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# Health-Seeking Behaviors in Rural West Ghana

## Abstract

This thesis is the result of an exploratory project that included a six-week period of fieldwork in the rural farming village of Humjibre in the Western Region of Ghana. It examines the health-seeking behaviors I witnessed in this village, and discusses the barriers and facilitators that control those behaviors. It is my intention to demonstrate that there are many factors that influence concepts of health that lead to health behaviors. To fully understand how an individual functions within a medical culture, all the social, cultural, political, historical, and economic factors must be considered. Extensive background research was conducted prior to engaging in fieldwork, providing a conceptual and historical context. Through the use of participant observation and semi-structured interviews, and a critically-interpretive theory of medical anthropology for analysis, I was able to witness the many different healthcare options and to identify the key barriers to the utilization of formal health care facilities.

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Alejandro Cerón, Ph.D.

## Second Advisor

Richard Clemmer-Smith

## Third Advisor

Karen Albright

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Health-Seeking Behaviors in Rural West Ghana

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A Thesis

Presented to

the Faculty of Social Sciences

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In Partial Fulfillment

of the Requirements for the Degree

Masters of Arts

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by

Cathryn Perreira

June 2017

Advisor: Dr. Alejandro Cerón

Author: Cathryn Perreira  
Title: Health-Seeking Behaviors in Rural West Ghana  
Advisor: Dr. Alejandro Cerón  
Degree Date: June 2017

## **Abstract**

This thesis is the result of an exploratory project that included a six-week period of fieldwork in the rural farming village of Humjibre in the Western Region of Ghana. It examines the health-seeking behaviors I witnessed in this village, and discusses the barriers and facilitators that control those behaviors. It is my intention to demonstrate that there are many factors that influence concepts of health that lead to health behaviors. To fully understand how an individual functions within a medical culture, all the social, cultural, political, historical, and economic factors must be considered. Extensive background research was conducted prior to engaging in fieldwork, providing a conceptual and historical context. Through the use of participant observation and semi-structured interviews, and a critically-interpretive theory of medical anthropology for analysis, I was able to witness the many different healthcare options and to identify the key barriers to the utilization of formal health care facilities.

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## Table of Contents

List of Figures	vi
List of Acronyms	vii
Introduction	1
Chapter 1 Literature Review and Theoretical Framework	6
1.1 Conceptual Framework	6
1.1.1 What does “health” mean?	6
1.1.2 Medical Culture	7
1.1.3 Adaptation and Integration	10
1.2 Theoretical Framework	12
1.2.1 Interpretive Anthropology	13
1.2.2 Critical Medical Anthropology	15
1.2.3 Critical-Interpretive Medical Anthropology	17
1.3 Conclusion	18
Chapter 2 Methodology	19
2.1 Research Design Summary	20
2.2 Setting	21
2.2.1 Ghana	21
2.2.2 Humjibre	22
2.2.3 Ghana Health and Education Initiative (GHEI)	24
2.3 Cultural Context	24
2.4 Data Collection	25
2.4.1 Background Research	25
2.4.2 Participant Observation	26
2.4.3 Fieldnotes	26
2.4.4 Informal Interviews	27
2.4.5 Semi-Structured Interview	27
2.5 Data Analysis	28
2.6 Limitations	28
2.7 Ethics	30
2.8 Conclusion	30
Chapter 3 Historical Background	31
3.1 Pre-Colonial Health Beliefs	31
3.2 Colonial Health Services, 1480-1950	32
3.3 Postcolonial Health Services, 1951-1980	39
3.4 Current State of Health Services, 1980-Present	42

3.5 Conclusion	45
Chapter 4 Community Level Health Behaviors	47
4.1 Popular Sector: Preventative and Curative Care	47
4.1.1 Preventative Care for Children	49
4.2 Popular Sector: Curative Care	51
4.3 Folk Sector: Pharmacies and Vendors	52
4.4 Professional Sector	55
4.4.1 Kofi	56
4.4.2 Ama and Abby	58
4.4.3 Family Planning	60
4.5 Folk Sector: Childbirth and Spiritual Ailments	61
4.5.1 Sage	62
4.5.2 Healing Church	64
4.6 Conclusion	66
Chapter 5 Facilitators and Barriers to Formal Health Services	68
5.1 Issues of Access	68
5.1.1 Transportation	69
5.1.2 Cost of Medical Care	72
5.2 Issues of Capacity	75
5.2.1 Humjibre Clinic	76
5.2.2 Bibiani District Hospital	78
5.2.3 Shortages of Staff, Supplies, Equipment	82
5.2.4 Staff-Patient Interaction	83
5.3 Issues with Education	86
5.3.1 Formal Education	87
5.3.2 Public Health Education	88
5.3.3 Churches	89
5.3.4 Ghana Health and Education Initiative	91
5.4 Conclusion	93
Conclusion	95
Bibliography	99
Appendices	
A. Kleinman's Questionnaire (1980) with Some Modifications	104
B. Additional Questions Asked of American Volunteers	105

## List of Figures

Figure 2.1 Map of Ghana, with Regions and Major Cities	19
Figure 4.1 Ingredients for Herbal Remedies	51
Figure 4.2 The Humjibre Pharmacy	53
Figure 4.3 Herbal Medicines Sold by Travelling Vendors	54
Figure 5.1 Informational Poster at Humjibre Clinic	76
Figure 5.2 Infant Resuscitation Cot at Bibiani District Hospital	80



## **List of Acronyms**

CMO – Chief Medical Officer

FDB – Food and Drugs Board

GAFTRAM – Ghana Federation of Traditional Medical Practitioners

GHEI – Ghana Health and Education Initiative

GPRSP I/II – Ghana Poverty Reduction Strategy Papers

HIPDIP – Health Deliver and Incentives Program

ITN – Insecticide Treated Bed Net

MFU – Medical Field Units

MOH – Ministry of Health

NGO – Non-Governmental Organization

NHIS – National Health Insurance Scheme

ORS – Oral Rehydration Salts

TBA – Traditional Birth Attendant

WHO – World Health Organization

WAMS – West African Medical Service

## **Introduction**

A typical day in Humjibre began around 5:30am as the morning announcements blared through the village over the loud speakers. Myself and one of my three roommates roll out from under our bed nets and prepare to meet the education coordinator to go for an early, pre-breakfast run. We jog up the dirt road, past the Anglican Church and the corner shop to reach the paved road wandering through the center of town. We run south along this road and out of the village for about a mile and a half. People are beginning to head out to farm, and we pass many young men and women with machetes and buckets. They enthusiastically greet us as they call out encouragement and laugh at our exercise. We were always made to feel welcome throughout the village, and were never shunned, insulted, or told to leave.

Heading out of the village, the trees come right up to the edge of the pavement, limiting visibility for drivers, and the road itself is not well maintained. We stick close to the side of the road to avoid the cars and the worst of the cracks. It had rain the previous night so there were several points where we had to jump over or navigate around large puddles. We turn around when we get to the checkpoint that marks the next market district. There are more people out now, and more cars we must let pass. When we re-enter the village, the women have begun setting up their breakfast stalls and uniformed children are heading off to school.

We return to the GHEI compound as the other volunteers are beginning to stir. The compound's water tank and attached pipe system allow me to take a fast, albeit cold, shower. We then grab our supplies and head out into the village to conduct the annual Community Health Evaluation Survey. Today we are surveying a neighborhood called Israel. Myself and two other American volunteers sit on a borrowed bench in the shade of a tree as our local co-workers head to their assigned households to conduct the surveys. Almost immediately we are surrounded by children too young to go to school. We play games, color, and talk with them in-between coding surveys. Occasionally adults would approach and sit with us to ask "what we are doing?" and to tell us stories of their lives. Once we reach our quota of households to survey for the day, the children would go home and we would head back to the compound for dinner and conversation before turning in for the night. This was an average work day in Humjibre, Ghana.

### *Barriers and Facilitators to Health-Seeking Behaviors*

This thesis is an examination of the medical culture of the rural farming village of Humjibre, located in the tropical Western region of Ghana. The people of this village display a wide variety of health beliefs and behaviors, and it was my intention to understand how this population understood illness and health, how they chose the treatments that they did, and the outside factors that influenced that decision. In order to do this, I had to examine the sociocultural forces within the village that play a role in dictating how an individual is supposed to act and the duties they must perform. I also considered the historical, political, and economic factors affecting health options and behaviors. Historically, the population of the country has been clustered along the coast, and this is where the majority of the hospitals are located. As the population has grown

and access to rural areas of the country have improved, more hospitals and clinics are being constructed in previously isolated regions.

Despite having a clinic on the outskirts of town and a hospital six miles down the road, Humjibre is still an isolated village. This isolation, while limiting access to biomedical care, has served to preserve much indigenous knowledge about health and health behaviors that many have otherwise been repressed or subsumed under colonial forces. Their historical isolation also means that the entire community must work together and rely on every individual to remain strong. During my six weeks of field work, I was able to witness many of those health beliefs and behaviors. I was also able to visit the local clinic and a couple hospitals to provide context for what I was being told. There are many facilitators and barriers in accessing formalized medical facilities, not least of which is cost, but those barriers do not necessarily apply to methods and options already present within the village.

This thesis examines the health-seeking behaviors I witnessed in this village, and discusses the barriers and facilitators surrounding those actions. It is my intention to demonstrate that there are many factors that influence concepts of health and that lead to health behaviors, and to fully understand how an individual functions within a medical culture to make those decisions, all the social, cultural, political, historical, and economic factors must be considered.

### *Overview of Chapters*

Chapter 1 discusses the major concepts and theories that I utilized in my data gathering and analysis. It will provide examples from related studies and ethnographies that will help situate my research within the larger field of medical anthropology. The

first half of the chapter will introduce the concept of an inclusive medical culture that can be loosely divided into three overlapping sectors: popular, professional, and folk. It will also stress the necessity of considering both sociocultural and political-economic factors in an analysis of health-seeking behaviors. This necessity is reflected in my choice to use a combined theoretical approach, that of critical-interpretive medical anthropology. The second half of this chapter will discuss the applicability of this theory to a such of this nature.

Chapter 2 will broadly introduce Ghana, and more specifically introduce Humjibre and its inhabitants. My methodology will be outlined to track the evolution of my project over time. My methods of data collection and analysis will be discussed, as will the ethical considerations of my research and the limitations that I faced.

Chapter 3 provides a historical background of the Ghanaian healthcare system, beginning with limited information available on health beliefs and practices pre-colonization and tracking through the era of colonialism to the present. The purpose of this chapter is to explain how the country arrived at its current biomedically based formal healthcare system.

Chapter 4 will present an in-depth discussion of the medical culture of Humjibre. This chapter provides a window into the health behaviors in the village from the ground up, starting with popular medicine and working up to the professional. The illness experiences of three individuals will be offered for examination in order find more explicit discussion of the barriers and facilitators to formalized healthcare access.

While Chapter 4 focused more on the people and their beliefs and behaviors, Chapter 5 takes a closer look and the healthcare facilities themselves. The primary

barriers and facilitators to healthcare access as identified in the previous chapter will be discussed. Then attention will be given to the status and capacity of the Humjibre Clinic and Bibiani District Hospital in order to show that the facilities are also influenced by political-economic factors that limit their capacity to serve the population.

This paper will conclude with a summary of my findings on Humjibre's medical culture and a discussion on the barriers and facilitators to health-seeking behaviors in this region. The implications of my findings and possible avenues for further research will be discussed before concluding statements. What this paper will showcase is the need for an evaluation that considers all determinants of health belief and treatment behaviors to fully understand how an individual moves within a particular medical culture. Once that movement is understood, steps may be taken to remove some of the factors negatively affecting healthcare access.

## **Chapter 1: Literature Review and Theoretical Framework**

This thesis is an ethnographic study rooted in the concepts and theories of medical anthropology. It includes an examination of the social, cultural, political, economic, and historical factors that influence the health-seeking behaviors of a rural village in Western Ghana. In this chapter, relevant literature will be examined in order to situate the processes I observed whilst conducting fieldwork. This examination will consider such things as conceptions of health and illness in this region in addition to providing examples of similar processes from other ethnographies. The later part of this chapter will provide an overview of the theoretical framework I utilized to analyze my data.

### **1.1 Conceptual Framework**

#### *1.1.1 What does “health” mean?*

Before attempting to decipher my fieldnotes for examples of health behaviors, a question must first be asked: In this context, what exactly does “health” mean? The World Health Organization (WHO) has defined health as “the state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (WHO 1948). While this definition has been criticized as too broad, it succeeds in conveying the idea that health is a complicated concept that encompasses many factors and states of being. As humans are social and biological beings, we are influenced by both social and

biological forces. This means that health and illness, as perceived and experienced by humans, have biological and sociocultural determinants (Owoahene-Acheampong 1998). Furthermore, how people understand and react to illness is culturally and biologically determined (Singer and Baer 1996, 32).

For the people of Humjibre, to be healthy means both the absence of illness and the ability to fulfill social obligations. Each individual has a responsibility to provide for their family and is expected to participate in community activities. Illness can cause, and be caused by, a disruption in these social relationships. Health is also understood as influenced by environmental and biological factors. One example of this is the increasing number of people in the village who recognize the relationship between mosquitos and malaria, and the importance of washing hands before food preparation. Understanding that the cause of illness can be social as well as biological influences how those illnesses are addressed. A more in-depth discussion of these causes and treatments will take place in Chapter 4.

### *1.1.2 Medical Culture*

In the examination of an area's medical culture, Michael Winkelman (2008) suggests a cultural systems approach in which health and healthcare must be considered within the context of the local social and cultural systems. He reiterates the fact that "economic, political, and other social conditions, as well as cultural values, beliefs, and meanings, have active roles in the causation of disease and the allocation of remedies" (Winkelman 2008, 21). It is the interaction of these determinants that produce health behaviors.



Those interactions can get complicated in a setting such as rural Ghana. The colonial influence which created the current formal healthcare system in conjunction with the continued isolation of rural areas has allowed for the preservation of indigenous health knowledge and practices. This means that a multitude of healthcare options exist in this village and the surrounding area. Given the variety of behaviors I witnessed while in Humjibre, I will not say that these practices constitute a single defined medical system. Rather, I will follow the example of many other anthropologists and consider these health behaviors and beliefs in the context of a larger medical culture (Beirlich 2007, Dein 2002, Last 1981).

In identifying this as a medical culture, I mean to include all things medical that occur in this area (Last 1981). My use of the term is meant to provide a more inclusive approach than the term “medical system,” which implies a “solid, monolithic organization” with predictable parameters (Bierlich 2007, 86; Dein 2002). This is not to say that medical systems do not exist within the medical culture. Biomedicine definitely constitutes a system within the larger culture. In reality, there is no single pattern of resort in seeking treatments, nor is there a consistent body of theory in regards to the cause of illness that is understood and applied by both the lay people and the practitioners (Last 1981, 387). This approach also acknowledges the fact that indigenous medical cultures were not replaced during the colonization process. This has resulted in the coexistence and utilization of multiple healthcare beliefs and practices (Last 1986; Owoahene-Acheampong 1998).

When it comes to health-seeking behaviors, people are essentially pragmatic. They will do what they think is necessary to survive, using the resources available to

them. An individual may utilize several different avenues of treatment that have very little to do with one another. To facilitate further discussion of this process, I am going to borrow Kleinman's concept of three overlapping healthcare sectors: the popular sector, the professional sector, and the folk sector (Kleinman 1980). The popular sector is the largest and consists of several layers. It includes the lay, non-professional, non-specialist options for healthcare that can include the individual, their family and other social networks, as well as incorporate community beliefs and activities (Kleinman 1980, 50-51). The professional sector consists of organized healing professions. In the case of Ghana, this means modern biomedicine as performed in clinics and hospitals. The last sector is the folk sector. This group consists of non-professional, non-bureaucratic specialists. These specialists can be spiritual or secular, and frequently resemble and work in conjunction with both the popular and the professional sectors. There has been a push in recent decades for the professionalization of the folk sector in Ghana, complicating the definition of this group as non-professional specialists. There has been push-back from these practitioners, many of whom have no desire to be incorporated into the formal healthcare system. The utilization of these sectors is not mutually exclusive, and individuals will move back and forth between them as they assess their health needs. This concept of overlapping sectors and the people's use of them will be examined in the later discussion of my data.

