



**ASSOCIATION OF CHURCH-BASED  
DEVELOPMENT NGOS (ACDEP)**



**CATHOLIC ORGANIZATION  
FOR RELIEF AND DEVELOPMENT AID**

## **TRADITIONAL MEDICINE PROJECT**

### **SURVEY ON THE PRACTICE OF TRADITIONAL MEDICINE IN THE OPERATIONAL AREA OF EIGHT ACDEP-MEMBER PRIMARY HEALTH CARE PROGRAMMES IN THE UPPER EAST AND NORTHERN REGIONS OF GHANA**



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## **LIST OF ACRONYMS**

ACDEP	Association of Church-Based Development NGOs
BCC	Behaviour Change Communication
BMC	Baptist Medical Centre
CAM	Contemporary or Alternative Medicine
GHAFTRAM	Ghana Federation of Traditional Medicine Practitioners Association
MDG	Millennium Development Goals
NGO	Non-Governmental Organization
NR	Northern Region
PHC	Primary Health Care
PPHC	Presbyterian Primary Health Care
TM	Traditional Medicine
TMP	Traditional Medicine Practitioners
UER	Upper East Region

## FOREWARD

The Association of Church-Based Development NGOs (ACDEP) in Northern Ghana as part of its development efforts continues to generate and disseminate information on various developmental issues within its thematic areas with its partners and other development organizations. This work is one of such publications in ACDEP's efforts to provide baseline information for its partners to be able to take informed community level actions. The goal of the data build-up of ACDEP is to "build into programme implementation process for ensuring proper documentation, information sharing as well as monitoring and evaluation of projects".

In its quest to improve upon the health service delivery of its member Primary Health Care programmes, the Association of Church-Based Development NGOs (ACDEP) carried out a rapid follow-up assessment in 2005 to the previous project implemented. The purpose of the assessment was to identify the gaps in the service delivery of its member programmes to enable the programmes design appropriate interventions to address these gaps. Thus the Traditional Medicine Project came into inception in 2007 to try and address one of the gaps identified. The project seeks to forge collaboration between Traditional Medicine Practitioners (TMPs) and ACDEP-member Primary Health Care programmes and as well improve upon the practice of traditional medicine within the project catchment area. Although traditional medicine has been generally accepted by the Ministry of Health as Alternative or Complementary medicine, little has been done with the practitioners at the community level who are mostly the first point of call within communities. Some mission health institutions have tried to work with some specialized group of Traditional Medicine Practitioners like the bonesetters and male circumcisers but little has been done with the general group of practitioners.

In Northern Ghana as in most part of Africa, traditional medicine is still perceived to be "Voodoo" and "Primitive" due to inadequate documentation on the practice. For this reason, scientists continue to doubt the efficacy of time tested practices of these practitioners. This baseline study is to serve as a snapshot of the general practice of traditional medicine within the project pilot area.

This write up provides information on the socio-demographic characteristics of Traditional Medicine Practitioners (TMPs), general information on traditional medicine practice and collaboration between TMPs and other actors in the in the sector. Data was collected from sixty six (66) communities located within eight (8) ACDEP-member Primary Health Care stations in six (6) districts of Northern and Upper East Regions.

It is our hope that this document would serve the purpose of sharing and challenging new development actions in the area of traditional medicine.

We are grateful to all ACDEP-member Primary Health Care programmes for making time out of their busy schedules to collect the data.

We are also grateful to Dr. Kofi Issah for the technical advice in the design of the study and Mr. Rudolf Abugnaba Abanga for design of the baseline survey instrument.

We wish to express our heartfelt gratitude to CORDAID for the partnership over the years and for providing funds for the project thus making this work possible.

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Executive Director, (ACDEP)

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 BACKGROUND**

Access to quality health care is said to be a fundamental human right but the numerous challenges faced by modern health care system makes this a reality for only a section of the Ghanaian populace. Inadequate number of the already ill-equipped health facilities coupled with the unavailability of adequate trained personnel at the facilities makes traditional medicine and medical practitioners an important part of the health care system in Ghana. The tendency for Ghanaians to patronize both indigenous and modern systems simultaneously also makes the subject an issue of great public health concern.

Despite the efforts of government and its development partners to make modern health services accessible, available and acceptable to all people, most of these institutions are distances away from the communities they serve and the road network system linking some of the communities to the health facilities are mainly inaccessible, especially during the rainy seasons. This and other factors make it difficult to access quality health care and undoubtedly make traditional medicine an obvious choice for the rural people. In the Northern and Upper East regions of Ghana where the people are considered the country's poorest, dependency on traditional medicine as the first recourse is becoming inevitable as orthodox health care gets increasingly expensive.

Traditional beliefs differ from one ethnic group to the other in Ghana, but the belief in ancestral spirits is one phenomenon that runs through all the cultures. Whilst some traditional healers focus primarily on medicinal plants gathered from their farms, forest or market, some heal with plants through the consultation of ancestral spirits. Literature suggests that apart from Generalist Traditional Practitioners, there are Specialists who master the treatment of a narrow range of conditions, for example, bonesetters, Traditional Birth Attendants and Mental health practitioners. Others treat combination of a number of conditions ranging from fungal to viral infections. The area of interest for ACDEP as a development organization is how this practice impacts on the development of the people whose livelihood we hope to improve.

##### **1.1.1 WHAT IS TRADITIONAL MEDICINE?**

Traditional Medicine refers to health 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 (WHO, 2003). In industrialized countries, adaptations of traditional medicine are termed "Complementary" or "Alternative" Medicine (CAM).

##### **1.1.2 PATRONAGE OF TRADITIONAL MEDICINE**

Countries in Africa, Asia and Latin America use traditional medicine (TM) to help meet some of their primary health care needs. In Africa, Up to 80% of the population uses traditional medicine for primary health care. In China, traditional herbal preparations account for 30%-50% of the total medicine consumption whilst in Ghana, Mali, Nigeria and Zambia, the first line of treatment for 60% of children with high fever resulting from malaria is the use of herbal medicine at home (WHO, 2003).

According to UNDP (2007) Human Development Report however, it is estimated that about 80% of the Ghanaian populace relies on herbal preparations for primary health care. The high patronage of traditional medicine is either because it is cheaper, more convenient or simply believed to be more effective (VOA News, 2006).

