Cultural Traditions and the Implications for Medical Treatment in Contemporary Ghana

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ABSTRACT

This paper provides an ethnographic account of medical practices from the Sunyani, Brong-Ahafo region of Ghana. Research was undertaken to assess the relationship between traditional Ghanaian medical treatments and contemporary medical treatments in hospital and to determine how these impact the effective treatment of chronic disease. Interviews conducted both with traditional practitioners and medical doctors indicate that religious beliefs are a strong factor in determining whether traditional or contemporary medical treatment is sought. My research proposes to narrow the gap in perceptions about health and treatment between physicians and their patients as well as physicians and traditional Ghanaian healers. Given the spread of Ebola virus in West Africa, this research contributes to the question about how health and illness are perceived and treated and why certain viruses escalate to epidemic proportions. Future research aims to enlarge the research area to greater Ghana and to conduct periodic ethnographic studies to gauge the health care delivery system in the country.

INTRODUCTION

Pre-Colonial Rule

Ancient Ghana's narrative resonates with others of its time. Between the 9th and 11th centuries C.E., the ancient Republic of Ghana was an expansive and fearsome empire that included modern day Ghana, Mauritania, Mali, and Senegal (ushistory.org, 2014). However, in 1240 C.E., the growing nation of Mali expanded and most of the Ancient Ghana was absorbed. As a result, Akan migrants and other ethnic groups moved south into what is now modern-day Ghana.

Modern-day Ghana is a country the size of Illinois and Indiana combined. The 2011 population estimate was 24 million people. Ghana is comprised of 10 regions that include the Upper West, Upper East, Northern, Brong-Ahafo, Ashanti, Eastern, Volta, Greater Accra, Central and Western Regions. Ghana's main cities include Accra (the country's capital), Kumasi, Tema, and Sekondi-Takoradi. Ethnic groups of Ghana include the Akan people, who make up about 45.3% of the country, the Mole-Dagbon, who make up 15.2% of the country, and the remainder of the country is made of Ewe, Ga-Dangme, and other ethnic groups (Department, 2012).

History of Religions

Additional migration and colonization continued to impact the religious composition in modern-day Ghana. Today, traditional Ghanaian religions account for only 5.2% of the population. The early impact of Islam is still present in the country, as Muslims, primarily located in the northern region of the country, make up 17.6% of the population. Similarly, the colonial influence of countries such as Portugal and Great Britain brought in Christianity and, today, Christians, including Roman Catholics and Protestants, make up 71.2% of the state (E. o. Ghana, 2014).

Islam

As the Mali Empire expanded, the Akan established new kingdom states in the south, while other ethnic migrants arranged in the north. The north, predominated by the Dagomba kingdom state, was not originally Muslim but migrants brought with them

Muslims medicine men. This is the origin of the influence of Islam in what is now Northern Ghana (G. o. Ghana, 2014).

Christianity

Early European contact came in 1471 by the Portuguese, and they maintained a steady hold on the country for nearly a century, bringing in Catholicism (ghanaweb.com, 2014b). Other branches of Christianity were introduced by the long-stayed occupancy of the British and visiting missionaries (Gocking, 2005).

Traditional religion

Though more than 80% of the population practices non-traditional religions, traditional religious beliefs have been engrained in the mores of Ghana. Perhaps, the most sacred Ghanaian belief centers on the rise of the Asante. Under the rule of *Asantehene*, "Asante king," Osei Tutu, the Asante kingdom became a prolific empire, with its capital as Kumasi (G. o. Ghana, 2014). As folklore states, Osei Tutu's chief priest, Okomfo Anokye, caused a pure Golden Stool to float out of the sky and land on the lap of the *Asantehene*. Tradition says that in this Stool resides the *sunsum, "s*oul," of the nation (Muller, 2013). This sacred stool is so revered that none are allowed to sit on it . It is kept under the strictest security and taken outside only under the most exceptional circumstances, never coming into contact with the ground. The sacredness of the stool and belief of the *sunsum* is best explained through the 1900 war with the British. Though the Asante were conquered, they claimed victory, as they fought only to preserve the Golden Stool and thus the soul of the nation (ghanaweb.com, 2014a).

Despite the reach of Christianity and Islam, traditional religions have retained their influence on Ghanaian life. The traditional religions venerate *Nyame*, "the Supreme Being." *Nyame* transcends all religions because rather than being directly worshipped, he possesses inseparable ties to many cultural practices and beliefs. Along with *Nyame*, traditional beliefs revere lesser gods that reside in landscape such as rivers, trees, and mountains. These lesser gods, ancestors and other spirits complete this network of religion. Ancestors are the most direct linkage to the spiritual realm and serve as mediators for their lineage (Insoll, 2003).

Colonial rule and independence

Known as the Gold Coast until March 6th, 1957, Ghana became the first African country south of the Sahara to gain independence. Situated on the coast of West Africa, it shares its borders with three French-speaking countries, La Côte d'Ivoire to the west, Burkina Faso to the north, and Togo to the east (Gocking, 2005).

Like any young country establishing its presence in and rule over its people, the country of Ghana was subject to coup d'états by unsatisfied citizens. Perhaps the most notable was the 1979 coup that brought Lieutenant Jerry John "JJ" Rawlings into power. Despite his tumultuous entrance into politics and leadership of the country, subsequent peaceful democratic elections have prevailed (Africa, 2014).