Bierlich's (2007) ethnography of the medical culture of the Dagomba of Northern Ghana, also demonstrates these sectors and how their use overlaps. He observed that people use a wide variety of medicines – local, biomedical, Islamic – without becoming committed to the philosophical premises accompanying those remedies (Bierlich 2007,

96). These three categories represent the popular, professional, and folk sectors of this area. Treatment choice was often based on trial and error, past experiences, or family recommendation. This pattern can be seen in several other studies as well (Bierlich 2007; Sabo 2004; Owusu, et al. 2012; Sullivan, et al. 2016). If plant-based medicines had proven effective in the past, they would be used again. Bierlich further observes that biomedicine is preferred in many cases because it is considered stronger, especially in the form of injection. However, it is not always available due to excessive cost and lack of access.

At the same time, biomedicine is not considered safe for all ailments, and is treated with some amount of fear. There is a belief that purchasing the medicine with money, instead of bartering for it from a healer who imbues the medicine with power from the ancestors or God, removes the personal aspect that many local and folk remedies require to be effective. Removing that aspect can make the medicine too powerful, and therefore harmful. There is a structural component to this fear as well. Since these medicines can be purchased with money, women now have direct access to remedies instead of having to beg their husbands or other male relatives to acquire it for them. This grants women a level of power that some of the elders feel is threatening the structure of their society (Bierlich 2007). It is important to note aspects such as this when examining the medical culture and health-seeking behaviors of an area.

### *1.1.3 Adaptation and Integration*

Even when it is available and desired, biomedical treatments are not always utilized in the manner for which they are intended. For example, Bierlich relates the story of a woman who would break open tetracycline tablets and rub the powder directly onto

sores caused by guinea worm instead of ingesting them as instructed. This integration of healing methods, the application of biomedicine as if it were an herbal salve, demonstrates a level of practicality and resourcefulness that can be found in many other ethnographic studies (Hampshire and Owusu 2013; Owusu and Adamba 2012; Sabo 2004). Parkin calls these “latticed practices...the fragmentary appropriation of healing practices and resources” (Parkin in Hampshire and Owusu 2012, 248). In examining the medical culture as a whole, the endurance and stability of many indigenous medical practices can be seen, as can the ways in which those practices have adapted to confront the forces of modernity (Nichter and Lock 2002, 15). This re-appropriation of biomedicines is one example. Another is that of traditional medical practitioners, those of the folk sector, who adjust their practices to meet the expectations of their clients.

In their article, “Grandfathers, Google, and Dreams: Medical Pluralism, Globalization, and New Healing Encounters in Ghana” (2013), Kate Hampshire and Samuel Asiedu Owusu look at four healers who have creatively adopted, adapted, and modified many diverse therapeutic traditions to appeal to their clientele. In so doing, they have combined the desired personal and spiritual touch associated with more traditional methods of healing with the perceived power and efficacy of Western pharmaceuticals. For example, all four healers wore a white lab coat and called themselves ‘Doctor,’ though not all of them had formal biomedical training. They also all mixed herbal remedies for those who desired them, and would place them in biomedical pill bottles to add a sense of power. One doctor would adjust his performance and treatments based on how “authentic” his patient expected him to be (Hampshire and Owusu 2013, 252). Another incorporated non-Western treatment options, offering the use of “Chinese

machines” (water tubs for the feet, foot massagers, etc.) which he believed to be relaxing as well as hygienic. The machines would, “get rid of all the dirt in the body” (Hampshire and Owusu 2013, 256). Here we see the adaptation of both local and biomedical health beliefs and behaviors to address the needs of the patient. The Ghanaian Government has also been attempting to incorporate some popular and folk medical practices into the professional sector by starting the professionalization of folk healers and the incorporation of their herbal medicines into the sphere of formal healthcare, but they have been less successful than the above mentioned healers (Tsey 1997). This is due to a variety of reasons that will be discussed more thoroughly at the end of Chapter 3.

These healers further demonstrate that Ghana is participating in, and being influenced by, larger global processes that play a part in healthcare formation. All but one of these men has a website where they advertise their practice and wares. Funding from organizations outside the country and the importation of medicines and technologies are making their mark on healthcare policy and on the minds of the populace. The many levels of healthcare access and the increasingly global nature of knowledge dissemination have contributed to an already diverse medical culture, adding further options for healthcare. In order to consider the role that these local and global forces have had on the health-seeking behaviors I witnessed in Humjibre, I will now outline the theoretical approaches I used to make sense of my data.

## **1.2 Theoretical Framework**

Health behavior theory suggests that, in an examination of health-seeking behaviors, the observer should describe what the most important variables affecting those

behaviors are, and then determine how those variables interact (Noar and Zimmerman 2005). As there are multiple determinants to health and illness, an approach that examines both the sociocultural and the political-economic factors must be utilized. For this reason, I took a two-fold theoretical approach in the analysis of my data. I initially went into this project with an aim to gather information rooted in an interpretive anthropology influenced by Kleinman's (1976) concept of explanatory models. Explanatory models outline an individual's perceptions of their illness and treatment in order to examine the ways in which the patient feels the illness has impacted their lives beyond physical symptoms (Kleinman 1980, 105). While I did gather much data in this regard, it is not fully comprehensible without considering the outside socioeconomic and political factors that helped produce them.

Therefore, I examine the medical culture of Humjibre with both an interpretive and a critical view. As interpretive approaches are often accused of having too narrow a focus, considering only local social interactions, and critical medical anthropology is accused of focusing too much on wider economic processes and not enough on local behaviors, the two theories complement one another to create a well-rounded examination (Young 2002). Margaret Lock and Nancy Scheper-Hughes encourage this integration with their theory of critical-interpretive medical anthropology (Lock and Scheper-Hughes 1996). A closer look will be given to interpretive theory and critical theory individually before they will be examined as a single combined theory.

### *1.2.1 Interpretive Anthropology*

According to Geertz (1973), interpretive anthropology should be a search for meanings rather than laws. In adopting an interpretive approach in this study, I aimed to

discover the meaning associated with health behaviors given the cultural and social context. In my fieldwork, I utilized a questionnaire (Appendix A) created by Kleinman (1976) for eliciting explanatory models. His purpose in developing this questionnaire was to better the illness experiences of sufferers by providing their biomedical caretakers with an understanding of more than just the biological processes of the patient's disease. The intention was to foster communication between doctor and patient by making them aware of each other's understandings and perceptions, hopefully leading to better care. My purpose in using this framework was to gather information on illness experience and perceptions of illness, health, and healthcare. In understanding these primary perceptions, I hoped to better understand health behaviors.

I found that perceptions of health and illness are largely rooted in cultural factors such as social structures and religious beliefs. Friends and family are usually consulted before treatment decisions are made, meaning that health knowledge at the village level is in large part socially determined. Churches also play an important part in influencing health perceptions. Not every church is a healing church, but every church is a nexus of social connections and interactions. Health workers often come to church assemblies to give public health announcements. Church communities also offer support to individuals or families experiencing hardship, and they can become safe-havens for those experiencing abuse or discrimination at home (Gakpe-Ntsri 1989; Owoahene-Acheampong 1998).

As previously mentioned, there are critiques of the interpretive approach. It has been criticized for having too narrow a focus and not considering the economic or political factors that go into illness experience and treatment decision (Rubel and Hass

1996, 121; Baer et al. 2013, 41). In other words, they do not represent the population as a whole or place experiences into the larger political-economic context. It must also be remembered that cultural understandings of disease may not have anything to do with treatment behaviors, and that those behaviors may not relate to any underlying explanatory model (Dein 2007). For these reasons, I will also consider critical medical anthropology.

### *1.2.2 Critical Medical Anthropology*

The second principle of the WHO Constitution is, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (WHO 1948). The critical approach is interested in addressing this right. In looking at the wider determinants of health and how they interact, the reasoning behind certain health-seeking behaviors can be determined. This approach looks at access to resources and the societal factors that influence the distribution of health threats (poverty, crime, environmental contaminants) and health resources (immunizations, facilities, adequate nutrition) (Winkelman 2008, 16). This distribution of threats and resources is informed by both political-economic forces and sociocultural processes that eventually lead to specific health behaviors.

In his ethnography, Bierlich (2007) identified the primary barriers to healthcare in his area of study as local availability, proximity to urban centers, and access to money (Bierlich 2007, 96). I found my primary barriers to be similar: money, physical access, capacity of facilities, education, and patient-doctor interaction. This is in keeping with many other critically positioned medical anthropology studies. For example, Tabi and



colleagues (2006) conducted a study to determine whether a rural Ghanaian population would prefer to use biomedicine or traditional medicine as an initial treatment, and the majority of respondents chose biomedicine. When asked why they frequently used traditional methods as a first treatment when they would prefer to use biomedicine, many answered that it was because biomedicine was just too expensive (Tabi, et al. 2006).

As physician anthropologists, Farmer and Kleinman are well positioned to comment on these topics. Their work examines patient perspectives of health and healthcare, how those perceptions influence health behaviors, and how the broader political-economic situation of the area contributes to those perceptions and behaviors. Farmer pays particular attention to the impact of social inequality on health and illness. In his books, *Aids and Accusation* (1993) and *Infections and Inequality* (1999), Farmer thoroughly outlines the many ways in which social and economic forces (poverty, discrimination, exploitation, etc.) can negatively influence illness causation, course, and care. I keep these works in mind as I examine the forces that influence health-seeking behaviors practiced at my rural research site.

The critiques against the critical approach are that it tends to blame the overarching social-political-economic system for health problems experienced at the local level without first considering what those local health problems are and how behavioral risk factors may be involved. It is also criticized for focusing too much on the patient in doctor-patient interactions, without giving enough thought to the processes that shaped the doctor's knowledge, behaviors, and intentions (Wallace 2011). In combining this approach with an interpretive approach, these shortcomings will be addressed.

### *1.2.3 Critical-Interpretive Medical Anthropology*

The primary focus of a critically-interpretive approach is to examine “the ways in which all knowledge relating to the body, health, and illness is culturally constructed, negotiated, and renegotiated in a dynamic process through time and space.” (Lock and Scheper-Hughes 1996, 43). This approach considers the fact that health knowledge and policy are influenced by cultural processes and that they change over time. Furthermore, it looks beyond the culturally sensitive presentation of this process and reveals the contingency of power and knowledge that plays into its creation and its relationship to the individual (Lock and Scheper-Hughes 1996, 68). Illness experience is rooted in the individual body, and social and political forces act on and through that body to influence that experience.

In using a critically-interpretive approach in conjunction with Kleinman’s theory of explanatory models, I will be able to see the illness experience from the inside and the outside to examine broader socioeconomic factors along with the underlying cultural factors that go into health-seeking behaviors. Further considering the historical factors that have led to the current medical culture will allow for an examination of the renegotiation of beliefs and behaviors over time. For example, how biomedicine has become largely accepted even though it is not always used for its intended purpose, or how the power behind spiritual healing has largely shifted from the ancestors to the Christian God.

### **1.3 Conclusion**

This thesis will examine the health-seeking behaviors of a rural village, with consideration given to all the social, cultural, economic, political, and historical factors that influence those behaviors. In using the concept of a medical culture, I intend to incorporate all things medical that go on in this region into my analysis. In using a theoretical framework based on critical-interpretive medical anthropology, I will consider all the internal and external factors that influence health understanding, illness experience, and health-seeking behaviors. It is my belief that this approach has allowed for an holistic analysis of the situational factors that influence health-seeking behaviors.

The next chapter will outline my methodology and provide some basic information about the people and the culture. Then Chapter 3 will discuss the history of the Ghanaian Healthcare System and how that history has affected its utilization today.

## Chapter 2: Methodology



Figure 2.1 Map of Ghana with regions and major cities. Fieldwork occurred in the circled Western Region. The purple dot is the approximate location of Humjibre. (Source: ghanamap.info.co)

## 2.1 Research Design Summary

My fieldwork took place over a six-week period in June and July of 2016 in the rural farming village of Humjibre in the Western Region of Ghana (Figure 2.1). My purpose in conducting this fieldwork was to perform an exploratory and inductive examination of the health beliefs and behaviors within the village. My initial design was to see the extent to which biomedical and herbal healing methods interacted and integrated in a rural setting such as Humjibre. To do this, I volunteered with a local NGO, the Ghana Health and Education Initiative (GHEI), and participated in conducting their annual community health evaluation survey. Working with this group introduced me to the village population, allowing me to conduct my own research.

My primary methods of data collection were participant observation and interviews with my local co-workers, some of whom did experience illness episodes, and with nurses stationed at the local clinic and at Bibiani District Hospital. The interviews with my co-workers were based on a questionnaire designed by Arthur Kleinmen (1976) (Appendix A). This questionnaire is meant to elicit illness narratives with the purpose of discovering explanatory models. I modified the questions as necessary to best suit the needs of the interview. In addition to working within the village, I also went on two tours each of the Humjibre clinic and of Bibiani District Hospital. These facilities and their available resources will be examined in greater detail in Chapter 5. I informally interviewed the nurses who guided my group through these facilities.

Upon returning home, I typed up my fieldnotes and coded them for themes. I found I had collected a great deal of information on the barriers and facilitators to Ghanaian healthcare access, and that my data was better suited to an examination of

health-seeking behaviors over that of illness experiences. In an attempt to better understand local perceptions of illness, I had acquired a wealth of information outlining the utilization of medical resources at the local level, and many factors connected with that utilization. In interviewing both nurses and ill individuals, I was able to examine perceptions of available healthcare options from both sides of the patient-provider relationship. Further examination of my fieldnotes and transcripts led me to formulate the following questions for analysis:

1. What health-seeking behaviors are common at the village level?
2. What are the primary facilitators and barriers to healthcare access in this village and how are they handled?
3. What are the people's perceptions of formal healthcare facilities and staff? And what are the physicians' and nurses' perspectives of the people they treat?

In answering these questions, I was able to paint a picture of the health-seeking behaviors of this village as they were practiced, while also discovering the historical, sociocultural, and political-economic factors that influenced access to resources, the understanding of illness, and the eventual choice of treatments. I will now introduce the site of my research and provide some cultural context in which to situate my observations.

## **2.2 Setting**

### *2.2.1 Ghana*

Before looking more closely at my methods and ethical considerations, a brief introduction to the study site is necessary. Ghana is located in between the countries of

Ivory Coast and Togo on the West African coast along the Gulf of Guinea. For the sake of governance, the country is divided into ten regions, which are further divided into districts. The country is home to approximately 27 million people of many different ethnic groups, with the Akan being the majority (CIA World Fact Book 2017). This group lives primarily in the south-western part of the country, and is also the majority ethnic group of my study site in the Western Region. The country is primarily Christian (72%), with a small Muslim population located in the northern regions (Bierlich 2007). They are the world's second largest source of cocoa, with oil and minerals being the country's second most exported goods. In 2010, they gained the status of a lower-middle income country, as defined by the World Bank (Cooke, et al. 2016).

The climate varies depending on the region. The Western Region is tropical, and Humjibre is surrounded by rainforest. It is located very near the equator, so it is always warm. There are two rainy seasons, one of which I was present for, that do much in quelling the heat, but not so much in reducing the humidity. The rainy season is important for a population of farmers, but it also leads to a lot of standing water, creating vector breeding grounds. The rainy season is also the season of sickness, bringing with it flu, malaria, and respiratory disease.