Worldwide, it is estimated that there are an estimated 21,000 medicinal plants. These are concentrated in the global biodiversity 'hot-spots' such as the Amazon rainforest of South America, the eastern Himalayas and Western Ghats in South Asia, and the Eastern Arc Mountains and Coastal Forests of East Africa. In tropical Africa, for example, more than 4,000 plant species are used for medicinal purposes and 50,000 tons of medicinal plants are consumed annually (NTFP, 2006).

In Ghana, plant medicine abounds in generous quantities and in many instances, the only treatment option available. Indeed about 1,000 medicinal plants are known to exist in Ghana, 80% of which have been identified by baseline studies (Cultural News, 2007).

According to the African Conservation Foundation (2007) report, there are approximately 45,000 traditional healers in Ghana, most of who are recognized and licensed through various associations that fall under the nationally mandated Ghana Federation of Traditional Medicine Practitioners' Association (GHAFTRAM).

### **1.1.3 SAFETY AND EFFICACY OF TM/CAM**

As health care gets increasingly expensive and sometimes ineffective in many African countries, a growing number of people are turning to traditional medicine. In many countries however, these drugs are not certified and their uses raises safety concerns (VOA News, 2006).

Unregulated or inappropriate use of traditional medicines and practices can have negative or dangerous effects. For instance, the herb "Ma Huang" (Ephedra) is traditionally used in China to treat respiratory congestion. In the United States, the herb was marketed as dietary aid, whose over dosage led to at least a dozen deaths, heart attacks and strokes (WHO, 2003).

Studies have also shown that about 3,000 herbal formulations have been documented as being efficacious for specific conditions in Ghana, out of which over 600 are circulating as herbal medicine products and 60 of which have undergone preliminary phyto-chemical analysis and safety test at the centre for Scientific Research into plant Medicine and through MSc project works (Cultural News, 2007). It is worth noting that three hundred of these herbal products have also been given market authorization by the Food and Drugs Board.

The limited scientific evidence about TM/CAM's safety and efficiency as well as other considerations makes it important for governments to:

- Formulate national policy and regulation for the proper use of TM/CAM and its integration into the national health care system in line with WHO strategies on Traditional Medicine;
- Establish regulatory mechanisms to control the safety and quality of products and of practice;
- Create awareness about safe and effective TM/CAM therapies among the public and consumers;
- Cultivate and conserve medicinal plants to ensure their sustainable use (WHO, 2003).

As a result of WHO's promotion of traditional medicine, countries have been seeking assistance of WHO in identifying safe and effective herbal medicines for use in national health care systems. Against this background, WHO came out with guidelines for assessing herbal medicines to facilitate the work of regulatory authorities, scientific bodies and industry in the development, as well as the assessment and registration of such products. These guidelines include assessment of quality, safety, efficacy and intended use of herbal medicines (HerbalGram, 1993).

#### **1.1.4 EFFORTS IN PROMOTING SAFE, EFFECTIVE AND AFFORDABLE TRADITIONAL MEDICINE**

The World Health Organization launched its first ever comprehensive traditional medicine strategy in 2002. The strategy is designed to assist countries to:

- Develop national policies on the evaluation and regulation of TM/CAM practices;
- Create a stronger evidence based on the safety, efficacy and quality of the TAM/CAM products and practices;
- Ensure availability and affordability of TM/CAM including essential herbal medicine;
- Promote therapeutically sound use of TM/CAM by providers and consumers;
- Document traditional medicines and remedies.

At present, WHO is supporting clinical studies on antimalarials in the Democratic Republic of the Congo, Ghana, Mali, Nigeria, Kenya, Uganda and Zimbabwe in the research and evaluation of herbal treatments for HIV/AIDS, malaria, sickle cell anaemia and diabetes mellitus (WHO, 2003).

#### **1.1.5 BIODIVERSITY AND CONSERVATION OF MEDICINAL PLANTS**

Biodiversity of plants collectively known as "Plant Genetic Resources" is a key component of any agricultural production system. Indeed it is key component of any ecosystem, without which natural evolutionary adjustment of the system to the changing environmental and biotic conditions would be impossible and this is an irreplaceable resource (Ramakrishnappa, 2002).

Demand for medicinal plants is increasing in Africa as the population grows. The threat posed by over-exploitation of medicinal plants has serious implications on the survival of several plant species, many of which are faced with extinction. While loss of habitat is the major factor contributing to the depletion of natural resources in Africa, collection of wild plants for traditional medical use is extremely detrimental to certain species. African medicinal plant resources may be doomed to extinction unless energetic conservation measures are taken to ensure their continued availability. This could be done through the establishment of medicinal plant gardens and farms.

In order to sustain the sensible utilization of medicinal and aromatic plants, conservation has to be kept as the central focus. In conducting research and developmental activities, plant parts from which extracts are obtained should be done such that it will not destroy the plant. Furthermore, the methods of harvesting the desired plant parts should take cognizance of the conservation of the plant. Ex situ cultivation of the desired medicinal and aromatic plants would be necessary so as to obtain raw materials grown under the same conditions of climate, ecology etc. (Ernest Rukangira, 2001).

### 1.1.6 INTEGRATING TRADITIONAL MEDICINE INTO ORTHODOX MEDICINE

There are so many people who live in areas where there are no health facilities and so the first point of call for these people is to see the herbal practitioner (VOA News, 2006).

In many rural-based populations, traditional healers are the only source of health services for majority of the people and in most cases they are the preferred source of health care. In Ghana, for example, in Kwahu district, for every traditional practitioner, there are 224 people compared to one university-trained doctor for nearly 21,000 people (Ernest Rukangira, 2001).

This is not peculiar to Ghana. The records suggest that countries like India, China and a number of other Southeast Asian states have developed their traditional medical practice better and have used this in supplementing and complementing the modern health care system. Thus it is logical that the burden on public healthcare delivery system in Ghana will be made lighter if traditional medicine is further integrated into the healthcare system.

At the centre of Ghana's modern healthcare system is a serious shortage of health workers. Ghana's case feeds into the fact that despite the unprecedented advances in health care, the world is immensely confronted with severe shortages of health workers especially in the poor countries.

WHO and its Associates explain that in African region, traditional medicine is better integrated in Ghana's healthcare system compared with other African countries, where there is mutual distrust between traditional healers and conventional medicine. In Ghana, one of the seven directorates of the Ministry of Health is Traditional and Alternative Medicine (TAM).