Ghanaian medical system

Ghana has mandated nine years of compulsory education for its citizens; however, the country is still battling a crippling literacy rate of 57.9%. The 2011 estimate of infant

mortality rate was 48.55/1000 live births (Bank, 2014). Ghana is a "young" country by average age. The life expectancy for women is 62.3 years, and the life expectancy for men is 59.8 years (Department, 2012).

The healthcare system in Ghana has recently gone through a significant change. Most of the country's healthcare is provided by the government, largely administered by the Ministry of Health and the Ghana Health Services (Health, 2012; Service, 2014).

Functionally, the healthcare system of Ghana has five different levels of providers. These include primary care physicians for rural areas, sub-district level clinics, district hospitals, regional hospitals, and the national hospital (Service, 2014).

In 2000, while seeking the presidency, John Kufuor promised to reform the health care system of Ghana. In 2003, the government adopted the National Health Insurance Scheme (NHIS) that is regarded as the triumph of the Kufuor administration (GhanaWeb, 2014). This system was quickly implemented and its successes were hailed, however, with the subsequent changes of administration, many of the victories were soon lost.

The NHIS aimed to abolish the "payment before treatment" system in which patients, regardless of emergency were mandated to pay for treatment before receiving care. The NHIS assured equitable and universal access to healthcare for all citizens (GhanaWeb, 2014). Unfortunately, this goal is far from achieved.

In recent years and with ideologically dissimilar government leadership, there have been major problems with the NHIS. Healthcare providers are not paid regularly, and in some cases wait more than six months for government reimbursement (Kwabena Saarah-Akyerekoh, 2014). Due to the delay of the reimbursement, providers are unable to sustain basic standards of functioning and must resort to the former "payment before

treatment" system that the Kufuor administration worked to abolish. This has resulted in patients seeking more unorthodox avenues of healthcare.

This poses a major threat to the country. Particularly, during my research, fears of the Ebola virus whispered around the town. It was clear that the existing medical system of Ghana, like many of its neighbors, was simply not equipped to deal with any additional burden. Failure of the government to properly implement the NHI Act is compounded by traditional misconceptions of illness and disease. This and the high illiteracy rate in the country have poised Ghana for disaster on a catastrophic level if an epidemic strikes the country.

Investigation

This project hopes to serve two purposes: the first is to be an ethnographic account of medicine in Ghana, and the second is to investigate their implications for medical treatment in contemporary Ghana and suggest solutions aimed at improving the communication between these groups. Particularly, this research examined how traditional beliefs about disease and illnesses affect modern medical treatment.. In countries such as Ghana, the medical system, in practice, includes hospitals and their physicians, but also traditional priests, traditional herbalists, and Christian and Muslim spiritual leaders. In addition, an unexpected finding was the emergence of herbal-physicians, who have come to the scene as the bridge between orthodox and traditional medicine.

RESEARCH METHODS

This project was conducted through a series of interviews with traditional priests, herbalists, prayer camps, and orthodox physicians with the intent of representing the main avenues of care that people seek when ill. Each interview was conducted individually and in some cases, with the help of a translator. The project and interview strategy as reviewed and approved by HIRB0001965.

A standard list of questions was asked in each interview, and interviewees were encouraged to answer any or all of the questions as they wished. Samples of questions for the orthodox physicians are as follows:

1. Are you comfortable answering questions that will require brief reflection on the work that you have done or observed in the Sunyani Regional Hospital so far?
2. How long have you been working at Sunyani Regional Hospital?
3. Are you familiar with the traditional religions or spiritual beliefs in the area?
4. Do you have any accounts of patients who prefer unorthodox cures to your care?
5. If you do, how do you counsel patients to remain in hospital-care instead of pursuing alternative routes of medical care?
6. What is your opinion of the services of traditional priests/herbalists/prayer camps?
7. Theoretically, would you be open to a public health partnership between these alternative caregivers and Sunyani Regional Hospital?

(Interview questions varied to fit the population that was interviewed.)

The final interview was conducted of a renowned anthropologist who has written a series of books on the Ghanaian culture and served as the Catholic Archbishop of Kumasi. His insight contextualized the perception of disease and illness in the country.

RESULTS

A brief history of the river god, Tano

Before Independence, the Asante people regarded the River Tano as a sacred sacrificial place. In the past, the river was referred to as *Asuotene*, "Long River", as it spanned several villages. Before Dr. Kwame Nkrumah, the first president of Ghana, assumed his presidency in 1957, the Brong-Ahafo Region did not exist, and all of the land belonged to the Asante Region. During Nkrumah's campaign, many residents of the massive and powerful Asante Region did not support him. Though he won the election, he realized that the size and power of the Asante Region was a threat for his presidency and to his goals. Nkrumah wanted all of the regions to unite against the British and fight for Independence, a sentiment that the Asante did not initially share. As a result, Nkrumah reduced the once massive Asante Region and carved a new region from it, the Brong-Ahafo Region.

Previously, the Brong people were a smaller ethnic group who lived adjacent to the Asante. With the creation of this arbitrary border, many Asantes, who spoke Akan and owed allegiance to the *Asantehene* were separated from their families and forcibly placed with the Brong people who spoke Bno and owed allegiance to their king. Though the difference between the two languages is best compared to the difference between British and American English, the ethnic groups have subtle differences that resulted in conflict with the creation of this new region (Kwabena Saarah-Akyerekoh, 2014).

