
The contribution of indigenous health care providers to health care delivery in Rural Ghana: An exploratory study of Bongo District

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To cite this article:

Philip Aniah. The Contribution of Indigenous Health Care Providers to Health Care Delivery in Rural Ghana: An Exploratory Study of Bongo District. *Science Journal of Public Health*. Special Issue: Health Behavior and Public Health. Vol. 3, No. 1-1, 2015, pp. 20-28. doi: 10.11648/j.sjph.s.2015030101.14

Abstract: Ghanaians have been using indigenous medicine since time immemorial where 80% have reported its utilization. It is claimed to be easily accessible, affordable, available and acceptable; but the contributions of indigenous heal care providers have not been documented. Most of the studies conducted so far are focused on perceptions of people on traditional medicine. The study presents descriptive data from fieldwork carried out on fifteen indigenous healers and 100 patients in the Bongo District of Ghana to ascertain the health seeking behavior of patients and the reasons for visiting indigenous healers. The study shows that indigenous/traditional healers contribute significantly to public health care in Ghana. Fifty four percent (54%) of patients interviewed resorted to traditional medicine as their first choice when they face health problems. The reasons for preferring traditional medicine were efficacy, dissatisfaction with modern medicine, and cost. Traditional healers complained of lack of cooperation with modern health professionals. Community members need to be sensitized on the proper treatment for diseases and on the dangers of taking traditional medicine. This study suggests further exploration of key reasons behind high levels of satisfaction and utilization of traditional medicine.

Keywords: Indigenous Medicine and Healers, Health Seeking Behavior, Public Health, Bongo District, Ghana

1. Introduction

Prior to the emergence of modern scientific methods of disease prevention and treatment, people from different cultural backgrounds have since pre-historic times, used different herbal plants, plant extracts, animal products and mineral substances as the means to prevent, treat and/or manage ill-health [1,17]. In African societies, this indigenous system of health care delivery is widely known as Traditional Medicine (TM).

According to [7], traditional medicine encompasses all health care practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being. These approaches to health care delivery belong to the traditions of each culture, and have been handed down from generation to

generation [41]. Tribes, cultures and indigenous people of nations throughout the world have evolved this system of traditional medicine for generations, and communities have found most of these medical practices valuable and affordable and still depend on them for their health care needs. Traditional medicine is commonly used to treat or prevent a wide range of diseases including chronic illness. A traditional healer or a Traditional Medical Practitioner (TMP), is an educated or layperson who claims ability or a healing power to cure ailments. He could have a particular skill to treat specific types of complaints or afflictions and might have gained a reputation in her/his own community or elsewhere. Traditional healers may base their powers or practices on religion, the supernatural, experience, apprenticeship or family heritage [25, 7].

TM is assuming greater importance in the primary health care of individuals and communities in many developing countries [27, 40, 42]. The WHO estimates that about 60% of the world's people uses herbal medicine for treating their

sicknesses and up to 80% of the population living in the African Region depends on TM for some aspects of primary health care [40, 6].

Overall, it is estimated that more than 80% of health care needs in developing countries are met through traditional/indigenous health care practices [7]. The reasons for the continuous patronage of TM in developing countries despite the presence of orthodox medicine include cultural acceptability, perceived efficacy, affordability, accessibility and psychological comfort on the one hand, and inaccessibility of modern health services in terms of geographical availability of modern health care facilities and personnel and affordability of cost on the other hand [43, 25, 7, 15, 34].

In rural communities in Ghana, like other developing countries, TM continues to remain a vital and permanent part of the people's own health care system. Until the middle of the 19th century, most rural people in Ghana had no access to orthodox medicine and relied entirely on herbal and other traditional medical services for their primary health care needs. Even up to date, the scarcity of orthodox doctors, nurses and modern health care facilities have made many rural people to still rely partly or fully on TM for their health care needs. For example, it is estimated that, in Ghana there is one traditional practitioner to approximately 386 people as against the orthodox doctors to population ratio of about 1:10 700 and nurses to population ratio of 1:1 578 [21].

There have been suggestions and counter debates for the integration of traditional medical practices into the routine modern health care system of Ghana like it happened in China. However, several challenges for this possible systemic integration including diversity in TM practices and a lack of clear understanding of the TM system have been raised [22]. This stems from the fact that the contribution of traditional medicine to the public health care system of Ghana and other African countries have not been adequately assessed and documented. Studies conducted so far are limited on the perceptions and practices of modern and traditional health practitioners about traditional medicine [28, 2].

This study therefore seeks to contribute information on the operations of TM in rural Ghana and document their contribution to health care delivery so as to identify areas of synergies for potential integration of TM into the routine health system of Ghana. We therefore specifically investigated and documented the operations of traditional healers, consumer reasons for choosing traditional healers and the contribution of traditional healers to public health care delivery in the rural district of Bongo in the Upper East Region of Ghana.