### *2.2.2.Humjibre*

This study took place in the town of Humjibre in the Bibiani-Anhwiaso-Bekwai District of Western Ghana (Figure 2.1). Humjibre is a rural farming village made up of ten neighborhoods that house approximately 5,000 inhabitants. The town's water comes from the community well and from mechanized boreholes that have been drilled within the last few years. Most of the adult population are cocoa farmers. To support local

agriculture and to avoid trading disputes, the government now buys all the cocoa grown each season for a fixed rate. Farmers were also recently provided with hybrid seeds meant to produce trees that bear more fruit and are more resistant to drought and disease. These measures provide a degree of stability to the income of the farmers, as they are guaranteed to make at least a little money each year. Other crops, such as plantain, corn, yam, cassava, and cocoa yam are also grown. Incomes are supplemented between harvests by jobs such as teaching, trading, taxi driving, tailoring, and hairdressing. Men work outside of the home on the farm or in a shop, with some working in the cities. Women are the homemakers in charge of cooking, cleaning, laundry, shopping, and child-rearing. Many women also sell the products of their personal gardens in the village market, or run the shops of their husbands and brothers when they are away.

There is one main road through the center of town where vendors and shopkeepers gather to sell their wares. Very few individuals own vehicles, so the primary mode of transportation is walking. If the destination is more than an hour's walk away, bicycles, motorcycles, taxis and trotros (minibuses that seat about 20 people) are used. There is a gendered division of labor between men and women.

The majority ethnic group is Sefwi Akan, a subgroup of the Akan linguistic family. While the official language of Ghana is English, the primary local languages spoken here are Sefwi and Twi. Both English and Twi are taught in primary schools. In recent years, the local population has been supplemented and diversified by migrant workers brought by the growing mining and timber operations in the area. Many of these immigrants congregate in their own neighborhood on the edge of town.



### *2.2.3 Ghana Health and Education Initiative (GHEI)*

During my fieldwork, I volunteered with the local non-profit organization, Ghana Health and Education Initiative (GHEI). This is a grassroots organization that works to improve the chances of local children to live a good and successful life. Their current goals focus on the prevention of malaria through the distribution of insecticide treated mosquito nets (ITNs), the education of mothers on proper health and nutrition for themselves and their young children, and the education of the youth through tutoring and scholarship programs. During my stay, I assisted with data collection and coding for the yearly Community Health Evaluation. The purpose of this survey is to evaluate the overall state of the health of the community and to assess the efficacy of the organization's health education and illness prevention programs. This particular survey also tested the ground for a new program aimed at assisting first time mothers. Volunteering with this NGO granted me a level of access to the village population that I would not have had on my own. I was also able to interview and converse with the local GHEI workers to get their perspectives on the health situation.

### **2.3 Cultural Context**

During my first week of residence in Humjibre, several of my local co-workers were quick to point out the most important aspects of the Ghanaian worldview. By their explanation, Ghanaians possess a strong belief in fate, destiny, and divine intervention. They also believe that time is the servant and tool of the people rather than the meter that dictates daily activities. Perhaps the most essential belief is that all things are contingent upon maintaining a balanced life. This balance includes an individual's interpersonal

relationships as well as their relationship with God and the environment (Appiah-Kubi 1981, 9). Upsetting that balance can negatively influence anything from prosperity to health.

Traditionally, Akan society is organized around family, kinship, and community. Grandmothers, mothers, aunts, and sisters support each other and assist with various household responsibilities, especially during pregnancy. At the community level, every individual is expected to contribute. As mentioned in the previous chapter, part of being healthy is being able to fulfill one's role in the community (Owoahene-Acheampong 1998). Because of this, illness and hardship are not experienced individually, but are the concern of family and community members as well.

Because this approach to health encompasses many factors, the healing experience is holistically focused (Owoahene-Acheampong 1998, 132). To heal a sick individual, the entire person must be healed: mind, body, and soul. This holistic approach is not always congruent with the isolating nature of many biomedical treatments. Biomedicine is often accused of focusing on treating the ailment, but not the person (Owoahene-Acheampong 1998, 134). This difference in biomedical and indigenous approaches to health is one of the leading factors that play into the health-seeking behaviors of the people.

## **2.4 Data Collection**

### *2.4.1 Background Research*

Prior to conducting fieldwork, I conducted extensive background research into the history of Ghana, and of the Akan people of the Western Region specifically. I did

research into the history of GHEI in order to see how their relationship with the community might influence my data. I also found documents from the Ghanaian Ministry of Health in reference to Health Policy and the layout of the current medical system. I consulted ethnographies and scholarly articles having to do with Ghana and medical anthropology in general to add some perspective to my observations.

#### *2.4.2. Participant Observation*

I participated with GHEI as a data collector for their Community Health Evaluation survey for their Mother-Mentor Program. This entailed my accompanying our local co-workers into the village where they would interview members of randomly pre-selected households. They would bring completed surveys to us and we would check them for errors and code them. Later in the evening we would input those surveys into an Excel spreadsheet for later analysis.

The majority of my observations took place in the village while waiting for interviews to conclude. The villagers, especially children, were very curious and would sit and talk with us. I was also able to observe where people had access to water, what their daily routines looked like, and how they interacted with one another. In addition to wandering through the village, I also attended several church services and toured the nearby medical facilities.

#### *2.4.3 Fieldnotes*

I took extensive fieldnotes in three notebooks over the course of my stay. One notebook I took with me into the field to record what I witnessed and to make observations during our daily conversations. The back of this notebook also became filled with children's drawings and alphabet exercises. Another notebook was exclusively for

taking notes during formal interviews. The last was a journal in which I recorded my thoughts and impressions of the most important events of each day before going to bed. My interview notebook and journal were kept in a secure location when not in use, and my field notebook was almost always on my person.

#### *2.4.4 Informal Interviews*

A significant amount of conversation took place with my local co-workers while we were out in the village. They were very happy to answer any questions I had in regards to the healthcare system, the layout of the village, and their own personal experiences with illness. I also learned much about the local history and culture of Humjibre, providing context for general cultural observations and more specific healthcare observations. During the tours of the clinic and hospital, I also asked formal medical practitioners, primarily nurses, questions that occurred to me as we were led around their facilities.

#### *2.4.5 Semi-Structured Interviews*

Using Kleinman's explanatory models questionnaire adapted for the context of the conversation (Appendix A), I formally interviewed seven individuals to learn of their recent and ongoing illness experiences. I created a second questionnaire (Appendix B) to give to the American volunteers who did not fall ill in order to get their opinions and perspectives on what they saw. The purpose was to examine their insight as outsiders to compare to my own observations and the answers I was given by the sick individuals.

## **2.5 Data Analysis**

As previously stated, this project was exploratory, and therefore inductive in nature. During and after typing up my fieldnotes and transcribing recorded interviews, I read through them and coded for themes (Bernard 492). As those themes emerged, I found that the information I had collected was best suited for an examination of health-seeking behaviors as seen from the perspective of both interpretive anthropology and critical medical anthropology. Using a critically-interpretive approach allowed for a full examination of all the sociocultural and political-economic factors that determined health-seeking behaviors.

## **2.6 Limitations**

There were some limitations to my project. For one, I am a white female. While this was not a severe limitation, it did affect where I could go and who I could speak to without an escort. I could not go to the village or district palaces alone, as these are the buildings where the Chief conducts his affairs. Nor could I approach male elders unless they first spoke to me. Another hindrance was the fact that I was only in Ghana for six weeks. This was not enough time to establish good relations with the entire village, though it was sufficient time to become friendly with the GHEI staff and the people who lived near our compound. In that same vein, because I was staying with and volunteering for GHEI, I was unavoidably associated with the organization and their programs. Attitudes towards the NGO are generally positive within the village, but this association may have influenced the answers I was given. For example, I know that a belief in witchcraft is still present in the Humjibre, as it was mentioned in passing several times,

but GHEI is an advocate for biomedicine. The individuals I spoke to were more likely to tell me about their trips to the clinic than about the witches who caused their illness and the herbal remedies they had obtained from their family healer.

Part of this was caused by GHEI's activities in the village, but it was also caused in part by a language barrier. Language proved not to be as large a problem as I expected, though it did still limit who I could talk with. While English is the official language of Ghana, many older adults, the individuals most knowledgeable about traditional health beliefs and practices, are not fluent or do not bother trying to speak it. From my observations, they either did not have a good grasp of English or they consciously chose not to speak it. This was the case with the leader of the Healing Church (discussed in Chapter 4) who would only discuss the particulars of her ceremonies in Twi. My brief study of Twi was not extensive enough to provide me with the vocabulary to hold extended conversations of this nature. What I did learn from these elder individuals was usually in regards to the various foods that I should and should not eat depending on my physical state, and various taboos that are loosely recognized throughout the village.

The fact that it was generally the younger and more educated people who spoke the best English, and who I therefore spoke with the most, probably skewed my data in favor of more modern conceptions of health and healthcare. Basic public health education is integrated into schools, but the older population are not always exposed to, or accepting of, these concepts.

## **2.7 Ethics**

This project was approved by the International Review Board at the University of Denver. Upon arriving in Humjibre, myself and the other American volunteers were taken to greet the village Chief at the district palace. He granted us his protection and the freedom to wander about the village as we pleased. I also gained permission from the founders of GHEI to write about this area and use the proper name of their organization. As I was asking about personal health experiences, pseudonyms are used throughout this thesis in place of proper names. Informed consent was sought and verbally obtained before every interview, formal and informal. I used an audio recorder only for the formal interviews, and those recordings were erased after transcription. None of the information shared here puts any of the interviewees at risk.

## **2.7 Conclusion**

Now that a general background of the research setting and cultural context have been provided, we will now examine the historical forces that led up to and created the current medical culture of Ghana as a whole. We will then examine the medical culture of Humjibre more specifically, keeping in mind the historical factors that influence treatment options and how those affect health-seeking behaviors.

## **Chapter 3: Historical Background**

In this chapter, I will outline the development of the current structure of the Ghanaian healthcare system, traced back to colonial times. I will demonstrate that the philosophies and institutions started there have continued to exist in the post-colonial era. The resultant structure has created some problems in relation to access for the rural populations (Owoahene-Acheampong 1998, 2). With the majority of hospitals possessing adequate supplies and personnel located in the urban centers along the coast, a sharp divide in rural vs. urban health has formed. Though the poverty level of the country has dropped in the last decade, the percentage of inequality has risen. This means that the rich have gotten much richer much faster than the poor have become less poor (Cooke et al. 2016). Ghana has made great strides in recent years to better the scope of its healthcare, but there is still room for improvement. This chapter will show how the structure of formalized medicine emerged in Ghana, and the current effort of biomedical professionals and traditional healers to address that gap in services.

### **3.1 Pre-Colonial Health Beliefs**

There are very few records of health knowledge and behavior at this time, but a general idea can be pieced together from current traditional practices and the records of



early colonists. Illness and misfortune were largely believed to be caused by supernatural means (Mohr 2009; Owoahene-Acheampong 1998; Tsey 1997). This required that the treatment also be supernatural in nature, or at least have a supernatural component. The spirit world was made up of several deities (abosom) that existed to serve the sky god (nyame). Health and prosperity were maintained through rites of passage and appropriate worship of the deities. Evil spirits were the cause of illness and misfortune, and priest and prophets would make sacrifices to the relevant deities in order to heal an individual or community (Mohr 2009). Medicine makers, amulet makers, and herbalists also existed to provide medicines for the purposes of preventing or curing illness. They could also offer means of poisoning others. This poison was often spiritual in nature. Prophets could divine who had sent the poison and how an individual should treat it. The only spiritual entities that only caused harm and never provided assistance were witches (Mohr 2009, 442). Apart from supernatural influences, some consumable medicines were prepared and consumed by the people of this time. Many of these practices would become suppressed by Christian missionaries as colonial powers gained a foothold in the region.

### **3.2 Colonial Health Services, 1480-1950**

Prior to declaring independence in 1957, Ghana was known to European traders as the Gold Coast. The first permanent European settlement was the Portuguese trading post turned military fort, Elmina, established in 1482 (Gocking 2005). They were soon followed by the Dutch, Swedes, Danes, Germans, and the British, all interested in gaining access to the region's abundant natural resources. Centuries of struggle between these various European powers ensued, with the British eventually gaining control of the coast

in 1850. In 1874, with the assistance of allies from the local coastal populations, the British also managed to prevail over the Ashanti kingdom, thereby claiming the interior of the region as well (Gocking 2005; Mohr 2009). The area became known as the British Colony of the Gold Coast.

These first settlers were primarily soldiers and merchants interested in utilizing the country as a source of natural resources and of slaves. Given the transient nature of many of these early visitors, establishing a stable medical presence was not a priority. It can be assumed, however, that doctors were commissioned from ships' surgeons to provide basic care and treatment to the settled European population at the coastal forts and trading posts. There is little evidence to suggest that these services were extended to the local population at this time, though African trading partners were free to visit the settlements and receive medical treatment if they wished (Addae 1997). Medical treatment was not actively offered to the larger African public until missionary societies began to arrive in 1828 (Mohr 2009, 431). These organizations were optimistic as they made their way into the interior to spread Christianity and education, but their activities became severely limited due to the high mortality rate of missionaries caused by West African fevers, most likely yellow fever and malaria (Addae 1997; Mohr 2009). Despite this, several missions, schools, and health outposts were established with the aim of ensuring that the indigenous population had doctors to care for the body and priests to care for the soul.

The establishment of schools and outposts did not mean that indigenous health knowledge and behaviors completely disappeared. Instead, they came to coexist alongside the Church (Mohr 2009). The first missionaries believed in biomedical

treatment, but they also accepted the concept of faith healing through prayer. This concept was not incompatible with the Akan healing beliefs mentioned above, as they also believed in a supreme deity (nyame) and conducted rituals to maintain and regain health. For many converts, a negotiation took place in which it became understood that God, not the ancestral deities (abosom), gave power to the medicines that made an individual well again (Beirlich 2007).

The bacteriological revolution in the 1880s caused a shift in this thinking. Missionaries began practicing biomedicine exclusively, becoming much less tolerant of spiritual healing practices, be they Christian or Akan (Mohr 2009). From this point on, the accounts of early administrators, physicians, and missionaries show the active discouragement of the practice of local religions and healing methods, seeing indigenous medical knowledge as simplistic and ineffective (Oppong and Williamson 2012). This caused some problems for Akan Christians, who believed that pharmaceuticals could not address the evil spirits causing their ailments. Thus, many continued to participate in local healing practices in addition to the promoted biomedical treatments (Mohr 2009, 451). Despite their misgivings, many did come to appreciate the power of Western pharmaceuticals in healing the body. The beginning of non-religious medical outreach began with the construction of the first civil hospital in Accra in 1878 (Addae 1997, 16). This facility was open to all, including Africans, provided they were able to pay the small consultation fee. Most were not able to pay this fee, however, and African use of the hospital was limited.

By the 1890s, the European population in the region had grown exponentially, yet mortality rates remained unacceptably high. This highlighted an increasing need for a

formal medical policy. Governor Clifford, upon taking office in 1912, described the situation of most towns and villages as entirely lacking in terms of sanitation, water improvement, effective layout, and trash disposal (Clifford in Addae 1997). It was obvious that improvement was greatly needed. From this point on, the colonial governors began to actively implement health policies to protect their citizens. Rigorous medical research commenced in efforts to combat the leading causes of death among colonists, namely the West African fevers. Hospital construction and sanitation reforms were put in place in areas with the highest concentration of Europeans, primarily along the coastline. In 1908, separate African and European hospitals opened in Accra. As the population continued to grow and more people became knowledgeable about health and disease, dissatisfaction emerged with the unsanitary conditions of their villages and towns. Segregated communities developed, with the Europeans removing themselves to areas believed to be more protected from disease and disease vectors (Addae 1997). Many tropical diseases were thought to be endemic to the Africans, so the Europeans hid themselves away to avoid contamination. These communities did not remain specifically black and white, however. Movement between the towns continued for work purposes, and many affluent Christian Africans went to live in the European communities. The distinction between communities became more about wealth and education, than about European and African (Addae 1997; Mohr 2009; Owoahene-Acheampong 1998).