Serendipitously, this project came at a time when my grandfather, Dr. Kwabena Saarah-Akyerekoh, was compiling narratives to publish a book on the history of our family, our royal lineage, and the town that we founded. In one family story a man

named, *Tano-Bofuo,* "hunter of *Tano"*, was the first to discover the village, *Tanoso,* which sat on a hill above the River Tano. *Tano-Bofuo* ran away from *Danchechea*, due to his inability to settle financial debts. My great-great-grandfather a hunter by the name of Opanin Owusu, who would later be the founder of *Kootokrom,* "Tiger Town," was sent to look for him. After searching, Owusu found *Tano-Bofuo* prosperous and living by the riverside in a town he called *Tanoso*. *Tano-Bofuo* gave Opanin Owusu payment to return to settle his debts and then invited him to move his family to the area. Convinced of the promise of the new town which was blessed by the god Tano, my great-great-grandfather moved his sister and nephew to settle in the new town and thus moved the family crown from *Danchechea* to *Tanoso (Kwabena Saarah-Akyerekoh, 2014)*.

Without ever being explicitly told, through my frequent travels between Sunyani and Tanoso, I could sense the importance of the river that Tanoso sat above. Quite literally, *Tanoso* means "on top of the Tano" in Akan, with Tano being the name of the river.

For many cultures, including the Asante's, water is revered as a powerful force of nature with special healing and protective powers. Long before independence, the Asante would send captives to the River to be killed in the water or make sacrifices before a significant battle. Due to the sacrifices placed in the water, people who lived on its extensive riverbanks learned not to bathe or fish in it because of illnesses that befell on those who did. The tendency of the river to cause illness furthered the belief of the powerful deity that resided in it.

Because of the prolific spread of this belief, the fish in this river were never hunted, and to this day, remain undisturbed. As a result, the fish grow to be very large, as

they are free to grow until natural death. Traditional religions say that the river itself is a god, and the fish are his incarnations (Kwabena Saarah-Akyerekoh, 2014).

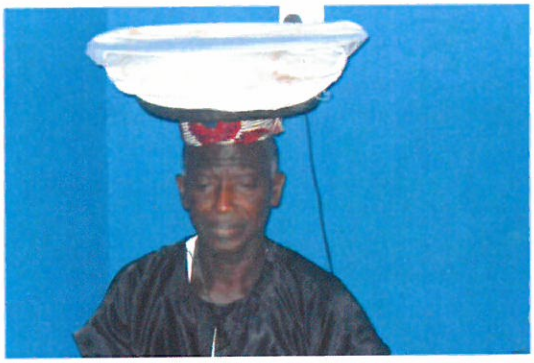
Though, today, many people in the Brong-Ahafo/Asante Regions do not practice traditional religions, this belief of *Nyame*, his demigods and power of the River Tano has played an unsuspectingly negative role in the deliverance of medicine.

There are many ways that the reverence of a supernatural deity is manifested, but the most common is for a family to put themselves in the care of the god, for example, Tano. The family would, theoretically, offer gifts periodically to the traditional priest of the river, and in exchange would receive protection and care from the god. In many circumstances, when a person gets into an altercation with another, they may curse their adversary using Tano's name. Whether what befalls the adversary next is coincidental or a manifestation of the god's powers, the person may become ill. Once this person is ill, he/she believes that in order to be cured of the illness, they must appease the god who caused it. This is where the problem arises, because in order to appease the god, the now ill adversary would rather seek the traditional priest in charge of the deity instead of the hospital or clinic.

Traditional priests interviews

These traditional priests became the first realization of medical care in the country and even today, play a large role in the medical care system. I had the opportunity of interviewing two traditional priests during my project.

Left: "Nana Kwasi" pictured in his shrine with the incarnations of the demi-gods atop his head, holding blades.
Right: "Nana Abena," traditional priest of the Tano river, pictured on her throne holding traditional relics.



Left: "Nana Kwasi" pictured in his shrine with the incarnations of the demi-gods atop his head.
Right: A closer look at the vessel in which the gods are housed, protected by blades.

Left: "Nana Kwasi" pictured in his shrine with a shell and offerings of liquor for the gods at his feet.
Right: "Nana Abena," the traditional priest of the Tano River, on her throne holding traditional relics in her shrine.

The first traditional priest that I interviewed will be referred to as "Nana Kwasi" in order to respect his privacy. Nana Kwasi has been working as a traditional priest for forty years, and recalls coming into his own around the same time that the traditional priest of the River Tano. Nana was an older man when he received 'the spirit' and learned his trade through dreams and visions. People come to see him for conditions including spiritual maladies, convulsions, curses, bareness, persistent diarrhea, severe stomachaches, skin diseases, and snakebites. Nana Kwasi asserted that he sees people from all religious backgrounds, however he would characterize the majority of his clients as practicing Christians. He expressed that the problem with Christians and other religious groups who come to him for services is that they are reluctant to carry out his intervention after counseling. He explained that he often has to accompany them because they are be too "shy" to do it on their own (N. K. T. Priest, 2014). Nana Kwasi strongly believes that he offers a service that cannot be provided by hospitals. "If someone curses you and you step on something and hurt your foot, the hospital can't help you because it is the curse that caused it" (N. K. T. Priest, 2014).