2. Review of Literature

Traditional medicines and healers are defined by the World Health Organization (WHO) as 'the sum total of the 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 the prevention, diagnosis, improvement or treatment of physical and mental illness' [39]. The integration of traditional medicine and its related practices with orthodox systems (public, private not-for-profit, private-for-profit) was endorsed as early as 1978, when the World Health Organization officially recognized that many relied on traditional medicine owing to its relative accessibility, affordability, acceptability and availability [40]. Combining these two broad and often conflicting systems, however, has proved a great challenge in many countries. Orthodox personnel disregard traditional practitioners as untrained personnel who often trade informally without medical training and certification. Traditional practitioners often see orthodox practitioners as impatient individuals who rush their patients in and out of their consultation rooms as soon as a diagnosis is made and a prescription given [30]. As a result, many countries have agreed on the WHO recommendation to integrate the systems by developing national drugs policies and tweaking existing regulations to incorporate traditional medicines and encourage the cross-fertilization of ideas [30]. The Ghana National Drugs Policy stipulates [23]: 'the role of traditional medicines and traditional medicine practitioners (TMP) in the health care delivery system is recognized and the Traditional and Alternative Medicines Directorate of the GHS has been established. Efforts are directed at bringing all traditional medicine practitioners under one national organization, preparing guidelines for standards of practice and ethics, and a training manual for the profession.' However, this has resulted in a largely top down approach to policy making, without much exploration or understanding of users' perspectives. Choice of medicine providers within Ghana's medically pluralistic system [35], medicines can be obtained from an array of sources. The classification of providers varies across regions and districts, but here providers are classified into the orthodox (public and private), traditional (private only) and 'self' (medicines obtained at home, both traditional and orthodox). The orthodox system constitutes primary, secondary and tertiary institutions—some of which specialize (e.g. maternity homes)—in addition to informal services provided by drug peddlers. Formal institutions include hospitals, health centers', community health posts, pharmacies and drug sellers, and clinics. All these institutions are required to be licensed, although enforcement is not necessarily strong or successful. The traditional system constitutes a wide range of providers and remedies which include herbal medicines, folk knowledge, rituals and spiritual elements [33]. Practitioners may include traditional birth attendants, bone setters, fetish priests, herbalists (non-spiritual and spiritual), spiritual diviners and circumcisers. To date, the traditional system is largely unlicensed and very few practitioners are authorized by the state as being qualified to practice officially, but by definition, those in surrounding

communities have given them recognition, though often only after many years of effective practice. Much like orthodox systems, the traditional practitioner specializes in specific diseases and illnesses, each with their diagnostic and treatment structures [36, 4, 37, 30]. Compared with orthodox systems, however, there are spiritual elements that are little understood to those without detailed anthropologic knowledge of customs and rites, frequently local in nature [24]. Conventional scientists and medical personnel fail to fully accept this spiritual element and some also reject purely herbal remedies on account of their untested, hence unviable, powers to heal [29], for a similar case in Sri Lanka. Added to this the high propensity to self-medicate [19, 37, 30] and the popularity of local pharmacies and medicine sellers [38, 31, 16], and Ghanaians are faced with a complex web of possibilities when deciding what actions to take when illness strikes.

For many, traditional medicine and its practitioners are favoured for commonly cited factors related to accessibility, affordability, availability and acceptability [4]. Herbal remedies grow in local areas or within the compound, so they are conveniently and freely accessed, they have been tried and tested by ancestors and locals alike and are often administered by those who live in the community (cultural path dependency), and are grown abundantly on fertile lands. A study undertaken on stroke patients in Tanzania shows that causation beliefs, such as supernatural causes for illness, outweighed other factors such as cost and geographic distance for care seekers, and multiple treatment-seeking was the norm [24]. [26] shows that in a community in South Africa, some individuals believed that doctors were able to make the illness better but could not necessarily 'treat the cause'. Thus, even if costs of orthodox treatment may be covered by the NHIS, the preferred choice may be to obtain additionally traditional medicines/services of traditional medicine practitioners (TMPs), which can be acquired with even fewer barriers to access and are thought to be more acceptable than using orthodox medications [30].