One of the key vehicles to integrating traditional medicine into Ghana's healthcare system is the mechanism of decentralization. The records however suggest that in Ghana as in other African States, the decentralization of the healthcare system is a response to poor economic conditions, poor logistics, and reduced public finance for health services (ACF, 2007). It is important to note that although PNDC Law 207 (1988) provided the framework for decentralization of Ghana's healthcare system, it failed to formally integrate traditional medicine into the system, especially at the local level.



In recent years, research has established that 80% of general practitioners are referring some conditions to complimentary practitioners and 75% of patients have indicated that they would prefer to have available both western orthodox and complimentary approaches to enable them to access the benefits of each system (Cultural News, 2007).

Despite its popularity and the fact that the Ministry of Health has made efforts in several ways to demonstrate its willingness to facilitate the development and integration of traditional medicine in primary health care, data on traditional medicine and healing has been very scarce in Ghana. Obviously if we are to ensure sustainable development in especially rural areas, there is the need to understand the role of traditional healers with the aim of fostering the needed integration of the two health systems in Ghana for the benefit of the people. It is in this regards that this study that seeks to understand the types of traditional healers in northern Ghana and their role in the provision of healing to the people become crucial.

### **1.3 OBJECTIVES OF THE SURVEY**

The principal objective of the study was to obtain documented baseline information on traditional medicine practice in the catchment area of eight ACDEP- member PHC programmes.

The specific objectives include:

- To identify the traditional medicine practitioners in the project catchment area.
- To determine the level of collaboration between traditional medicine practitioners and the PHC programmes (orthodox health institutions).

- To identify areas of intervention to improve upon the practice of traditional medicine.
- To identify possible areas of collaboration with other actors in the field of traditional medicine.

#### **1.4 THE STUDY AREA**

The Upper East and Northern Regions are two of the three regions normally referred to as northern Ghana. According to the Ghana Statistical Service (2000 census report), Upper East which covers a land area of 8,842 square kilometers has a population of 917,251 whilst Northern Region covers a land area of 70,384 square kilometers with a population of 1,854,994.

These two regions are located in the Guinea savanna zone which is characterized by low vegetative growth mainly grasses, low shrubs and dispersed trees.

The population in these areas, apart from the district capitals, is largely dispersed.

The study was conducted in eight PHC coverage areas namely; PPHC-Widana, PPHC-Garu, PPHC-Woriyanga, PPHC-Sandema, PPHC-Langbensi, PPHC-Namolgu, BMC- Nalerigu and CFRHP-Walewale. These are located in six districts of the Northern and Upper East Regions. The East and West Mamprusi districts are in the Northern Region whilst Bawku municipality, Builsa, Talensi-Nabdam and Garu-Tempene districts are in the Upper East Region.

## **CHAPTER TWO**

### **SURVEY METHODOLOGY**

#### **2.1 SAMPLING**

The data collection method involved eliciting primary data from identified Traditional Medicine Practitioners (TMP) through interviews using semi- structured questionnaires.

A combination of a number of selection methods were employed during the survey. Between six (6) and thirteen (13) communities were purposefully selected by the PHC programmes as pilot communities for the project hence samples were drawn from those same communities.

The selection process involved identification of all Traditional Medicine Practitioners in the selected communities and this constituted the sample frame for the survey. The identification of traditional medicine practitioners was done by selected staff of the PHC programmes and their community level volunteers who are natives resident in these selected communities.

#### **2.2 SAMPLE SIZE**

A total number of three hundred and seventy one (371) traditional medicine practitioners were identified and interviewed in the study area.

Table 2.1 indicates the number of traditional medicine practitioners identified and interviewed by each programme.

**Table 2.1: Sample size distribution**

District	Programme	Sampled Communities	Number Sampled
Bawku Municipality (UER)	PPHC – Widana	Kouse, Zong Natinga, Tachingo, Kolongu Zongo, Bempela No.1, Widana, Kunjam, Pognaba	38
Builsa (UER)	PPHC- Sandema	Bachongsa, Banyangsa, Doninga, Yikpien, Changsa, Zogsa, Naasa, Zundema, Danwarinba, Wupiensa, Kaasa, Guuta, Kapusa	61
East Mamprusi (NR)	PPHC – Langbensi & BMC - Nalerigu	Kasape, Namango, Boayini, Langbensi, Buzulungu, Bumboazio, Nagbo, Kolinvai, Kulgona, La-Atari, Langbina, Jawani, Jablajo, Nalerigu, Yankazia	96
West Mamprusi (NR)	CFRHP - Walewale	Banawu, Zangu-Vuga, Zungum, Diani, Silinga, Zangu-Yakura	32
Garu –Tempane (UER)	PPHC – Garu & PPHC - Woriyanga	Kpatia, Busunatinga, Gbanterago, Kpikpira, Duadiyidiga, Wedchingo, Kpatua, Tempane, Bianboog, Ninsum, Bimpella, Nadrigu	94
Talensi – Nabdam (UER)	PPHC - Namolgo	Sakorit, Kpatia, Yale, Sawaliga, Tindongo, Gaare, Namolgo, Abee, Sheega, Duusi, Tindongo, Yagzore	50
<b>TOTAL</b>	<b>8</b>	<b>66</b>	<b>371</b>

*Source: Field survey, 2008*

### 2.3 DATA COLLECTION TOOLS

- ❖ Semi-structured Questionnaire
- ❖ Focus Group Discussions

## **2.4 DATA COLLECTION**

Both qualitative and quantitative data were gathered using semi-structured questionnaire as the principal tool. The questionnaire was in three parts. The first part gathered socio-demographic information of respondents such as name, sex, educational background, marital status, religion and tribe. The second part collected information on general practice of traditional medicine in the study area, whilst the third part tried to identify possible areas of collaboration between the PHC programmes and the Traditional Medicine Practitioners as well as the other actors in the field of traditional medicine.

A team of four (4) comprising of three (3) enumerators and one (1) supervisor from each of the programmes was involved in the data collection. The supervisors and their enumerators were given an intensive training at Bolga where they were taken through the various interview skills required for data collection. The supervisors were the Managers of the programmes whilst the enumerators were mainly staff and community level volunteers.

Qualitative data was also collected through focus group discussions of various stakeholders in the field of traditional medicine.

## **2.5 DATA PROCESSING AND ANALYSIS**

After collecting the data and editing the questionnaires, responses were coded and analyzed using the computer software SPSS 12.0.

The results are presented as frequencies, percentages and cross-tabulation in tables and graphs.