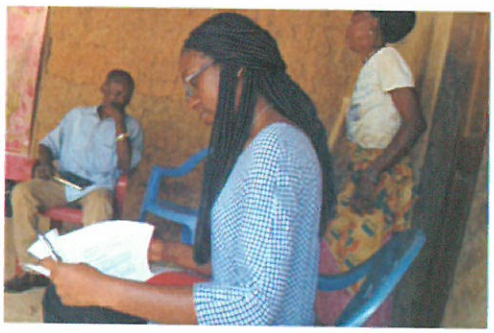
When asked what kind of medicines he typically uses when patients come, he found it hard to explain. "Most of my instruction comes in the form of dreams, so for some people, it is different," he explained. He did however, recall a recent case of an unclosed fontanelle in a five-year-old child in which he had to use a medicine referred to as *Nyame Aso*, God Axe, to close it (N. K. T. Priest, 2014). *Nyame Aso* is an artifact made of smooth or polished stone buried by the 'Ancients' (ancestors). *Nyame Aso* is usually discovered when farmers clear land for plotting, and because of their association with the ancestors, they are often ground up and the powder used for medicinal purposes (Bartle, 2012).

The second interview was with the traditional priest of the River Tano. She is regarded as the most powerful traditional priest in the area. In a patriarchal society, it is unusual to see a woman well regarded as she is. In an effort to respect her privacy, for the purpose of this paper, she will be referred to as "Nana Abena." Nana Abena has been working as a traditional priest for thirty-one years. She was in elementary school when she started "having the spirit" and did not go through any type of apprenticeship.

Nana Abena explained that she typically sees ailments including goiter, rectum prolapse (a condition in which the rectal walls protrude outside of the anus), typhoid fever, convulsions, madness, exorcisms, and stomach worms. She was proud to inform me that people of all religions come for her help. She believes that most illnesses are not "hospital illnesses," but they are spiritual illnesses or curses. She, and many believe that in order for the afflicted person to be healed of any disease or illness, she must reverse the curse that caused it before sending them to the hospital (N. A. T. Priest, 2014).

Herbalist interview

As the popularity of the traditional priests grew, the niche of a local herbalist was created. Some herbalists can be very grounded in the traditional beliefs and others have learned to integrate more of the orthodox medical beliefs into their practice.



Left: Looking through my notes as "Nana Kofi" prepares for the interview. To the left is my guide and translator, Mr. Kojo Frempong.
Right: "Nana Kofi" pictured (right) with his wife in the shrine.

Left: Figure of *Nananom* "ancestors", who must be offered gifts before consultation for assistance.
Right: "Nana Kofi" pictured (center) with his linguists who function to speak for him when he is in a trance.

I had the opportunity of interviewing one herbalist for my project. For his privacy, I will refer to him as "Nana Kofi." He has been working as an herbalist for thirty years and learned the trade from his father. It is common for herbalists to partake in an apprenticeship whereas spirits of ancestors guide traditional priests.

He explained that he typically sees people who need treatment of epilepsy, impotency, madness, barrenness, cardiac ailments, persistent migraines,. He is also used to resolve issues such as problems finding mates as well as other bodily ailments, which hospitals "cannot help because they are spiritual in nature." Unlike the traditional priests who seemed to have a working relationship among each other, the herbalist did not. He was unaware of any other herbalists in the area and stated that "no one can do what [he] can (Herbalist, 2014).

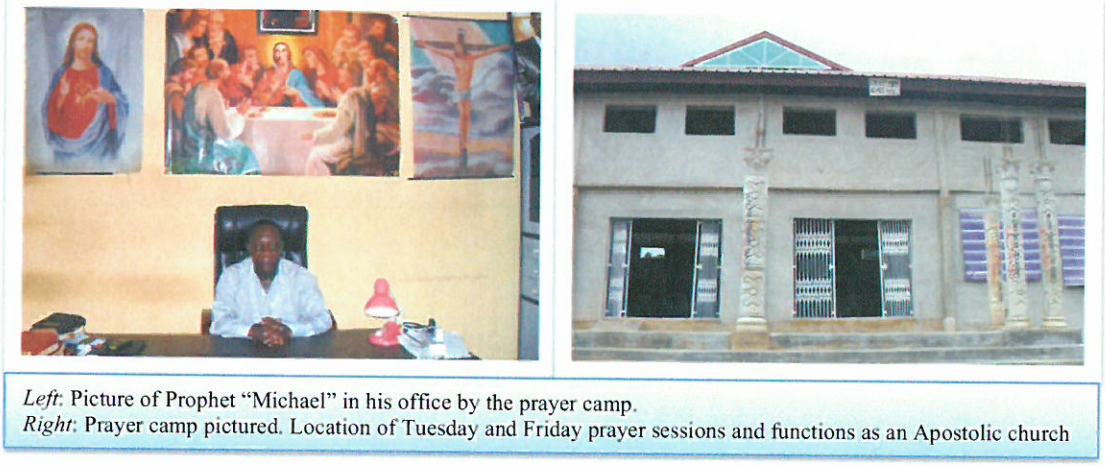
This herbalist was one who deeply integrated traditional beliefs in his practice. Before beginning the interview, we offered thanks to *Nananom* (ancestors), pictured above, and an offering of liquor was presented to ask their permission for the interview. When asked whether he has ever encouraged a client to go to a hospital for care of an ailment, Nana Kofi stated that he occasionally sends clinets to the hospital. "When the doctors fail, then I know for sure that it is a spiritual illness" (Herbalist, 2014).