2.1. Satisfaction Levels

Many studies fail to measure user satisfaction in a tangible manner. This is largely because most efforts to document effectiveness have been focused on scientific results to show herbal properties, rather than the user level. Of those which do ask about satisfaction, they seek to obtain an answer to the question, 'how satisfied were you with the service received?', or 'how satisfied were you generally?'. Although this assesses an outcome, it would be better complemented with measures incorporating a before-and-after effect to measure the change in satisfaction resulting from treatment and to avoid assuming that all individuals began at the same level or extent of health problem [30]. Stekelenburg's study in Zambia asked respondents about their opinions and perceptions of healer service satisfaction, although detail is omitted about the precise methodology [32]. The results show that 74% of

respondents using traditional healers were satisfied with their treatment, but 86% of those who were not satisfied would opt for hospital treatment in the future. Therefore asking individuals who have been visiting traditional healers and/or using traditional medicine to self rate on a scale of one to five aspects of health and overall quality of life and health before and after treatment/traditional medicine use.

3. Methodology

3.1. Study Setting and Sampling

The study was conducted in the Bongo District of the Upper East Region of Ghana. The Bongo District is one of the 13 political and administrative districts of the Upper East Region of Ghana. The district spans a total land area of 488km² which constitutes approximately 5.52% of the total landmass of the region. The district shares boundaries with Burkina Faso to the North, Kassena-Nankana West District to the West, Bolgatanga Municipal to the South West and Nabdram District to the South East. It lies between longitudes 0.45° W and latitude 10.50° N to 11.09. It lies within the Oncho-cerciasis-free zone. The predominant economic activity in the district is subsistence farming. According to the 2010 population and housing census of Ghana, Bongo District has a total population of 84, 545 people, representing 0.34% of the Ghanaian population. 48.8% of the total population are males and 72 % live in rural areas [14].

The modern health care system of the Bongo district is made up of one (1) District Hospital in the district capital Bongo, four (4) Reproductive Health Clinics, seven (7) completed Community Health Planning and Services (CHPS) compounds, sixty-two (62) outreach points, ten (10) feeding/nutrition centre's and one (1) rehabilitation centre. The district health administration is managed by a District Health management Team (DHMT) headed by the District Director of Health Services (DDHS). The team is supported by Sub-district Health Management Teams (SDHMTS) in all six sub-districts [8].

The target population comprises users of traditional medicine, traditional medical providers (TMPs) and orthodox medical providers (OMPs). A total sample size of 140 respondents comprising 100 local residents who have ever used the services of traditional/indigenous health care providers, 15 Traditional Medical Practitioners (TMPs) and 25 Orthodox Medical Practitioners (OMPs-doctors, medical assistants, nurses, midwives, pharmacists, etc) was selected for the study. The various sub-samples were categorized based on their composition in the target population of the study.

The respondents were selected from 6 rural communities across the district: Zoko, Veaa, Gowrie, Kunkua, Dua and Soe. The overriding factor in the selection of the communities was to ensure fair coverage of the district as a guarantee of geographical representativeness of the sample. The allocation of the respondents to the communities took

into consideration the size of their population.

Snowball technique was used to select the TMPs; simple random sampling was used to select the clientele of about 6 to 7 people. Each TMP and the OMPs were purposively selected from the target population. The criteria for selection of the OMPs were based on proximity to TMPs. On reaching the field, the sub-samples for each community were sub-divided to reflect the categories of the target population for the purpose of interview.

3.2. Data Collection Tools and Procedure

This study is primarily cross-sectional and descriptive in nature. Primary data on the practices of Traditional medicine (TM), interactions between the two medical systems, perceived efficacy, safety and client satisfaction, etc of TM were collected by means of unstructured interview between June 2013 and January 2014. An interview guide comprising both open and close-ended questions was used to collect data from all respondents. The first section of the guide contained questions on respondent's basic socio-demographic characteristics such as age, sex, marital, educational, religious and occupational status which was administered to all respondents. The second section was administered to only TMPs on community awareness of their existence, their expertise, mode of operation and interaction with OMPs. The third section was administered to clients of TMPs on their utilization of TMP, their reasons for using TMP, the importance of TMPs, the type of diseases or health conditions that push them to seek treatment from TMP, their general opinions on the operations of TMPs and their integration into the routine medical system. The last section was administered to OMP on their perceptions of the importance of TM, diseases that are best handled by TMPs,

the interaction between TMP and OMP and integration, and their general opinion on traditional medicine. The data collected from these different groups served the purpose of triangulation to improve upon the rigor of the study.

The interviews of TMPs and their clients were conducted in the local language Gurene but OMP were interviewed in English. The respondents and opinion leaders in each selected community were notified and briefed on the objectives of the research and asked for permission before interview begun. The interviewees were assured of strict confidentiality of the information they disclose. Informed consent was obtained from all respondents before data collection. Each interview lasted for about 45 minutes. Detailed notes were taken and those in Gurene were then translated into English. The working environments or the sanitary conditions of the various traditional clinics as an indicator of hygiene were directly observed.