Up to this point, medical officers had been appointed by the British Secretary of State and led by a Chief Medical Officer (also chosen by the Secretary) whose duty it was to advise the colonial Governor on the formulation, execution, and administration of government health policy and services (Addae 1997, 55). Several colonial surgeons

worked under the CMO, in addition to a subordinate staff of African dispensers, male nurses, dressers, and laborers. The primary goal of these professionals was to look after the health needs of European officials, then African officials, military and police, and the inmates of jails and asylums (Addae 1997, 57). The larger African population continued to be largely ignored, but as mentioned previously, they were not actively seeking these services. To address this issue, Governor Griffith suggested in 1894, the training of African doctors in Accra from the dispensers already in use. Though this suggestion was not officially acted upon until 1910, it did lead to the creation of the West African Medical Service (WAMS) in 1902. In this program, an Inspector General would travel to health stations in all the West African colonies to see what was happening: How did medical officers work with the materials available to them and what are their capabilities? Answering these questions would lead to more reliable recommendations for resources, equipment, and personnel promotions (Addae 1997).

Other advancements in the early twentieth century include, the creation of the Sanitation Branch and the Accra Laboratory in 1908, the inclusion of Africans in the medical service in 1910, and the expansion the Laboratory Branch into a Medical Research Institute in 1919. In 1917, a plan for a dispensary scheme was submitted. In order for that plan to have worked, mass recruitment and training of nurses, midwives, dispensers, vaccinators and other staff would have been needed to run said dispensaries. The plan ultimately failed, but highlighted the need for a policy to train African medical officers (Addae 1997; Owoahene-Acheampong 1998).

The 1920s witnessed an increased sense of responsibility among European countries for the welfare of the indigenous populations of their colonies (Addae 1997).

Health care was made available to all Africans, and there was a growing use and acceptance of biomedicine, though medical research still focused primarily on ensuring European health. There was a growing awareness of sanitation, leading to more health consciousness among Africans in their homes. More schools, hospitals, and health outposts were constructed in rural areas, serving the dual purposes of delivering medical care while also educating the local population. Large scale disease eradication programs were put into place, and tropical fevers ceased to be the main cause of death in Europeans. The twenties also introduced Governor Guggisberg (1919 - 1927), an important figure in the development of Ghanaian health policy. Reflecting on the status of the health department between 1900 and 1910, he wrote:

“The medical department was in a primitive state. Activities were chiefly confined to the principal towns lying along the coast line where hospitals of a sort had been established and where efforts were being made to introduce modern medicine and surgery. The hinterland at this time was very imperfectly opened up; there were no motor roads, and the means of transport were scarce and unreliable. A few medical officers were sent off to the bush and to three or four towns lying in the Northern Territories. These men did what work they could, and they should be kept in remembrance as they had great difficulties to contend with, and lacked equipment, buildings and staff which their successors possess today” (Guggisberg in Addae 1997)

To address the service gap in the hinterlands, the amount of revenue spent on public health services was increased to 16-18%. This money went towards water supplies, town improvement, drainage construction, and infrastructure in the form of roads and railways (Addae 1997, 61). The Gold Coast Hospital (which would later become Korle Bu Teaching Hospital) opened in 1923. Three more large hospitals were constructed in Tamale, Kumasi, and Sekondi, while also improving other existing district hospitals by adding dispensaries and operating theaters (Addae 1997, 67). In 1928, the

first motor travelling dispensary made it to the isolated and hard-to-reach rural regions. Other points of Guggisberg's policy were care of the sick, professional training of African medical and public health officers, infant welfare, general health education of the people, sanitation and improvement of towns and villages, and medical research.

A major economic depression in the 1930s combined with the beginning of the Second World War had serious impacts on public health development. The colony was left with no money and no medical officers, both having been repurposed to assist with the war effort. A greater acceptance of biomedicine and a dearth of doctors led to severe overcrowding in hospitals and a shortage of supplies. Between 1931 and 1945 a complete halt in construction of major hospitals began. The few remaining medical officers began encouraging "native authorities" to build their own dispensaries, supplying them with building materials and standard medical supplies (Addae 1997, 76). In addition, Medical Field Units (MFUs) were established in 1944 to reach rural areas in place of hospitals and dispensaries. Their task was to track down endemic and epidemic diseases in rural areas, treat them, take stock of available resources, and encourage a shift from curative to preventative health measures among the population by means of health education (Addae 1997, 170-1). They became the most important source of statistical data on rural health and endemic disease at the time.

Hospital construction resumed in 1947 with plans to build several new medical facilities. A plan for a network of health centers placed in small communities located around major hospitals was proposed. This network would become the foundation for the system of medical facilities spread across the country today. By 1950, adequate coverage

had been achieved in urban areas, but the isolated nature of rural populations meant that coverage for the majority of the population was spotty at best.

### **3.3 Postcolonial Health Services, 1951-1980**

In 1951, an African government took power in Ghana. This new government inherited a health care system with many weaknesses, principally overcrowding in hospitals, uneven distribution of services, a focus on curative over preventative practice, and inadequate organization and recordkeeping (Addae 1997, 83; Hampshire and Owusu 2013; Opong and Williamson 2012). The political upheaval had also resulted in leadership instability and a shortage of funding. To address these weaknesses, an enquiry called the Maude Commission was created in 1952 to travel the country and assess the health needs of the population. Its primary purpose was to discover and analyze the most pressing problems of the various regions and give realistic recommendations for improvement based on the current state of the Ghanaian economy (Addae 1997, 84). The Commission decided that the immediate and most urgent needs of the country could be met by expanding the Medical Field Units, improving existing hospital facilities, setting up the proposed health centers at nodal points in a network which would include hospitals and dispensaries, increasing the number of dispensaries, and attempting to shift focus to a more preventative style of healthcare.

As the cheapest and most effective way to reach rural populations, MFU operations were greatly expanded and their headquarters relocated to Accra, allowing for specialist training and better coordination with other professional organizations. The proposed network of health centers would serve several purposes. First, they would



provide more easily accessible care to rural populations. Second, in an attempt to decrease the amount of overcrowding in hospitals, clinics would screen patients for severity before treating them on-site or sending them to a larger facility. Third, by collaborating with other sectors, such as agriculture, education, and community development, the goal of improving the social and health standards of communities may be achieved. The local authorities placed at these clinics also became solely responsible for school health services, maternity and child welfare, and health visitor services (Addae 1997, 88). A Ten-Year Plan followed the Maude Commission with the purpose of integrating these rural health clinics into a system of hospitals, health centers, and other medical services. This plan was founded on the health needs of the population as seen by the initial commission report, and on sound medical and economic considerations on how to best meet those needs (Addae 1997, 92).

In 1957, Kwame Nkrumah was elected the first President of Ghana, making Ghana the first West African country to declare independence from Europe. President Nkrumah implemented a policy based on the concept of New Africanism as a way to reclaim their identity as an independent African people. One of the main features of this regime was the gradual phasing out of all European officers in the country. Up to this point, many young African men who wished to become doctors would receive scholarships and funding to continue their medical education abroad in Britain or the United States. In efforts to avoid this process, many Ghanaian physicians were commissioned into conducting courses at the teaching hospitals so students could gain a full education without having to leave the country (Addae 1997, 457). The Ghana Medical Association was established in 1958, and in 1969 the first class of medical

students graduated from Korle Bu Teaching Hospital. Another aspect of this New Africanist policy was a call for the professionalization of traditional medicines through the formation of the Ghana Psychic and Traditional Healers Association to, “organize traditional healers to form Associations for the advancement of their art and techniques in the delivery of health care” (Van der Geest and Krause 2012, 10-11). There was some hesitance on the part of the healers to participate, the formation of this association did succeed in bringing traditional healing practices back into the larger policy conversation.

In 1966, the Nkrumah government was overthrown. Three military and two civilian regimes followed from 1966-1982. The cocoa market took a severe dive in the 1960s, which had severe impacts on the national economy and on the livelihood of rural farmers (Kraus 1991). It soon became more profitable, and therefore more attractive, for the youth to become tradesmen instead of academics and doctors (Gocking 2005). Medical infrastructure and institutions were in regression, causing many young medical students to go abroad for their education. A large number of these students remained abroad even after obtaining their degrees, causing a significant “Brain Drain” movement that still impacts the country today (Hampshire and Owusu 2013).

By the 1980s, a measure of political stability had been achieved, and a structural adjustment program was implemented by the World Bank and IMF to assist with the reorganization and revitalization of the country’s economy. In response, the country became very focused on a market economy that led to severe cut backs in health and education funding. From the time of independence, healthcare had been free, but a user fees were introduced in 1985 with the adjustment program, causing hospital utilization to plummet. In 1988, the Government of Ghana, recognizing these issues, implemented a

Program of Action to Mitigate the Social Cost of Adjustment (Abukari, et al. 2015). This program was later followed by the Ghana Poverty Reduction Strategy Papers (GPRSP I and GPRSP II). The focus of GPRSP I (2003-2005) was on growth and prosperity, followed by GPRSP II (2006-2009) which was focused on growth and poverty reduction (Abukari, et al. 2015, 3). These programs would eventually result in the National Health Insurance Scheme, and free and compulsory primary education.

### **3.4 Current State of Health Services, 1980-Present**

The slow recovery of the economy and government focus on repair social damage caused by the adjustment programs allowed for the resumption of medical expansion and building projects. The Ministry of Health (MOH) had adopted primary health care as their main strategy for improving the health status of Ghanaians in 1978, and by the 1990s, there were two large tertiary hospitals with attached teaching facilities at Accra and Kumasi, three regional hospitals located in Tamale, Cape Coast, and Sekondi-Takoradi, and district hospitals had been placed in the regional capitals and larger towns in every region (Addae 1997, 479).

There are currently over 250 health centers scattered across Ghana, mostly in Brong-Ahafo, Ashanti, and Volta regions. While the establishment of these centers has improved access in many rural areas, service is still inadequate due to a combination of cost and isolation. In 2003, the National Health Insurance Scheme (NHIS) was implemented as a result of GPRSP I and II as a means of alleviating the cost of care (Blanchet et al. 2012). While the program has increased the utilization of health care facilities, it still does not provide full coverage and does not reach the entire population.

Medical care is not restricted to government facilities, however. As stated previously, indigenous healing practices were suppressed by the colonial regime, but were never fully eradicated. In the 1970s and 1980s, the WHO began actively promoting the integration of traditional healers into mainstream biomedical health services in low-income countries (Tsey 1997; WHO 1978) as a means of “addressing gaps in service provision” by providing more affordable alternatives (Hampshire and Owusu 2013, 248; Tsey 1997). For Ghana, this was taken as a need to “create a system of medical care tailored to the specific socio-economic and cultural realities in Ghana” (Tsey 1997, 1065). These realities suggest that those who do not utilize clinics and hospitals do so because they cannot reach the facilities, cannot afford those services, or they think that biomedicine is inappropriate for their ailment (Bierlich 2007; Hampshire and Owusu 2013; Mohr 2009; Owoahene-Acheampong 1998).

President Nkrumah had attempted to revitalize and integrate traditional practices into the public sphere for nationalist purposes, and subsequent administrations have established many universities, policies, and organizations in an attempt to address the apparent gap in services. The Centre for Scientific Research into Plant Medicine was established in 1975 to conduct scientific research on the efficacy of indigenous medicines for the purpose of mass pharmaceutical production. Legislation specific to traditional practices began to formalize in 1992, beginning with the stipulation that all herbal remedies must be approved by the Food and Drugs Board (FDB) before they can be sold (Hampshire and Owusu 2013). This policy was not widely followed as most local medicines are not sold through official channels. In 1999, the Ghana Federation of

Traditional Medical Practitioners (GAFTRAM) was established. The Traditional Medical Practice Act 575 followed the next year to establish the Traditional Medical Practice Council. Though it did not become an acting body until 2011, the purpose of this council was to license and oversee practitioners and to regulate the preparation and sale of herbal medicines (Hampshire and Owusu 2013, 251). Most medical schools now require their students to take courses in herbal medicine, and in 2001, the Kwame Nkrumah University of Science and Technology in Kumasi became the first university to offer a degree (BSc) in Herbal Medicine (Hampshire and Owusu 2013, 251).

Despite all of this, it is widely believed that the government is not doing enough to support traditional healers (Tsey 1997, 1070). While the chemical benefits of herbal medicines can be proven scientifically, removing them from their cultural context may diminish their effectiveness if they are traditionally used to treat more than just the physical symptoms. Another issue is that healers had to give up their secret recipes and methods so that the components of those recipes could be tested in a clinical setting (Hampshire and Owusu 2013, 251). For these and several other reasons, many healers do not want to be incorporated into the government system. As individuals still prefer to come to healers for certain problems, especially those perceived as spiritual in nature or having to do with mental health, it has been suggested that a policy of cooperation, rather than integration, may be more beneficial, as the government could then support these healers in their own domains and extend medical coverage to areas previously unreachable (Tsey 1997, 1073; Oppong and Williamson 2012).

### **3.5 Conclusion**

The current structure of the formal Ghanaian healthcare system and understandings of health and disease have been greatly influenced by colonial practices. However, the continued isolation of rural areas has meant that many indigenous healing behaviors have survived and been adapted to coexist with current processes. As can be seen, there has been a concerted effort in recent years by the government to incorporate herbal medicine into the formal healthcare arena. While many practitioners are willing to register and follow stipulated guidelines, many are not for the reasons stated above. Some have taken their training and become itinerant vendors who travel between villages selling herbal and pharmaceutical drugs (Oppong and Williamson 2012). Others have taken to combining spiritual and biomedical healing methods to best meet the needs of their patients (Hampshire and Owusu 2013). While the government may resist allowing these practices to continue unchecked, they do fulfil a need, canvassing the rural areas where there are little to no formal health care facilities.

Healthcare is not, and never has been, restricted to government run institutions. There still exist several varieties of local healers and other individuals specializing in healthcare. European influence in the creation of a health policy focused on biomedicine has led to the primary idea that this method of medicine is the most effective, but outside factors prevent many from accessing biomedical facilities. This has led to the creation of a variety of healthcare options. With larger hospitals and specialized medical facilities located in the more densely populated urban areas, the rural poor must find other ways of addressing their health needs.

The next chapter will begin the examination of health-seeking behaviors in Humjibre. The village had many options for treatment, possessing a clinic, a pharmacy, and a hospital six miles away. These formal medical facilities exist alongside the popular and folk healing options already in the village such as the healing church. This next chapter will begin with a discussion of healthcare options in the popular sector, before moving on to consider some of the folk options. Three patient profiles will be considered for examples of those behaviors and as a demonstration of healthcare utilization. The professional sector will be examined later in Chapter 5, with a discussion of the clinic and district hospital.

## **Chapter 4: Community Level Health Behaviors**

This chapter will discuss what I witnessed of the medical culture of Humjibre. It will be an examination from the ground up, starting with the most basic of preventative and curative homecare up through the use of specialized hospitals. The profiles of three sick individuals will be considered in context to give a brief demonstration of the many ways in which health can be addressed. As previously discussed, people are essentially pragmatic when it comes to healthcare, with treatment often chosen based on past experiences, trial and error, and individual health knowledge. Most individuals see nothing inconsistent in combining different forms of therapy in their quest for restored health (Nichter and Lock 2002, 4; Bierlich 2000, 87). The follow discussions and anecdotes will demonstrate this concept.

### **4.1 Popular Sector: Preventative and Curative Care**

On our daily excursions into the village and during meals times, I had plenty of time to time asked my local co-workers how a person stays healthy. I received a wide range of responses. Answers covered topics from eating correctly and staying active, to washing hands and using bed nets, to praying and attending church regularly. Some of the most frequently given answers revolved around the concepts of strength and weakness. A strong person is a healthy person, and if a person falls ill, it is because they have become



weak. Adequate food and rest are the first steps to maintaining physical strength.

Mornings begin with a large, filling breakfast, typically of rice, porridge, bread, or any combination of the three. This is meant to provide strength for a full day of farming. The main roads in and out of the village are lined every morning with women cooking and selling foodstuffs to those headed out to work. Lunch is often a small affair, but dinner is another large and filling meal.