## CHAPTER THREE

### FINDINGS AND DISCUSSIONS

#### 3.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

##### 3.1.1 AGE OF RESPONDENTS

Findings suggest generally that Traditional Medicine Practitioners are largely senior citizens. The survey results show that the greater proportion of traditional medicine practitioners (57.4%) were above 60 years whilst only 1.6% were within the ages of 15-29 years. As indicated in table 4.1 below there is a decline in the number of practitioners as one goes down the age groups. Discussions further revealed that this trend is mainly due to the lack of interest of the youth in becoming apprentices. Generally the notion is that formal education and modernization (Christianity and Islam) have created the situation that makes it unattractive to become a traditional healer. The situation is obviously a threat to the survival of the industry as majority of practitioners are old and weak and may not be able to practice in the near future. Considering the fact that documentation on the practice of traditional medicine in Ghana is limited, this revelation poses a challenge to any intervention that aims at preserving knowledge of the practice.

**Table 3.1: Age of Respondents**

Age-Group	District						Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
15-29	-	1.0	-	3.3	2.1	2.0	1.6
30-59	46.9	39.6	28.9	57.4	28.7	52.0	41.0
60 and Above	53.1	59.4	71.1	39.3	69.1	46.0	57.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Source: Field survey, 2008.*

### 3.1.2 SEX OF RESPONDENTS

In general, 92.7% of respondents were males with only 7.3% females. The gender disparity seems to follow the lines of the role of women in patriarchal societies. It may be attributed to the fact that the act of healing is held sacred by traditional families thus mostly passed on to male children who are considered heirs to families especially in the northern sector of the country where the system of inheritance is patrilineal.

**Table 3.2: Sex of Respondents**

Gender	District						Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
Female	6.2	3.1	10.5	13.1	7.4	6.0	7.3
Male	93.8	96.9	89.5	86.9	92.6	94.0	92.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Source: Field survey, 2008.*

The male dominance of this occupation could also be linked to gender roles. Clearly most of the plants used in curing diseases are found in the forest or bush which are usually distances away from the communities. Thus, considering the time and effort required, most women cannot be actively involved in the practice because of the work load on traditional northern women who though have fewer income generating opportunities, assume heavier agricultural responsibilities in addition to housekeeping chores.

### 3.1.3 EDUCATIONAL BACKGROUND OF RESPONDENTS

As shown in table 3.3, there is a general decrease in number as one goes up the educational ladder. Although the 2000 Ghana Living Standards Survey Report indicates that only 32% of the Ghanaian adult populace have never been to school, the survey revealed that 91.9% of respondents have never been to school. The survey also made an interesting relationship between the level of education and religious background of respondents; 94.6% of traditionalist, 86.1% Muslims and 77.3% of Christians had no formal education, an implication that the number of practitioners who practice religions other than traditional religion are more formally educated. See table 3.4 for details of figures.

**Table 3.3: Educational levels of Respondents**

Educational Level	District						Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
None	84.4	89.6	94.7	100.0	90.4	92.0	91.9
Primary	-	3.1	5.3	-	7.4	6.0	4.0
JSS	-	7.3	-	-	1.1	2.0	2.4
Secondary	-	-	-	-	1.1	-	0.3
Middle School	15.6	-	-	-	-	-	1.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Field survey, 2008.

**Table 3.4: Relationship between Educational level and Religious background of Respondents**

Educational level (%)	Religion			Total (%)
	Traditional (%)	Christianity (%)	Islam (%)	
None	94.6	77.3	86.1	91.9
Primary	2.9	9.1	6.9	4.0
JSS	1.8	9.1	2.8	2.4
Secondary	0.4	-	-	0.3
Middle School	0.4	4.5	4.2	1.3
Total	100.0	100.0	100.0	100.0

Source: Field survey, 2008.

### 3.1.4 RELIGIOUS BACKGROUND

From the survey it was evident that majority of traditional medicine practitioners, 74.7% were traditional believers although the 2007 Jubilee calendar indicated that about 45% of Ghanaians were traditionalist. The high percentage of practitioners professing the traditional faith could be due to the mode of operation since in some cases the healing process involves consulting the gods or ancestors for the cause of the ailment and invoking the spirits to heal the patient. Although traditional beliefs vary from one ethnic group to the other, the belief in ancestral spirits is common to all. This spiritual aspect of traditional medicine practice makes it unattractive to researchers and also poses a treat to the survival of the practice as far as transfer of knowledge to the younger generation who may be less interested in traditional religion is concerned. This also makes documentation on the practice difficult as some aspects cannot be explained. Figure 3.4 shows the details of religious background of respondents.

**Table 3.5: Religious background of Respondents**

Religion	District						Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
Traditional	56.3	65.6	28.9	96.7	80.9	100.0	74.7
Christianity	9.4	8.3	2.6	3.3	8.5	-	5.9
Islam	34.4	26.0	68.4	-	10.6	-	19.4
Total	100.0	100.0	100.0	100.00	100.0	100.0	100.0

*Source: Field survey, 2008.*

## 3.2 GENERAL INFORMATION ON TRADITIONAL MEDICINE PRACTICE

### 3.2.1 CONDITIONS TREATED BY TRADITIONAL MEDICINE PRACTITIONERS

The kind of conditions treated by traditional medicine practitioners vary from common infections to complicated conditions as revealed by the survey and shown in table 3.5. Although in some cases it is difficult to understand the means by which the patient is treated due to the spirituality of some aspects of the healing process, the bottom line is that these practitioners treat various diseases within the communities in which they operate and are usually the first point of call for most rural people. This result also reveals the need for collaboration between orthodox and traditional medicine since apart from complicated surgery which is mostly done at the health institutions, traditional medicine practitioners equally attend to clients with all kinds of conditions also treated at the health institutions.

