65	Christian	Midwifery, Maternity	Tertiary	35
PWM5	Male	40-45	Muslim	SSN and GN	Tertiary	11
PWM6	Male	25-30	Muslim	PA and PN	Tertiary	3
PWM7	Male	40-45	Christian	Pharmacy	Tertiary	11
PWM8	Male	30-35	Muslim	PA and Anesthesia	Tertiary	8
PWM9	Male	60-65	Muslim	Sr. Lab Technician	Tertiary	41
PWM10	Female	55-60	Muslim	Midwifery, Antenatal	Tertiary	35

SSN = Senior Staff Nurse, GN = General Nursing, GS = General Surgery, SNP = Senior Nurse Practitioner, PN = Pediatrician Nurse, PA = Physician Assistant

Source: Field data, 2015

Table A.3: List of consumers of health services in the 1st focus group discussion and their demographic features

Serial number	Sex	Age range	Religion	Occupation	Level of formal education
CHS1	Female	90-95	Muslim	House wife and a Cook	None
CHS2	Female	50-55	Muslim	Farming	None
CHS3	Female	50-55	Muslim	Farming and trading	None
CHS4	Female	20-25	Muslim	Farming	None
CHS5	Female	50-55	Muslim	Petty trader	None
CHS6	Female	40-45	Muslim	Petty trader	None
CHS7	Female	45-55	Muslim	Trader and Food vendor	None

Source: Field data, 2015

Table A.4: List of consumers of health services in the 2nd focus group discussion and their demographic features

Serial number	Sex	Age range	Religion	Occupation	Level of formal education
CHS8	Male	30-35	Muslim	Farming	Primary
CHS9	Male	65-70	Muslim	Farming	None
CHS10	Male	65-70	Muslim	Farming	None
CHS11	Male	45-50	Muslim	Farming	None
CHS12	Male	55-60	Muslim	Farming	None
CHS13	Male	75-80	Muslim	Farming	None
CHS14	Male	65-70	Muslim	Farming	None

Source: Field data, 2015

Appendix B

Table B.1: List of common illnesses treated under the traditional medical system (TMS)

No.	Native name of illness	Western medical name	Age group affected	Gender affected	Causation	Basic symptoms
1	kpaʔa	rheumatism or haenia	all age groups	both sexes	innate illness	painful movements within body
2	dirigu/dulugu	migrain	all age groups	both sexes	innate illness	bleeding nose, headache
3	chua/kpante	piles/hemorrhoids	all age groups	both sexes	innate illness	person grows line or gets bloated
4	kpaʔ'pielga	gonorrhea	matured males	males	sexual intercourse	itching around the sex organ and fluid discharge
5	kpaʔ'ʒieʔu	malaria	all age groups	both sexes	mosquitoes	fever, headache
6	daʔu	convulsion	infants	both sexes		vomiting, cal lead to physical deformation
7	bɨngoo	boils	all age groups	both sexes	can be caused by *yoʔu* or other infections	visible inflammation on the skin
8	waʔ'gurugu	lordosis	the aged	both sexes	–	outward curvature and Pains within spinal cord
9	dihili	spiritual food poisoning	all age groups	both sexes	spiritual means	swollen stomach and other body parts
10	yinyahili	lunacy/mental illness	all age groups but not children	both sexes	spiritual means	unnecessary/senseless talk usually to one's self and tendency to walk naked in public
11	nina doro	eye disorder	usually the aged	both sexes	family line, *dirigu* or infections	not able to see well
12	yumaha/konga	syphilitic sores or leprosy	adults	both sexes	spiritual means, family line	the sores never heal
14	yoʔʊ	anthrax	all age groups	both sexes	spiritual means, *nantoo* insect	boils
15	Sichiri doro	diabetes	adults	both sexes	family line, diet	weak skin, sores don't heal fast