As previously discussed, part of being healthy is being able to perform daily tasks and participate in community activities. Doing so requires an individual to take care of themselves by maintaining their strength. We American volunteers were often teased for not being able to eat as much as the local staff. For example, one morning myself and another volunteer were conducting surveys with two local GHEI members in a small village fifteen minutes' walk from Humjibre. One of the staff members lived in this community and took us to his family home when our work was complete. His daughter had prepared a (delicious) mid-day meal for us, and the following interaction ensued:

“(Our host) kept giving us a hard time because we could only eat seconds and not thirds. He said that they have to eat very large morning meals because they go out to farm for hours and need the energy. My American partner argued that we do not farm so us eating as much as them would just make us fat, not strong. He laughed and said no, it just meant that we had more energy and needed to do more work.” (Fieldnotes, 1 July 2016)

This interaction demonstrates several social aspects as well as health beliefs. It is a host's responsibility to ensure that guests are well-fed. This is in part a sign of good hospitality, but also a means of ensuring community strength. Laziness is seen as weakness and is

frowned upon, as is implied in our host's last comment. The individual and the community are reliant on one another, with every member working to strengthen the community. The sharing of food promotes community cohesion and vitality by reinforcing positive social interactions and ensuring the strength of individual members.

While community members take care of one another to prevent illness, they also care for the individuals who do fall ill. Exhaustion and loss of appetite are worrisome indicators of illness, and are symptoms that most volunteers experienced at some point during my stay. Our Ghanaian co-workers would check on the group regularly and tell the sick individuals to rest. There are certain foods associated with specific medicinal qualities, and the women would offer bland foods such as bread and eggs to the ill volunteers and encourage them to eat and regain their strength. One of the women made all of us a hot, spicy, ginger beverage meant to fortify our health and our spirits. As another example, there is a small, round vegetable called *kwaune souse*, known in English as a 'garden egg,' that was described by a market vendor as "good for the blood, it gives you more blood." The GHEI worker with me explained that it has a high iron content, biomedically concurring with the vendor's claim.

#### *4.1.1 Preventative Care for Children*

Aside from food, there are other preventative measures for maintaining health, particularly in regards to children. Children are understood as inherently weaker than adults, so more provisions are made to ensure their health. Though it was often not outwardly acknowledged by the GHEI staff, there is still a belief in the concept of witchcraft as a cause of illness. Infants are particularly susceptible to their curses. It was casually mentioned once during a discussion on motherhood and childcare that one of the

reasons that grandmothers, sisters, and aunts come to live with the new mother is to make sure that the infant is never left alone where a witch could lay hands on them. I did not have the chance to delve further into this topic, but it stuck with me as one of the few obvious examples of witchcraft I heard mentioned. Local gender-specific practices are also in use. Girls wear strings of beads around their wrists as infants, and then around their waists once they become ambulatory. These beads are worn under the clothing until they hit puberty, at which point they are removed. This practice served the dual purposes of measuring the growth of the child while also promoting good health and the development of curves to eventually attract a husband and bear healthy children.

Another feature of childhood care is vaccination. There has been a large push by the MOH in the past decade to improve rates of childhood immunization (Ghana Health Policy 2005). In fact, most of the children in our surveyed households were up-to-date on their childhood rotavirus and DPT inoculations. Another measure promoted in conjunction with vaccination was the use of insecticide-treated bed nets (ITNs). Malaria is considered a common childhood illness, and the use of bed nets and the availability of effective medication means that most children now survive the ailment. It is, however, still a leading cause of childhood mortality in areas with limited access to those medications. Several of the local staff informed me that they had had malaria at some point in their lives, and most of them claimed they never contracted it as an adult. As more and more volunteers fell sick with the disease, I asked the local staff why they thought this was happening, despite our diligent use of bed nets, bug spray, and prophylaxis. Consistently, their first response was that we, as foreigners, are not used to the environment. Because they had had malaria as children, they were used to it and it

was much harder for them to get it as adults. This demonstrates an overlap in biomedical practices and local understandings of disease. Despite all of our preventative measure, or perhaps because of them, we were equated with children in our weakness and susceptibility to this common disease.



*Figure 4.1 A stall in the market where a woman is selling various ingredients for herbal remedies. (Source: Personal Photo)*

#### **4.2 Popular Sector: Curative Care**

Despite these preventative measures, illness does occur. As previously mentioned, those who fall ill are those who are experiencing some level of weakness in their lives. This weakness can be physical, mental, social, or spiritual. Just as there are many ways of being ill, there are many ways of regaining strength. Various home remedies are used in the treatment of common maladies such as cough, fever, upset stomach, and minor injuries. Some of these home remedies include hot towels wrapped around the middle for stomach problems, cold towels on the chest and forehead for fever, and using soap made

with the ash of burned cocoa pod husks to clean and heal cuts and bug bites sustained whilst farming. Some of the more elaborate home care methods includes special food and beverage mixtures (i.e. the ginger drink mentioned above), easily acquired drugs and herbs (Figure 4.1), and prayers and other rituals. Again, these weaknesses and the methods used to address them are not mutually exclusive, and may occur individually or in any number of combinations.

Illness is also not something that is dealt with in solitude. It is a family's responsibility to care for their sick and injured until they regain full health. If one remedy is tried and found unsuccessful it is common to consult with family members and friends for suggestions on what to do next. Important community members, such as elders, church leaders, healers, and pharmacists are also consulted for possible diagnoses and treatment. I was informed that there were healers in the village who sold herbal remedies and performed healings, but I did not have the opportunity to meet any.

#### **4.3 Folk Sector: Pharmacies and Vendors**

This is branching into the folk sector of healing. Church leaders, healers, and pharmacists all assist in curing physical ailments, though in slightly different capacities. Pastors and priests deal with the spiritual, healers with the mental and social, and pharmacists tend to stay with physical ailments, unless they were previously trained as healers. This is not to say that any of these groups cannot act in the specialized field of the other. Healers can and do sell pharmaceutical drugs, pharmacists carry both biomedical and herbal medicines, and church leaders promote certain remedies for all illnesses as well as diagnosis and healing through prayer. Many pharmacists are also

healers that became certified so that they could practice their trade with some state recognition (Oppong and Williamson 2012).



*Figure 4.2 The interior of the single-roomed Humjibre pharmacy. A variety of pharmaceutical drugs and tonics are on display. (Source: Personal Photo)*

The village pharmacy (Figure 4.2), located on the main road through town, sells both pharmaceutical and herbal medications, along with a variety of tonics, topical salves, and bandages. In Ghana, they occupy a liminal state between the folk and professional sectors. While the pharmacist and his shop both have to be certified and recognized by the government to practice, the type of healing that takes place within can follow a biomedical or an herbal route and is largely determined by what the patient desires for treatment. Pharmacies are attractive to many because they are usually closer to home and much cheaper than a visit to the clinic or hospital. Many of the surveyed mothers did state that they had taken their ill and feverish children to the pharmacy instead of, or before, going to the clinic. This practice is reinforced by the fact that these establishments serve the dual purpose of diagnosing common illnesses as well as

distributing medication. Consultations are free, and medications can be purchased by the pill rather than having to immediately pay for the entire course of treatment. This presents some problems, however, and allows for some harmful medical practices. Selling medication by the pill, especially antibiotics, can lead to the evolution of resistant strains of diseases such as malaria. Selling outdated or ineffective medicines is also harmful. Quinine was still being sold in this shop as a malaria medication. When asked, the pharmacist acknowledged that the MOH was trying to phase this substance out of the market. He then explained that while it was no longer effective on adults, because it is a weaker medication it is still acceptable to give to children. Other examples of potentially harmful practices are the sharing of leftover prescription medications to address certain symptoms, and the portioning of adult strength medications for use on children.



*Figure 4.3 A table of herbal medicines set up by visiting drug vendors. (Source: Personal Photo)*

In addition to established pharmacies, travelling drug peddlers periodically come through the village to sell their wares. One of the groups I met had a table set up across the street from the pharmacy (Figure 4.3). All the pills and liquids were in plastic medicine bottles with clear labels proclaiming their ability to heal such things as asthma, stomach problems, malaria, gonorrhea, and syphilis. They did not have ingredient lists to identify what they were made from, but the vendors were adamant that they worked. I did not see anybody purchase any of these medications.

#### **4.4 Professional Sector**

Professional help is usually sought when self-treatment proves ineffective or it becomes too much or is too severe for an individual to handle alone. Most visit the Humjibre clinic before they go to any of the nearby hospitals. This is partly due to the fact that the nearest district government hospital is in Bibiani, 32 miles away. This is a 45-minute trip by taxi. The nearest private hospital is in Bekwai, ten minutes away by taxi, but two hours walking distance. The clinic is stocked with supplies to handle most emergencies, including generators for power outages and a car in case a patient needs to be driven to a hospital. The nurses at the clinic said that the most common issues they encountered, other than family planning consultations and childbirth, were malaria, children with fevers and diarrhea, cuts from farming accidents, and infected bug bites. Examples of cases sent to the hospital are complicated pregnancies and severe injury and illness.



#### *4.4.1 Kofi*

Some people choose to bypass the clinic and go straight to the hospital. While hospitals are better equipped in terms of medications, technology, and staff, they come with their own set of difficulties. For example, one of the local volunteers, a young man named Kofi has been dealing with a severe kidney disease for the last couple years. He and his family became aware of his problem when he fell extremely ill shortly after completing Senior High School. His parents, having already lost their eldest son to illness, decided to check Kofi into a private hospital located in Bibiani. This was done in the belief that in a small, private institution he would receive more attention and better care than in a large, crowded, public hospital.

After a couple weeks of various tests and attempted medications, Kofi did begin to recover. However, when it came time to leave, he and his family were unable to pay the full extent of his medical expenses. Kofi was prevented from leaving the hospital until he could cover the cost, but the hospital also continued to charged him for each additional day he occupied a bed. In addition to asking relatives and using the money he had saved for college, Kofi's parents began to consider selling some of their farmland to cover the costs. As farming is the primary means of livelihood in this area, such a move could have proven devastating. Before it came to that, they received some outside assistance. Kofi had been involved with GHEI for many years, first as a student and then as a volunteer teacher, and had made many good friends within and through the organization. Some of them decided to help out and lend the family some money.

This is not the end of Kofi's dilemma, however. Though he was eventually able to leave the hospital, he was not cured and still requires treatment. This means that he

must make the trip to visit his doctor every couple of weeks, or as he can afford. He is charged for each of these appointments and, as this doctor is not located in Humjibre, Kofi must also pay for transportation to get there. The doctor has also done his best to convince Kofi to continue coming to him, and not transfer to a public hospital, by doing such things as informing Kofi that his issue is fairly unique and needs special attention, that he wants to write a paper on him, and by telling him that he has to take the drugs provided by his hospital because the medicines in the pharmacies and street stalls are cheaply made and imported from India and have been diluted and tampered with, making them less potent and very unreliable. On his way to one of these visits, Kofi jokingly told me that despite all of this and having to pay so much just to stay well, he did not mind very much because he was becoming very friendly with the nurses.

In Kofi's case, homecare was for the most part bypassed, as was the trip to the clinic. Having already lost a child, his parents were far more willing to go straight to the hospitals to have him looked over, and a private hospital at that. Private hospitals, while being much smaller and focused on the patients, are much more expensive as many NHIS advantages do not apply. Hence the inability to pay the bill. As Kofi's condition was complicated and they still are not entirely sure what it is, there were a lot of tests that had to be run and various medications to attempt. They still monitor his medications and his responses to them.

I later asked Kofi what he thought he was sick with and he could not give a technical medical diagnosis. He stated only that there was something wrong with his kidneys that caused him to hold water and swell all over, while also making him too tired to go back to school or do his work. He could not tell me much about the tests he had to

go through either, but he did indicate that none of his medications have remained effective for very long. I later discovered that this is most likely due to the fact that he habitually stops taking his medications once he begins to feel better instead of finishing the entire course.

Here we can see that the main obstacles Kofi faces in acquiring treatment are cost and transportation. He also lacks a thorough understanding of his condition and the importance of adhering to his medications. Though the majority of his treatment comes from the hospital, he does rely on friends and family for financial support, and keeps his mind healthy by continuing his studies independently, staying positive, and volunteering as a teacher to pass knowledge down to the next generation.

#### *4.4.2 Ama and Abby*

Though Kofi does not fully demonstrate this, most individuals utilize more than one of these options in their treatment behaviors. Using home remedies or consulting a healer does not preclude a visit to a medical facility. Neither does a trip to the clinic negate any self-treatment or familial care. These practices are woven together to suit the needs of the sick individual, as is demonstrated by the experiences of Ama and her eight-year-old daughter, Abby. Ama had the appearance of good health for much of my visit, but began to look drawn and tired in the last two weeks of my stay. This is about the time many of the foreign volunteers began to fall ill with malaria, so it was not particularly surprising when I learned that she had also contracted the disease. What I did find surprising was the reason given for why she had gotten it at the time that she did. Ama had fallen ill because she was sad and this had made her weak.

Ama is raising her daughter alone and does not have any family locally available to assist her. This is an unusual situation in this village. Her situation is made more difficult by the fact that her daughter, Abby, was born with a disease I was told is a congenital heart disease. Abby is a happy and playful child, but she does wear a brace around her abdomen that is meant to protect her heart and stomach. She also has a speech impediment that causes her some trouble in school and with friends. Abby's illness requires medication that must be taken daily, which means that the two of them have to make monthly visits to a hospital in Kumasi, a city located two hours away by trotro. Such a trek is necessary because that particular facility is the closest to Humjibre that has the necessary equipment and personnel to perform Abby's check-ups and the supplies to refill her prescriptions.

Ama's position as a single mother with a sick child and lacking the support of local family is far from ideal, and causes her a good amount of stress. However, they are not as alone as they may initially appear. Ama has an uncle in the United States who regularly sends her money to help pay for Abby's hospital visits and medicine. Ama also receives a stipend for her work with GHEI and has a garden to grow produce that she then sells for profit at the local market. These small sources of income, in addition to the allowance from her uncle, allow Ama to make a small, but sufficient living. They also allow her to put away some money so that she will hopefully be able to afford heart surgery for Abby in the future.

As far as coping with her own illness, Ama has the GHEI community and her neighbors who readily and eagerly step up to support her. Even before it was confirmed that she had malaria and began taking the necessary medicine, the neighborhood women

came together to offer her support and assist her with her everyday tasks, including cooking and watching Abby so she could rest. Ama is also a member of the Anglican church, and would go to prayer with another GHEI member every morning before beginning the day's work. In this case, it was not access to medical facilities that was the most beneficial to her own personal healing process, but the existence of a strong and empathetic support structure.

Much like Kofi, Ama was obligated to seek out treatment far from home requiring her to pay for transportation in addition to consultations and medications that she would not have been able to afford on her own. She demonstrates many of the economic and social problems present in the rural areas of the country. As a single mother she is not expected to be wealthy, particularly with a sick child who requires biomedical intervention to thrive, yet she is doing well for herself due to family abroad and friends at home.

Thus far, these snap-shots show the effectiveness of biomedical treatments but also highlight problems surrounding money, access, and education. They also demonstrate the necessity and success of the social support structure provided by community that hospitals are unable to provide.

#### *4.4.3 Family Planning*

There are instances where a trip to the clinic or hospital is considered preferable to the alternatives. The younger generations are now receiving more information about safe sex practices and family planning, leading to young men and women attempting to access materials and supplies that their elders either do not approve of or do not know about. It is somewhat a point of contention. At both the Humjibre clinic and Bibiani

District Hospital, girls and women have the option to leave their record books at the facility so that their parents, boyfriends, or husbands do not have to know that they are using contraception. Also for the sake of secrecy, the preferred method of birth control is the Jubelle implant, which is placed in the arm and lasts three to five months. Both locations also do HIV clinics, tests, and treatment. A nurse at the hospital remarked that they have seen an increase in the number of people seeking these services, but when asked, she did not think this indicated a rise in the disease, only more awareness and access to affordable medications.