**Table 3.6: Summary of conditions treated by Traditional Medicine Practitioners**

Conditions	Districts						Group Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
Jaundice	1.6	-	2.8	3.0	1.7	4.1	1.6
Abdominal/Stomach pains	6.5	18.6	15.6	17.9	15.3	16.3	16.0
Migraine	-	5.3	-	-	0.9	-	2.1
Diarrhoea	4.8	3.7	-	7.5	3.4	-	3.4
Malnutrition	8.1	2.7	1.4	1.5	2.6	8.2	3.4
Skin diseases	1.6	4.3	2.8	16.4	3.4	6.1	5.3
Piles	8.1	4.8	8.5	3.0	-	2.0	4.2
Epilepsy	1.6	10.1	4.2	-	8.5	2.0	6.1
Stroke	1.6	3.7	2.8	-	-	-	1.8
Body pains	1.6	1.6	5.6	6.0	3.4	-	2.9
Infertility/Impotence/ Sexual Dysfunction	8.1	9.6	9.9	-	15.4	8.2	9.4
Mental Disorders	1.6	4.3	12.7	-	8.5	12.2	6.1
Fractures/Bone setting	8.1	5.9	5.6	11.9	9.4	2.0	7.2
Boils	8.1	2.7	11.3	7.5	6.0	8.2	6.1
STI	3.2	1.0	1.4	1.5	0.9	4.1	1.6
Chest pains	11.4	2.1	-	3.0	1.7	6.1	3.2
Chronic cough	4.8	2.1	-	1.5	0.9	-	1.6
Convulsion	3.2	2.1	2.8	4.4	3.4	-	2.7
Eye infection	3.2	2.1	-	1.5	1.7	-	1.6
Food poisoning	4.8	3.2	4.2	4.5	0.9	-	2.9
Menstrual Problems	1.6	1.0	-	-	5.1	-	1.6
Snake bite	3.2	5.9	4.2	4.4	4.3	12.2	5.4
Tuberculosis	1.6	-	2.8	3.0	1.7	4.1	1.6
Spiritual Sickness/Spells	1.6	3.2	1.4	1.5	0.9	4.1	2.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Field survey, 2008.

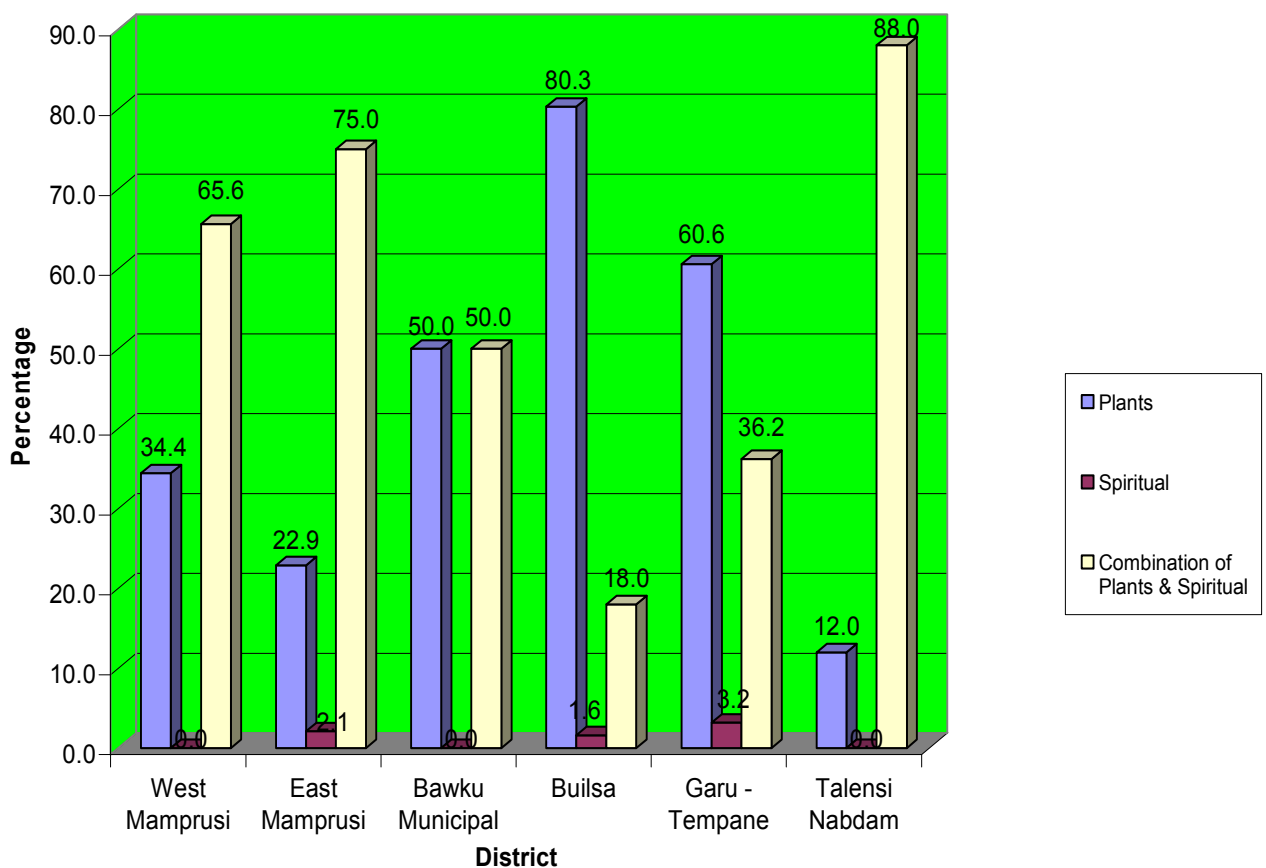
### 3.2.2 MEANS OF HEALING

From the survey, 54.2% treat through the combination of both plant and spiritual means, 44.2% treat solely with plant parts and 1.6% treat solely by spiritual means. Traditionally, healing is done through a number of ways. This is either done by solely using plant parts, through the consultation of ancestral spirits or gods and a combination of both. The survey also revealed some disparities within the districts, some depend mainly on plants whilst others on the combination of both plants and spiritual means.

For instance, in Builsa district, 80.3% of traditional medicine practitioners depend solely on plants for treatment whilst only 18.0% depend on both plant and spiritual means for treatment and within Talensi-Nabdam district, 88.0% depend on the combination of both plant and spiritual means whilst only 12.0% depend solely on plants for treatment.

Although this research may not be directly interested in the spiritual aspect of the healing process, this revelation helps us understand how some disease conditions are perceived at the community level. As development workers who are aware of the contribution of the traditional medicine sector to health and socio-economic development of people especially the rural majority, it is imperative to identify ways of improving upon the practice as well sustain the raw materials used in the sector. The fact that 98.4% of traditional medicine practitioners use plants for treatment gives an insight into the practice and the basis for designing an intervention to sustain the industry. Figure 3.1 indicates the details.