3.3. Data Analysis

Simple quantitative and qualitative data analytical approaches were used. The quantitative data was generated from the open-ended questions. It was coded, and entered into the computer and analyzed using SPSS statistical software. The notes and transcripts obtained from the interviews were inductively coded after its translation into English. Thematic analysis was manually conducted to identify the key issues that emerged from the interviews. The coding and analysis was done and cross-checked in order to ensure inter-researcher reliability.

4. Results

Basic information of the respondents

Table 1. Socio-demographic characteristics (age, sex and religion) of the respondents (Clients of TM, TMP and OMP)

Characteristics	Clients of TM		Traditional medical providers		Orthodox medical providers	
	Total	percentage	Total	Percentage	Total	percentage
Age						
0-25	24	24	1	6.67	3	12
26-35	27	27	3	20	7	28
36-45	29	29	5	33.3	9	36
45+	20	20	6	40	6	24
Sex						
Male	43	43	15	100	17	68
Female	57	57			8	32
Religion						
African Traditional Religion	43	43	11	73.3	2	8
Christianity	38	38	0	0	15	60
Islamic Religion	19	19	4	26.67	8	32

Source: Field Survey, September 2013.

4.1. Health Seeking Behavior of Patients Visiting Traditional Healers' Clinics

Traditional healers' clinics were the first choice for fifty-four percent (54%) of patients for diseases like swelling, wound, fracture, paralysis, back-pain, liver diseases,

stomach pains, skin diseases, asthma, anthrax, cough and pneumonia. Thirty-eight percent (38%) patients got information about traditional healers' clinics from friends, twenty-six percent (26%) from family, twenty percent (20%) from previously treated individuals and sixteen percent (16%) from multiple sources. Most patients, sixty percent

(60%) visited traditional healers' clinics escorted by their family, whereas thirty-two percent (32%) went by themselves, and eight percent (8%) with friends. Fifty six percent (56%) of the patients visited healers' clinics once, twenty eight percent (28%) twice, twelve percent (12%) three times, and four percent (4%) four times or more in

their life time.

The table below shows the various sources of information available about traditional/indigenous healers' clinics, the frequency of visits by patients per year and the visiting assistance.

Table 2. Sources of information about traditional healers' clinics, visiting assistance and frequency of visits per year

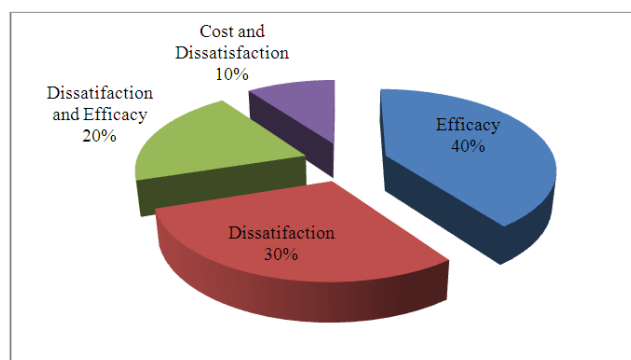
No.	Sources of Information	Percentage %	Visiting Assistance	Percentage %	Numbers of Visits per year	Percentage %
1.	Friends	38%	Escorted by Family	60%	Once a year	56%
2.	Family	36%	Escorted by Friends	8%	Twice a year	28%
3.	Previous treated individuals	20%	Own/personal Visits	32%	Three times	12%
4.	Multiple Sources	16%			Four times or more	4%

Source: Field Survey, September, 2013.

4.2. Reasons of Visiting Traditional Healers' Clinics

24.2% of the patients that visited traditional/indigenous healers' clinics reported that they were previously treated and cured. They were treated of diseases such as stomach pains, skin diseases, chronic sores, asthma, toothache, anthrax, sore throat, cough, scorpion and snake bites, diarrhoea, ulcer sores and easy delivery of women.

The reasons for visiting traditional/indigenous healers' clinics by patients were 40% efficacy, 30% dissatisfaction with modern medicine, 20% dissatisfaction with modern medicine and efficacy, 10% cost and dissatisfaction. The majority 65.4% of the patients had positive attitude to the efficacy of traditional medicine and out of these patients, 37.9% rated the efficacy of traditional healers' service as good and 57.8% indicated side effect was low. About fifty-nine percent (59%) of patients reported that they were satisfied with traditional healers' clinics services.



Source: Field Survey, September, 2013

Figure 1. Clients/Patients reasons for visiting Traditional healers' clinics in the Bongo District

4.3. Knowledge and Practice of Healers in Ghana

The majority (70.0%) of healers identified diseases and causes of illness by history-taking and physical diagnosis. During history taking, patient or person accompanying the patient was interviewed about the sign and symptoms of the

disease, the duration of the disease, age of the patient and history of similar disease in the family. In examination, they observed signs of diseases such as face color, abdomen size and discomfort, wound size and site, and urine color. On the other hand, a minority (30.0%) of the healers were using combination of history-taking, physical diagnosis and divination in identifying diseases and determining the type of medication.