#### **4.5 Folk Sector: Childbirth and Spiritual Ailments**

Of course, there are also instances where hospitals are avoided or used as a last resort. Many women prefer to give birth in their homes, and there are several reasons for this. One is that elder female relatives encourage new mothers to stay home and use a traditional birth attendant (TBA). They believe that delivering in a facility is unnecessary. In Humjibre, there was also a certain amount of fear associated with the clinic's midwife. I heard several stories which painted her as a mean and strong-handed woman who would yell and beat on the women in labor as encouragement. This and the fact that childbirth can be very expensive kept several women away. For the women who did utilize the clinic or go to the hospital, they would be asked for things like soap, eggs, palm oil, buckets, and sheets in addition to a fee that ranged from 20 to 150 GH¢ depending on the nurse or doctor, the location of the delivery, and whether or not there were any complications. TBA's are also given compensation, but the amount was left up to the family and was generally not as costly as a hospital visit.

Those whose problems are perceived as mental or spiritual in nature, particularly in rural areas such as this, tend not to visit hospitals for treatment. Mental health institutions do exist, but they are all located in or around the country's capital (Fosu 1995), and the mental health ward at Bibiani District Hospital was the smallest and least populated ward in the hospital. The head nurse said that the majority of their patients are women suffering from depression or schizophrenia, and they do not stay in the ward. They either come alone or are brought by their relatives to be evaluated, collect their medications, and then leave again. She confirmed that mental issues are stigmatized, in that many feel that they cannot admit they have a problem, but she also made the point that many people do not know that these are things that can be treated. Most will stay home to be taken care of by their families, or they seek help from other sources such as a healer or church leader. Sage and his experiences exemplify this stigma clearly.

#### *4.5.1 Sage*

Sage is a local GHEI teacher that I interacted with on a regular basis. Around the time that everyone else was getting sick, he began to behave erratically. Usually a calm individual, he would start to fidget after sitting too long, and have bouts of energy where he would jump up and down, pace in a circle, or play pranks on people. Every now and then, he would have to dash off on his bicycle, claiming that he had to go "take medicine." I am still not entirely sure what he meant, but after a couple days of this I finally asked him if he was ok. His response: "I'm fine. I just have anxiety."

At that point in time, I did not pursue the subject and after another couple days he seemed to calm down. Then one morning he came by our house to ask Doc (an American volunteer who is a physician) if he should "take some food" with his malaria

pills. I was quite surprised, as that made him the fourth GHEI member to contract malaria. After he had recovered I asked if I could talk to him about his illness, and he said yes. For the first question I asked him what he called his illness, thinking that we would be discussing his malaria. I was proven incorrect when he answered, “Fear. Yeah, my problem was fear.”

Sage has had anxiety, specifically a fear of death, for many years. He used to have panic attacks as a child (my definition, not his), but has a better handle on it now as an adult. As a child it manifested as nightmares, fevers, and shakes. As an adult it became insomnia, worry, and restless energy. There had been two recent deaths in the village, and he had been very close to one of the women who died. This had triggered his anxiety, which manifested in the erratic behavior described above. He stated that he had a lot of fear and that it was affecting his everyday life. He said this was why he got sick with malaria, because the fear had made him weak.

I asked him what he did to help with his fear and the steps he was taking to get better, and his answers centered around talking about it, or more frequently, his inability to talk about it. He said that many of his friends did not understand and would make fun of him if he tried to talk to them, so he did not. Instead he would come talk to the GHEI coordinators because they are not Ghanaian and they are more sympathetic and able to give good advice. He also mentioned that when he went to the hospital to get medicine for his malaria, they told him that there was a medicine he could take that would help him with his anxiety, but that he would have to go to the city. They also implied that he would not be able to afford it.



Sage personally thought that he needed the medicine to get better, but realized that talking about it with the right people was currently his best option. The inherent stigma towards any issues regarding mental health can be seen in the way the majority of his local friends had no interest in understanding his problem. He is an educated young man fully aware of the stigma regarding his illness, knowledgeable enough to recognize his problem for what it is, and desiring an unattainable biomedical solution. Instead, he utilizes the most beneficial option available to him, relying on the strength and support of friends.

#### *4.5.2 Healing Church*

Sage also remarked that one of the ways he deals with his worry and insomnia is by reading the bible. Though he no longer attends church services, he says that his faith is very important, and that it helps him deal with his problem. Many others use faith and the spiritual community to cope with their illnesses. Owoahene-Acheampong has noted the rise and increasing numbers of African Independent Churches, or “healing churches,” throughout Africa in general, and Ghana in particular. I had the opportunity to experience an example of one of these during my stay. Unlike the Anglican and Catholic services I attended, this event was highly interactive. There were no sermons or lessons, only prayers to say and healings to perform.

This church is rooted in more traditional beliefs and practices and serves as a good example of the meshing of Christianity and more cultural behaviors in the act of healing. Technically, this “healing church” is attached to the Twelve Apostles Pentecostal Healing Church, but the actual healing ceremony happens independently of the Sunday service. This gathering is also different from other religious events in that it was founded

by, and is currently led by a woman. The original founder was gifted with the art of healing by the ancestors and when she died (at age 118) her gift was passed on to another younger woman. This new healer directed the ceremony with four other women in purple robes and two men in blue robes. I feel this excerpt from my fieldnotes best captures the feel of the place:

“The ceremony itself took place under an open awning attached to a courtyard containing a fountain. Shoes had to be removed before entering this courtyard. Unlike other services I had attended, this one seemed centered more on action and feeling than on contrition and contemplation. Wands were being waved over dancing people. The women in purple would lay hands on pregnant women and new babies, blessing them. The music was all very rhythmic and loud, consisting of drums and tambourines that encouraged dance. Drumming is culturally significant in that it is a holdover from religious practices in the past. The women in purple would dance in a circle and the Healer would send one or two of them into a trance. Those entranced women would then go into the congregation and pull a couple people into the circle. The chosen either knelt to be blessed by the Healer and the men in blue, or they would trance and start to dance. Some individuals started twitching and fitting while standing in the congregation and those around them would usher them into the circle so they could carry-on. One woman had to have her baby pulled from her back as she started trancing. That same woman was later pulled into the courtyard by one of the blue men and three purple women. The

women held her by the hair and arms while she pulled and fitted, obviously possessed. The man placed his hand on her head and began to pray. I do not know if it was just a healing prayer or if he was speaking to whatever, or whoever, was possessing her.” (Fieldnotes)

The majority of people present were women, with only a few younger men. A couple children were present, but they sat off to the side and did not participate. Many women come here to be healed and to take their medicines away from their families, or to be healed when medications fail them. I was informed that this is because they wish to avoid any stigma associated with their ailments, many of which do have to do with mental health. Several women who come for this healing end up staying due to their fear of going home. As a result, an entire community has formed around this Healer and her church. Sage and the Healer are only two examples of alternative methods of addressing the stigma and difficulties surrounding mental health issues.

#### **4.6 Conclusion**

What this chapter has attempted to show is that there are variety of options and behaviors when it comes to healthcare in the village of Humjibre. The medical culture includes a mixture of biomedical, herbal, and spiritual remedies, and all are utilized on an individual basis in a way that addresses the needs of the patient. Some of these options and behaviors are the product of the local worldview and commonly held beliefs and knowledge, but as the stories of Kofi, Ama, and Sage demonstrate, the socio-economic and political situation of the country also plays a part. The difficulty in physically reaching a hospital means that options already available within the village are going to be

utilized first. From there, the nature of the illness and the cost of care will influence which treatments will be sought. These factors will be more closely examined in the next chapter.

## **Chapter 5: Facilitators and Barriers to Formal Health Services**

The previous chapter provided a very brief glimpse into the medical culture of Humjibre. We were able to see that when it comes to health, the meaning of illness is influenced by worldview and sociocultural norms, the availability of and access to treatments is influenced by the political economy, and that the practice of treatments is based on personal knowledge and preference. As was clearly demonstrated, there are many resources and avenues available when it comes to health care. The profiles of Kofi, Ama, and Sage show how biomedical and locally based treatments work together in the healing process. While the last chapter examined the navigation of health practices, this chapter will examine the social, political, and economic forces that have made such behavior necessary. Kofi and Ama were both forced to climb the ladder of health care to find the rung that best suited their needs. The problem with their choices were that neither of them would have been able to afford those services unsupported. Neither of the hospitals they utilized were located nearby, and they both had illnesses that required long term care and frequent hospital visits.

### **5.1 Issues of Access**

Perhaps the largest factor influencing health behaviors is access and all its implied difficulties. What is accessible is based primarily on physical location, transportation,

cost, and the capacity of the medical facilities themselves. Self-treatment by the individual and their family is usually the first choice of intervention across a wide range of cultures because resources are generally readily available and relatively inexpensive (Kleinman 1980). If remedies are not initially on-hand, they are easily acquired through friends, family, healers, pharmacists, the market, or, if the individual is knowledgeable, a trip into the forest for fresh ingredients.

Individuals are more likely to use resources that are locally available for several reasons. The most obvious is that facilities located nearby are physically and fiscally easier to reach. Much as in colonial times, larger hospitals and specialized medical facilities are found in the most densely populated urban areas. This presents a problem, as 46% of the country's population lives in rural areas (World Bank 2013). Building projects in the 1960s and economic assistance in the 1990s led to the creation of smaller hospitals and clinics spaced throughout the regions in an attempt to provide accessible medical coverage to the entire population. Each regional capital has a government hospital, and several district hospitals are spaced throughout each region with clinics placed in the larger villages. In addition, private hospitals are now appearing in greater numbers in larger market towns. While these smaller facilities are more easily accessible, they are not as well-supplied or well-staffed as their larger counterparts. Hospitals located farther away may be larger and better stocked, but many individuals would rather not pay the necessary travel expenses to reach them if there are other options available.

### *5.1.1 Transportation*

For those in this village who did decide to visit a hospital rather than the local clinic, the nearest private hospital is located in Bekwai, 15 minutes away by taxi. Very

few people in Humjibre own vehicles, and those who do are primarily taxi drivers. Taxi is the best option for travel between villages, and trotros are used for longer trips. Trotros typically do not make stops in Humjibre, unless it is specifically ordered. Individuals must take a taxi to Bekwai to catch one. Taxis and trotros tend to be overcrowded, holding many more people than they are meant to transport, thereby increasing the risk of disease transmission. In terms of infrastructure, the roads are not well kept, leading to many cracks and potholes which fill with water in the wet season. The forest comes up to the edge of the pavement, decreasing visibility and making it dangerous to walk along. There is a high rate of vehicular accidents. In addition, checkpoints along the way have guards that demand bribes or fines, further complicating the process. Finding transportation to hospitals is costly in both time and money.

Here is an experience that highlights many of the access issues faced by individuals such as Kofi, Ama, and Sage when seeking medical treatment. This volunteer's experience with the medical system was quite an adventure. Though Lydia is an American volunteer with access to more resources than many in the village, she still encountered difficulties with supply shortages, transportation, hospital costs, and belittling treatment by medical staff.

Lydia was the first of the volunteers to fall ill, and the first of us all to contract malaria. She had been tired and running a mild fever for a couple of days. As these are the symptoms for malaria, the Volunteer Coordinator decided to take her to the Humjibre clinic for a malaria test. They arrived and met the nurses, only to learn that the clinic was out of malaria tests. They then took a 15-minute taxi ride to visit a private hospital in Bekwai. No one greeted them upon arrival, so they sat in the waiting room for thirty

minutes watching TV (in Twi) waiting for someone to come help them. The GHEI Director arrived at this point. As he knew the doctor who runs this hospital, he went into the back and found a nurse to come and help them. This nurse insisted on taking Lydia's temperature. Lydia had already taken her own temperature orally, but the nurse took it under her arm, which gave a lower temperature. Lydia felt that the nurse did not believe she was truly sick, and told her that if she wanted a malaria test she was going to have to go somewhere else because their lab was closed.

They were then referred to another hospital in another town, but the Director said it was too far away and instead took them to another private hospital in Bekwai. They were met by a nurse who told them that they had to pay 20 GH¢ to have a folder made for Lydia before she could get the malaria test. After her folder was complete, her test was finally performed. They drew a blood sample, which then had to sit for a couple minutes. While they waited, Lydia went with the nurse to have the rest of her vitals taken. She then returned to the lab to get her folder with her results, and then had to take the file to the doctor so he could tell her what those results meant.

This should have been a 15-minute trip to the clinic to have a rapid malaria test done, and instead it was a three-hour ordeal. Lydia claimed to be angry and tired by the time they were able to return to our compound. While she complained about the attitudes of the nurses, she also said that the last doctor was very calm and professional in his explanation of the disease and its treatment, and that his attitude helped to keep her calm and process the information. She was also grateful for the presence of the Volunteer Coordinator and Director throughout the process. The Director covered the cost for all the files, taxis, and the medicine, and the Coordinator was there to offer emotional support.



For the next three days, GHEI staff members would come by the compound to check on her, ask if she needed anything, and try to raise her spirits.

Here we can see more clearly many of the challenges that face individuals seeking medical care. Lydia had to travel to several facilities before she could be helped. Much as in the cases of Ama and Kofi, this caused unnecessary costs in time and transportation. She had to visit these many hospitals due to underequipped and understaffed facilities. The clinic had run out of tests and the first hospital's lab was closed because the single lab technician was not available. Lydia also encountered patronizing attitudes from the nurses, which, given the many stories I was told by several individuals, is not an uncommon occurrence, and is in fact one of the primary reasons why certain of the interviewees only conceded to a hospital visit as a last resort.

#### *5.1.2 Cost of Medical Care*

One of the other factors that these four informants dealt with was money. Though Lydia did not handle the expenses directly, it still affected her hospital experience. This is even more true for Kofi, Ama, and Sage, who do not have the luxury of drawing on GHEI funds. The various costs that come with visiting a health facility add up. The villagers are not wealthy, but they do make enough to live well if funds are used wisely. One of the many reasons people do not go to health facilities is because they cannot pay for it, which is why many individuals will use home remedies before they seek professional care.

Pharmacies and drug vendors are a cheaper option. Here people can be diagnosed and receive medicine without the hassle of a medical exam. They can also request the medicines they think they need, pharmaceutical or herbal, or buy their prescribed

medicines by the pill if they cannot afford the cost of the entire course. This practice poses some problems, however. Not every pharmacist possesses a full understanding of all the products in their stores. This leads to misdiagnosis and the prescription of incorrect medications. Selling by the pill fosters drug resistance, specifically when it comes to antibiotics. For these reasons, the MOH now requires that all chemists, pharmacists, and vendors undergo training and gain a certification before they can peddle their goods. This is not a final solution, however, as regulation is lax in these areas and these behaviors continue.

Ghana instituted a National Health Insurance Scheme (NHIS) in 2008 to try and assuage some of these costs and encourage more people to use hospitals. According to their website, premiums range from 7.20 GH¢ to 48 GH¢ a year, depending on the income of the individual or family (NHIS 2017). This insurance scheme is meant to cover most necessary tests and procedures, but does not include the consultation fee required at most institutions. This fee was 5 GH¢ at the Humjibre clinic but 20 GH¢ at the private hospital in Bekwai. Some medications must also be purchased, such as the pills Sage wanted for his anxiety. Other out of pocket costs include things like birth control implants (20 GH¢) and eye glasses (150-300 GH¢).

As mentioned in the previous chapter, childbirth is a very expensive experience. Though it is technically covered under the NHIS, nurses and doctors still ask for compensation. Extended hospital stays are yet another cost, especially in private hospitals where a patient must pay for every day they occupy a bed. Furthermore, if the facility did not have what was needed for treatment, the patient could be referred to another. The nearest district hospital, Bibiani District Hospital, received patients from all over the

district, but was itself a referral hospital. If they did not have the equipment or personnel, they would stabilize the patient and call an ambulance to take them to Kumasi (1.5 hours away). The patient was charged 150-200 GH¢ for this service.

All of these fees can add up to a significant portion of a family's yearly income. As in the case with Kofi when initially fell ill and had to stay in the hospital for a couple weeks. He did not question the necessity of this process, but complained about the amount of stress it put on his family. They eventually had to rely on friends to help cover the cost. One American volunteer, reflecting on this process, said:

“I think the Ghanaian medical system needs much improvement. I think bribery could be a real problem – a local staff member told me that he has to pay additional out-of-pocket fees every week he sees his doctor, or he won't get the necessary treatment. People like him cannot afford that!”