**Figure 3.1: Means of Healing**



#### 4.2.3 ROLE OF ASSISTANTS

In general, a significant number, 73.9% of respondents indicated that they work with one (1) to five (5) assistants. These assistants are mostly the male children of the practitioners themselves or the extended family. This partly explains the male dominance seen in table 3.2 and discussed earlier. Their duties range from searching for the plants in the bush to its preparation and helping with the actual treatment where clients are too weak to do anything on their own or in cases where the practitioners themselves are old and weak. These assistants are normally not in school and spend most of their time traveling long distances either on foot or on bicycles looking for medicinal plant parts. This is how knowledge on the practice is normally passed on to the next generation. As shown in table 4.7, 83.1% of those who heal through the combination of both plant and spiritual, 66.7% of those who heal solely by spiritual means and 62.8% of those who heal solely using medicinal plants work with assistants, thus it is important that any intervention aimed at traditional medicine practice take these assistants into consideration since they would eventually take over the practice.

**Table 3.7: Cross tabulation of number of assistants and means of healing**

No. of Assistants	Means of Healing			Total (%)
	Plants (%)	Spiritual (%)	Combination of Plants and Spiritual (%)	
0	37.2	33.3	16.9	26.1
1	18.9	16.7	23.9	21.6
2	20.1	33.3	23.9	22.4
3	14.0	16.7	18.9	16.7
4	2.4	-	8.5	5.7
5	4.3	-	6.0	5.1
6	1.8	-	0.5	1.1
7	-	-	1.0	0.5
8	0.6	-	-	0.3
10	0.6	-	-	0.3
Total	100.0	100.0	100.0	100.0

### 3.2.4 MEANS OF ACQUIRING SKILLS

Out of the total number interviewed, 73.9% inherited the practice from direct blood relations mostly parents or grandparents. 16.4% acquired the skills and knowledge naturally therefore said they were chosen by their ancestors to heal. 9.7% acquired the knowledge either from friends or people who treated them when they suffered the same conditions earlier in life. It is however worth noting here that those who acquired the knowledge and skills by inheritance were the assistants who used to help their parents or grandparents in treating people and thus took over the practice after the death of these relations as in most cases. The means by which knowledge and skills was acquired goes to stress the point that these skills are usually held sacred by traditional families and are considered secrets that are only disclosed to trusted family members, thus not even all children of a parent qualify to inherit the knowledge and skills on the practice.

**Table 3.8: Means of acquiring skills**

Ways of Acquiring skills	District						Group Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
Inherited	71.9	65.6	78.9	88.5	67.0	82.0	73.9
Chosen by Ancestors	9.4	25.0	7.9	11.5	19.1	12.0	16.4
Knowledge acquired through others	18.8	9.4	13.2	-	13.8	6.0	9.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

*Source: Field survey, 2008.*

### 3.2.5 DURATION OF PRACTICE

Majority of respondents, 67.8% have been practicing over 10 years. 32.2% have been practicing between 1-10 years. Majority of the older practitioners have been practicing over a long period of time without any modifications in terms of processing and packaging of products in particular and the practice on the whole due to the assertion that tradition must not be changed. Looking at the statistics presented in table 3.8, one may be tempted to believe that those traditional medicine practitioners who have been practicing for less than 10 years are the youth but this may not necessarily be so since in most cases the assistant who understudies the older practitioner only practices within the community after the death of the practitioner. This again raises the question of how long one must understudy another person before h/she can practice. This may also be one of the reasons why the youth are less interested in the practice.

**Table 3.9: Duration of practice**

Duration	District						Group Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempane (%)	Talensi Nabdam (%)	
1-10	19.4	34.4	26.3	29.5	36.2	36.0	32.2
11-20	48.4	24.7	26.3	21.3	35.1	32.0	30.0
21-30	19.4	24.7	10.5	24.6	16.0	12.0	18.8
31-40	12.9	7.5	10.5	11.5	5.3	8.0	8.4
41-50	-	6.5	13.2	9.8	6.4	10.0	7.6
Above 50	-	2.2	13.2	3.3	1.1	2.0	3.0
Group Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Field survey, 2008.

### 3.2.6 NUMBER OF CLIENTS TREATED

From the survey, 59.8% of respondents attend to between 1-5 clients/day, 29.9% attend to 6-10 clients/day, 5.6% attend to 11-15 clients/day, 3.7% attend to 16-20 clients/ day, whilst 0.9% attend to above 20 clients/day. Meanwhile, it is estimated that in Ghana, every one (1) traditional healer attends to approximately 200 patients, while one (1) doctor attends to approximately 20,000 patients (ACF, 2007).

The statistics given above confirm the fact that the role of traditional medicine practitioners in health care delivery cannot be overlooked especially in rural areas where they mostly are the first point of call. Therefore since majority of the people even those who have access to orthodox health services are likely to access both methods simultaneously for reasons which include accessibility, cultural acceptance, affordability etc., it is imperative to integrate the traditional medicine into orthodox medicine as it has been done in some Asian countries such as China and India.

**Table 3.10: Number Of clients treated in Days & Months**

District	Number of clients/ Day & /Month									
	1-5		6-10		11-15		16-20		Above 20	
	D (%)	M (%)	D (%)	M (%)	D (%)	M (%)	D (%)	M (%)	D (%)	M (%)
<b>West Mamprusi</b>	77.8	36.4	11.1	27.3	11.1	27.3	-	9.1	-	-
<b>East Mamprusi</b>	65.3	46.7	26.4	26.7	4.2	6.7	4.2	6.7	-	15.0
<b>Bawku Municipal</b>	50.0	22.2	50.0	25.9	-	18.5	-	18.5	-	14.8
<b>Builsa</b>	-	43.6	-	33.3	-	-	-	17.9	-	5.1
<b>Garu-Tempene</b>	25.0	34.1	62.5	48.8	-	7.3	6.3	4.9	6.3	5.0
<b>Talensi Nabdam</b>	-	33.3	-	66.7	33.3	-	-	-	-	-
<b>Group Total</b>	59.8	36.6	29.9	36.7	5.6	8.6	3.7	11.5	0.9	7.2

*Note: D=DAYS, M=MONTHS*

*Source: Field survey, 2008.*

### 3.2.7 PEAK SEASON OF PRACTICE

Slightly more than a half (50.7%) of the total respondents indicated that there was no peak season for them since they receive clients all year round. However, 21.4% said they attend to more clients during the raining season, 15.7% attend to more clients during the harmattan season whilst the remaining 12.2% indicated the heat season as their peak period. Although the distribution of some responses to the various seasons as indicated in 3.10 was almost even as in the case of East Mamprusi and Talensi-Nabdam districts, majority of traditional medicine practitioners receive almost the same number of clients all year round. The peak season observed by a traditional medicine practitioner however, depends on the type of conditions treated by the practitioner and its predisposing factors since some conditions are more prevalent during certain specific times of the year than others. Although there may be seasons for the outbreak of certain conditions, one should not be tempted to jump to the conclusion that there is a peak season for the patronage of traditional medicine on the whole.