4.4. Source of Medicine, Preparation, Prescription and Fee

The sources of medicine for the majority of interviewed traditional healers were plants, animals and minerals while for two healers were plants and animals, and for one healer were only plants. Two of the healers had home-gardens for cultivation and as source for some medicinal plants. All healers used both dry and fresh plant parts for preparation of remedies. Crushing, powdering and pounding were indicated by six of the healers as the methods of preparations of herbal drugs, while four of the healers only used squeezing. All healers stored medicinal plants in the form of powder or dried and cut into pieces within a closed container. The time of storage varied among the healers and depended on the type of traditional medicine. The doses of the medicine were measured using cup, spoon, glass, pinch, and lid of the container; it was determined by age of the patient, physical status of the patient, severity of the disease and the experience of individual healer. All healers had offices for their healing practice but none of them admitted and treated in patients. Seventy percent (70%) of healers responded that they had additional persons working with them as assistant healers, their number ranged from 1 to 5. Healers received payment for their services that included registration fee and cost of medicine. The registration fee ranged from Ghc5 to Ghc 10 (1 USD = Ghc 2.85) though none of the traditional healers' have formal registration system for their patients. The cost of medicine was paid immediately after getting the treatment and showed variation from healer to healer as well on type of disease.

4.5. Problems Associated With Traditional Medicine

Some plants used in traditional medicines, such as “Yilinga”, are widely known to be toxic. For example, abortion and miscarriage are repeatedly found in women who take “Perika”. Also, “Buringa” is used to force feeding of babies but can cause blindness in overdosed. Traditional healers may cause great delays in the treatment of communicable diseases such as Tuberculosis if they fail to refer patients to modern health services.

5. Discussion

The number of individuals found in the indigenous healers' clinics during the study and who responded indigenous healers' clinics were their first point of call/choices indicates the significant contribution of indigenous healers' clinics to the public health care delivery in rural Ghana. The number of repeated visits of these clinics by patients and number of individuals that gave information to the patients about indigenous healers' clinics that might have previously visited traditional healers' clinics also demonstrated the significance of the indigenous/traditional healers' clinics for the public health care delivery of the Bongo district. These showed that a considerable number of the population was treated by the traditional healers' clinics and hence, the contribution of these clinics to public health systems in the Bongo district of the Upper East Region and the nation at large. The majority of patients in the study area preferred traditional health care clinics than modern health facilities.

Females, individuals with middle-income level and those with education visited traditional healers' clinics more frequently than the rest of informants. This is in tandem with the study by [10]. However, this study disagrees with the studies conducted in California [20] in Israel, [5] and in Colombia University [9] where females, those with higher education and high-income level had statistically significant association with traditional medicine use. [7,17] has expounded that the declining hospital attendance in 1984 could be traced to the overall economic crises, but continued through 1986 due to the introduction and increase in hospital fees. In most studies, low income has been mentioned as the reason to visit traditional healers' clinics [7,15, 34] whereas in this study, low income was not found to be a determinant in visiting traditional healers' clinics since other categories were equally important, reasons indicated by respondents-patients for using traditional medicine as their first choice is similar to the study done in Trinidad [10] where efficacy of indigenous medicine was the reason for choosing herbal medicine as the first line of health care option. This high efficacy perception is as a result of the fact that, traditional medicine is embedded in the belief and culture of the society [15, 34, 7]. In Ghana and other countries like Kenya and Mali, treating malaria with pyrimethamine/sulfadoxine is expensive [3], whereas

treating malaria with herbal medicines is very cheap and may sometimes even be paid for in kind according to the social standing of the client [6]. I agree with [6], the study conducted in Addis Ababa to determine the epidemiology of herbal drug use [12] showed the main reasons given for choosing herbal medicine as the first line medication option were dissatisfaction with the services of modern health institutions due to their time-consuming practice, cost and perceived efficacy. Study conducted in Nigeria [11] also agrees with the research findings that high efficacy of traditional medicine and dissatisfaction with modern medicine was the reasons to visit traditional healers' clinics. Study conducted in Pakistan [18] showed that 43% of the patients preferred traditional healers for skin disorder treatment indicating that the effectiveness of the remedies given by traditional healers against dermatological diseases. The WHO [40] reports, that in Ghana, Mali, Nigeria and Zambia, the first line of treatment for 60 per cent of children with high fever resulting from malaria is the use of herbal medicines at home. According to [1], the WHO estimates conservatively that between 60 per cent and 90 per cent of the populations of low-income countries rely on plant medicines to meet their health care needs. Apart from effectiveness of plant medicine, the populations generally patronize the services of TMPs because TM is affordable, accessible and available.