(Personal Communication)

At this point in time, young men and women are leaving their home villages for the cities and more urbanized areas in the hopes of finding more profitable employment. It is expected that these individuals will send some of that money back home to help support their families. Family is incredibly important, and it is a duty to take care of and support one another. I heard of several families that were receiving extra income from sons, brothers, and uncles abroad in other cities or in other countries. This is the case for Ama, who is able to afford Abby's medications because she is receiving money from her uncle in the United States.

There are clear access problems when it comes to seeking biomedical treatment, especially for those coping with long term conditions. Difficulties getting to hospitals as

well as the costs incurred upon arrival frequently deter people from seeking medical assistance from these facilities when there are closer and cheaper options available. It is not entirely the fault of the hospitals, however, as they are also constrained by the amount of assistance available to them.

## **5.2 Issues of Capacity**

Not only are the people limited in their ability to access biomedical facilities, the facilities themselves often have difficulties meeting the needs of their patients. Clinics are only located in villages of a certain population (~5,000), so they are scattered widely through rural areas. These clinics feed into small public and private hospitals that then feed into the district hospitals. The district hospitals are also expected to send personnel out to the smaller facilities periodically to check-in and do educational and public health clinics. This means that district hospitals are expected to provide coverage over a vast area containing many people in areas that are not always easily accessible.

There are definite issues of capacity in terms of personnel, supplies and equipment. For example, there is always the chance that farmers going out into the bush will accidentally anger a mamba. The local clinic does not possess the necessary anti-venom, however, and those who are bitten must be driven to the clinic in the next village over. Supply shortages are common given the remote locations and poor infrastructure. Electricity is also an issue. The government is known to shut off the electricity in certain areas in order to re-direct it to other sectors. Farmers have also been known to accidentally fell power lines. This means that the village experiences frequent power

outages, making it very difficult keep medicines that are meant to be kept cool, and to perform operations and exams after dark.

Here I offer profiles of the Humjibre clinic and Bibiani District Hospital to highlight the resources they have available and the difficulties such facilities face.



*Figure 5.1 Some of the informational posters on display at the Humjibre Clinic. (Source: Personal Photo)*

### 5.2.1 Humjibre Clinic

The local Humjibre clinic is located on the edge of town, requiring a 10-20 minute depending on location within the village. It is always open and staffed by nine nurses who work in shifts of two, serving a population of about 6,000. The primary reception area is outdoors, with two long benches for people to sit on as they wait. The walls of this area are covered in informational posters, ranging from the promotion of family planning and vaccination to the use of pictures to describe the symptoms and prevention of things like parasites, cataracts, Buruli ulcer, and Ebola (Figure 5.1). The

clinic has three wards – male, female, and maternity. The male and female wards each have three beds, and the maternity ward has one delivery bed and one recovery bed. The women are expected to stay for 12 hours after giving birth, but the nurses said that they usually only stay for about six. The clinic also has an examination/blood drawing room, an office where all the paper records are kept, a small separate building for supply storage, and housing for the nurses.

The nurses were friendly and accommodating each time I visited. When questioned, they identified malaria as their most seen malady, and they heavily rely on the rapid diagnostic tests. They do not often run out of these, as was the case above with Lydia, but it had been a particularly bad year for the disease. Their next frequent ailments were childhood illnesses (fever, diarrhea, etc.) and farming related injuries such as cuts and snake/bug bites. They did have oral rehydration salts (ORS) to give to these children, but they did not have the zinc that is now often included in ORS packets per recommendation of the WHO. They see five to six births per month, but do not have the equipment for C-sections. There is a midwife on staff, but I did not have the opportunity to meet her. They also had a family planning program, and worked with GHEI to promote it in the local schools. Here, as with the hospital, the Jubelle insert is the most popular form of birth control, though condoms and oral contraceptives are also available.

The Humjibre clinic is a small facility equipped with basic equipment to address common illnesses and injuries. They can handle small emergencies, but must send their most severe cases to larger hospitals, either in Bekwai or Bibiani. The nurses themselves were placed here by the government after they received their certifications, and while some of them did not seem bothered, others of them had no trouble admitting that they

did not like the remote location. Despite their dissatisfaction, they genuinely seemed to care for their patients and desired to do the best they could with the supplies they had available.

### *5.2.2 Bibiani District Hospital*

I went on two tours of Bibiani District Hospital with the GHEI group. My visits took place three weeks apart and both were eye-opening and educational. The hospital is made up of several wards connected by raised and covered outdoor walkways.

Appropriate informational posters line the walls of each ward. The staff primarily consists of nurses holding varying degrees of rank, as distinguished by their outfits, with a few lab technicians and pharmacists. There are only three doctors of full standing, though we were followed around by two interns on our second visit. Before beginning the tours, we had to greet the administrator – the nurse matron the second tour because the administrator was not available – and tell him the purpose of our visit. After this formal greeting, we were shown around by a nurse.

We were first shown the laboratory where they do blood drawing, blood tests, and other lab work. There were many people waiting in the covered sitting area. The lab had the basic equipment, and though it all appeared to be functional, it did look old and out-of-date. The technician who showed us around this area was very proud of the manual microscope and enjoyed explaining the equipment, its uses, and the work they did there. This was the general attitude of most staff members we met; happy to explain everything and show us around.

The next stop was the building set aside for family planning and reproductive health. This ward is run entirely by women. They do HIV clinics, tests, and treatment in

addition to birth control and female health. When asked, the nurse in charge of this area did not think there was a rise in the disease, only more awareness and more affordable drugs so more people are now coming. For safety reasons, patients have the option of leaving their files at the hospital instead of taking them home.

We briefly stopped by the Psych ward next. This is the smallest and most run down looking department of the hospital. There were only a couple of beds for examinations, and the three orderlies were sharing a very small office. The head nurse here said that their patients are mostly women suffering from depression and schizophrenia. She confirmed that there is a stigma against those with mental issues, but that those suffering from them are usually taken care of by their families and not left in hospitals. The patients come to collect medications and then leave again. They did not have any patients in the ward either of the times I was there.

The next building was the largest in the facility, housing the male, female, and maternity wards. The male and female wards both consisted of a long room holding about twenty beds, with two much smaller rooms coming off it; one for recovery post-surgery and one for contagious disease. Both wards contained only four or five people during my first visit, but nearly every bed was filled during my second. Additional beds had to be wheeled into the female ward. The maternity ward also had one room with about ten beds and a delivery room off to the side. These beds were occupied by women in early labor and those who had just given birth. Women are permitted to stay for up to 24 hours after delivery and their female relatives could visit. The delivery room was through a door to the side of this main room. It was fairly small with three delivery beds of questionable quality. While sturdy and functional, they looked old and worn, with torn cushions. There



was a cot and equipment against the wall for emergency infant resuscitation, should it be necessary. The wall above this cot featured instructional posters for this procedure (Figure 5.2).



*Figure 5.2 Infant Resuscitation Cot at Bibiani District Hospital with instructional poster located on the wall above. (Source: Personal Photo)*

The most occupied ward during both of my visits was the children's ward. This department is headed by a Russian pediatrician, a woman that the administrator warned us about as she tends to be a bit brusque. She was indeed very no nonsense, but obviously cared deeply for her patients. She wanted to know where we were from and what we were doing and asked that we not take any pictures of people, especially not the children. Not that we would have done this anyway. Though many female nurses head departments, I found it interesting that the only female physician in the hospital was a foreigner.

The last two areas we saw were the emergency ward and the operating theater. The emergency room had separate male and female sides, with a few beds curtained off for privacy. More posters cover the walls here. There were two resuscitation beds with attached oxygen tanks near the entrance, and the head orderly made a point of saying that this was a referral hospital, so people are stabilized here and then sent to another hospital that is better equipped where they can receive further treatment. The operation theater is one small room with a single bed and necessary machinery and supplies. The primary operations performed in this hospital are C-sections, cataract surgery, and hernia treatments. The more complicated cases are sent to Kumasi. We walked past the pharmacy on the way out, and it was extremely busy both times. We did get to speak with a very knowledgeable pharmacist who had a lot of ideas for how he would like to improve the facility, if given the staff, funding, and supplies.

The patients in the hospital were, for the most part, completely bedridden. The most populated ward during both of my visits was the children's ward, with the least populated being the mental health ward. The hospital was busy, more so our second visit, and people lined the edges of the walkways sleeping, waiting, and eating. Some of these people were patients getting some fresh air, but most of them were relatives waiting to see their family members. Waiting areas were crowded as people waited to register to be seen, or to get their medications from the pharmacy. The staff were friendly to we visitors, but they were occasionally short with the patients. They all seemed tired and stressed, especially the nurses. Though the hospital did not have the most up-to-date materials, the consensus among our group, which included Western trained doctors and

medical students, was that they were doing the best they could with the resources they have.

### *5.2.3 Shortages of Staff, Supplies, Equipment*

As can be seen in these examples, small rural facilities like the clinic suffer from staff and supply shortages. These problems extend as far up the chain as the District Hospital. While they are still able to provide care for their patients, their level of funding can be seen in the run-down state of their buildings and equipment. It could also be seen in the disgruntled mutterings of the nurses. At the time of my first visit, our nurse-guide complained that they had not been paid in three months. Money within the health care system is not evenly distributed. In keeping with colonial times, the hospitals in urban areas, especially those that are also training hospitals, receive most of the funding as they serve the largest populations. It does make sense that the allocation of personnel, supplies, and equipment would go to areas with the highest concentration of patients, but it often leaves the rural areas struggling.

While supplies and equipment are issues of money and infrastructure, there are several factors that contribute to the lack of personnel. Once doctors and nurses have completed their schooling, the government decides where they are to be placed. Urban areas are more desirable, so the individuals that end up in the rural areas are not always pleased. There is a high turnover rate of nurses in the rural regions because they leave or drop out of the service after marriage. Brain drain is also a problem. Many individuals who can afford it choose to study abroad, and many never come back. Or they are educated in Ghana and then leave to work in other countries for better pay. Currently, the government is trying to come up with ways of enticing students from rural regions, who

are currently few in number, to return home and practice medicine there once they graduate. They have not been very successful thus far.

#### *5.2.4 Staff-Patient Interaction*

Beyond transportation, cost, and hospital capacity, the differences in medical understanding and the resultant doctor-patient interactions also act as deterrents to seeking medical care. There are frequent misunderstandings that lead to arguments with doctors complaining about stubborn patients and patients complaining about being talked down to. From what I could understand, individuals did not like going to the hospital partly for financial reasons, but also because the process is isolating and the nurses and doctors can be very belittling with their treatment.

Many nurses at both the clinic and the hospital expressed frustration towards patients who waited too long or who tried to treat themselves before arriving. The clinic nurses were adamant about wanting women to deliver at the clinic, just in case there was a problem the family or the TBA could not handle. Most of their concerns had to do with blood loss and infection, reinforced by their explanations of what drugs they would need to deal with these potentially life-threatening problems. They complained about how many women preferred to stay at home. Again, when asked why they wanted the women to come to the clinic, they said what would happen if they bleed too much? Or what would the family do if the woman had HIV/AIDS? It could infect the others and then what would they do?

This is another factor that influences doctor/nurse-patient interactions: judgement, misunderstanding, and lack of communication. Doctors and nurses do bemoan the fact that some patients use herbal remedies or buy their own medications, but they also

acknowledge that cost and limited supply at the hospital pharmacy often make this a necessary practice, even for those who would prefer to come to hospital or take biomedicine. For example, our nurse-guide at Bibiani expressed vexation when I asked how often they see people who had first tried to treat themselves. She said that she definitely saw it happening, and that people use herbal remedies because they don't have the money to pay for medicines. She told me a story about a girl who had had abdominal surgery and was released, but then did not come back to have the bandages changed as she was instructed. The wound got infected and the girl got really sick. She tried to treat it herself with herbal medications and this only made the problem worse. The nurse complained that many poorer people, like this girl, operate under the assumption that "if the ancestors could keep themselves well this way, then we can too." (Fieldnotes) She related this story with frustration and disdain, but did not offer any suggestion on how to fix the problem.

As previously discussed, biomedicine privileges an isolating view of medicine in which illnesses are rooted in a single individual and do not include social factors in the diagnosis or the treatment. This is very different to the local view where an illness affects the whole family and the individual stays home to be looked after by various relatives. These family members want to stay with their sick people and take care of them, regardless of their physical location. This practice is not discouraged at Bibiani DH, because these family members will bring and make food for their ill relative. As the hospital does not have kitchen facilities, their presence is beneficial. There is not enough room in the wards for families to sit inside, so they often line the walkways that connect all the hospital buildings. There is a building specifically for these visitors, as our guide

pointed out, but she said they prefer the walkways because they are closer to the wards. She could not understand this choice.

Another part of this mistrust of doctors also has to do with money. Doctors are perceived as well-educated and rich. The villagers scorn those who they perceive as hoarding wealth. For example, there is a row of very large, very nice houses just down the road on the outskirts of town. These houses had electricity, private wells, and were surrounded by large walls and fences. I asked who lived in these houses once, and was answered, “Oh there? Some guys. They are not friendly. They have oil money.” As another example, we noticed a group of three young men calling themselves health and sanitation workers going door to door asking for donations in the section we were surveying. Nobody wanted to talk to them, which is striking because it was my observation that people very rarely passed up a chance to stop and have a chat or engage in some good-natured gossip. These men were not well received, and were called “city-folk.” Observing them from a distance, the woman working next to me said they had no respect because they used their money to dress themselves up to look impressive instead of supporting their families. These examples provide a brief look into the attitudes much of the rural population has towards those they perceive as selfish and money hungry. This attitude often extends to clinics and hospitals and the fees incurred there, creating even more of an understanding gap between doctors and patients.

Doctors and hospital administrators were typically better dressed than the rest of the village. They also take advantage of the fact that some of their wares are rare, or purchased straight from the pharmaceutical company. Kofi’s doctor did try to convince him that he would not be able to find his drugs on the general market at the correct

strength. Kofi is also in danger of extending the duration of his illness due to his lack of education in health matters, as shown in his failure to finish an entire course of medicine and his taking his doctor's word for it that he would not be able to find cheaper, effective medication elsewhere. This relationship hints at the power struggle between doctors who assume that their patients know next to nothing about health matters, and patients who have to either completely rely on their doctors or who have learned not to completely trust them.

### **5.3 Issues with Education**

One of the main reasons for Ghana's current state of health and for the miscommunication and mistrust between doctors and patients is education. Doctors are so far removed from the population, the rural population especially, by their education that relating can be difficult. Some of this has to do with location as well. Lifestyle is very different in the cities than in the country, with different risk behaviors and different options for health care. How people behave has much to do with where they are from and the kind of health knowledge they were raised with.

Knowledge is a nebulous and complex term that encompasses many concepts. It could be considered in terms of formal education – school, university, specialized training, etc. – or informal education – life experiences, common sense, teachings from parents and elders, etc. This to say that when it comes to medical knowledge, to what people know about health and healing and what it means to be “healthy” or “well,” there is much variation. Informal knowledge bleeds into formal education and vice versa due to cultural influence. What people know very much influences what they do, and the extent

and content of knowledge is layered and constantly changing generation to generation as people move around and are introduced to modern technologies and to new concepts.

### *5.3.1 Formal Education*

When I speak of formal education I refer to knowledge obtained in an institution or government run facility. School is free and mandatory through primary high school, though senior high schools and private schools charge a fee. I was told that the education received is actually better in public schools, and the only advantage to private school was that they accepted the children at a younger age. Though school is mandatory, many children skip their classes to either play around with their friends or to help their parents with their jobs or chores. Although attending public school is technically free, this does not mean that it is free in practice. While there is no tuition fee, parents must purchase uniforms and school supplies. For those who can afford it, many go to senior high school and then proceed on to university and other forms of higher education.

Education is expensive. Though primary and junior high school are free, senior high school must be paid for. It costs about \$900 USD to attend for three years. College was quoted at about \$1200-\$1500 USD total. This is quite a bit of money. For this reason, grade levels are not necessarily divided by age. There are often age gaps, particularly in Senior High School, because some kids have to work or their parents have to save for a couple years before they are able to pay for it. There are no senior high schools in Humjibre, so these students have to leave home and go live in another town to attend school.