**Table 3.11: Peak season of patronage of TM**

Peak Season	District						Total
	West Mamprusi	East Mamprusi	Bawku Municipal	Builsa	Garu-Tempane	Talensi Nabdam	
Rainy Season	12.5	29.2	-	27.9	16.0	30.0	21.4
Harmattan	3.1	20.8	7.9	9.8	14.9	28.1	15.7
Heat Season	15.6	10.4	10.5	4.9	16.0	16.0	12.2
All year round	68.8	39.6	81.6	57.4	53.2	26.0	50.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Field survey, 2008

### 3.2.8 MODIFICATION OF SKILLS

Generally the overwhelming majority (94.3 %) of respondents revealed that there has been no modification of the practice over the years. However 5.7% admitted that there have been some changes in the practice. According to this group who were the minority modification in processing and packaging of the herbal products have occurred over the years. For instance some herbs which were previously not boiled are now boiled and prepared in more hygienic environment whilst herbal preparations which were previously kept in uncovered pots are now kept in plastic containers with lids. Traditionally, the most important rituals are known to revolve around the cycle of ancestral and royal observances. Therefore changes in such practices do not easily occur and this explains why majority of practitioners have not modified their skills over the years.

**Table 3.12: Percentage of Practitioners who have modified their skills**

Any modification of skills	Age			Group Total
	15-29	30-59	60 And Above	
Yes (%)	16.7	4.6	6.1	5.7
No (%)	83.3	95.4	93.9	94.3
Total	100.0	100.0	100.0	100.0

Source: Field survey, 2008.

### 3.2.9 CHALLENGES ENCOUNTERED BY TRADITIONAL MEDICINE PRACTITIONERS

The traditional medicine sector faces a number of challenges among which are scarcity of herbal plants, packaging, certification and marketing. On the whole, 36.5% of respondents indicated the scarcity of plants as the major challenge, 28.6% indicated payment for treatment, 10.7% indicated lack of accommodation for admitting clients who sometimes have to stay over for the period of treatment, 9.1% indicated transportation to the bush to gather plants, 3.2% indicated the lack of certificates as the main challenge, 0.8% lack of appropriate equipment for harvesting the medicinal plant parts whilst 0.8% indicated the non compliance of clients who usually do not come back for review. Table 4.12 presents the district specific challenges. 63.6% of traditional medicine practitioners in West Mamprusi, 44.8% in East Mamprusi and 37.5% in Talensi-Nabdam indicated the scarcity of medicinal plants as the major challenge whilst 67.6% in Bawku Municipal, 56.5% in Builsa and 30.5% in Garu-Tempene indicated the non payment of required fees for treatment as the major challenge. These challenges are obviously disincentives to the development of the industry in these parts of the country.

**Table 3.13: District Specific challenges encountered**

Challenges	District						Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
Scarcity of Herbs	63.6	44.8	27.0	13.0	28.8	37.5	36.5
Means of Transport	-	8.0	-	17.4	15.3	12.5	9.1
Equipment for harvesting plants	-	-	2.7	-	-	4.2	0.8
Payment/ Provision of required things	18.2	4.6	67.6	56.5	30.5	33.3	28.6
Others( Packaging , finance etc	-	2.3	-	-	-	-	0.8
Transportation & Equipment	9.1	10.3	-	4.3	1.7	12.5	6.3
Payment, Transportation, Equipment	-	9.2	-	-	-	-	3.2
Certificates	-	8.0	-	4.3	-	-	3.2
Accommodation	9.1	12.6	2.7	4.3	20.3	-	10.7
Clients don't come back for review	-	-	-	-	3.4	-	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Field survey, 2008

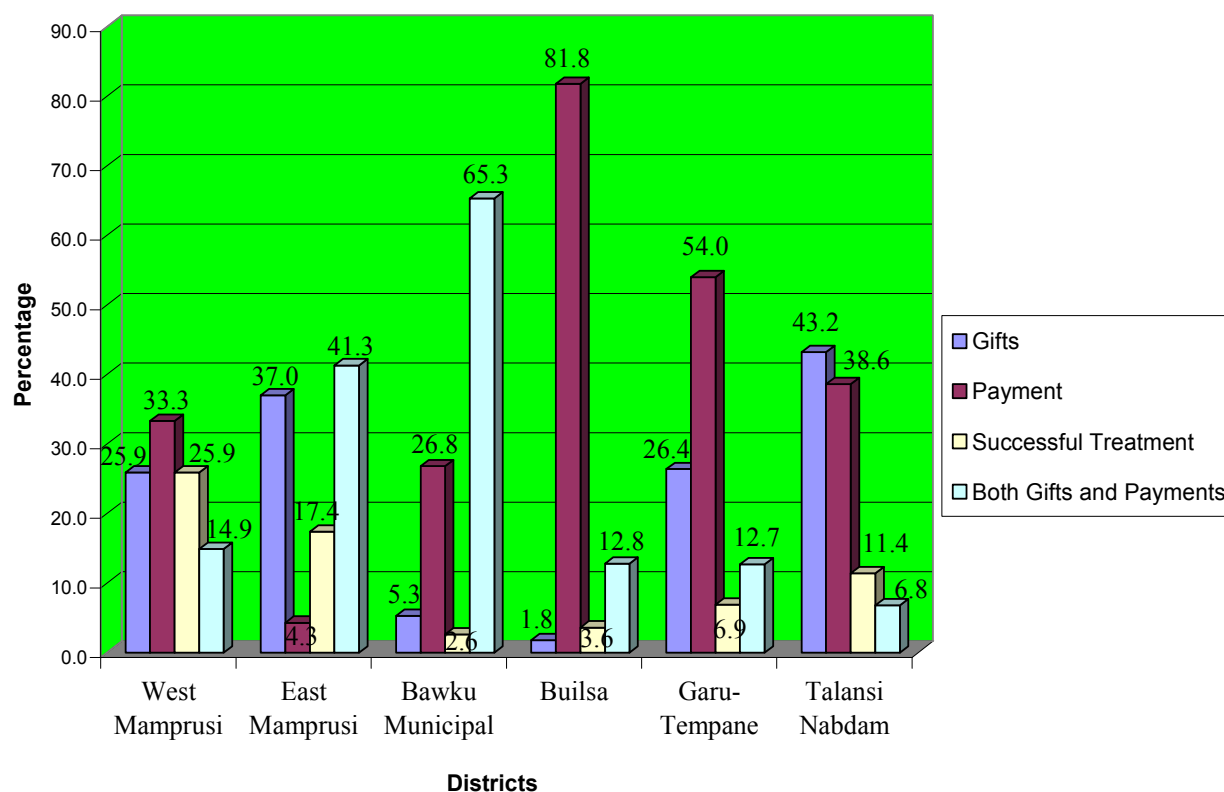
Unfortunately however, the forest ecosystem is being destroyed and used for other activities such as agriculture and human settlement resulting in the reduction of medicinal plants as well as the potential of the forest to regenerate itself. This is one reason that explains why traditional medicine practitioners have to travel long distances on foot to get plant parts for treatment.

