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THE ROLE OF DIVINATION IN HEALTH SEEKING PRACTICES IN THE TALENSI-NABDAM DISTRICT OF NORTHERN GHANA

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DECLARATION

I hereby declare that except where specific references have been made, this thesis is the result of my own research conducted under the supervision of my supervisors. This work has not been submitted in part or whole to any institution for the award of a degree.

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ABSTRACT

In spite of the available modern technologies for dealing with ill-health, many people continue to resort to divination in the search for therapy. The persistence of the practice of divination in health seeking suggests that there is a considerable use derived from its practice. Against this background this study was conducted to assess the extent to which divination influences health-seeking behaviour as people utilise modern healthcare facilities in the Talensi-Nabdam district in Northern Ghana, findings of which could provide clues to some barriers to healthcare delivery and utilization in Ghana at large.

A mixed-method approach involving Focus Group Discussions with community elders, in-depth interviews with practicing diviners and experienced healthcare practitioners, and a community survey using a questionnaire was used. Analysis involved triangulation of both the qualitative and quantitative data. Qualitative data was analysed by importing verbatim transcripts of all interviews and discussions into Nvivo-7 software, while quantitative analyses involved logistic regression procedures, using Stata-10 software.

The use of divination in health seeking was found to be significantly correlated with age, sex, marital status, number of wives possessed by men, number of children, level of education and religious affiliation. Findings also suggest that on the pathway between symptoms recognition and therapy options divination is often employed to pin down supernatural and other causes of misfortunes and ill-health and to determine the appropriate patterns of resort. Patients with such diseases as burns, boils, anthrax, and snakebites tend to consult diviners first as they believe these conditions are of spiritual or supernatural origin. Diviners don't consider themselves as healers, but rather consider themselves merely as custodians of the spiritual conduits by which people can find out the causes of ill-health and other misfortunes from the spiritual and ancestral world in order to determine the course of action.

The findings have implications for healthcare service and utilization: delays in seeking and utilising modern healthcare services and the tendency for patients asking for "discharge against medical advice" to enable alternative treatment at home, as well as reasons for treatment failures at modern healthcare facilities.

It is proposed that a bio-psycho-social-spiritual model should be integrated into clinical care of patients at modern healthcare facilities especially in diagnostic interviews and treatment regimes of patients. Collaboration between the Ghana Health Service and diviners together with other magico-religious healthcare practitioners could facilitate incorporation of this model into medical and nursing training curricular.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS/ACRONYMS

5YPOW	Five-Year Programme of Work
APA	American Psychological Association
BPS	Bio-Psychosocial
CBSVs	Community-based Surveillance Volunteers
CHAG	Christian Health Association of Ghana
CHPS	Community-Based Health Planning and Services
DA	District Assembly
DAMA	Discharge Against Medical Advice
DCE	District Chief Executive
DDHS	District Director of Health Services
DHMT	District Health Management Team
EM	Explanatory Model
FDB	Food and Drugs Board
FGD	Focus Group Discussion
GCE	General Certificate of Education
GDP	Gross Domestic Product
GHc	Ghana Cedi
GHS	Ghana Health Service
GHS-ERC	Ghana Health Service Ethical Review Committee
GLSS	Ghana Living Standards Survey
HAs	Health Assistants
HATS	Health Assistants Training School
HBM	Health Belief Model
HCP	Health Care practitioner
HSB	Health seeking behaviour
IDI	In-depth Interview
IUD	Intra-Uterine Device

JSS	Junior Secondary School
LGA	Local Government Act
MA	Medical Assistant
MDC	Medical and Dental Council
MOH	Ministry of Health
NCC	National Commission on Culture
NEPAD	New Partnership for Africa's Development
NMC	Nurses and Midwives Council
NTP	National Tuberculosis Programme
OR	Odds Ratio
PHC	Population and Housing Census
PI	Principal Investigator
POP	Plaster of Paris
RA	Research Assistant
RDHS	Regional Director of Health Services
SN	Senior Nurse
SSS	Senior Secondary School
TB	Tuberculosis
TBA	Traditional Birth Attendant
TNDA	Talensi-Nabdam District Assembly
UER	Upper-East Region
WHO	World Health Organization

CHAPTER ONE

1.0 BACKGROUND TO THE STUDY

1.1 INTRODUCTION

The desire in human beings to stay alive and be physically and mentally fit enough to take part in everyday life activities suggests that health-seeking behaviour is a fundamental human activity. Good health is therefore intrinsically desirable and cherished by all and steps are always taken for its continued maintenance and sustenance. These steps towards optimum health however are often as many and varied as the social, cultural, economic, mental, spiritual, physical, and even political circumstances of the particular individual would dictate. Hence, in a milieu in which medical facilities cannot offer sufficient answers to health afflictions, coupled with pervasive reverence for ancestors, one would expect attempts by people to solicit divine interventions to satisfy their health needs.

This study examines the practice of divination (popularly referred to as soothsaying) as it is used as a means of understanding the causes, treatment, and prognosis of ill-health among a predominantly traditional religious society. It is conducted against the assumption that magico-religious practices such as divination play an important role in the quest for health and it is often employed to pin down supernatural and other causes of misfortunes (including ill-health) and to determine the appropriate patterns of resort.

The World Health Organization (WHO, 1946) offers a somewhat comprehensive definition of health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity". This means that the determinants of health encompass not only the anatomy and physiology of the body but also interpersonal and wider group interactions as well as emotions and temperaments that can impinge on wellbeing.

Comprehensive though this definition might be it is doubtful if it captures as well the spiritual aspect of man that borders on his religious beliefs. For example the Ghanaian worldview is that the individual is a tripartite being consisting of body, mind and spirit and that the wellbeing of man requires fostering harmony among body, mind and spirit (Appiah-Kubi, 1981). Ill-health is therefore regarded as the deviation of any of these from the desired optimum state. Does the WHO notion of 'complete health' as intended in the above definition include health emanating from people's beliefs in supernatural forces, including divination?

Helman (1984) has argued that the medical definition of ill health is largely based on objective demonstrable physical changes in the body's structure or function (anatomy and physiology) which can be quantified by reference to normal physiological measurements or standards. Diagnosis of the cause of any deviations from these standards is often conducted through laboratory analysis and/or the doctor's logical and rational analysis. This overemphasis on scientific rationality perhaps is the bane of the modern healthcare system as it turns to over concentrate on curative measures and fails to recognize that health delivery cannot be divorced from the socio-cultural milieu in which it is delivered. For example, traditional medical practitioners often determine the cause of disease or other problem through divination which is not meaningfully equivalent to laboratory diagnosis. Divination as a diagnostic procedure can explain the cause of ill-health and misfortune resulting from such phenomena as witchcraft, sorcery, curses, and evil eye (Twumasi, 2005). It is however doubtful if these can be explained by the modern healthcare system as causes of ill-health; yet these beliefs have profound effects on the health of people.

Mbiti (1969) observed that the African is notoriously religious and that religion permeates into all departments of life so fully that it is not easy or possible always to isolate it. Many

authorities in African traditional studies have re-echoed this fact. For example, Nukunya (2003) in defining religion as "beliefs and practices associated with the supernatural" has stressed that religion always played a key role in people's perceptions of any phenomenon including perceptions of disease and ill-health. He explained that perceptions of the cause of disease of the typical traditional Ghanaian stem mostly from his cosmology and worldview. Thus the traditional man believes in a pantheon of gods: God the *Supreme Being*, believed to be omnipotent, omniscient and omnipresent; the *Nature gods* (certain hills, rivers, totems, etc,) who can exert influence on human beings; the *Ancestors,* who can sanction the behaviour of the living; and the *Lesser gods* which are required for protection against evil.

A general observation of the health-seeking practices of the people of the Talensi-Nabdam area suggests that their worldview is largely fostered and dominated by beliefs in the existence of these supernatural forces. These beliefs are also important factors in illness causation and therefore can influence the people's health-seeking behaviour. Almost every misfortune or illness can be blamed on the influences of these supernatural powers. Most diseases are believed to be caused by the direct or indirect actions of these supernatural powers. Therefore supernatural means such as divination are often employed to first discover the cause of any ailment.

One would expect that this world view of supernatural causation of disease would be very much influenced by the cornucopia of Western religions and lifestyles which tend to largely frown upon those beliefs; but as noted by Nukunya (2003) in referring to the extent to which the introduction of Christianity influenced the lives of its converts in Ghana, noted that "their Christian beliefs were superficial and when they felt threatened by difficult situations had recourse to their old beliefs" (p.124). This is consistent with the observations of Mendonsa

(1975) while studying the role of divination in the management of misfortune and afflictions among the Sisala of Northern Ghana several decades ago. Mendonsa wrote:

> *"Divination is a powerful mechanism for the release of anxiety in Sisala society. In a society where illness is unchecked by modern medicine; where wells can go dry or water holes dry up; where crop success is at the mercy of the elements; divination provides the answers in a world of questions. Even Moslems, Christians and the educated elite find it difficult, indeed, to resist the 'concreteness' of divination when faced with affliction. More than once I have been sitting with a diviner and had an educated Christian enter the room to consult. In one case I had a conversation the previous week with this Christian about divination in which he passed it off as a mere superstition of 'uneducated pagans,' yet when faced with the severe illness of his wife, he resorted to the ways of his forefathers." (p. 10)*

People's health-seeking behaviour, to a large extent, depends upon their understanding and interpretation of the causes of their sickness. Where people accept the germ theory of disease causation, their attitude to the search for a cure to that disease will be different from the attitude of those who attribute the disease to a supernatural cause (Awusabo-Asare & Anarfi (1997). The germ theory is a fundamental tenet of medicine that states that microorganisms, which are too small to be seen without the aid of a microscope, can invade the body and cause certain diseases. But, as Ofosu-Amaah (2005) also suggests in commenting about the factors affecting the health of Ghanaians, personal hygiene is based on one's belief about the causes of infection, and what one is willing to do about the threats to disease" (p.175). Referring to the disregard of many Ghanaians for sanitary conditions in their living environments he noted that "the average Ghanaian has either no fear of germs or is unaware of the germ and dust theories of disease" and that for the Ghanaian "disease is mostly theurgical in causation".

In ethno-medical systems disease and misfortune are regarded as having socio-religious foundations. Consequently the treatment process must go beyond addressing the symtomatology of disease to discovering its deep-seated causes and subsequent ways of preventing it from recurring (Mbiti, 1969). African ethno-medical systems define disease and

illness within social contexts. Thus health, disease and illness are intricately interwoven with the social status of the group concerned. Understanding the social significance of disease and health is therefore the key to understanding how local people perceive, interpret and respond to ill-health (Twumasi, 2005).

If the creation and provision of good health is to be an essential component of our developmental process then the spiritual matters bordering health must be taken much more seriously. Understanding, appreciating and consequently integrating some of our indigenous medical practices into the modern healthcare system could go a long way to provide better healthcare for the people. But as Millar et al (2008) have admonished, we must first overcome some of the Western biases regarding health and begin to make our peoples' worldviews and livelihood strategies the starting point for our development.

This study therefore attempted to explore the practice of divination which is endemic among the predominantly traditional religious people of the Talensi-Nabdam traditional area of Northern Ghana as it relates to their health-seeking behaviour. The objective was to determine the extent to which divination, as a process of seeking divine interventions for health afflictions, affects their health seeking at modern healthcare facilities. The proof of efficacy or otherwise of this practice was not of primary concern in this work however, but in as far as the practice affects behaviour and practices that have consequences for the peoples' health, a scientific study of the phenomenon was imperative.

1.2 THE PROBLEM STATEMENT

There is a general belief among Ghanaians that supernatural forces of one kind or the other are behind both their successes and misfortunes, and that supernatural phenomenon can only be understood through supernatural means (Nukunya, 2003,). By inference, this probably explains why divination, as a form of diagnosing what the gods or ancestors expect from living humans (in the event of ill-health), is very popular in most parts of Ghana including the Talensi-Nabdam traditional area.

General observations suggest that divination is an integral part of the belief system among the people and in most cases it forms the first line of action in therapy seeking. This practice could be an important factor in the people's healthcare-seeking behaviour in terms of when and from whom to seek the appropriate attention for an illness. Most misfortunes especially diseases are believed to be caused by the direct or indirect actions of supernatural powers, and the diagnosis and course of action as well as the prognosis are most often first decided through divination to determine the mode of treatment. This situation has the potential of causing patients with acute and severe diseases that would require immediate allopathic medical attention to miss out in the course of divination consultations, and may not be given the most appropriate and timely treatment and attention required to avoid symptom worsening or complications. Therefore, on one hand, timely utilization of medical healthcare facilities appears to be affected since these consultations often determine choice of therapy. Countless lives have been maimed or lost due to delayed health-seeking or wrong choice of healthcare facility. Families may delay seeking treatment at a modern facility and continue visiting one diviner or shrine after another until the patient's condition deteriorates beyond remedy before he or she is rushed to the hospital.