Rural schools are overcrowded and there is a shortage of teachers. Many of my Ghanaian co-workers were teachers, and they were concerned that their more gifted



students were not getting the attention they needed. In Humjibre, teachers could refer certain excelling student to GHEI for extra lessons and tutoring as well as scholarship opportunities. Health and medicine are not big topics of discussion in basic schooling institutions, unless a senior high student plans their course load specifically with the goal of entering medical school upon graduation.

There are several medical schools and training hospitals in Ghana, and several universities that deal specifically with traditional medicines and healing practices. Even if it is not their focus, most nurses and doctors are required to take a course in traditional medicine. The few that I spoke with, though, did not think very highly of it or think it very useful. For example, our guide at Bibiani DH confirmed that she had taken a course in it, but admitted that she did not really remember it because it was not her main interest.

### *5.3.2 Public health education*

Though formalized medical care, and the personnel at medical facilities, push for a biomedical style of healthcare, these discussions show that this is not happening. It is not that rural populations are wholly against the use of biomedicine, but the terms of use and understanding need to be improved on both sides. It is not feasible to advocate a fully biomedical system in the current setting. Public health programs have been introduced through churches and schools, but more effort needs to be placed on improving doctor-patient discourse. The conditions of hospitals need improvement, but it seems things are headed in the right direction. More communication efforts are needed, though, and more efforts at the formal integration of traditional healers should be made to make it a safer and better understood practice. Social relations are changing, with the young and the

educated replacing the elders as the holders of knowledge. Both groups should be included in any decision making when it comes to reaching out to the public.

Public health education and outreach is not widespread because district hospitals are expected to cover vast areas and they do not have the time or capacity to reach everybody. Instead, partnerships are formed with clinics, schools, churches, and NGOs like GHEI. Posters are placed in the clinic and in smaller hospitals, and pamphlets are handed out in schools and at inoculation and baby-weighing clinics. Periodically, public health officers will come and make announcements or give talks at schools and churches discussing sanitation, safe sex, family planning, specific medical conditions and when it is time to go to a medical facility. I attended one such talk delivered during an Anglican church service.

### *5.3.3 Churches*

As stated, churches can function as avenues of health education. Not only do they teach morals and correct behavior, they support community members through hardship and host events to spread public health knowledge. I attended several church services where such lessons were taught. My experience with the healing church, discussed in the previous chapter, focused more on curative aspects of health and on strengthening the social cohesion of the group. The Catholic service I attended stressed the importance of being kind and generous to your neighbors for the sake of prosperity and community strength. Other services at other churches I attended promoted preventative care.

The first service I attended in Humjibre was at the Anglican Church. The congregation was organized into rows facing the podium and alter, though people were frequently on their feet and in the aisles singing and dancing. The sermon itself was in

Twi, though the pastor would occasionally switch to English so we could follow along. After the sermon, a long prayer was said asking God to bless the childless and the sick, and then a nurse from Health Services was brought forward to make a public health announcement. One of the GHEI staff members came to sit near us in order to translate.

The main topics for this announcement were ulcers, diarrhea, and breast cancer. The descriptions, causes, and treatments of these issues, as explained by the nurse, were largely situated in biomedicine, with some cultural influences shining through. For example, ulcers were defined as excessive amounts of hydrochloric acid in the stomach, the five leading causes of which are cigarette smoking, alcohol, stress, genes, and aspirin. For diarrhea, she stressed that people should go to the clinic, and not try to treat themselves with herbal medicines because “you do not know how the herbs will react with what is in your stomach” (informant translation). She then went on to denounce birth control, stating that it was bad for you and could cause breast cancer. She talked about the importance of checking for lumps in the breasts, and said that wearing tight bras can also cause cancer. (“Let the breasts rest!”) Some other interesting facts shared were: Ghanaians should eat more fruit, white people are strong because they eat lots of fruit, but acidic fruits in the morning are bad for everyone, and tea and coffee are bad for people with O+ blood type.

Here we have an imported religious ceremony, which has been adapted to suit the charismatic nature of the local people, advocating for a Western style of medicine while incorporating and reinforcing certain of their own cultural ideals. The church is not only a site of community and worship, it is also a place to share information and to educate.

Another site for education that is apart from the religious aspects are health NGOs. In Humjibre, this is GHEI.

#### *5.3.4 Ghana Health and Education Initiative*

GHEI has several programs focused on improving the health of their community. Much of their focus up to this point has been on educating children, but they have starting branching out to the wider community. Several water tanks have been installed throughout the village, especially at schools to promote a hand-washing-with-soap program. One of their longest lasting programs is a bed net distribution and education program aimed at reduce the amount malaria related death and morbidity in the village. A baby-weighing clinic with an educational presentation is held once a month to provide health information to mothers who wish to attend.

As GHEI is managed by people who grew up in Humjibre, the organization has a close relationship to the community, and it generally regarded positively. There have been some negative perceptions of the GHEI staff having more money than the rest of the village due to their interaction with Westerners, but the staff are very careful to explain and demonstrate that most of the money they receive goes towards community improvements. One of the purposes of the annual community health evaluation survey is to assess the health needs of the community and see if anything can be done to improve the situation. The staff attempts to work closely with the community and be accountable for their programs, but they are also trying to education the community on how they can improve their own health behaviors. GHEI partners with the local clinic and with the schools and churches to provide avenues for communication and knowledge dissemination. GHEI has been very successful in promoting the education of girls and in

providing several students with scholarships to attend senior high school. Their hand-washing-with-soap program has also been implemented almost every school in the village. Due to their communication with the village population and their dedication to improving the lives of their children through health and education, GHEI has been very successful in the implementation of their programs.

Two of their most recent programs focus on supporting and educating young and first-time mothers. As previously discussed, childbirth can be a very expensive experience. It can also be a very dangerous experience. GHEI's Health Facility Delivery Incentive Program (HIPDIP) is aimed specifically at mothers to encourage them to give birth in a facility by providing them with materials to help cover the delivery cost. Even if they deliver at home, the TBA must be compensated. Some women won't go to a facility until too late because relatives tell them they are not ready. This causes health problems and may lead to the need for a C-section.

The program costs 50 GH¢, and the pregnant mothers receive a pre-delivery package and a post-delivery package. The pre-delivery package has bleach, soap, and antiseptic for the women to take with them to the hospital. These supplies help relieve some of the cost so that they can afford to deliver in a facility. Even if they use a TBA, they must go to the clinic and deliver those supplies while the baby is checked. Surveys are conducted when they come to retrieve their post-delivery package. They are asked where they delivered, how much it cost, and if they got anything from the facility (i.e. a bed net). The post-delivery package has a blanket and four diapers. Some said that they went to the facility with their TBA. Some of the women responded that they had the baby in the taxi on the way to the hospital, or while waiting for the taxi. The first time this

answer was given, I thought that was an interesting story, but then three more women answered with this same story. A coordinator explained that they often say this because they think that they will not receive their post-delivery packet if they say they delivered at home, though I was assured that it would have been given to them anyway.

Their other primary program, and the program I was assisting them with, is their Mother-Mentor Program. This program is focused more on health and education, and aims to including the entire family in each informational session so everyone can learn something. First time mothers can sign up for the program, and they are given food vouchers to help them maintain a healthy diet and assigned a mentor to help them through pregnancy and the first two years of their baby's life. The mentor is there to educate on nutrition, sanitation, and other good health behaviors while also checking-up on the mother and making sure they are using their materials correctly and receiving the necessary vaccinations. Once the baby is born, they focus on promoting infant vaccination and exclusive breastfeeding for the first six months of life. I was informed that those who do not breastfeed exclusively do so because they do not think their babies are getting what they need, for example giving them water when it is especially hot out. After infancy, the program focuses on child stimulation. The goal is to act in a culturally sensitive way to suggest healthier maternal practices.

#### **5.4 Conclusion**

As can be seen, there are several socio-economic factors that influence the use and understanding of biomedical facilities. Many of these have to do with access and education. A rural setting in conjunction with poor infrastructure makes difficult to

physically access facilities. The majority of the Humjibre population work as farmers. This is a labor intensive profession that does not pay enough to allow for easy financial access to many specialized treatments. Doctor-patient interactions are also a major deterrent for many seeking healthcare. Though the implementation of the NHIS has increased the use of biomedical facilities, it has not resolved all the problems that prevent access to professional healthcare. Improvements in access, education, and economy are needed if further advances in health are going to be made.

This and the previous chapter have outline the healthcare options available in and around Humjibre, and the primary factors that influence health-seeking behaviors. Those factors include both sociocultural influences as well as political, economic, and historical influences. The concluding chapter will summarize the observed determinants of health and health-seeking behavior, and then suggest the implications of this research.

## Conclusion

We have now discussed the medical culture of Humjibre at the local level, and have examined the barriers and facilitators to health care access with regards to current socioeconomic and political conditions. I have found that my case is comparable (LeCompte and Schensul 2010) to many other medical ethnographies regarding health-seeking behaviors in rural areas, finding many of the same influential factors and resultant practices present. In terms of health-seeking behaviors, the people of Humjibre typically conform to the model of attempting self-treatment before consulting any outside professionals. When this step is skipped, it is because the case has been assessed as needing outside attention, as with Kofi's use of a private hospital or Abby's heart condition. As people leave the popular sector and enter the folk and professional sectors, they tend to choose facilities that are located nearby, as it can be difficult and expensive to secure transportation to other areas. The primary barriers to access, as I discover them, were distance to facilities, cost of services, capacity of the medical facilities, education levels, and doctor-patient interactions.

Before further examining the barriers to healthcare, the many determinants of disease should be discussed, as they do inform behaviors. Humjibre is located in a tropical climate, and the people are subjected to all of the ecological hardships endemic in those areas. They are also farmers. This is a labor-intensive profession that requires the



lifting and carrying of heavy materials and the wielding of large blades. Back problems are commonplace among the older community members, and scars are frequently seen on the legs of farmers where they have had mishaps with their blades. As farming is such an intensive exercise, it makes sense that strength is an important factor in health. In the same vein, the isolated nature of the village requires that community members get along and support one another for the good of the group. Thus strength and the ability to fulfil societal obligations are important to concepts of health and illness.

Another determinant is the political economy and the history attached to it. Historical processes placed most of the hospitals along the densely populated coast, leaving the rural populations stranded. The facilities that are located in the rural regions are not a top priority for policy makers. Financial support, the allocation of equipment, and the delivery of medical supplies is often hindered by bureaucracy and infrastructure. Rural hospitals are left to do the best they can with the supplies they have on hand. Financial concerns also prevent many individuals from utilizing formal healthcare facilities. The National Health Insurance Scheme has made some headway into lowering the cost of care, but it still does not provide full coverage for those in need.

This is often one reason why people prefer to use folk healers instead of professional medicine. Folk healers are more likely to barter with a patient to determine cost of treatment instead of demanding an outright fee. Folk healers are also often preferred because they offer an aspect of spiritual healing and social support that biomedicine lacks. The healing church is a perfect example of this. Those women form a group of like-minded individuals with which to stay and worship as they gained healing through ritual and prayer.

The government recognizes that this is happen, and has made efforts in recent years to incorporate folk healers and their medicines into the professional field. While some healers consent, many do not. A policy of cooperation instead of incorporation may work better, as healers would then be recognized and support on their own turf.

Beyond ecological, economic, and spiritual health determinants and actions, there is education and knowledge of health and health practices. The formal education system, much like the medical sector, is still in recovery from structural adjustment programs, but they are making headway. Attendance has increased, and more student are graduating senior high school and heading into college. Public health information is often disseminated in the school setting, but it does not always reach the adult population that is no longer in the system. This has created some tension between the older and younger generations, particularly in terms of birth control. Older populations are instead reached through public announcements at church and over the radio. There is still no guarantee that they hear or acknowledge this information, however.

The different level of education also lead to contention between doctor and patients. The view of health and illness held by one is not always compatible with the one held by the other. Doctor often do not spend much time in the rural areas or they have become dissociated from that reality through their schooling. Patients often feel belittled by the doctors who treat them ignorant. The quality of communication between these two groups needs to improve, and understanding needs to be advocated on both sides.

### *Implications*

As previously stated, the primary factors influencing health-seeking behaviors were money, physical access to facilities, capacity of those facilities, and personal

knowledge and education in regards to health. These factors are comparable to the results found in other studies. The implications here are that strides need to be made in increasing funding to hospitals and introducing an educational initiative to improve conversation between doctors and patients. Further and more extensive use of Kleinman's questionnaire to outline explanatory models may start that interaction by explaining to biomedical providers exactly where their patients are coming from and how their reality influences their understanding of health and ability to practice certain health seeking behaviors. Cooperation with folk healers is also a step in the right direction, as they can reach populations that the professional sector cannot.

#### *Closing Remarks*

In this study, it has been shown that an holistic view of all the processes and factors that exist within a medical culture in order to fully understand why people act the way that they do. In this study, it was seen that historical forces helped shape the medical culture by preferring one philosophy over another and by constructing biomedical facilities. Economic forces influence what resources people can access and what resources a clinic, pharmacy, or hospital may have in stock. Social and cultural forces pattern health beliefs and practices and influence the way that illness and treatments are understood and approached. It must be acknowledged that all of these factors exist in a state of constant flux and renegotiation due the larger global forces. All of this helps to demonstrate the importance of considering all angles of a medical culture so that barriers and facilitators to health-seeking behaviors can be identified and adjusted as necessary.

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## Appendices

### Appendix A: Kleinman's Questionnaire (1980) with Some Modification

Tell me about the last time you were ill:

1. What would you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What did your sickness do to you?
  - a. How does it work?
  - b. What would it do to you over time?
5. How severe was your problem? Did it have a short or long course?
6. What did you fear most about your sickness? Why?
7. What were the main problems your sickness caused for you?
  - a. Physically?
  - b. Mentally?
  - c. Emotionally?
  - d. Socially?
8. (For non-locals) Did the fact that you were in a rural area in a foreign country contribute at all to your illness experience? Why or why not?
9. What kind of treatment do you think you should receive/should have received, if any, for this problem?
  - a. Did you treat the problem yourself?

- b. Did you ask someone else for advice/treatment?
    - If someone else, who was that person(s)? (i.e. family member, clinician, midwife, etc.)
  - c. What are the most important results you hope to get from this treatment?
  - d. Has the treatment worked for you? Why or why not?
10. (For non-locals) Did you see a medical professional upon returning home?
- a. If yes, how did that experience compare to your experience in Ghana?
11. Is there anything else you wish to share with me?

## **Appendix B: Additional Questions Asked of American Volunteers**

### University Specific

1. What preventative measures does your University take to avoid illness in students traveling abroad?
2. What protocols are in place for students who do fall ill while abroad?
3. *Optional*: Were you taking any other medications immediately prior to or during this trip? If so, which ones?

### Personal Observations

1. Who of the volunteers got sick?
  - a. What were they sick with?
  - b. Why do you think they got sick when they did?
2. Who of the staff members got sick (local and foreign)?
  - a. What were they sick with?
  - b. Why do you think they got sick when they did?

3. What did you think of everyone's reactions to the volunteers getting sick? To staff members getting sick?
  - a. Do you think wanting to send the sick volunteers home was an overreaction?
4. Did anything stick out to you about the way any of the sick individuals reacted to their illnesses? Any physical or behavioral observations?
  - a. Any difference between staff and volunteer reactions?
5. Did you observe anything interesting about the way the sick individuals were treated by others?
  - a. Were there any differences between the ways the volunteers were treated versus the ways the staff members were treated?
  - b. Were there any differences in the way local vs foreign staff were treated?
6. What did you think of the medical treatment the sick individuals received, and their reactions to that treatment?
  - a. Do you think this treatment was appropriate and/or effective?
7. What did you think of the Ghanaian medical system as a whole? Any specific impressions from the clinic or hospital(s)?
8. Is there anything else that you would like to share with me that you think might be useful to the project?