The findings of this study which indicated that majority of patients were satisfied after being treated by traditional healers is corroborated by the study conducted in Zambia [32] and Tanzania [13]. The study conducted in Nigeria [11] which indicated that 33.4% of the respondents reported that herbal medicines had no adverse effects though lower than the current study. The difference could be due to the variation in the dosage and the type of herbs used. The source of the healers' knowledge in this study is similar to the study conducted in Tanzania [13] where for 41.9% of the healers were their families. [7]

According to [30], 76.7% were satisfied or very satisfied with the effects of treatment, fifteen per cent (15%) felt neutral, whilst the remainder was dissatisfied. Those pleased with the results claimed that herbal treatments cured them of symptoms previously experienced, with many being able to return to their daily activities very soon after use of medicines. Individuals who were dissatisfied remarked that symptoms were still persistent, that they still felt the pains and that although at times the pains were relieved, sickness sometimes recurs. [7]

Most healers in Tanzania kept patient records containing demographic, diagnosis and treatment data whereas in the current study none of the healers kept patient records. The healers in the current study followed traditional treatment systems. Healers in Tanzania [13] agree on diagnosis of patients with this study though they also use laboratory test results made in the hospital in addition to history taking, physical diagnosis, and divination to identify diseases. In the current study, only one healer referred his patients to

modern medicine but the study done in Tanzania [13] showed that almost all healers referred their patients to hospitals when they failed with their own treatment [7]. This difference may be because absence of collaboration and lack of training of traditional healers in Ghana. Although beliefs in traditional healers are receding and giving way to biomedical treatment in some parts of Africa, many countries still have populations that use traditional medicine (also called alternative medicine) and this happens in low middle and high income countries. However the proportion using traditional medicine increases in more remote areas where medical services are thin [7].

6. Conclusion

The study conducted showed that for the majority of patients interviewed traditional healers' clinics were one of the options to solve their health problems, which indicated the considerable contribution of these clinics to the public health care system in the Upper East Region and the nation at large. The main reasons for choosing traditional healers' clinics were efficacy, safety of the traditional medicines and affordability of the services provided by the healers' clinics. Nevertheless, in this study the contribution of traditional healers' clinics to the public health system would have been better shown if individuals who are not customers of the healers' clinics were included in the interview. However, the study might be useful as a base line data for future evaluation of the significance of traditional healers' clinics for public health system and the services rendered in the healers' clinics.

7. Recommendations

7.1. Partnership and Co-Operation

There is the need for sharpening and intensify the partnership of TMP and the OMP with a platform for recognition of each group by one another as playing complementary role. It is interesting to note that much as the OMP have information to share with TMP such as education on signs and symptoms of common ailment, on when to refer cases how to prevent diseases etc; the TMP have experiences and insights from many years of attending to patients, how to respond to common questions on concerns of patients in terms of the local culture and language, knowledge of local beliefs and traditions relating to treatment, absence of which makes rural people (patients) feel uncomfortable each time they visit health facilities. Discussions on topics of this nature can only be achieved through co-operation. Traditional Healers rooms should be created in the health facilities so patients can freely attend and air their views without fear of being ridiculed. These healers' rooms would be manned by TMPs.

7.2. Recognition and Support

To ensure effective role of TMPs, it is important to put measures in place for their support whether financially, psychologically and materially. Members of rural communities should mobilize and committees be formed to oversee the extent to which financial support could be made through some form off revolving fund either by contribution or proceeds from community owned resources such as community farm products or animals. At best, the National Health Insurance should be discussed at length to incorporate financial support for TMPs and other Community Health Workers who are notably doing effective work in health delivery. Throughout discussion with TMPs and patients, it is noted that TMPs need recognition and that; the orthodox health workers should see them as partners in the health care delivery system and not just local practitioners as they view them. The community members should recognize their role and respect them and avoid seeing them as witches.

7.3. Training

Regular training is very important to enhance the work of TMPs. This is in view of the fact that, new diseases whether general or specific continue to unfold in several ways. Regular in-service training will keep TMPs inform about the types and nature of diseases and they will be in position to address them. Sustaining the work of TMPs will mean to train young ones to go into the field as the old give way. Judging from the survey conducted it was realized that, about 78% of the TMPs are old with only 12% who are in their late forties (40's).

7.4. Capacity Building of TMPs

District Assemblies and NGOs should help build the capacities of TMPs to enable them work in association with health authorities and other organizations to enhance their performance. With their capacities built, TMPs will be in the position to channel their grievances about their needs to the appropriate authorities for redress.