On the other hand, divination could complement allopathic healthcare delivery by providing the needed spiritual and psychological diagnosis, therapy and prognosis. As Sackey (1999:26) observed: "as biomedical delivery services in Ghana become more technologically sophisticated, the cultural construction of medicine also become more prominent. Remarkably, some Western scientifically trained medical personnel either having exhausted all the scientific approaches or genuinely believing in the cultural competence of healing are referring patients to spiritual churches for treatment." This suggests that there is a corps of indigenous healthcare resources that can be utilised to augment the rather scarce modern healthcare resources, and it is in the light of this that Hevi (2005) has suggested that "in the face of increasing scarce medical resources the greatest challenge is to help people to exploit the positive elements of indigenous health resources."

Many studies have been conducted in Ghana and elsewhere which relate to the work of diviners and the practice of divination (Fortes & Goody, 1987; Mendonsa, 1974; Mendonsa, 1982; Cardinall, 1969; Nukunya, 2003; Abotchie, 1997; Oppong, 1973). However, most of these studies were purely anthropological and focused on the general functions of divination in society rather than how divination influences healthcare seeking behaviour. Survey of current literature suggests a considerable dearth of literature on how the practice of divination could influence healthcare seeking especially at the modern healthcare facilities. A recent study that involved diviners directly on issues specifically related to health seeking was that of Adongo, et al (1998) in which ancestors were interviewed through diviners to determine the ancestors' views about a family planning method that was about to be implemented in the area. However, it appears there is scarcity of literature on the role that diviners play in influencing the health seeking behaviour in relation to utilization of modern healthcare

facilities. This lack of literature on the role of divination in health seeking practices limits the exploration of its consequences and possible benefits in healthcare practice.

Although the strategic objectives of the 5YPOW I-III (Five Year Plan of Work – Phases I-III) and related conceptual framework guiding the operations of the Ghana Health sector development recognized the need for inter-sectoral action, actual implementation of this plan rather focused mainly on delivery of health care services. In the area of medical care, the focus has been on allopathic curative services, and to a more limited extent on the development of traditional medicine. Very little attention has been given to alternative medicines, even though Ghanaians continue to use those services. The current National Health policy therefore adopts an approach that addresses the broader determinants of health. The policy seeks to build a pluralistic health service that recognizes allopathic, traditional and alternative providers in order to provide health care services comprising preventive, curative and rehabilitative services. In spite of this, not much research has been attempted in Ghana to explore especially some of the spiritual determinants of health, probably because of the general belief that it is often difficult if not impossible to scientifically appreciate the efficacy of spiritual services in health delivery.

This study seeks to pursue the current shift in health policy by exploring the phenomenon of divination as used in health seeking. There is the need to explore the extent to which divinatory practices affect health-seeking behaviour in terms of utilization of allopathic healthcare facilities and in terms of its own effectiveness in providing therapy satisfaction. There is therefore the need to explore the practice of divination not necessarily to prove its efficacy or otherwise but to determine the extent to which the practice affects people's behaviour as they try to seek for explanations for the causes and consequences of their ill-health.

1.3 OBJECTIVES OF THE STUDY

1.3.1 Broad/general objective

The broad objective of this study was to assess the influence of divination on health-seeking behaviour in the Talensi-Nabdam traditional area.

1.3.2 Specific objectives:

The specific objectives of the study were therefore:

i. To determine the general patronage of divination as a health-seeking practice.
ii. To examine the role of divination from the perspectives of the community, health workers and the diviners.
iii. To explore the reasons why one would consult a diviner in conjunction with seeking medical attention.
iv. To identify the illnesses that would mostly require consultations with diviners

1.4 RESEARCH QUESTIONS

Health seeking behaviour is influenced by a matrix of factors which could be social, economic, religious or cultural. The quest for health in Ghana within the context of the pluralistic health care system in which there is the interplay of traditional modes of healthcare and Western medical practice has resulted in a situation described by Hevi (1989:5) as 'conflict and complementarity': whereas traditional medical practice treats the patient in the context of his or her social relations including the spiritual and religious dimensions, Western medicine tends to view the patient as an individual, often ignoring the religious and spiritual dimensions. In spite of this both systems are known to offer specific benefits to their respective clientele.

In the light of these the objectives of the study seek to answer the following questions:

i. To what extent is the use of divination for health prevalent, and what are the relationships of the socio-demographic characteristics of community members and the use of divination for health?

ii. How do modern healthcare practitioners perceive the role of diviners in health delivery?

iii. Why would one resort to divination in spite of the available modern healthcare facilities? And why do people still consult diviners even after attending modern health facilities?

iv. What specific types of illnesses would warrant consultations with diviners?

1.5 THEORETICAL, CONCEPTUAL, AND PHILOSOPHICAL UNDERPINNINGS

1.5.1 Introduction

Fortes (1945) noted that the anthropologist's task in studying a people is not merely a question of putting his observations on record but 'it involves breaking up the vivid, kaleidoscopic reality of human action, thought, and memory, in terms of the general principles or organization and motivation that regulate behaviour in it. It is a task that cannot be done without the help of theory'. (p. vii). A study of this nature should therefore have some theoretical, philosophical and conceptual foundations on which it is based, and therefore it is in the light of this that the following discussion is done. In this section I present a review of the determinants of health-seeking behaviour, approaches to the study of care-seeking behaviour, some models of health-seeking behaviour, and finally a discussion of the model chosen as the conceptual framework for the study.

1.5.2 Determinants of health-seeking behaviour

In this study health seeking is regarded as a dynamic process in which the factors involved are organised sequentially to incorporate the different key steps in health seeking which constitute the course of the path to therapy – recognition of symptoms, decision-making, medical encounter, evaluation of outcomes, and re-interpretation of illness. Health seeking behaviour is based on an explanatory model that incorporates specific cultural features that influence health-seeking behaviour of people. According to Foster & Anderson (1980) the explanatory model of a particular illness consists of signs and symptoms by which the illness is recognised; presumed cause of the illness, and the prognosis established. This is followed by interpretation of the problem by the individual and or significant others, and on labelling the problem proceed to address it through recommended therapies.

According to Olenja (2003) the nature of health seeking is complex and not homogenous and depends on cognitive and non-cognitive factors that place health seeking in specific context. Therefore no one single method may be used to explain or establish any pattern, for it is largely a reflection of the prevailing conditions. Thus health seeking is preceded by a decision making process that is further governed by individual and/or household behaviour, community norms and expectations as well as provider related characteristics and behaviour.

Olenja (2003) also noted the assertion by Foster & Anderson (1980) that underutilization of modern health services rarely depended on local beliefs or an aversion of Western medicine but rather depends on cost and availability factors. While agreeing with Foster and Anderson he also drew attention to the client's perspectives on the quality of care during the client-provider encounter which has become apparent. Client satisfaction is crucial in determining whether a person seeking care will comply with treatment or will call on the provider the next time around. Ringheim (2002) has described client satisfaction as the subjective assessment of the quality of the services received by the client, which is based on the verbal and non-verbal interaction during the therapeutic encounter. The interplay of the various factors discussed above is crucial to the final choice of a care seeking option.

1.5.3 Patterns of resort to therapy

De Zoysa et al, (1998), in their focused ethnographic study of illness in young infants and associated care seeking practices in an urban slum in India have described patterns of care-seeking of mothers. Not only were the mothers not oblivious of signs and symptoms of illness in their young infants, but were also proactive in finding ways for proper therapy for them. Patterns of resort were often sequential, beginning in the home, and if the disease continues

to clinic, and in the case of a prolonged unusual illness such as one that involves 'persistent strident crying' or convulsions they resorted to folk healers. The folk healers performed a diagnostic role by performing certain rituals to ascertain whether a spiritual cause could be identified. The mothers were sure that the intervention of these folk healers should bring relieve in the infants' condition, especially those they thought to be associated with bad luck or spirits. According to De Zoysa et al, in general, the choice of healthcare provider was initially determined by three factors: convenience, courtesy and cost. Although the mothers could not distinguish between qualified and non-qualified healthcare practitioners they tended to consult those they thought could help to make a good diagnosis and those who could provide medications; after all a good doctor to them was one who could give medications to effect quick recovery of their sick infants. Some were prepared however to consult private practitioners where they had to pay a little more, provided they believed such practitioners had the necessary experience in treating sick children.

This pattern of care-seeking was largely corroborated by Hill et al (2003) who explored the relative importance of illness recognition as a barrier to care-seeking and the feasibility and potential impact of improving recognition. They confirmed their RAA data that suggested that care-seeking was typically sequential. They combined qualitative, quantitative and RAA methods to explore the local illness classification system, narratives of recent episodes of child illness and tested the hypotheses that emerged. Their key findings included problems of recognition of illness, care-seeking barriers such as classifying certain diseases as 'not-for-hospital' and 'untreatable' by modern medicine, problems of access and frequent use of traditional medicines. They concluded that the recognition of problems evolved around local illness classification systems and recommended that any care-seeking barriers intervention

should identify and assess the type of illness recognition problems in the community for incorporation.

1.5.4 Approaches in health-seeking research

According to Good (1994) illness behaviour describes 'the nature in which persons monitor their bodies, define and interpret their symptoms, take remedial action, and utilise the healthcare system' (p. 32). This influences health practices or health-seeking behaviour, which are aspects of illness behaviour, and therefore understanding human behaviour is prerequisite to change behaviour and improve health practices. In order to respond to community perspectives and needs regarding health, healthcare systems must adapt strategies taking into account findings from behavioural studies. Therefore the approaches to health care studies derive their theoretical underpinnings from behavioural sciences such as cultural epidemiology, anthropology, social psychology, medical geography and social economy (Hausmann-Muela et al, 2003). Some of the approaches to health-seeking behaviour studies include the following:

1.5.4.1 KAP surveys

These approaches according to Hausmann-Muela et al, (2003) assess the Knowledge, Attitudes, and Practices of people regarding their illnesses, and are probably the most frequently used studies in health-seeking behaviour, and typically solicit knowledge about causes and symptoms of the illness or phenomenon under study. However in such studies people's reported knowledge is often termed 'beliefs' and the distinction between 'knowledge' and 'beliefs' which markedly deviates from the use of the terms in psycho-

social theory where 'beliefs' have a much broader meaning that includes beliefs concerning perceptions about oneself (Hausmann-Muela, et al (2003).

According to Ribeaux and Poppleton (1978) attitude is "a learned predisposition to think, feel and act in a particular way towards a given object or class of objects". Attitudes therefore result from a complex interaction of beliefs, feelings and values (Hausmann-Muela et al, 2003). Data on attitudes are important in studies that aim at designing health promotion campaigns aimed at attitudinal change. Much as attitudes are central to understanding behaviour they are quite problematic to obtain as not only can they be obtained from direct questioning but also may have to be inferred from a variety of statements and answers of respondents.

Soliciting practices usually require questions about the use of a certain measure such as preventive or the choice from different healthcare options. According to Hausmann-Muela et al (2003) special caution must be made when making deductions to explain health seeking behaviour because questions normally asked on attitude are often hypothetical thereby yielding information on people's normative behaviours, and not on their actual practices. They are therefore limited in their use to explain actual health-seeking behaviour.

1.5.4.2 Focused ethnographic studies (FES) and rapid assessments

In a collaborative work of applied anthropologists and public health practitioners, focused ethnographic studies and rapid assessment tools were developed using a combination of anthropological theory and techniques of rapid, focused data collection aimed at producing more comprehensive recommendations for implementation. A typical rapid assessment

manual developed from FES, aimed at identifying local illness concepts is the rapid assessment manual for malaria (Agyepong, et al, 1995). FES and rapid assessment studies are strongly influenced by Kleinman's (1986) concept of explanatory models that explain the aetiology, onset of symptoms, pathophysiology, course of illness and treatment. The strength of FES and rapid assessment studies lie in the identification of illness categories and complex local illness classifications whose findings and recommendations have been used in designing locally tailored IEC messages which took into consideration local illness terms, (e.g. Nichter, 1993; Hill et al, 2003).

1.5.4.3 Studies on the logic of interacting concepts

Categorising illness has one major limitation as it assumes an 'either' 'or' situation, as in the case of an illness being associated with natural or supernatural agents, which determines different therapy options (Hausman-Muela, et al, 2003). Studies that focus on logics take into detail account the complex interactions of different knowledge sources in shaping local illness understanding. For example, Lewis (1975) found out that a single cause could lead to different symptomatologies and a same symptomatology could be provoked by different causes and could render classification of illness for understanding behaviour useless. Also, Janzen (1978) showed how in peoples' illness narratives, viruses and bacteria interact with witchcraft, and Hausmann-Muela et al, (1998) described how malaria and witchcraft can be interrelated in illness interpretations. Therefore the logic of interacting concepts gives much more meaning to explanation of treatment seeking behaviour.