Nana Kofi was adamantly against any future public health partnership between area herbalists and orthodox physicians. "I would never work with the hospitals. They can never pay me enough and also, not everyone who needs my help can go to the hospital. I visit my people at their home (Herbalist, 2014)."

Prayer camp interview

Recently, there has been an emergence of a new venue of medical care that is the prayer camps. Prayer camps are ministries that invite those who are ill to congregate and pray for healing. In planning my trip, I was unaware of the emergence and popularity of these prayer camps, and did not plan to interview one of these leaders. However, through

the help of Mr. Fred Frempong, I had an opportunity of an interview. To protect the privacy of this spiritual leader, we will refer to him as Prophet Michael.



Left: Picture of Prophet "Michael" in his office by the prayer camp.
Right: Prayer camp pictured. Location of Tuesday and Friday prayer sessions and functions as an Apostolic church

Prophet Michael welcomed us by explaining the origin of the camp. He founded his camp in 1996 and it was among the first to be organized in the Brong-Ahafo Region. Normally, churches and mosques pray for members of their congregation who are sick, but this "camp" was the first to be organized to solely devote evenings or weekends for prayers for anyone who is ill (Michael, 2014).

Camps differ dramatically depending on the leadership. There are some camps that take place in clearings in the woods, whilst others take place in specially built structures of worship. Prophet Michael's prayer camp is one of the latter. He hosts sessions all evening every Tuesday and all day every Friday in which those who are ill come to pray with him and others. During the other times the building functions as an Apostolic Church.

Prophet Michael sees people come with similar types of illnesses as the traditional priests and herbalists do. Common maladies he encounters are madness, epilepsy, persistent diarrhea, barrenness, and curses. Prophet Michael added paralysis and

blindness, conditions that were not mentioned by the traditional priests and herbalist. He believes in the care that a hospital provides, and feels that his value is in providing counseling, a caring community, and the occasional miracle (Michael, 2014).

Prophet Michael has established trust with the local hospitals in the area by building a relationship with the physicians. "I have had doctors come and talk to me and my congregation and those who use our services. We have talked about types of illnesses that should be seen by doctors first. I also know some doctors who encourage patients to come to my camp."

Anthropologist interview

The popularity of traditional priests, herbalists, and prayer camps was best elucidated through an interview with Most Reverend Peter Sarpong, the former Catholic Archbishop of Kumasi and a renowned Ghanaian anthropologist.

Archbishop Sarpong has worked as a priest since 1959 and received his degree as an anthropologist from Oxford University in 1965. He chose to pursue anthropology to better help him understand theology. Through the interview, he aptly put it that in the Western world, disease is caused by one of two things: the malfunctioning of an organ or the lack of that organ. However, in Ghana, diseases are caused by not two factors, but rather nine (Sarpong, 2014).

The first of these factors is the anger of *Nyame*. Regardless of religion, almost all Ghanaians believe in *Nyame*, the master of life and of health. The second cause of illness are deities underneath *Nyame*. The deities are spiritual beings, such as the River Tano. They have their own regulations and those who put themselves under their protection

most obey those laws. Once someone is under the protection of the deities, if they are offended, the deity will punish on their behalf. Likewise, those under the deity's protection who disobeys their wishes will be punished..

The third cause of illness is from ancestors. Ancestors are human spirits who were have died, "passed on." They left behind a set of rules that are passed on orally, referred to as ancestral laws. "These laws include commands such as not to steal from the blind, engage in pedophilia, slap a king, engage in homosexuality, or abandon your wife and family." If a person breaks any of these ancestral laws, they are subject to punishment from the ancestors.

The fourth cause of illness is destiny. In a way, Ghanaians believe in fate and that some events are planned out even before your birth. The fifth cause of illness is witchcraft and the sixth is from sorcerers. Witches and sorcerers are human beings that are intrinsically evil and work to harm others. The difference between witches and sorcerers is that witches act spiritually and do not have to be in contact with the person, whereas the sorcerers act both physically and spiritually. "A sorcerer uses an item like a voodoo doll. They will hold the doll of the victim and pierce a loaf of bread and chant a curse that may say that 'whenever this person eats bread, may their stomach swell and ache.'"

The seventh cause of illness is by evil men who have no magical powers, but wander around leaving poisonous roots or traps for people. The eighth is related to the seventh, but comes about in a more benign fashion. The eighth cause of illness is physical poisoning. "For example, there are certain trees and herbs that we should not eat, but sometimes young children do not listen and ingest them and get ill." The final cause of

illness, and only one that would necessitate hospital care, is natural body degradation (Sarpong, 2014).

Causes one to eight are all spiritual causes, leaving only the ninth cause to be one that resembles the Western causes of illnesses. Disease and medicine, therefore, is a concept starkly different in Ghana and based mostly on spiritual beliefs. As a result, whenever someone is ill, they will exhaust the list to find the cause, but as 8 of the 9 causes are of spiritual origin, when they cannot find remedy from hospitals, it makes sense for them to leave their care in search for another avenue of care.