Although the government through the health ministry has introduced some guidelines for the registration of traditional medicine practice to help assess each practitioner on merit for accreditation, it is obvious that majority of practitioners identified in the study area were not aware of these guidelines and therefore do not know how to assess this help. Hence there is a need for GHAFTRAM to extend its activities to the rural communities.

### **3.2.9 MOTIVATION FOR THE PRACTICE**

The survey revealed that 39.7% of traditional medicine practitioners were motivated by the payments made by clients for their services. 25.1% were motivated by the gifts they received from clients who have been cured. 24.5% were motivated by both fees paid and gifts. It is however worth noting that contrary to what happens in other parts of the world such as China and India where traditional medicine has been well integrated into the national health service delivery system, thus motivation for service well coordinated, the study showed that whilst some traditional medicine practitioners take some fees for their services, others do not charge any fee at all and depend on the goodwill of clients in the form of gifts for survival. The fee charged usually takes the form of foodstuff (cereals), poultry and small amount of money though this varies from community to community. Figure 3.2 indicates the district specific source of motivation.

**Figure 3.2: Source of Motivation**



### 3.3 COLLABORATION BETWEEN PRACTITIONERS AND OTHER ACTORS

This section sought to identify stakeholders traditional medicine practitioners work closely with and the areas in which they collaborate.

#### 3.3.1 Referral of Cases

Overall 53.0% of the total respondents admitted there were usually cases beyond their capacity which they referred to other places or people. 47.0% do not refer cases. Among the latter sub-group of practitioners were those who believed they had never failed in their duty to treat any case brought to them and those who thought once they were unable to treat the condition then no one else could. However, for effective integration of traditional medicine into the primary health care system, traditional medicine practitioners and orthodox health practitioners would have to accept the strength and weaknesses of each other.

**Table 3.14: Number of Traditional Medicine Practitioners who refer cases**

Response	District						Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
Yes	40.	67.4	68.4	36.1	55.3	38.0	53.0
No	59.4	32.6	31.6	63.9	44.7	62.0	47.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Field survey, February-April, 2008

Those who refer cases do so to health institutions, colleague Traditional Medicine Practitioner or Spiritualist depending on the type and severity of the condition. It is also worth noting that this system of referral is not a structured system as in modern health institutions and whether a patient would be referred to another point for treatment or not depends on how the practitioner perceives himself. If he believes that his ancestors have given him the power to cure all conditions and therefore can not fail then such a practitioner would never refer cases. However, if the practitioner admits that his skills and knowledge is limited to specific conditions, then there is a great probability that he would refer cases beyond his capability to other points for further treatment.

**Table 3.15: District specific points of referral**

Point of Referral	District						Total (%)
	West Mamprusi (%)	East Mamprusi (%)	Bawku Municipal (%)	Builsa (%)	Garu-Tempene (%)	Talensi Nabdam (%)	
Health Institution	76.9	72.3	76.9	95.5	82.7	68.4	78.2
Another Herbalist	23.1	27.7	23.1	4.5	15.4	31.6	21.3
Spiritualist	-	-	-	-	1.9	-	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Field survey, February-April, 2008

Among the names of collaborators that came up during the survey were Baptist Medical Center (BMC) and PPHC-Garu where some practitioners in East Mamprusi and Garu-Tempane districts respectively refer clients. Others were the Ghana Federation of Traditional Medicine Practitioners (GHAFTRAM) which is the mother association of all smaller associations of traditional medicine practitioners in the country and the East Mamprusi District Assembly.

## CHAPTER FOUR

### CONCLUSION / CHALLENGES FOR DEVELOPMENT

#### 4.1 GENERAL CONCLUSION

There was significant number of traditional medicine practitioners operating in the study area whose services are patronized by seemingly quite large number of people. Although their contribution to the health status of these communities as well as their overall socio-economic development cannot be overlooked, the subject has been relegated to the background for too long. Hence, there has been no proper documentation of the activities of these traditional medicine practitioners operating especially in rural areas of the country and Northern Ghana in particular. However if the third and fourth Millennium Development Goals (MDG) which seeks to reduce child mortality and improve maternal health respectively must be achieved by 2015, then more attention has to be given to this informal sector involved in health care delivery at the grassroot level. It is evident from the survey that, although some traditional medicine practitioners collaborate with the primary health care institutions in terms of referral, there are still a number of them who do not refer cases to health institutions.

Specifically, we conclude that:

- There are 371 identified traditional medicine practitioners of whom 92.7% were males and 7.3% were females in the study area.
- Of the total number of traditional medicine practitioners identified in the study area, 153 (41.2%) collaborate with the PHC programmes in terms of referrals.

#### 4.2 CHALLENGES FOR DEVELOPMENT

We therefore conclude that having learnt about the practice, identified the level of collaboration between traditional medicine practitioners and other actors in the field, especially the PHC programmes and as well identified the challenges facing the sector in the study area, development workers need to break the barriers that hinders the integration of traditional medicine into orthodox medicine.

Hence we recommend that interventions targeted at improving traditional medicine practice should aim at:

- Building trust between traditional and orthodox medicine practitioners
- Creating a regular platform for experience sharing between the two parties for better understanding of both practices
- Promoting documentation on traditional medicine that explains “myths” for better understanding
- Identifying the capacity gaps and building the capacity of traditional medicine practitioners to improve upon the practice

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