1.5.5 Some health seeking behavior models

1.5.5.1 Definitional and conceptual aspects of health seeking behaviour

Health seeking behaviour (HSB) has been variously defined and from different perspectives. Mosby's Medical Dictionary, 8th edition, 2009, defined HSB as personal actions to promote optimal wellness, recovery and rehabilitation. According to Weinert & Burman (1994) HSB can be considered as the range of activities that individuals undertake to promote and/or restore health. However, such definitions fall short of insights into what constitutes 'personal actions' and 'range of activities' of activities undertaken in relation to seeking health. In surveying the literature on health seeking behaviour I found two main expositions on HSB that illustrate these quite satisfactorily. These are Olenja's (2003) editorial comment in a journal and MacKian (2003) review of literature on HSB.

In citing Ward, et al, (1997) Olenja (2003) considered health or care seeking behaviour as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. This definition is based on an explanatory model that a particular illness consists of signs and symptoms by which the illness is recognized; presumed cause of the illness and prognosis established. These are in turn interpreted by individuals and or significant others and on labelling the problem, proceed to address it appropriately through recommended therapies. This suggests that health seeking goes through a certain pathway: the patient perceives his ill-health in terms of the initial manifestations i.e. the presentation of signs and symptoms of the ill-health. On recognising the signs and symptoms the patient then begins to conjecture what the cause(s) of this could be, as well as contemplating what effect the illness could have on his body and its consequences. The patient then would make known his condition to others who may include immediate family members and close friends. The involvement of these significant others

will result in definite decision of what the illness really is and hence decisions of what therapy options to adopt.

Since health seeking behaviour is preceded by a decision making process that is further governed by individual and/or household behaviour, community norms and expectations as well as provider related characteristics, Olenja suggested that the nature of care seeking is not homogenous. This is because quite apart from the explanatory models that the patient and his significant others might hold, there are also 'non cognitive factors' such as availability and cost of health services that also factor into the decision making process (Woods & Graves (1973); Young (1981). For example, Ryan (1998) has found out that the determinant models of health seeking behaviour include demographic aspects such as the level of education, occupation and income of the head of household, are crucial particularly in developing countries, thus confirming that cost and physical accessibility of services play a role in influencing the observed health seeking behaviour.

Olenja (2003) also noted other equally important factors that might influence health seeking behaviour. For example the nature of the client-provider encounter has been noted to play a major role in health seeking behaviour, with specific reference to quality of care experienced within this encounter and that can be measured by client satisfaction of those services. He defined client satisfaction as 'the subjective assessment of quality of care received by the client', (p. 61), the measurement of which is based on the verbal and the non verbal interaction that occurs between the health provider and the individuals seeking the services.

In conclusion Olenja noted that health seeking behaviour is so complex a phenomenon that no one single method can adequately be used to explain or establish any pattern, for 'it is a

reflection of the prevailing conditions, which interact synergiscally to produce a pattern of care seeking but which remains fluid and therefore amenable to change'(p. 61).

MacKian (2003) has also provided some useful insights into further understandings of health seeking behaviour. MacKian views HSB from two approaches: (1) from the 'end point' (utilization of the formal system or health care seeking behaviour) perspective, and (2) from the 'process' (illness response or health seeking behaviour) perspective. In looking at HSB from the perspective of the 'end point' or the utilization of the formal system of health care the emphasis is often on the types of barriers or determinants that might stand between patients and services and therefore the types of processes or pathways to therapy. This view is often on the assumption that the individual would first and foremost seek help from a trained modern health practitioner such as a doctor when confronted with an illness episode. According to MacKian (2003) several studies have demonstrated that the decision to engage with a particular medical channel is influenced by a variety of factors that can be categorised into geographical, social, economic, cultural and organisational factors. These factors can further be broken down into the types of therapy measures often used as informal, infrastructure and formal.

Based on the assumption that HSB eventually ends at the adoption of 'modern care' MacKian also identified some studies that attempt to categorise the types of processes or pathways that a patient may follow to final therapy. For example, she cited the Bedri (2001) study in which a pathway to care model was developed to explain HSB of women with vaginal discharge in Sudan. However, MacKian drew attention to several studies including Ahmed et al, (2001) that showed that for some illnesses people will choose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or

government health facilities. She also cited Rahman (2000) as a study that found that gender differences are also reflected in the choice of therapy. For example Rahman's (2000) found out that 86% of women in Bangladesh received healthcare from non-qualified health care providers.

By the above analysis MacKian, drawing on Ahmed et al (2000), conceptualised health care seeking behaviour as a 'sequence of remedial actions' taken to rectify 'perceived ill-health'. The other dimension of looking at HSB is from the perspective of 'process' or illness response or health seeking behaviour. Here HSB is looked at from a more general perspective by highlighting the factors which enable or prevent people from making 'healthy choices' in their lifestyles or their utilization of medical care. Here the assumption is that behaviour is best understood in terms of an individuals' perception of their social environment. What is perceived to be ill-health is influenced by much wider social cognition models. She argued however that these models are based on the assumption that health is influenced by behaviour and that behaviour is influenced by knowledge. But several studies, including those of MacPhail & Campbell (2001), have noted a rather poor relationship between knowledge and health seeking behaviour particularly in developing countries. This means knowledge or information does not necessarily lead to healthier decisions regarding health seeking. In order to understand how people make decisions around health seeking there is need to understand not only the nature and interpretation of information available to them but also 'the underlying, unspoken, unconscious feelings and assumptions which support that cognitive process and the journey taken during it' (p.9). MacKian emphasized that in making decisions about their health people would normally not only weigh up the potential risks or benefits of a particular behaviour, but would also do that in a way that is mediated by their immediate practical environment, their social rootedness and their whole outlook on life more generally.

Thus health seeking behaviours are not only influenced by rational cognitive processes but also by affective-emotional processes.

1.5.5.2 The Five "A"s Access model

While considering the HBM which focuses on the cognitive and behavioural determinants of health seeking, it is also important to examine another model that focuses on access factors, for several studies have shown that access to health care services affect utilization. Researchers have often grouped access factors into four categories popularly known as the 'model' of the Four 'A's. These four factors include availability, accessibility, affordability and acceptability. This model has been widely used by medical geographers, anthropologists and epidemiologists who mainly emphasise distance (both social and geographical) and economic aspects as key factors for access to treatment (Good, 1987). Although this model provides for easy identification of key potential barriers to adequate treatment it has often not considered the livelihood context of the health seeker, especially from resource-poor settings. Obrist et al, (2007) have attempted to fill in this gap.

Obrist et al (2007) have developed an innovative community-based approach for a better understanding of the issues of access in resource-deprived settings that perhaps fits very much with most local communities in Ghana and in Africa at large. In their framework for appreciating access issues they added a fifth "A" (adequacy) to the earlier proposed dimensions of access. The Five 'A's factors are defined in *Table 1*.

***Table 1.*Definitions and examples of the Five "A"s**

Dimension of access	Definition	Examples
Availability	Degree of fit between existing health services and clients' needs	Therapies and necessary medical equipment for diagnoses; health personnel able to diagnose and treat diseases
Accessibility	Extent to which the geographical location of health service coincides with the location of clients	Acceptable distances and transport to health services; health personnel offer services such as vaccination locally
Affordability	Degree of fit between service prices and clients' ability to pay	Clients can pay fees of health services without selling critical assets, e.g. through health insurance coverage
Acceptability	Degree of fit between characteristics of the provider and those of clients	The provider is able to communicate with the client during medical consultations; clients are satisfied with the outcome and quality of care
Adequacy	Extent to which the organisation of services meet clients' expectations	Opening hours of services match daily schedules of clients (e.g. small-scale farmers) and are acceptable to health personnel (e.g. day/night shifts are established.

Source: *Express 3/08. Access to healthcare – what matters?* P.4. www.novartisfoundation.org

In Obrist's framework it is proposed that the extent to which the five dimensions of access will determine utilization of health facilities depends on the interplay between two critical factors: (1) the health care services and the broader policies, institutions, organisations and processes that govern the services, and (2) the 'livelihood assets' people can mobilise in particular 'vulnerability contexts'. By livelihood assets he meant human capital – local knowledge, education, skills; social capital – social networks and affiliations; natural capital – land, water, livestock; physical capital – infrastructure, equipment, means of transport; and financial capital – cash and credit. He also defined vulnerability context as forces over which people have little or no control, e.g. economy, politics, climate variability and natural disasters. This interplay has to be combined with quality of care (provider competence and diagnostic accuracy, safety of products and patient compliance) to improve utilization. Thus the framework (the Health Access Livelihood Framework) is conceptualised as in the figure 1.

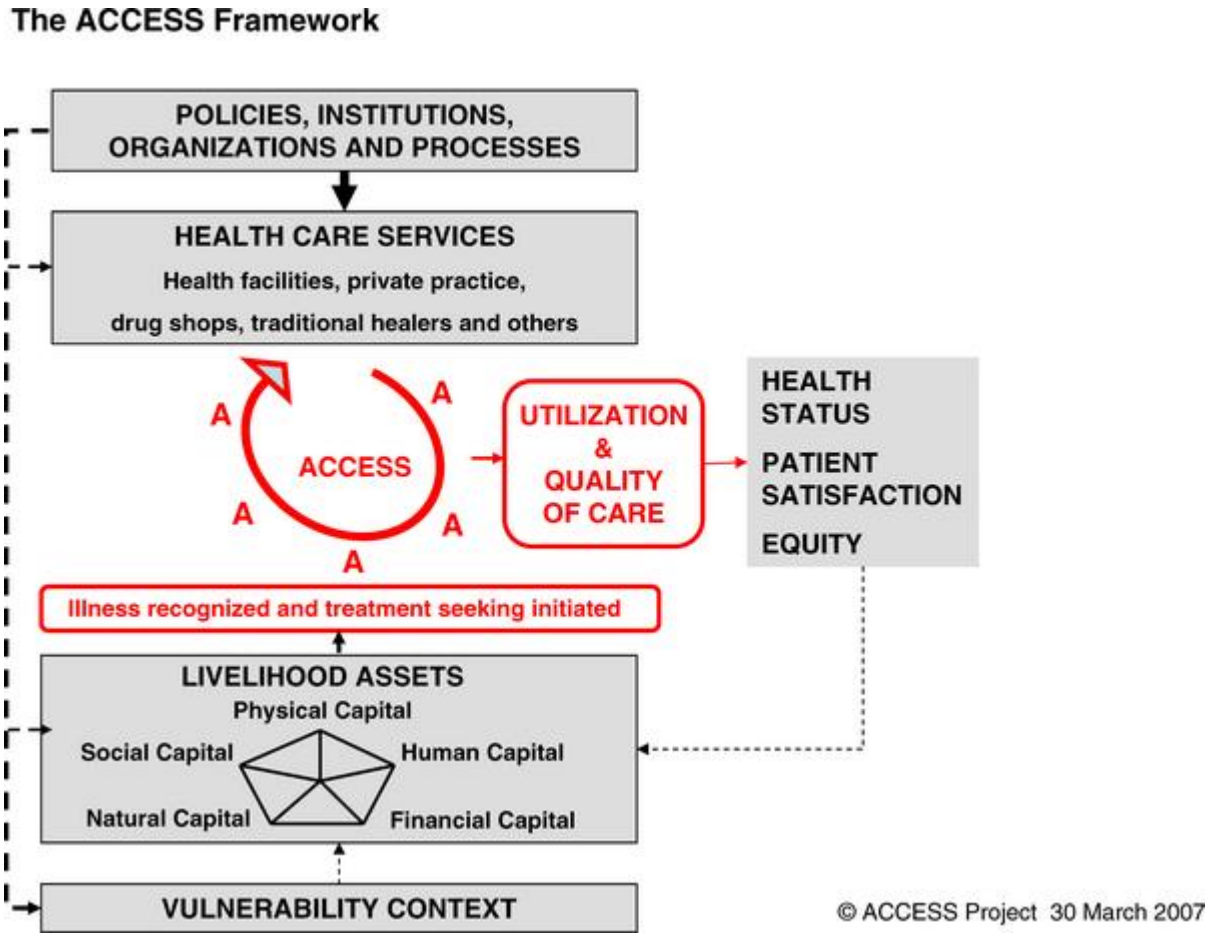


Figure 1: The Health Access Livelihood Framework. Source: Obrist, et al (2007)

The Health Access Livelihood Framework looks at access to health care from three perspectives: (1) health-seeking (2) health service utilization, and (3) livelihood perspectives. From the health-seeking perspectives people are interested in understanding (from the demand side) why, when, and how individuals, social groups, and communities seek access to health care services and the nature of the layperson-professional interactions. The health service utilization approaches concentrate rather more on the supply side i.e. policy interventions such as availability of health facilities, equipment, qualified staff, and staff skills, protocols for diagnoses and treatment, and quality of care. From the livelihood perspective emphasis is on assets (human, natural, social) and activities that will enable sustainable living conditions under hard economic circumstances.