Sunyani Regional Hospital herbal-physician interview

Perhaps in the hospital setting, the most familiar type of physician to those who prefer the unorthodox medicine is the herbal-physician. Prior to my research, I did not realize that there existed such a branch of physicians. The herbal-physician I interviewed had been working at Sunyani Regional Hospital for six months as a part of his housemanship program (similar to the medical internships in America).

He explained that he was trained for four years to be an herbal-physician. The first year he was taught clinical and diagnoses skills, the next year he learned pharmacological and anatomy skills and the last two years were internship years, one in an herbal facility and the other in a hospital (Herbal-Physician, 2014).

He explained that the motive of herbal medicine is to bridge the gap between traditional and orthodox medicine. "Ours is better than the orthodox medicine because people are more comfortable knowing that we are attempting to compromise with their beliefs (Herbal-Physician, 2014)."

However, even among the herbal-physicians, there is a high rate of patient attrition with certain cases. "It happens more often in the chronic diseases. I had a case of leukemia where the patient opted out of hospital care. Before they go, I typically counsel them about the condition that they have and that in some cases, they can exacerbate it by going to these other sources of care. This sometimes helps. Some choose to either stay with orthodox care, do a mixture of orthodox and traditional care, or leave all modes of care altogether (Herbal-Physician, 2014)."

With the rise of herbal-physicians, a new association named the Traditional Medicine Practice Council has been created. The Traditional Medicine Practice Council regulates the practices and sanctions unprofessional herbal-physicians. It was the interviewees hope that herbalists could one day be included in the association. He believed that incorporating traditional herbalists in the association to unite the two trades would be the best solution for future medical care in the country. "It is a good practice to continue to integrate herbal and orthodox medicine. This blend is what yielded my field."

The interviewee also believed that a regulatory board similar to the herbalist one needed to be established for prayer camps. "Some prayer camp conditions often aren't good. They are sometimes in the woods or other places like that that can worsen conditions. Having a board would be helpful if they can provide an safe location for the camps to occur (Herbal-Physician, 2014)." Perhaps most shocking was his blunt rejection of any sort of partnership with traditional priests. "There is no acceptance by the traditional priests of herbal doctors. They don't like us at all and we don't have a good relationship." Unwilling to elaborate, I was just left with my speculations.

It seems that the emergence of herbal-physicians have pushed some herbalists, such as Nana Kofi to practice more as a traditional priest would practice, interacting more with the ancestors as they do. Perhaps this competition has caused disdain for the herbal-physicians by the traditional priests. This is merely a speculation, but a likely outcome of the ever-molding healthcare system.

Sunyani Regional Hospital physician interviews

The final layer of the medical care system in Ghana is the one most familiar to many Americans – the orthodox physician. I was fortunate to obtain perspectives from six physicians. The orthodox physicians are coded as P01-06. P01-05 is a mixture of physicians who have been at Sunyani Regional Hospital for anywhere between five and ten months as they complete their housemanship program. P06 is my grandfather, Dr. Saarah-Akyerekoh, who worked in Sunyani Regional for more than thirty years before leaving to found his own hospital thirty-five years ago.

When asked about the familiarity of traditional religions and gods in the area, some physicians were very knowledgeable and responsive to questions; others were offended by the question and refused to elaborate. P01 identified that he was familiar with the common practices because of their implications on his ability to practice medicine. "For example, when I was rotating in surgery, I noticed that I would get patients come in with an infected leg fracture because of attempts of herbalists to heal the fracture. The various concoctions they applied to this boy's leg led to an ulcer. I also had an instance of chronic hypertension that was treated by an herbalist and traditional priest.

The unfortunate thing is that the remedies that they gave this lady caused nephrotoxicity. It's a very delicate battle (P01, 2014)."

P02 and P06 responded that they were familiar with the traditional beliefs in the area (Kwabena Saarah-Akyerekoh, 2014; P02, 2014). P03 and 05 sharply responded that they were not familiar with the beliefs nor were they interested in learning about them (P03, 2014; P05, 2014). P04 was unfamiliar with the traditional beliefs of the area because she was not from the immediate area (P04, 2014).

Many physicians spoke of instances in which patients have left hospital care to seek traditional caregivers. "In my experience, people leave our care when they are in admission for a prolonged time. Health care here is too expensive, they cannot stay if they cannot afford it" (P01, 2014). P01 continued to explain that he tries to counsel patients to stay, especially when parents are making the decisions for sick children. P04 also agreed with P01's sentiment. "Most patients with chronic diseases who come to the hospital and don't have a successful diagnosis or treatments are the ones who typically opt for the more traditional medicines. The only problem is that when they come back, which they almost always do, it is so badly progressed that they often die" (P03, 2014).

Many times, patients leave hospital care because of ideological differences. In Ghana, though there is separation of church and state, the extent to which that is realized varies in each institution. "I once had a young lady who claimed to be a Christian come to me for an abortion. I wasn't comfortable with doing so because she was healthy and the procedure was unnecessary. She left the hospital and came back two weeks later with a septic abortion, probably an attempt by a traditional priest or herbalist" (P02, 2014).

P03 put things in perspective. "I believe that people like to have options. Once physicians give diagnoses, we narrow people's options. They turn to their faith and spirituality to open their options back up… sometimes it works, most times it doesn't" (P03, 2014).