16	ʒim doro	hypertension	adults	both sexes	family line, diet	–
17	gmanchee	fibroid or whites	matured females	females	innate or through sexual intercourse	whitish discharge from the sex organ
18	sompuʔili	dysmenorrhea or menstrual pains	matured females	females	innate and through internal body systems	painful and irregular menstrual flow
19	nyomoʔli	respiratory problem/asthma	all age groups	both sexes	family line, *dirigu*, fall from a height	difficulty in breathing
20	darmihi	sickle cell	all age groups	both sexes	family line, spiritual means	body weakness and sick all the time
21	paʔ'kohingu	tuberculosis	adults	both sexes	coughing during sexual intercourse	grows lean and looks pale
22	muligme	sore rectum/thyphiod	all age groups	both sexes	infection of the colon	similar symptoms like lunacy
23	waʔ'dimli	snake bite	all age groups	both sexes	can be spiritual or natural	
24	alizina doro	Jinn possession	all age groups	both sexes	spiritual	similar to lunacy
25	sankpaga	ear ache/maumps or otitis	adults	both sexes	family line or internal body systems	pains in the ear, tooth lost
26	kabbu	fracture	all age groups	both sexes	natural or spiritual	–
27	sambu	spiritual infliction	adults	both sexes	spiritual means	pains in the bone, heat in the body
28	gbal ni boʔu	stroke	adults	both sexes	natural or spiritual	inability to move certain body parts
29	kpilinkpihi	epilepsy	All age groups except infants	Both sexes	family line, spiritual	
30	tahiga	syphilitic sores in the mouth	infants and children	both sexes	natural	sores in the mouth

31	sapibo/nyirnyooli	piles/hemorrhoids	children	both sexes	natural	the colon comes out after the child shits
32	sabli doro	hepatitis B	all age groups	both sexes	–	–

Source: Field data, 2015

Appendix C

Sample 1

A semi-structured interview guide for my interaction with TMPs

1. Tell us about yourself and how you learn to heal.
2. In your opinion, what causes illness among people?
3. What are some of the common illnesses you treat people with?
4. How do you know the illness a person is suffering from?
5. How do you heal a particular illness?
6. Do you have some people learning about traditional healing under you?
7. What things do you use to prepare your medicine?
8. What times do people come here for healing the most?
9. Why do you think people come to you for healing?
10. What category of people comes to you for healing or for herbal medicine?
11. Are there difference in the treatment process for men and women and why?
12. Why are different sacrificial animals used in the healing processes?
13. If you were to become part of the hospital system, will you like to work with the doctors?
14. How will you like to work with the formal health system?
15. Did you ever ask a patient to seek hospital treatment for his/her illness and why?
16. What kind of illness was it?
17. How do people feel about your medicine and healing process?
18. What will you say is good health? Or who is a healthy person?
19. a. How do you prepare your medicines?
    b. In what form are they administered?
    c. How do you get the herbs or herbal materials for the medicines?

Sample 2

Interview guide for the focus group discussion with CHSs

1. How is good health perceived among Dagomba?
2. What are the causes of illness in people?
3. Where do you go for treatment when you are ill?
4. Why do we go there?
5. What kinds of illnesses do you send to traditional healers and why?
6. What category of traditional healers do you go to for healing and why?
7. Why do we send those illnesses there for treatment and not the hospital?
8. Do you think traditional healers should be made part of the formal health system?
9. What do you propose should be the best ways they can be part of the health system?
10. What are some of the challenges you go through to access TMH?
11. In what forms are traditional medicine administered to you?
12. Do you think some things should be changed in how TMH is practiced and why?

Sample 3

Qualitative questionnaire for Western Medical Practitioners

Dear Sir/Madam, my name is Abukari Kwame. I am a Dagomba by tribe and a resident of Yendi. I am a graduate student in Indigenous Studies and a student researcher from University of Tromso, Norway. I am conducting a research on Traditional Medicine and Healing among the Dagomba as my master's thesis. I am kindly asking for your help to complete this questionnaire for me. All your responses to these questions shall be used purposely for this research. Also all responses shall be treated confidentially and your identity shall also be anonymous. I count on your support. Thank you.