References

- [1] Addae-Mensah I. (1992). Towards a National Scientific Basis for Herbal Medicine Aphyto Chemists Two Decade Contribution. Accra Ghana, University Press.
- [2] Addis G., Abebe D., Genebo T., Urga K. (2002). Perceptions and Practices of Modern and Traditional Health Practitioners about Traditional Medicine in Skirka District, Arisi Zone Ethiopia. *Ethiop J Health Dev*, 16(1):19-29.
- [3] Ahorlu C. K. (1997). Malaria-Related Reliefs and Behaviour in Southern Ghana: Implications for Treatment, Prevention and Control. *Tropical Medical and International Health*, 2 (5), 488-499.

- [4] Anyinam C. (1987). Availability, Accessibility, Acceptability and Adaptability: Four Attributes of African Ethno-Medicine. *Social Science & Medicine* 25: 303–11.
- [5] Arye E. B., Karkabi K., Karkabi S., Keshet Y., Haddad M., Frenkel M. (2009). Attitudes of Arab and Jewish Patients toward Integration of Complementary Medicine in Primary Care Clinics in Israel: A cross-cultural study. *Social Science and Medicine*, 68:177-182.
- [6] Asanti E., and Avornyo R., (2013). Enhancing Healthcare System in Ghana through Integration of Traditional Medicine. *Journal of Sociological Research* ISSN 1948-5468
- [7] Birhan Wubet, Mirutse Giday and Tilahun Teklehaymanot. (2011). The Contribution of Traditional Healers' Clinics to Public Health Care System in Addis Ababa, Ethiopia: A Cross Sectional Study. *Journal of Ethno-biology and Ethno-medicine*, 7:39 <http://www.ethnobiomed.com/content/7/1/39>.
- [8] Bongo District Assembly, (2013). A Report of the Annual Health Sector Review.
- [9] Chao M. T., Wade C. M. (2008). Socioeconomic Factors and Women's use of Complementary and Alternative Medicine in Four Racial/Ethnic Groups. *Ethnicity and Disease*, 18:65-71.
- [10] Clement Y.N., Morton G.J., Basdeo L., Blades A., Francis M., Gomes N., Janjua M., Singh A. (2007). Perceived Efficacy of Herbal Remedies by Users Accessing Primary Healthcare in Trinidad. *BMC Complementary and Alternative Medicine*, 7:4.
- [11] Fakeye T. O., Adisa R., Musa I. E. (2009). Attitude and Use of Herbal Medicines among Pregnant Women in Nigeria. *BMC Complementary and Alternative Medicine*, 9:53.
- [12] Gedif T., Hahn H. J. (2002). Epidemiology of Herbal Drugs Use in Addis Ababa, Ethiopia. *Pharmacoepidemiology and Drug Safety*, 11:587-591.
- [13] Gessler M. C., Msuya D. E., Nkunya M.H.H., Schair A., Heinrich M., Tanner M. (1995). Traditional Healers in Tanzania: Socio-Cultural Profile and Three Short Portraits. *Journal of Ethnopharmacology*, 48:145-160.
- [14] Ghana Statistical Service (GSS), (2013). Demographic, Social, Economic and Housing Characteristics.
- [15] Giday M., Teklehaymanot T., Animut A., Mekonnen Y. (2007). Medicinal Plants of the Shinasha, Agew-awi and Amhara Peoples in Northwest Ethiopia. *Journal of Ethnopharmacology*, 110:516-525.
- [16] Goodman C., Brieger W., Unwin A. et al. (2007). Medicine Sellers and Malaria Treatment in Sub Saharan Africa: What do they do and how can their Practice be improved? *American Journal of Tropical Medicine and Hygiene* 77(6 Suppl.): 203–18.
- [17] Gyasi R. M., Charlotte M. M., Prince Osei-WusuAdjei, Seth Agyemang (2007). Public Perceptions of the Role of Traditional Medicine in the Health Care Delivery System in Ghana. *Global Journal of Health Science*. Vol. 3, No. 2; www.ccsenet.org/gjhs.
- [18] Hussain F, Arif M, Ahmad M. (2010). Skin Care Knowledge, Attitude and Practices among Pakistani Diabetic Patients. *Egyptian Dermatology*, 6(1):5.
- [19] Kroegeer A. (1983). Anthropological and Socio-Medical Health Care Research in Developing Countries. *Social Science & Medicine* 17: 147–61.
- [20] Leung J. M., Dzankic S., Manku K., Yuan S. (2001). The Prevalence and Predictors of the Use of Alternative Medicine in Pre-surgical Patients in Five California Hospitals. *Anesth Analg*, 93:1062-8.
- [21] Ministry of Health (2006). Health Sector Five-Year Programme of Work. (2002-2006).
- [22] Ministry of Health (2005). A National Strategic Plan for Traditional and Alternative Medicine Development in Ghana (2005-2009). Accra: MoH Publication.
- [23] Ministry of Health, Ghana (MOHG). (2004). Ghana National Drugs Policy. Second edition. Accra, Ghana. Online at. <http://apps.who.int/medicine/docs/documents/s16185e/s16185e.pdf>
- [24] Mshana G., Hampshire K., Panter-Brick C., Walker R. (2008). Urban-Rural Contrasts in Explanatory Models and Treatment-Seeking Behaviours for Stroke in Tanzania. *Journal of Biosocial Science* 40: 35–52.
- [25] Mussema Y. (2006). A historical overview of traditional medicine practices and policy in Ethiopia. *Ethiop J Health Dev*, 20(2):127-134.
- [26] Peltzer K. 2000. Community Perceptions of Biomedical Health Care in a Rural Area in the Northern Province, South Africa. *Health SA Gesondheid* 5: (1).
- [27] Peltzer K. & Mngqundaniso N. (2008). Traditional Healers and Nurses: A Qualitative Study on Their Role on STIs including HIV and AIDS in KwaZulu-Natal, South Africa. *Afr. J. Trad. CAM*, 5 (4), 380-386. <http://dx.doi.org/10.1186/1471-2458-8-255>
- [28] Ragunathan M., Tadesse H., Tujuba R. (2010). A Cross-Sectional Study on the Perceptions and Practices of Modern and Traditional Health Practitioners about Traditional Medicine in Dembia District, North Western Ethiopia. *Pharmacogn Mag*, 6(21):19-25.
- [29] Sachs L., Tomson G. (1992). Medicines and Culture—a Double Perspective on Drug Utilization in a Developing Country. *Social Science & Medicine* 34: 307–15.
- [30] Sato Azusa. (2012). Revealing the Popularity of Traditional Medicine in Light of Multiple Recourses and Outcome Measurements from a User's Perspective in Ghana. Oxford University Press in association with The London School of Hygiene and Tropical Medicine Health Policy and Planning 2012; 27:625–637
- [31] Smith F. (2004). Community Pharmacy in Ghana: Enhancing the Contribution to Primary Health Care. *Health Policy and Planning* 19: 234–41.
- [32] Stekelenburg J., Jager B. E., Kolk P. R., Westen E. H., Kwaak A., Wolffers I. N. (2005). Health Care Seeking Behavior and Utilization of Traditional Healers in Kalabo, Zambia. *Health Policy*, 71:67-81.
- [33] Tabi M.M., Powell M., Hodnicki D. (2006). Use of Traditional Healers and Modern Medicine in Ghana. *International Nursing Review* 53: 52–8.