The problem with too many avenues of medical care in Ghana is that they are no modes of communication between them. "The problem is that don't buy or take the medications we prescribe, but rather go to the priests. The best way to indicate whether or not someone will remain in our care is by assessing their literacy" (P05, 2014). This lack of communication has also caused difficulty for physicians when prescribing medications. They are oftentimes unsure as to which herbs/concoctions that patients have been given outside of the hospital and patients, themselves, do not know.

A different perspective on patient attrition was given when I interviewed my grandfather, Dr. Saarah-Akyerekoh. Having retired from the hospital thirty years ago after thirty years of service, he saw a more positive trend in hospital use. "When I was a child and even as a young doctor, there was only traditional medical practices because doctors were unavailable and rare. Now, I would consider people to be more keen to use orthodox medicine because it is the first time that it has been an option for the masses" (Kwabena Saarah-Akyerekoh, 2014).

Orthodox physicians seem to be caught in the middle of an inherited problem. To the best of their training, they are offering care for patients who, at times, are not interested. P01 stated that he tries very hard to communicate with other modes of medical care. "There really is no monitoring of camps. Physicians go to communities to give talks on malaria symptoms, birthing methods, and signs of common diseases that people

should seek immediate hospital attention if they are affected" (P01, 2014). "I wouldn't advise any patient to stop their faith," P02 expressed, "I believe that God heals, but I just believe that He uses man to do this healing" (P02, 2014). Counseling patients on the pros and cons of hospital care seems to be their most difficult task. "Sometimes you do everything you can for the patients, but if they don't have a will to live, they won't live. I really try to encourage them to use their faith to support the medicine," P03 expressed (P03, 2014). P04 agrees, "I find that in counseling patients, the best thing for me to say is that it is okay to believe in faith and spirits. It doesn't have to be one or the other, and often only when both are integrated does the medicine work because compliance is higher" (P04, 2014).

All of the physicians agreed that by educating patients on the harm that can befall on them by mixing herbalist or traditional medicines with orthodox medicines, they often make the decision to stay in their care. "Illiteracy and the hyper-religious nature of Ghanaians are to blame for these lingering beliefs. I try to explain to patients, especially those with terminal conditions, that it is a biological cause, not a spiritual one that has brought them to the hospital" (P05, 2014).

On the opinion of prayer camps, many of the physicians were split in their opinion, however they regard them as the most benign alternative to orthodox medical care. "The only reason physicians don't like the camps is because patients go there first, so by the time they arrive to the hospital, their conditions are often too progressed" (P01, 2014). One physician brought up the concern that she does not understand why prayer camps cannot work in conjunction with hospitals, "I believe the patient can be prayed for everywhere because God is everywhere, so I don't understand why the camps pull

patients out of hospitals" (P03, 2014). The only risk of prayer camps that the physicians agreed on was the tendency of illiterate patients put all of their hope of healing into these camps and it is only the literates who seek medical care alongside the prayer option. "Most people that we see are illiterate, so it is understandable that they can't wrap their minds around the science. Religion is an easier concept to understand because no one knows the answer" (P04, 2014).

The opinion of herbalists is worse than that of prayer camps. One physician believed that they could refine herbalists to practice more safely. "We can do partnerships with them to offer them clean blades for herb harvesting and request that they refer patients to hospitals if conditions get too far out of hand" (P01, 2014). Other physicians did not see the possibility for herbalists to be refined at all, "I have tried, and it is too difficult to communicate with them. They think that we are pushing Western ideas onto traditional care. I think patients going to herbalists are very dangerous because we never know the side effects of their concoctions" (P03, 2014); some of the side effects that they shared included organ failure and loss of eyesight. Then, there were some physicians who saw herbalists as nothing more than more modern traditional priests.

Among the physicians, the opinion of traditional priests was more favorable than herbalists because of the lack of 'chemistry' in their practice. "I don't think they interfere too much with medical practices because people often go to them with issues involving theft, curses, relationships. They've become more of counselors than medical care deliverers" (P01, 2014). All of the other physicians interviewed responded that they had "No opinion of the traditional priests." This was interesting because they gave the impression that traditional priests were not socially accepted, but at the same time, they

were not a group of people to speak negatively about. "I have no opinion on them, but I think it is hard for people to let them go because of the high illiteracy rate. Most of their actions now are innocuous practices such as putting thread on babies' wrists and thighs to help monitor their growth. With the emergence of herbalists, people have begun to use them less for medicine (P04, 2014).

The final question asked of the physicians was if they would be open to a public health partnership between herbalists, traditional priests, prayer camps and Sunyani Regional Hospital. The answers were of a wide array. "I don't think it will be possible. Herbalists and traditional priests are often illiterate, unhygienic, and do not have any medical basis for their work" (P01, 2014). Another physician agreed. "We cannot mix faith and medicine. They are too different. Medicine is evidence-based and that is what makes it reliable. Faith is built precisely on what you cannot explain or conceptualize. After I give patients my medical opinion, the can go home and pray. We all pray" (P04, 2014).

There were some physicians who believed that there was already an integration of faith and medicine. "Most doctors here are Christian or Muslim and take their beliefs into their practice. Having a doctor of your faith eases patients. Hospitals are also cognizant of religious restrictions such as the belief of Jehovah's witnesses not to take the blood of others. I think that should be enough" (P02, 2014). Another physician agreed that there is already this partial incorporation present, "Most hospitals have a pastor or an Imam affiliate. This is all fine, the problem only arises when they convince patients to leave the hospital" (P03, 2014).