1. Please, tell me briefly about yourself in terms of:
   - Your age ……
   - Gender ……
   - Years of working as a health professional …….
   - Area(s) of specialization …….
2. What is/are the cause(s) of illnesses among people?
3. By what methods do you identify the particular illness a person is suffering from?
4. Do you find traditional medicine to be effective for some illnesses?
5. What kinds of illnesses do you find traditional medicine to be effective for?
6. Will you use or recommend traditional medicine for your patient in some circumstances and why?
7. a. Do you think traditional healers can effectively treat some illnesses?
   b. List the illnesses you think traditional healers can effectively treat?
8. If traditional healers were to become part of the health system, how will you feel working with them?
9. Which category of traditional healers will you prefer to work with and why?
10. If traditional healers were to become part of the formal health system, what, will you propose should be the best ways of including them in the system?
11. What are some of the reasons that will make you hesitate or reject the use of traditional medicine or healing?
12. Have you ever recommended some of your clients to seek traditional healing for their illnesses and why?
13. What kinds of illnesses were they?

14. What categories of illnesses will you recommend for traditional healing and why?
15. What are the determinants of good health?
16. What aspects of traditional healing would you recommend to be improved or changed?
17. Do you know about any traditional healer(s) who work in this hospital?
18. If Yes: Who is the person and what illness(s) does the person heals?
19. What are some of the challenges you know that relate to traditional medicine or healing?
20. What are some of the factors that can pose as challenges for successful inclusion of TMH in the formal health system?
21. What information will you like to add about traditional healers, medicine or healing?

Sample 4

Consent declaration form/letter for participation

Centre for Sami Studies

University of Tromso

Post Code 9037, Tromso Norway

17th June, 2015.

Dear Sir/Madam,

I wish to ask for you free and informed consent to participate in my research project titled: Traditional Medicine and Healing among the Dagomba of Ghana.

I am a student researcher from the University of Tromso, Norway on the master program in Indigenous Studies. I am conducting a research that relates to how the Dagomba of Ghana practice traditional medicine and healing. The purpose of this study is to help me document the Dagomba knowledge of herbal medicine and their philosophies surrounding the healing practices; to examine what factors influence people choice for traditional medicine and healing and finally, to discuss the possibilities of including traditional healers, medicine and healing in the formal Ghanaian health system.

I will be doing the fieldwork on this topic from June to August. My main data collection tools are in-depth individual interviews, qualitative questionnaire and focus group discussions. I will also be doing photo taking and personal observation. All interviews will be recorded on a voice recorder. Data obtained will be used solely for this study. All information will be treated confidentially and all names will be made anonymous.

I am kindly asking for your consent to help me with information on this topic. You have the right to opt out of the research process or to refuse me any information you do not want me to have at any point in time without me demanding for any explanation from you. I am very hopeful that you will grant me your support.

Thank you.

Sincerely,

Abukari Kwame

Participant ……. Student Researcher …….. Date ……

Sample 5

Letter to the Yendi Municipal Hospital

The Centre for Sami Studies
University of Tromso
Box 6050 Langnes, NO 9037
Tromso, Norway

22nd June, 2015

The Medical Superintendent
Yendi Municipal Hospital
Yendi, Northern Region

Dear Sir,

APPLICATION FOR PERMISSION TO USE THE HOSPITAL AND SOME OF ITS MEDICAL PERSONNEL IN MY RESEARCH

I wish to apply for permission to use the hospital and some of its medical personnel for my research data collection processes.

I am a graduate student from the University of Tromso on the Indigenous Studies master program. As part of my master's degree, I am conducting a research on Traditional medicine and healing among the Dagomba of Ghana in order to document their traditional knowledge of herbal medicine and healing with the aim of assessing the possibilities of including their knowledge and services in the formal health system. In order to do this successfully, I have to administer qualitative questionnaires to medical practitioners within the modern health system to help me identify some attitudes, challenges and the possibilities for successful cooperation between traditional medical practitioners and the western medical practitioners. This will help me to make plausible proposals or recommendations for their inclusion and for further research.

It is based on this ground that I am applying for permission to use the hospital and some of its medical staff to assist me in this study. I am very hopeful that your outfit will grant me the opportunity to use the institution.

Thank you.

Yours faithfully,

.....
Ibrahim Tikari Kwame
(ICIS Student)