The Health Access Livelihood Framework therefore combines health service and health-seeking approaches and situates the Five "A"s access factors in the context of livelihood insecurity.

Other health-seeking behaviour models include the healthcare utilization, otherwise known as the socio-behavioural or the Andersen (Andersen & Newman, 1973), and its modified form, the Kroeger's model, 1983.

1.5.5.3 The Kroeger model

Reichel & Ramey, (1987) have defined a conceptual framework as a set of broad principles taken from relevant fields of enquiry and used to structure a subsequent presentation. According to them a conceptual framework can be used as a starting point for reflection about the context of the research by assisting the researcher to 'scaffold' the research in such a manner so as to assist the researcher to develop a deeper insight and understanding about the subject under study and to assist to make meaning of subsequent findings.

Based on this understanding of a conceptual framework and upon survey and analysis of the models used for health-seeking behaviour studies, the Kroeger's (1983) model (illustrated in *Figure 2*) was adopted as the conceptual framework for this study. The Kroeger's model which is a modification of Andersen's model was used in the International Collaborative Study on healthcare (Kroeger, 1983). Based on extensive and well-elaborated literature reviews Kroeger proposed the framework to comprise three main interacting factors namely: predisposing factors, enabling factors and health service system factors. The predisposing factors include an individual's traits such as age, sex, marital status, status in the household, household size, ethnic group, degree of cultural adaption, formal education, occupation, asserts (land, livestock, cash, income), and social network interactions.

The enabling factors include characteristics of the illness and its perception: acute or chronic, mild or severe, aetiological model, expected benefits or treatment (modern versus traditional) psychosomatic versus somatic diseases. Health service system factors are characteristics of the services such as accessibility, appeal (opinions and attitudes towards traditional and modern healers) acceptability, quality, communication, and cost.

The Kroeger model has been used in several health-seeking behaviour studies, particularly in developing countries. Using this framework, and in reviewing literature on approaches used in the study of health-seeking behaviours and determinants of health service utilization Shaikh et al, (2008) commended the Kroeger model as the most holistic framework for examining , analysing and interpreting factors and determinants of healthcare seeking behaviours and health service utilization in developing countries. According to Shaikh et al (2003) using this approach helps in understanding the interrelationships of various factors and drivers of health-seeking behaviour from all angles. This approach therefore calls for mixed methodologies.

This study endeavours to explore the resort to divination along the path to choosing a definite therapy option. It is therefore important to understand at what point(s) – before, during or after deciding to use modern healthcare facilities, and the social, religious, cultural, economic, demographic factors that influence the practice. These considerations therefore informed the choice of methodologies employed in this study.

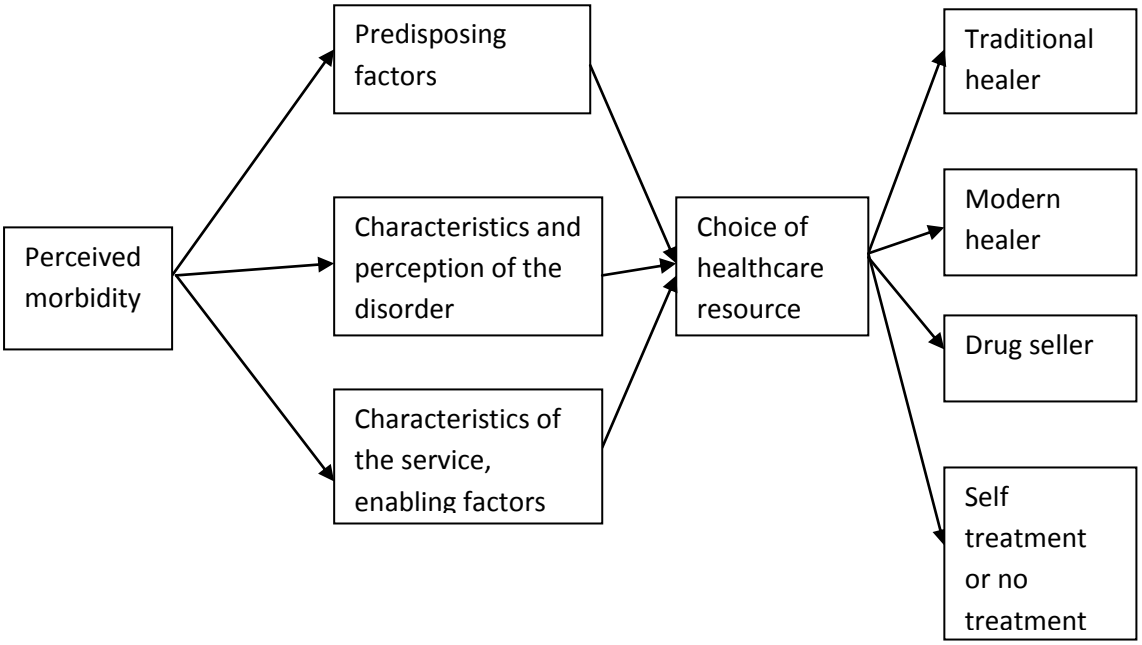


Figure 2. Kroeger's Model, 1983.

1.5.6 Conclusion

It can be seen from the above discussion on some of the approaches to health-seeking research that undertaking a study involving health seeking behaviour like the current study undoubtedly must take into consideration the various complex issues in human behaviour in general and care-seeking behaviour in particular. Thus the approach must incorporate a blend of the approaches. To do this perfectly so as to capture the nitty-gritty's of aspects of human behaviour is obviously practically not feasible, especially within the constraints of time and other logistics for a study like this. Nonetheless the choice, in this study, of both qualitative and quantitative involving a survey, focus group discussions, in-depth interviews, ethnographic methods, and observation methods was meant to access data as comprehensively as possible.

1.6 RELEVANCE OF THE STUDY

The mission of the Ghana Ministry of Health as stated in its Health Policy document is to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, reproduction and nutrition services for all people living in Ghana and promoting the development of a local health industry (MOH, 2007). This mission puts the concept of health beyond the confines of curative care and stresses the socio-economic determinants of health. The Ghana National Health Policy therefore views health in its broadest sense as a multi-sectoral programme focusing on the physical, social, economic and spiritual dimensions which can bring total health to individuals, their families and communities. The New Partnership for Africa's Development (NEPAD) Health Strategy document is also in tandem with the policy. For example, the NEPAD Health Strategy: 2007-2015 noted among others that a key health system factor that still undermines efforts to reduce the disease burden is 'marginalisation of African Traditional Medicine in national health systems' (p.3). NEPAD has therefore added its call to African governments to carve out pragmatic ways of incorporating African traditional ways of dealing with health into the orthodox healthcare systems. To be able to do this however requires that healthcare practitioners understand and appreciate the *modus operandi* of these African ways of dealing with health and disease.

For example, in recent times the Ministry of Health and the Ghana Health Service have been trying to integrate orthodox and traditional medical practices with the view of obtaining maximum benefits. But this has remained a pariah because of lack of in-depth understanding of traditional medical practice and the often associated magico-religious connotations with it. Warren et al (1982) and Helman (1984) attribute modern and traditional systems with a common goal of protection and preservation of health, but observe that the predominant

attitude between them has been mutual disregard, distrust and suspicion. Indeed, Helman (1984) has also noted that in the Western world, modern medicine views folk healers as quacks, charlatans or medicine men who pose a danger to their patients' health. This 'mutual disregard' between modern medical practitioners and indigenous healthcare practitioners, in my view, is unfortunate and totally unnecessary as cooperation and collaboration should rather prevail between them to tackle the myriad of health problems confronting the people.

It is probably in the context of this conflict situation, and against the backdrop of inadequate modern healthcare facilities that Hevi (1989) intimated that this challenge offers an opportunity to exploit the positive elements of indigenous health resources and therefore carve out ways in which the indigenous and Western medical systems can complement one another. Some advantages of traditional folk medicine have been recognised by the WHO and in 1978 they recommended that traditional healing be integrated into modern medicine, stressing the necessity "to ensure respect, recognition and collaboration among the practitioners of the various systems concerned".

It is hoped that the study will provide some empirical evidence of the strength or otherwise of socio-cultural factors such as the practice of divination as it relates to people's perceptions of health and ill health, and the therapy choices they make to remedy their health related predicaments. This will help in understanding issues of cooperation, collaboration and integration of biomedical and traditional methods of treatment. Indeed, the Adongo et al (1998) study on divination outcomes on whether to implement the Family Planning Programme in the Kassena-Nankana area in Ghana was insightful in the implementation of the programme in that area. Similarly Awalu (2009) examined the supernatural beliefs and practices affecting care of the sick among the Dagomba of Northern Ghana who believe in the influence of supernatural forces and witchcraft on health and disease. In an ethnographic study using in-depth interviews of diviners and indigenous healers he found out that belief in

the supernatural is pervasive in the worldview of the Dagomba. The social institutions including ritual performances and indigenous healing techniques are underpinned by the belief in the supernatural, and divination is often employed to diagnose illnesses and subsequently prescribe ritual performances in the treatment regimen. He called for more research in the area since belief in the supernatural has so much influence on the healthcare seeking behaviour of the people.

Therefore medical education will benefit very much from an in-depth understanding of the clientele's whole perception of the causes, diagnosis, course and treatment of disease. This study will advance knowledge in the role of Social Science discipline in medical/nursing training and practice and will help to strengthen the social science curricula of the Medical/Nursing training institutions in the country and other healthcare training institutions in the world at large.

This study will also enhance health educational and health promotional programmes. With better understanding of the socio-cultural milieu that shape people's reaction to disease and health, health educators and promoters will be more able to design socially and culturally more appropriate methods. It will help medical personnel to strive to decrease patient dissatisfaction and non-compliance, as these most often stem from the patient's entirely different concepts about the purpose and efficacy of the treatment regime.

With about 70% of the people in the rural areas depending mainly on traditional modes of dealing with ill-health (Tabi, et al, 2006) the Ministry of Health and the medical academia should be encouraging greater research into the socio-cultural determinants of health because healthcare practitioners must appreciate local cultures. According to Kirby (1993), delivering

better health care in Africa must go beyond merely offering good medical services, which concentrates more on the biological and material causes of ill health. According to him, it is equally important to take into consideration peoples' perceptions regarding the non-material causes of illness which emanates from people's religious orientations and beliefs, and which often require divination to unravel the exact problem and its remedy.

1.7 OVERVIEW OF THE HEALTH DELIVERY SYSTEM IN GHANA

1.7.1 Ghana's Health Policy framework for health development

In spite of the myriad of health problems we have in Ghana the programmes and projects of the Ministry of Health (MOH) have mainly focused on curative care leading to failures of the Ministry to make significant impact in the development of promotive and preventive health for the benefit of the entire population (Ghana Health Policy). In the light of this the new Ghana Health Policy proposes a paradigm shift from curative action to health promotion and the prevention of ill-health. The policy argues that a healthy population can only be achieved if a number of measures are taken including improvements in personal and environmental hygiene and sanitation as well as proper housing and town planning. These should be accompanied by the provision of safe water, food and nutrition. Furthermore there should be programmes to immunise mothers and children and to prevent injuries in work places and road traffic accidents, as well as practicing of safe sex to prevent sexually transmitted diseases.

The policy seeks to build a pluralistic health service that recognizes allopathic, traditional and alternative providers, both private and public. The policy therefore views health delivery in its broadest sense as a multi-sectoral programme focusing on the physical, social, economic and spiritual dimensions which can bring total health to individuals, families and communities.

The vision of Ghana's Health policy is set within the national developmental agenda of transforming the country into a middle income country with GDP of at least 1000 USD by 2015. Improving human capital, strengthening the role of the private sector in the development of the economy and the provision of good governance are the key strategies for

achieving this. Health is central in the strategic direction of improving human capital, for, only a healthy population can bring about improved productivity leading to a sound economic growth.

The health policy framework also derives from the WHO definition of health as a 'state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity'. This is consistent with the Ghanaian world view that the individual is a tripartite being, consisting of body, mind and spirit and that the wellbeing of man requires fostering harmony among body, mind and spirit. The policy recognizes that good health is intrinsically desirable and is a necessary ingredient for socio-economic development.