DISCUSSION

Physicians interviewed believed that patients should be more comfortable using hospital services with the new addition of herbal-physicians,, but I disagree. The one thing that herbalists and traditional priests offer these patients that hospitals cannot is a personal relationship. All of the physicians currently practicing at Sunyani Regional Hospital that I interviewed were only staying for the year of their housemanship program.

Herbalists, prayer camps, and traditional priests offer a permanent relationship between patients and the spiritual leader. The value of permanence is appreciated in other countries. It is common in western countries to stay with one primary caregiver for decades; however, this relationship is truncated to mere months in Sunyani. Orthodox physicians can, therefore, not challenge the trust that is established between herbalists, traditional priests, and prayer camp leaders,

This trust has further grounded people in the traditional beliefs and cultures of Ghana. This spiritual culture of the people partly explains the popularity of prayer camps. Prayer camps are a unique control because they do not offer any medications, placebo or otherwise, yet patients still feel healed and satisfied with their care.

Throughout the interviews, herbalists and traditional priests asserted that some illnesses were "hospital illnesses" and some were not. It appears that people only come to the hospital with cases such as malaria and Guinea worm disease, which they have been educated that only hospitals can help. In addition, diseases such as malaria are easily and rarely result in complications if diagnosed on time. This suggests that the community outreach programs that physicians have done to educate the masses have tremendously helped. The only pitfall with this solution is that chronic and terminal illnesses often are

hard to diagnose, harder to treat, and even harder for people to finance. In these situations, as the interviews have elucidated, alternative avenues of medication become a preferable option.

The healthcare system in Ghana lacks trust. Hospitals do not trust the government to pay them for their services and as a result, have begun to charge patients for even emergent cases. Physicians do not trust patients to take medications or to honestly report if they are seeing alternative avenues of medical care. Patients do not trust physicians to heal them because they feel many of their cases are spiritual in nature. This has led to physicians not trusting herbalists, traditional priests, and prayer camps to care for their patients. It is a vicious cycle that can only be interrupted by a mass education campaign and perhaps an association to formalize communication between these different avenues of medicine.

Limitations

The empirical evidence is limited to the area of Sunyani, Brong-Ahafo Region, Ghana. Thus, widening the reach of this study for the future to other critical areas of the country would be desirable.

CONCLUSION

In conclusion, the terrain of medical caregivers in developing countries such as Ghana is complex and extends farther than the hospital walls. Medical care originated from traditional priests and from there came herbalists and later prayer camp and

hospitals. Due to differing beliefs of what causes disease and illness, alternative avenues of medical care have prevailed.

Today, traditional priests function to lift curses that result in illness and disease to allow hospital medications to "work." The benefit of many traditional priests is that, they believe and encourage people to seek hospital care for many illnesses and diseases. This hospital referral can be contributed to community health education by physicians and nurses that have educated the population on symptoms of potentially life threatening and easily treated maladies.

The biggest problem in the healthcare system of Ghana is the lack of trust and until that is addressed, no progress will occur. The government needs to understand the critical and regulated service that hospitals provide the people and ensure that government reimburses is not kept from these institutions. In addition, the permanence of traditional priests and herbalists as medical caregivers is due to their stability in communities.

Often, physicians in hospitals remain only for the housemanship program and or "pass through" after short stay because of satisfaction issues involving income and working conditions. As a result, it is hard for physicians to build a foundation of trust between themselves and patients, something that herbalists and traditional priests have established over decades.

A common sentiment that was shared was that developing countries are more spiritual and religious than developed countries. Thus, inexplicable concepts of disease and medicine are based on those spiritual beliefs. The problem with the integration of

these unorthodox avenues of medicine is that modern-day hospitals function to practice evidence-based medicine.

This is reliance on evidence-based medicine is the reason that herbal-physicians were possible to integrate into hospitals –there is evidence to be found in herbs. In order to integrate unorthodox avenues further into hospitals, it would have to be limited to allowing faith leaders to have a greater presence in hospitals and in exchange, working with them to agree not to encourage sick patients to leave hospital care.

Education and literacy also seem to be a reliable indicator on whether or not patients will remain in hospital care. As the world combats the Ebola virus, these same issues of illiteracy, distrust, and combating views of the origins of disease have come to the forefront.

The medical care system needs to be uniquely tailored to the population that serves. It is clear that the system that works in the United States or the United Kingdom will not and cannot work in developing countries such as Ghana because the beliefs of the causes of illness and diseases are different. A system that formalizes herbalists, traditional priests, prayer camps, and orthodox physicians will clearly delineate responsibilities and recommended courses of action so as to offer an objective source for patients to refer to. Along with this, an association of medical caregivers should be established that would formalize communication between these different avenues of care.

It is imperative that these ethnographic studies on medicine are conducted periodically to ensure that in situations where disease epidemics arise, they may be properly attenuated. We are no longer simply citizens of our countries, but of the world.

In our current globalized world, what happens across the globe could land in our front door in a blink of an eye.

RECOMMENDATIONS

1. Continue integration techniques such as the one that led to the introduction of herbal-physicians
2. Establish an association for traditional priests, herbalists, prayer camps, and orthodox physicians to formalize communication and ensure that the patient's well being is considered among those who are seeking more than one avenue for care.
3. Periodically conduct these ethnographic studies on countries with a high risk of medical system failures. These are the countries that may have mismanagement of care during disease epidemics.

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