- [34] Teklehaymanot T., Giday M. (2010). Quantitative Ethnobotany of Medicinal Plants used by Kara and Kwegu Semi-Pastoralist People in Lower Omo River Valley, Debub Omo Zone, Southern Nations, Nationalities and Peoples Regional State, Ethiopia. *Journal of Ethnopharmacology*, 130:76-84.
- [35] Tsey K. (1997). Traditional Medicine in Contemporary Ghana: A Public Policy Analysis. *Social Science & Medicine* 45: 1065–74.
- [36] Twumasi P.A. (1979). A Social History of the Ghanaian Pluralistic Medical System. *Social Science & Medicine, Medical Anthropology* 13: 349–56.
- [37] van den Boom G.J.M., Nsowah-Nuamah N.N.N., Overbosch G.B. (2004). Health Care Provision and Self-Medication in Ghana.
<http://www.issr.org/publications/older/Health%20care%20provision.pdf>.
- [38] van der Geest S., Whyte S. (1988). The Context of Medicines in Developing Countries: Studies in Pharmaceutical Anthropology. Dordrecht: Springer.
- [39] W.H.O. (2011). Medicines definitions.
<http://www.who.int/medicines/areas/traditional/definitions/en/index.html>.
- [40] W.H.O. (2002). WHO Traditional Medicine Strategy 2002–2005.
<http://www.who.int/medicines/publications/traditionalpolicy/en/index.html>.
- [41] W.H.O. (1996). Traditional Medicine-WHO Information Fact Sheets. Fact Sheet N134, September 1996.
- [42] W.H.O. (1978). The Promotion and Development of Traditional Medicine. World Health Organization Technical Report Series 622 Geneva.
- [43] Yineger H., Yewhalaw D. (2007). Traditional Medicinal Plant Knowledge and use by Local Healers in Sekoru District, Jimma Zone, Southwestern Ethiopia. *Journal of Ethnobiology and Ethnomedicine*, 3(24):3-24.