1.7.2 The Ministry of Health (MOH)

The Ministry of health and its agencies are together responsible for the formulation of health service policies, provision of health services and the regulation of activities in the health sector. The Ministry of Health seeks to improve the health status of all people living in Ghana, through the development and promotion of proactive policies, provision of universal access to basic health service, and the provision of quality and affordable health services. This will be delivered in a humane, efficient and effective manner by well-trained, friendly, highly motivated, and client-oriented personnel with involvement of all stakeholders.

The Ministry of Health has specific mandate to assess and monitor the country's health status, advise central government on health policies and legislation, formulate strategies and design programmes to address health problems of the country, and implement, monitor and evaluate (in collaboration with other related sectors and agencies) all health programmes and activities in the country. As a policy, the MOH is to maximise the potential health life years of all

individuals resident in Ghana by reducing the incidence of illness, injury and disability, and the prevention of premature death.

1.7.3 The Ghana Health Service

The Ghana Health Service (GHS) as established under Act 525 is an agency of the Ministry of Health, is responsible for the delivery of primary and secondary health care services at the community, sub-district, district and regional levels. These services are provided through government-owned health institutions such as maternal and child health centres, clinics, health centres/posts, polyclinics and hospitals. Specialized hospitals such as the psychiatric hospitals and the leprosaria are also included in the service outlets of the Ghana Health Service.

As part of the effort to improve access to health services, the Community-Based Health Planning and Services (CHPS) has been designated as another level of health care delivery which combines public health and basic clinical care activities. It is the operational outcome of the GHS's "close-to-client" and "reaching the unreachable" concept of primary healthcare delivery where a Community Health Officer (CHO) is placed within a community to deliver basic healthcare services. The system is a community-based and community-involved care system that enables the District Health Management Team (DHMT) to adapt and develop approaches and strategies to community healthcare that are consistent with local traditions and sustainable within the prevailing needs.

The Teaching Hospitals provide tertiary and specialist services and act as the main ultimate referral centres in the country. Apart from their teaching responsibilities, each teaching

hospital has a number of Centres of Excellence that provide services to patients from Ghana and other countries.

The regulatory agencies such as the Nurses and Midwives Council of Ghana (NMC), the Medical and Dental Council (MDC), the Pharmacy Council and the Food and Drugs Board in the health sector focus mainly on consumer or client protection by ensuring that the requisite and appropriate human resources for service delivery are available at recognized service delivery points. They also ensure that products for service delivery are safe, efficacious, and of good quality, and that service delivery outlets and practices meet prescribed standards,

1.7.4 The traditional/indigenous healthcare system

Throughout human history every society has always had a healthcare system to deal with illnesses of all sorts. Man has always tried to confront any prevalent disease with some technology of some sort. In most communities this technology is largely derived from the indigenous or traditional medical system. Traditional healthcare delivery systems are those channels through which individuals and groups seeking healthcare can obtain intervention by recourse to indigenous methods. Healthcare systems are products of both culture and society and derive from the experiences and dictates of a particular socio-cultural environment.

Traditional systems of medicine contribute significantly to the medical needs of about 80% of the population in Africa (Patterson, 2001). The WHO defined traditional medicine as the comprehensive knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social disequilibrium and relying exclusively on practical experience and observation handed down from generation to generation, verbally or in writing. Some traditional outlets of health care include traditional

healers (medicine men), and traditional birth attendants. Traditional health practitioners practice various forms of health care – bone setting, psychiatric diseases and women's diseases. The most common type of healer in the traditional medical system is the priests and the priestesses of deities and gods who use techniques such as divination and rituals in healing practices (Hevi, 1989).

Traditional birth attendants are members of the local community who are mostly women who offer obstetric care especially during delivery of pregnant women. Since the MOH started to train them from the 1960s at the suggestion of the WHO, they have been the most widely used and have been closer to the MOH than the traditional medicine men.

Other agents of the traditional/indigenous health care system are the guardian spirits who act as spiritual protectors, the ancestors as guarantors of the survival of their lineages, living lineage heads as immediate guardians of their respective lineage units, diviners who reveal the cause of illness, and cultic officials who perform healing rituals. They are often members of the community and their services are often accessible, affordable, available and acceptable to the people. By their magico-religious mode of treatment they are often seen to be of immense psychotherapeutic value. They are therefore seen to be a better choice to deal with sicknesses diagnosed as social or psychological.

1.7.5 The African indigenous churches and healing in Ghana

Any discourse on health and healing in Ghana cannot ignore the churches and their role in that regard. Many of such churhes especially those described by Harold Turner (1968) as 'healing churhes' or *Aladura* whose main preoccupation is healing and protection from evil forces such as witches who can cause misfortune or harm to human beings. For such churches

the *raison d'etre* of religion is to gain access to spiritual power that can help human beings to overcome the forces which can disrupt life (Akrong, 2000).

Akrong (2009) has illustrated how the African indigenous churches continue to attract many seekers of spiritual healing in Ghana by their creativity in integratting 'Christian ideals, perspectives and practices of healing' into the people's own traditional understanding of healing, thus evolving a philosophy of healing. According to Akrong healing and care feature prominently in the African indigenous churches becase they are regarded as essential elements in salvation and wholeness. The philosophical underpinnings of the importance these churches give to healing and care of the sick is derived from their understanding of salvation as a process that deals with the conditions that promote health and weelbeing. Healing in African traditional society is based on the principle that health is a wholistic and multi-facetetd process which has spiritual, social, psychological and environmental or cosmic dimentions. This is consistent with the tripatite worldview of the Ghanaian (Appiah-Kubi, 1981) and of course the W.H.O. concept of health which is discused in the thesis.

Similarly Sackey (1999), in her case study of the health seeking behaviour of members of the Twelve Apostles Church in Ghana observed that as biomedical delivery services in Ghana become more sophisticated, the cultural construction of medicine becomes more prominent. This according to her is to the extent that some medical doctors either having failed in their efforts to cure their patients of certain diseases or have developed genuine belief in the cultural competence of healing are referring their patients to spiritual churches for further treatment. She underscored the growing importance of African religious movements in the health delivery system of Ghana. Their success in this regard, as alluded to above, lies in their ability to combine aspects of African and Euro-Christian cultures into a synthesis to

'advertise their christian elements without undervaluing their african credentials' (Sanneh, 1983, 180).

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter I present literature that I have examined and reviewed that enabled me gain in-depth understanding and insight into pertinent issues that I consider to be associated with the subject under study. This research tried to explore the influence of the practice of divination on the therapy seeking of a rural people at modern healthcare facilities. I first present briefly how the literature was searched, the manner of citations and how subsequent bibliography was built.

A topic of this nature will require first and foremost a good understanding of the concept of health which is fundamental to understanding any phenomenon that is perceived to influence the health of people. Therefore the concept of health and its multi-dimensional nature as viewed from the perspective of various authorities is presented. This also includes reviews of medical verses lay theories and perspectives of illness/disease causation, as well as the explanatory models of health and illness. The concept of health-seeking and some health-seeking behaviour models are also examined, together with brief reviews of some approaches to health seeking behaviour studies. The issue of divination is examined generally in terms of definitions, types and reasons for divination. These serve as background to understanding the relationship between health seeking behaviour and culture. Finally some studies that border on magico-religious practices in relation to therapy choices are examined in terms of the relevance of their objectives, methodologies, and findings to the current study.

2.2 LITERATURE SEARCHES

Literature search started as early as my topic for the study was contemplated, bearing in mind that literature review will help not only in reading and evaluating significant works that are relevant to my research topic but also will help in defining my research problem and develop my thesis. Hence searches were aimed at locating and accessing the relevant textbooks (or chapters or sections), journal articles, reports, dictionaries and encyclopaedia. Libraries and computer via internet searches were mostly conducted. Some key words in my topic were used as a guide in most of the literature searches in the internet. These key words included health, Health seeking, divination, Talensi-Nabdam distinct, Ghana, and Northern Ghana.

Computer internet searches included Open Access sources such as Google, Google-scholar, PLOS, Pub Med Central and Bio-Med, to read or download materials. Boolean searches were also done. I also benefited from journal articles downloaded and sent to me by senior colleagues (including my supervisors) and friends, as well as the Talensi-Nabdam District Profile presented to me by the District Assembly.

2.3 CITATIONS AND BIBLIOGRAPHY

The American Psychological Association (APA) citation style was used to cite works and bibliography. Microsoft Word processor was used to automatically generate the citations and bibliography. This was done by filling in the appropriate information (such as the citation style, the source material, the name of author(s), title of the paper, year of publication, etc.) on the “create source” template under the “References” menu, and finally clicking “ok” to generate the citations and bibliography automatically. However the source material and the citation style chosen determine the subsequent required information on the template. Finally

the characters, font size, line spacing and indentation are formatted to conform to standard requirement for the presentation of citations and bibliography.

2.4 THE CONCEPT OF HEALTH – REALITY OR 'MIRAGE'?

Human capital is crucial in the creation and pursuit of growth and/or development of any society, but human capital is only able to accomplish the desired objectives of society on the fundamental premise that the people are in good health (Bourne, 2009). What then is health and good health?

The World Health Organization (WHO, 1946) defined health as 'a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity'. This took into account earlier discussions in the 1940s that health was a composite function that includes biological, social, psychological, environmental and economic factors. This definition embraced all these factors. Prior to this bio-psychosocial model, health was conceptualized and viewed from a biomedical perspective. The biomedical model viewed health as primarily based on diseases or disease-causing pathogens and not on preventative care.

Following this all-embracing definition of health by the WHO some social scientists immediately hailed the definition as it seemed comprehensive enough to embrace the totality of the nature of the human person not only as a living organism but also as a social being. One of such earlier scientists to appreciate this definition was Raymond Firth who declared that the definition was adept in as far as it expresses an important truth – that one cannot understand the body without reference also to the mind, and that body and mind have full meaning only in relation to society (Firth, 1959).

However other social scientists have criticized the definition arguing that it is too broad and does not allow for making the differentiation between the healthy and the sick, and arguing further that social fitness for example is value-laden and very difficult to measure. Dubos (1965) for example contended that the concept of perfect and positive health is a 'utopian creation of the human mind' and therefore a 'mirage'. He viewed health as basically the extent to which man adjusts and adapts satisfactorily to his environment. But to what extent should this be? This means health cannot actually become a reality because man will never be so perfectly adjusted to his environment that his life will not involve struggles, failures and sufferings. Dubos therefore considered the concept of health to be a 'mirage' because according to him man in the real world must face the physical, biological and social forces of his environment which are forever changing, usually in an unpredictable manner and frequently with dangerous consequences for him and the human species in general.

Advancing the debate on the definition of health some authorities have suggested a two-way categorisation of the concept of health. For example Nukunya & Twumasi (1973) have suggested that health can be defined in terms of (1) the absence of disease and (2) an optimum capacity for task and role performance. The second category refers specifically to the Parsonian model of health. The Parsonian model is the sick role concept developed by Talcott Parsons in the 1950s which looks at sickness as a social phenomenon in which the sick has reciprocal privileges and obligations resulting in adjustments in social roles. According to the sick role model the sick person, once he/she communicates the state of un-wellness in terms of the presentation of signs and symptoms, is first of all exempt from responsibility for incapacity, i.e. he/she is assumed not responsible for his ailment. Secondly he/she is exempt from his/her normal social obligations. However, the obligations of the sick person are that he/she is to seek technically competent help in terms of seeking for a

therapist, and once therapy is instituted he/she has to try to get well by cooperating with the treatment regimen. Thus the function of the healer is one of social control by first legitimising the rights of the sick and secondly ensuring that the sick perform their duties. The Parsonian model therefore views health from the point of view of the individual's participation in the social system and hence defines health as the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized.

The Parsonian concept presents an interesting dichotomy as Nukunya & Twumasi (1973) explained that 'while a person showing no physical or visible signs of sickness but unable to perform his tasks satisfactorily may be sick in the Parsonian sense, he is not in the second' (p.89). For example, they noted that a barren woman is considered a sick person in the Parsonian sense because in the African context she is not able to perform her reproductive services by bearing children. This is in spite of the fact that a barren woman may not present any signs and symptoms of disease.

Perhaps it is in line with this diverse conceptualization of health that Kelman, (1998) suggested that the definition of the concept has been the most perplexing and ambiguous issue since its inception. He argued that the definitional problem is crucial to the determination of health care policy. He however suggested that health is primarily socially, rather than strictly biologically determined. Hence this means that we cannot view health as independent of the form of society in which it is studied.

From the foregoing discussion it can be appreciated that the concept of health has been a subject for much scrutiny and protracted debate. This is understood from the standpoint that the determinants of health are founded in human behaviour and as the human factor is more

and more appreciated in health issues the debate becomes more and more complex. As nebulous as the concept of health continues to be, perhaps the debate will continue unabated.

2.5 MEDICAL VERSUS LAY PERSPECTIVES OF ILL-HEALTH

According to Helman (1984), doctors and their patients, even if they come from the same culture, have different perspectives about ill-health. Their worldviews are based on different premises, employ different methods of proof and assess the efficacy of treatment in different ways. This often results in communication gaps in the therapeutic encounter during doctor-patient interactions. Helman illustrated this by describing the difference between illness and disease: the difference in understanding is merely a reflection of the fact that doctors and patients view the world from different perspectives. Illness is what the patient feels when he goes to the doctor; disease is what the patient has on his way home from the doctor.

2.5.1 'Disease' – The doctor's perspective

Practitioners of modern scientific medicine form a healing subculture with their own values, theories of disease, and rules of behaviour and role specializations. The basic premises of the medical perspective are (1) scientific rationality, (2) emphasis on objective numerical measurements, (3) emphasis on physio-chemical data, (4) mind-body duality and (5) the view of diseases as entities. Disease is therefore defined in contemporary medical textbooks as an 'objectively verified disorder of bodily functions or systems, characterised by a recognisable cause and by an identifiable group of signs and symptoms'.

The assumption underlying scientific rationality is based largely on the Western science model that postulates that all assumptions and hypotheses must be capable of being tested and verified under objective measurable controlled conditions. This results in the distillation of

certain clinical facts. In handling ill-health, the practitioners' duty is therefore to discover the logical chain of causal influences that led up to the clinical fact, and consequently prescribe the appropriate therapy.

In arriving at diagnosis and treatment doctors consider physiological measurements e.g. blood sugar levels and body temperature levels, to have more clinical significance than the less measurable emotional, psychological and socio-cultural factors. This according to Helman is based on their belief in the medical definition of disease which is "largely based on objectively demonstrable physical changes in the body's structure or function, which can be quantified by reference to normal physiological measurements.'' (P. 67). The mind-body dualism approach is manifest in the Western medical emphasis on the physical dimensions of ill-health, while largely ignoring factors such as personality, religious belief and social status of the patient.

2.5.2 'Illness' – the patient's perspective

Illness is the 'subjective response of the patient, and those around him, to his being unwell; particularly how he, and they, interpret the origin and significance of this event; how it affects his behaviour, and his relationship with other people; and the various steps he takes to remedy the situation.' (Helman, 1984) (p, 69). It is the patient's subjective experience which may or may not indicate the presence of disease. For instance a patient may report to a doctor with the complaint of having a 'chain system' in his brain that is giving him constant headache. On examination of the patient the doctor may not find any anatomical or physiological anomaly that may account for such a symptom, yet the patient really feels sick and he is not comfortable within himself.

2.6 LAY THEORIES OF ILLNESS CAUSATION

In general, lay theories of illness place the aetiology of ill-health (1) within the individual patient, (2) in the natural world, (3) in the social world or (4) in the supernatural world. According to Helman social and supernatural aetiologies tend to be a feature of non-Western societies, while natural or patient-centred explanations of ill-health are more common in the Western industrialised world, though the division is by no means absolute.

2.6.1 The patient

Locating the causes of ill-health within the individual mainly deals with malfunctions within the body that result mostly due to the diet we take or our behaviour and general lifestyle. Other aetiological factors include notions of vulnerability – psychological, physical or hereditary and certain personality traits that predispose the individual to certain illnesses. When ill health is perceived as caused by factors within the individual, the responsibility for illness falls mainly (though not entirely) on the patient – and this is important in determining whether people take responsibility for their health or whether the origin and treatment of ill health is within their own control.

2.6.2 The natural world

This is made up of aspects of the natural environment, both living and non-living, which can cause disease. This includes extreme climatic conditions of cold, heat, wind, rain, dampness, and draught. These give rise to certain conditions as such colds or chills, sun stroke; and natural disasters such as cyclones, tornadoes and severe storms. Also included are injuries caused by animals, birds and microorganisms such as bacteria, viruses, fungi, protozoa, helmets, rickettsia that cause the various infectious diseases. There are also parasitic

infestations and environmental irritants such as allergens, pollens, poisons, smoke, fumes and other pollutants that can cause disease.

2.6.3 The social world

The Dictionary of the Social Sciences provides the adjectival meaning of the word 'social' as 'pertaining to interpersonal behaviour'. This entails interacting with people or the way in which people in groups behave and interact. A patient's social world could therefore include his immediate and extended family relationships, as well as his entire support system; it could also include his peer influences, work side relationships, his vocational and financial status, and cultural influences.

In smaller-scale societies where inter-personal interactions are frequent intense blaming of other people for ones ill-health is a common feature. In witchcraft beliefs, which are particularly common in Africa and the Caribbean, certain people (usually women) are believed to possess a mystical power to harm others (Helman, 1984). According to Evans-Pritchard witchcraft does not strike at random and that for witchcraft accusation to come from someone, the supposed victim must have some relationship with the accused; also witchcraft accusation are motivated by jealousy, hatred, envy and fear. Witchcraft accusations are therefore a function of social relationships (Nukunya, 2005).

Sorcery, magic, juju and the evil eye have also been associated with aetiology of ill-health in relation with the patient's social world (Nukunya, 2005; Landy, 1977). Landy (1977) defined sorcery as "the power to manipulate and alter natural and supernatural events with the proper magical knowledge and performance of ritual". Sorcery, according to these authorities is often practiced amongst one's social world of friends, family, or neighbours and often based

on envy. Sorcery beliefs tend to be common in non-western societies and occur in groups whose lives are characterised by 'poverty, insecurity, danger, apprehension and a feeling of inadequacy and powerlessness' (Helman, 1984).

According to Nukunya (2003), magicians and sorcerers are consultants who can be found all over Ghana and their services are open to utilization by those who need them. He mentioned some of their services to include: 'intervention in a promotion exercise; interviews, causing harm to a rival or even having him killed; protection against accidents; protection against conviction in a court case or making it impossible for an opponent or policeman to appear in court to give evidence; or enabling a lost property to be found' (p. 62).

2.6.4 The supernatural world

According to Twumasi (1975) the term supernatural is used to include "... all that is not natural, inexplicable in concrete terms."(p. 9). The term is fundamental in the concept of religion as its connotations find expression in various definitions of religions as:

> "Beliefs and practices associated with the supernatural (Nukunya, 2003, p.55);
>
> "A unified system of beliefs and practices relative to sacred things..." (Durkheim, 1915, p.49);
>
> "The propitiation or conciliation of powers superior to man which are believed to direct and control the course of nature and of human life."(Frazer, 1890, p.222).

Thus, the supernatural embraces that which is not explicable in concrete reality, considered sacred and constitutes powers superior to man. In placing the aetiology of illness in the supernatural world, illness is ascribed to the direct actions of supernatural entities such as God, the gods, spirits, ancestral shades (Helman, 1984). However Helman indicated that in most cases theories of illness aetiology are multi-causal and not mutually exclusive,

consisting of several causes acting together. For example, careless or immoral behaviour can lead to natural illnesses, wrath of the ancestors, or an ostentatious lifestyle may attract sorcery, evil eye or witchcraft. It is often portrayed that traditional cultures, especially those of African is non-scientific or is approving or disapproving things not on scientific grounds but for supernatural related reasons. Western cultures on the other hand tend to be seen as scientific and rational as there is overreliance on the postulate that all assumptions and hypotheses must be capable of being tested and verified under objective measurable controlled conditions.

2.6.5 Supernaturalism, cultures and rationality

Due to the prevalence of belief in spiritual beings and the reality of some non-physical events in traditional cultures the worldview of the people is often typically regarded as super naturalistic. But while some anthropologists and philosophers see belief in the supernatural as irrational, others argue in ways that seem to suggest that supernaturalism limits the rational capacity of the African thinker (Majeed, 2012).

Traditional non-western cultures are often portrayed as non-scientific or as approving or disapproving of issues not based on scientific grounds but for supernatural related reasons, for that matter irrational. Supernaturalism is sometimes used in specific reference to such notions as witchcraft and magic which are regarded as irrational. But Majeed (2012) wonders why such thinking curiously fails to accept that even belief in God can also be regarded as supernatural and hence could also be irrational. Majeed (2012) points out that the description of a culture as rational or irrational needs to be understood in a special way and intimates that he does not think referring to a western culture as ‘scientific’ suggests that there cannot be any persons from that culture who engages in rituals. He argued that the use of reference to a

culture as rational or irrational 'indicates that in social and intercultural philosophy where predominant views are sometimes used to characterise cultures in 'traditional-scientific' or 'supernatural-anti-supernatural' terms, it is possible to apply or at least learn to apply the concept of rationality in this general context'.

Helman (1984) has also noted that belief in sorcery for example tends to be common in non-western societies and occur in groups where lives are characterised by 'poverty, insecurity, danger, apprehension and a feeling of inadequacy and powerlessness'. Much as this may be largely true one wonders if such situations are not equally commom in the Western world as well.

Drawing on some philosophical implications of the traditional Akan (the largest ethnic group in Ghana) position on supernaturalism and rationality Majeed (2012) illustrated that rationality is not only a non-cultural concept but that it is capable of being manifested by any individual from any culture.

2.7 TOWARDS A BIO-PSYCO-SOCIAL-SPIRITUAL MODEL OF HEALTH AND ILL-HEALTH

Following the discovery of the Germ Theory of disease causation by Louis Pasteur medical practice equated health to the absence of disease. Good health meant the lack of a fundamental pathological change in the body, whereas poor health or disease meant the presence of a proven biologically driven pathogen in the body. This narrow scope on health could have posed rather limited ways in which people understood wellbeing, and probably might have thwarted efforts at prevention and treatment of diseases.

The inability of the purely biomedical model to tackle sufficiently matters of health and illness perhaps culminated in the WHO definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity'. However, according to Rumbold (2007), a persuasive clinical expression of this expanded view of health did not manifest until Engel's articulation of the bio-psychosocial (BPS) approach to health care.

Following the discovery of the Bio- psychosocial (BPS) model by Engels (1977) perspectives on medical practice was broadened with the dramatic shift in focus from disease to health. The model accounted for biological, psychological and sociological interconnected spectrums, each as systems of the body. The model recognised 'that psychological factors (such as beliefs, relationships, stress) greatly impact recovery, the progression of, and recuperation from illness and disease'. The main tenet of the BPS model is illustrated in the words of Engels himself as:

"*To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model."*

The BPS model of health and illness was then adopted by many institutions and medical doctors and incorporated into their practice to ascertain a more comprehensive and holistic understanding of their patients. The BPS model yet still does not provide a comprehensive and holistic understanding of patients' health. It has been suggested that spirituality and religion are important yet they are often neglected factors in the health of patients (D'Souza, 2007). Anthropologists generally hold the view that spirituality and religion are inevitable factors in any cultural setting and that spiritual and religious beliefs across cultures often

include concepts related to prevention aetiology and treatment of disease. Many authorities, especially those concerned with clinical care of patients have therefore advocated for the inclusion of spiritual assessment in patient care, a process by which health care providers can identify a patient's spiritual needs pertaining to medical care. Some studies have given basis to this proposed model. For example, some studies in America revealed that up to 77% of patients would like spiritual issues considered as part of their medical care, yet only 10-20% of physicians discuss this with their patients (Anandarajah & Height, 2001). To this end D'Souza (2007) has strongly suggested that the incorporation of spirituality and religion into clinical practice will go a long way to improve patient care, doctor-patient relationship and patient well-being, as well as being seen as steps ahead of the bio-psychosocial model towards the more comprehensive "bio-psycho-social-spiritual" model.

2.8 THE PRACTICE OF DIVINATION

2.8.1 Why divination?

The truth, efficacy or otherwise of the outcome of divination is of no concern in this study. The practice of divination though often shrouded in myth and subjectivity is important in as much as it affects the health-seeking behaviour of a people. Middleton (1970) argued that Evans-Pritchard's (1937) study of the phenomenon of witchcraft among the Azande of Sudan was a classical intensive analysis showing witchcraft not to be a mere belief but an integral part of an ordered social life. This belief was 'not mere exotic fantasies, lacking common sense, but logical ways of comprehending and dealing with the existence of evil and bad luck in the world'. Nukunya, (2003) has also commented that the efficacy or otherwise of such beliefs in society is not the important issue but the fact of how such beliefs affect people's physical, social and psychological wellbeing. Divination does seem to have this influence.

There are many and varied reasons why people consult diviners. According to Oppong (1973) diviners are consulted upon every conceivable occasion; at birth to find which ancestor is returning; in misfortune to find the cause and sacrificial remedy; at marriage; at death; after dreams; at succession to office, or undertaking a new enterprise.

Mendonsa (1982) tried to show the social function of divination among the Sisala of Ghana. He showed that the divinatory process performs a "connective function in that it permits wilful individuals to negotiate and to recreate their social order as they attempt to explain misfortune, cure illness and redress impaired social relations". Mendonsa's work was about the use of divination by lineage heads to seek redress to misfortune among the Sisala of Northern Ghana. According to Mendonsa once a Sisala perceives himself as ill he has three lines of action to employ: firstly he consults the herbalist for treatment, and if he fails to

secure cure, secondly he consults the diviner. The third option is to consult a fairy caller especially in intractable cases. The first and third options in the quest for therapy are usually entirely the personal decisions of the patient, who can take those actions independently. However the second option normally goes beyond the personal decision of the patient to involve the entire lineage who is often represented by the lineage elders. When medicine from the herbalist fails to effect a cure it is then thought that the ancestors are involved and it is therefore the responsibility of the lineage elders to consult a diviner on behalf of the patient. The decision to consult a diviner "involves the patient in a diagnostic process that links his illness to (societal) rule violation". To the Sisala the misfortune, this includes disease, ultimately results from the withdrawal of protection or sanction from the ancestors who become aggrieved about a wrongdoing of a member of the society. To them deviance is inherently tied up with illness and misfortune.

In an earlier work Mendonsa (1975) found out that the Sisala practice five different kinds of divination which include necromancy, ordeal, cowries-throwing, fairy-calling and traditional divination. The latter is the most dominant and most important within their social structure because it is an important means by which they relate to their ancestors to secure answers to afflictions and misfortune. In this work he stressed the domineering powers of the ancestors in the lives of the living through consultations with diviners.

Divination deals with life crises. It is a set of institutionalized procedures and role for dealing with calamities of all sorts. It is a system of symbolic beliefs and practices that can be used to diagnose, explain and ameliorate misfortunes. A common feature of diviners is the fact that as agents that link the living and the spiritual world, they are very active members of the society, take interest in daily events and are accommodating to all their clients (Mbiti, 1968).

Mbiti referred to the diviner as a person who "fulfils an intermediary function between the physical and the psychical, between human and the spiritual, for the sake of his own community". …therefore people resort to them freely for both private and public affairs. Like the medicine-man, and many practice as such, the diviners are regarded as friends of their communities."

Kirby, (1993) has argued that in rural Africa delivering better health services is more complicated than simply offering good medical services; it for adaptation and dialogue between African traditional beliefs and Western medical institutions. This is in the context that in rural Africa delivering better health services is more complicated than simply offering good medical services; it must also take into account people' religious orientation and beliefs. Here the nonmaterial causes of illness are at least as important as the biological or material and, in many places, one can only determine the exact nature of the problem and its corresponding remedy after the fact, through a process involving divination and sacrifice.

2.8.2 Definitions and types of divination

Divination is defined by Rose (2003) as "the endeavour to obtain information about things future or otherwise removed from ordinary perception, by consulting informants other than human" , and it may be roughly divided into two kinds (a) 'automatic' divination, in which an omen is looked for and interpreted in its own right, with no thought of appeal to any supernormal power, god, or spirit; and (b) divination proper, in the strict etymological sense of the word, which inquires of some sort of deity, generally by means of signs conceived of as being sent by him (p. 775). Rose (2003) further notes that, of many cases it is hard to say which category they fall under; for instance, in case of divining by the Bible and key, it is

doubtful if the people who use this method could say definitely whether they suppose the answer to be sent by god or to come from some quasi-magical power inherent in the bible itself.

Rose (2003) further classifies divination, according to the means employed, in the following: *Divination by dreams.* The belief that a dream may be in some way prophetic is a view held by all races at all times and still popular, to judge the numerous modern dream-books. The explanation usually given is that the dreamer's soul goes away from his body and sees the things he dreams of; or that the temporarily liberated spirit visits the spirit world and secures information from there. Hence the reluctance in some cultures to awaken the sleeper for fears that 'his soul may be shut out, or an evil spirit get in' (Rose, 2003).

Divination from bodily actions. The involuntary human action such as a sneeze is the most universally regarded as ominous, and in nearly all cases, as a bad omen; for example, the Ashanti (of Ghana) believe a sneeze indicates 'something unpleasant or painful having happened to the indwelling *kra'* (soul) (Rose, 2003). This is consistent with the general belief in my own culture in which a sneeze is often interpreted as people talking evil of you.

Divination by death (necromancy). This is found in the practice of consulting either the souls of the dead in general or the soul of a particular dead man or his corpse. The inherent belief behind this is that death increases rather than decreases a man's magical powers, including his prophetic faculties (Rose, 2003).

Divination from animals. The movement of birds or beasts are considered ominous to some degree by nearly, if not quite, all races. In this case the sight of certain animals could mean

good or bad omen; for example, the Masai give certain interpretations to the cry of a bird they call *tilo*, when one embanks on a journey. If heard from the right, it is good; if on the right, bad. If heard from behind, it means, 'Go on you will be hospitably received' (Rose, 2003). Also in my cultural setting, and indeed during interviews with the diviners in this study, I learned that sighting a monitor lizard (called *woo,* in the local dialect) while on a journey is a sign of good omen. In fact, a small piece of the skin of this animal is always included in the diviner's bag, as part of the standard code items used for interpretation in real life situations (my personal observation during interviews with diviners in this study).

Divination by mechanical means. Divination may be divided roughly into (a) *coscinomancy*, or devices akin to modern *planchette,* and probably worked by unconscious muscular action and (b) *sortilegium,* or devices involving some kind of game of chance, generally of simple form. An example of *coscinomancy* is among the Malays in which a pendulum is made with appropriate rites – charm and sacrifices. Questions are the put to it; it says 'Yes' by swinging, 'No' by staying still. Also they can use a divining rod, which vibrates in the presence of a thief. Also, the Melanesians use a similar rod in cases of illness to discover which of the recently dead is eating the patient. Another example is that a thief may be discovered after appropriate rites, by two people holding a bowl of water between their fingers. The names of the suspected persons are presented to it in writing, and at that of the guilty man it twists around and falls. In all these cases the writer concludes that, ruling out the possibility of deliberate cheating, the diviner 'unconsciously moves his divining machine in the way he is expecting or perhaps contrary to his conscious expectations and even his conscious volition' (Rose, 2003). Rose (2003) however drew attention to the fact that explanations given by the 'lower races' is that the movements are caused by some spirit which 'controls' the instruments. The use of 'lower races' in my opinion stems from the writer's orientation and

perception of divination as being denounced repeatedly by ancient as well as modern thinkers as fallacious, and 'primitive' (p.775), being practiced by 'uncivilised' peoples (p 776), still practiced all over the world by 'the more backward races of mankind' and by 'uneducated members of the 'civilized peoples' (p. 775) allowing for 'uncivilised ways of thought' and that divination grew out of 'false induction' (p. 775), and many such derogatory terms which I think have long been rejected by modern anthropologists.

In *sortilegium* which is probably the origin of all games of luck, the following types occur: (1) the use of odd and even, (2) the *teetotum*, (3) the use of dice and similar implements, and (4) the use of a number of mechanical divination methods which have not resulted in actual games. An example in the use of even and odd is among the Masai and the Nandi, whose diviners shake pebbles out of a buffalo's horn, and observe whether an odd or even number results. In *teetotum* the coconut is often used in the Pacific both in games of chance and in divination. In the use of dice and similar implements the most rudimentary form is the mangrove embryo used by women in the Torres Straits to determine the sex of an unborn child (Rose, 2003). Rose admits that the principle is based on 'chance' which is the working of some non-human power, which makes a die fall a particular way.

Divination from nature. In this is as in (1) astrology where there is interpretation of the relative positions of celestial bodies such as the moon and stars and (b) the occurrence of other natural phenomenon such as earthquakes and lightning. According to Rose (2003) astrology is an elaborate pseudo-science which grew out of the belief that the position and influence of heavenly bodies more or less mould human affairs. However he adds that astrology 'is a product of comparatively advanced civilisation, and involves real knowledge of pure and applied mathematics, far beyond the capacity of most savage races' (p.780). I

tend to disagree with this assertion because in most cultures in Africa for instance some people have often predicted the onset of rains and the different seasons from interpreting the positions of the moon and stars at certain times during the year. This is being done by people who are not necessarily advanced in science and mathematics. Moreover, I don't think mathematics can be beyond the capacity of any one particular race as Rose tries to point out.

2.9 SOME STUDIES RELATED TO MAGICO-RELIGIOUS PRACTICES AND THERAPY CHOICES

In their study on the influence of traditional medicine on fertility regulation among the Kassena-Nankan in Ghana, Adongo, et al (1998) conducted interviews (through divination) with lineage heads who were diviners to solicit the ancestors' views about their reproductive preference. Comparing pairs of lineage heads and corresponding ancestral spirit responses to determine the role of traditional religion in influencing reproductive preferences, they found a shared preference for sons, and large family size. However some ancestral spirits preferred small family size. This suggested that some ancestral spirits can be open to modern ideas. They therefore concluded, inter alia, that family planning introduction will not encounter systematic opposition in the Kassena-Nankana area. This study was not only probably the first of its kind involving interviews with spiritual respondents but it also provided useful insights into the introduction of family planning methods in the study area.

Millar et al (2007) have stressed the importance of the Right to Culture in innovative participatory approaches to endogenous development: : "For many people in the world today their culture, faith and values are very important and provide the moral and practical basis for decision making in daily life." … Nevertheless, local cultures are often ignored or even outlawed from formal development programmes; especially those cultural aspects such as

spiritual or ancestral consultations – which are hard to understand for people from other cultural backgrounds or even locals who are removed from the cultural setting physically, mentally and/or spiritually."

Feyisetan et al, (1997) in their study of the influence of cultural beliefs on mothers' management of childhood diseases in Yorubaland had two main objectives: (1) to examine mothers' perceptions of the aetiology of the three most common childhood diseases (measles, diarrhoea, and fever) in the study area, and the effect of these perceptions on the mothers' suggested curative measures, and (2) to examine the persistence in the belief in *abiku*, and how this cultural belief can influence mothers' management of childhood diseases.

In addition to simple cross-tabulations they used logistic regression procedures to estimate the net impact of socio-economic variables on dichotomously measured dependent variables: whether or not a mother would know the correct causes of each of the childhood diseases; and whether or not a mother believed in *abiku.*

They were able to demonstrate that (1) high percentages of Yoruba mothers do not have accurate knowledge of the causes of the selected childhood diseases, (2) many of the mothers recommended modern methods in spite of high levels of ignorance about disease causation, and (3) belief in *abiku* was very strong among mothers in Yorubaland and therefore the curative measures likely to be adopted by a mother may depend on whether the sick child is believed to be an *abiku.*

They noted that the extent to which modern methods are adopted depend on the people's conceptions of the causes of ill-health and on their level of conviction about the efficacy of

such methods. Where conflicting views are held about the causes of ailment, people may be confused as to which of the traditional or modern methods is the appropriate treatment or preventive regime. They further noted out that over 50 percent of the women who are mainly responsible for seeking adequate health care for children believed in the *Abiku* child, and that such children can better be treated spiritually rather than by modern medical methods.
In the light of these they recommended the use of traditional healers and religious institutions irrespective of the nature of the illness.

Similarly, Denham et al (2010) have studied the characteristics of and circumstances surrounding the phenomenon of the *spirit child* and its relationship to infanticide among the Nankanis of the Upper-east region of Ghana. Through ethnographic and verbal autopsy methods the study gave ample insight into the socio-cultural context of the *spirit child* belief, thereby offering a clarified picture of the phenomenon. They posit that a portion (36%) of the spirit child deaths are not necessarily due to infanticide because severe illness or disability accompanies a significant portion of spirit child cases where infanticide occurs. The study thus provides further insights into shaping maternal and child health interventions as well as implications for verbal autopsy assessments and the accuracy of demographic data concerning the causes of child mortality.

Asare-Danso (2005) examined traditional health care systems in Ghana and the efforts made by the Ministry of Health and the Ghana Health Service to integrate traditional health care into the allopathic medical care system in the country. He identified the various types of traditional medical practitioners to include traditional Birth Attendants, traditional herbalists, diviners, traditional surgeons and traditional psychiatrists. According to him the 'social analysis' employed by these various traditional practitioners in diagnosis of disease, coupled

with the general belief among most Ghanaians that disease is a disintegration of the spiritual and physical component of the human being makes traditional medical practice quite popular and generally well patronized.

Sindiga (1995) examined the influence of a group's concept of disease causation on actual therapy-seeking behaviour within an environment of medical pluralism. He demonstrated that although disease aetiologies are articulated, this does not lead to clear cut selection of a medical system when faced with actual sickness. He argued that contrary to the impression created by earlier studies that in Africa diseases are believed primarily to come from supernatural causes, recent empirical work shows multiple causes; and people will choose mode of therapy depending on their perceptions of the cause.

Makundi et al (2006) concluded that traditional health care is not necessarily a significant impediment or a delaying factor in the treatment of severe malaria. They recommended the need to foster training in the management of severe cases, periodically involving traditional healthcare practitioners and health workers to identify modalities for better collaboration.

Treatment seeking was found to be a complex process where mothers would consult traditional health care practitioners and modern health care providers, back and forth. Referrals to health clinics increased during the project, whereby project staff facilitated the process after traditional medical care with the provision of suppositories. This finding is challenges the common view that traditional healers are an important factor of delay for malaria treatment, and postulates that they actually play a pivotal role by giving “biometrically accepted first aid” which leads to reduction in body temperature hence increasing chances of survival for the child. Increasing the collaboration between traditional

healers and modern healthcare providers was shown to improve the management of severe malaria in the studied areas.

Similarly, Oeser (2005) found no evidence that use of traditional remedies has an appreciable effect on diagnostic delay in Lima. They hypothesized that traditional beliefs prevalent in rural to urban migrant communities in Lima would lead suspected cases of TB to seek diagnostic and therapeutic assistance from outside the NTP, and that this would result in significant delays in the initiation of effective chemotherapy which would perpetuate avoidable, on-going transmission of TB. They further hypothesized that this situation might demand an intervention based around collaboration and formal engagement of the NTP with traditional practitioners to enhance TB control.

Tabi et al (2006) conducted qualitative interviews with a small number of Ghanaians to determine personal perspectives when choosing healers, particularly, Western or traditional medicine, or blending of both, for health care. Their particular interests were on cultural family, educational and religious influences on these choices. They indicated that choices in health care modalities by literate Ghanaians included either traditional or modern medicine, or blending of both. Strong influences on these choices were the level of education and related themes, influence of family and friends, and spiritual/religious beliefs. An implication of the study was that traditional and modern medicines will always be part of Ghanaian health care delivery and efforts should be made to integrate traditional practitioners into the national health care delivery system. The challenge for nurses and nurse midwives is to help people identify and use the positive elements of traditional health resources. A good understanding of preventative issues by nurses and policy makers could have enormous public health benefits.

The most common type of healer in the traditional medical systems is the priest and priestess of deities and gods who use techniques such as divination and rituals in healing practices. Jansen et al (2006), in a mini-ethnographic study using participant observation and ethnographic interviews, showed that an understanding of traditional structures have an influence on the decisions and behaviour of the community related to childbirth. They found that cultural and social factors have a significant influence on the decisions related to childbirth. The responsible persons for decisions related to a delivery were the older female relatives, rather than the mothers themselves.

However, Nsimba, et al, (2008) focused on malaria which is a major cause of morbidity and mortality in Tanzania. They identified three areas of concern for the management of malaria in children. First, there is the issue of patients and caregivers tending to rely heavily on socio-cultural beliefs and practices as means of treating the convulsions associated with severe malaria in children. They explain that the majority of malaria episodes in children are often noticed and treated first at home by the caregivers who are often under the directives of community elders who then consult diviners to ascertain that evil spirits related to witchcraft (*mashetani*) are the cause of the symptoms. The resultant employment of traditional medicines then results in delay to modern health facilities where the symptoms could have been more efficiently dealt with. Second, there is generally lack of accessible medical care thereby reinforcing reliance of caregivers/parents on the judgements of traditional healers. The caregivers often play the role of doctors as they obtain and administer anti-malarial medicines which results in complications of inappropriate use of those drugs. Third, there are barriers to translation of modern healthcare practices to community members especially to the matriarchs who often control caregivers at household levels. They then conclude that involvement of traditional health practitioners, influential community leaders and traditional

chiefs (who are custodians of traditional culture), in translation of modern medical care could go a long way to influence local policies on effective prevention and treatment of childhood malarial diseases in Tanzania.

CHAPTER THREE

3.0 METHODOLOGY

3.1 THE STUDY AREA

The study was carried out in the Talensi-Nabdam district in the Upper-East Region of Ghana. The district is bordered to the North by the Bolgatanga Municipality, to the South by the West and East Mamprusi Districts (both in the Northern Region), the Kassena-Nankana District to the West and the Bawku West District to the East. The district lies between latitudes 10.15^0 and 10.60^0 north of the equator, and longitudes 0.31^0 and 1 0.5^0 west of the Greenwich Meridian. It has a total land area of 912 square kilometres. The main towns in the district include, Tongo, Duusi, Winkogo-Awaaradone, Kongo, Pwalugu, Sheaga, Gbane, Pelungu, Wakii, Yikpemeri, and Tongo-Beo. *Figure 3* is the map showing the location of the district within the Upper-East region of Ghana.

The topography of the district is dominated by relatively undulating lowlands, gentle slopes ranging from 1% to 5% gradient with some isolated rock out crops and some uplands slopes at the Tongo and Nangodi areas. It falls within the Birimian, Tarkwaian and Voltaria rocks of Ghana. There is evidence of the presence of minerals especially gold. The district is drained mainly by the Red and White Volta and their tributaries. The climate is classified as tropical, and has two distinct seasons - a wet rainy season, which is erratic, and runs from May to October, and a long dry season that stretches from October to April with hardly any rains. The mean annual rainfall is 950 mm while the maximum temperature is 45 degrees Celsius in March and April with a minimum of 12 degrees in December.

The vegetation is guinea savannah woodland consisting of short widely spread deciduous trees and a ground flora of grass, which get burnt by fire or the scorchy sun during the long dry season. The most common economic trees are the sheanut, dawadawa, baobab and acacia.

The district has a total population of 100,879 (extrapolated from the Population and Housing Census, 2000). The population consists of 50,865 females and 50,014 males with a sex ratio of 50.4:49.6. The total number of houses is 8,839, total households is 16,375 with an average household size of 6; while the number of persons per room Occupancy is 4-5. (PHC, 2000).

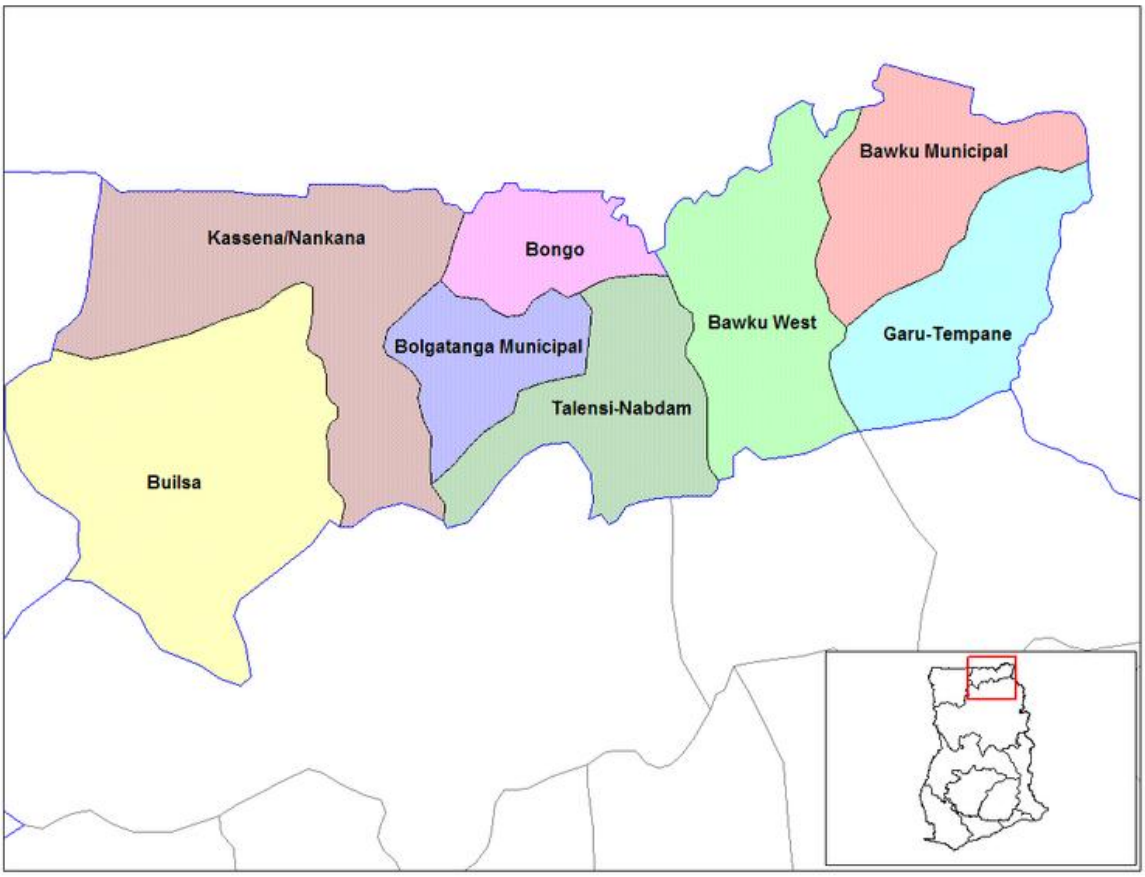


*Figure **3*** Map of the Upper East region of Ghana showing the location of the Talensi-Nabdam district. Source: http://en.wikipedia.org/wiki/File:Upper_East_Ghana_districts.png

There are two predominant indigenous groups of people that inhabit the district namely the Nabdams and the Tallensis, who reside in the Nabdam and Tallensi traditional areas respectively. According to Hunter (1968) the Nabdams call themselves the *Namnam* (singular, *Nabit*), call their country *Nabrug* and their language *Nabte* . The Tallensis also call themselves *Talih* (singular *Talin).* Both the Nabdam and Tallensis belong to a number of ethnic groups speaking very closely related Oti-Volta languages and exhibiting remarkable

similarities in their cultural traditions (National Commission on Culture), and also generally belonging to the Mole-Dagbani group of people. Generally they also belong to the Frafra speaking group that comprise the Bolgatanga and Bongo districts, the Tallensi of Tongo traditional area and the Nabdam of the Nangode and Sakote traditional areas. The Tallensis and Nabdams, though of two distinct ethno-linguistic groups, are in most respects a homogenous group with a common culture. Polygyny is generally prevalent where adults may marry more than one wife, though in recent times the younger generations tend to marry only one due to economic and religious reason as more and more of this generation tend to be Christians. The kinship and descent system is patrilineal in which an individual belongs to his father's descent group which is made up of persons, male and female, who are descended through the male line only from a common ancestor.

The district is one of the most economically deprived areas in the country with rain-fed subsistence cereal- based agriculture. Approximately 90 percent of the people rely on rainfall which is erratic and limited to the period from June to October, for their farming activities (TNDA, 2006). Agriculture plays the major role in the local economy. It serves as the source of cash crops such as cereals, legumes and vegetables and also provides foodstuff and protein. There is also a considerable amount of ownership and sale of livestock such as cattle, small ruminant animals and poultry. Surface gold mining activities (popularly called galampsay) are rampant. Other economic activities include quarrying and fuel wood extraction.

The District is served by 17 health facilities which comprise of 3 health centres, 5 clinics, one privately owned and two owned by CHAG. The district has eighteen earmarked CHPS zones out of which nine are completed and functioning. There are other health providers like chemical sellers (10) and traditional healers (75) who provide health services in the district.

These are normally the first point of call for many ill people as many people are into self medication. There are also TBAs (72), and CBSVs (170) located in various parts of the district. Qualified medical staff is also inadequate For example for a population of over 100,000 the district has no qualified medical officer, one medical Assistant.7 general nurses, 12 HATs, 11 midwives, 2 PHNs, 52 CHN. 7 HAs.

In order to increase geographical access and to ensure effective health service delivery and administration, the district has been divided into six administrative sub-districts namely; Tongo Central with the capital at Tongo, Tongo West, capital Pwalugu, Nangodi-Kongo, capital Nangodi, Sakote-zolba capital Pelungu, Tongo East capital Namolgo and Datoko with Datoko as capital. The District Health Management Team (DHMT) headed by the District Director of Health Services (DDHS) headquartered in Tongo is responsible for the administration and coordination of health delivery services in the district.Though efforts have been made to improve access to health services delivery, patronage of health facilities has been low due to poverty, illiteracy, long distance to health facilities and ignorance in the rural communities.

3.2 STUDY DESIGN

The study design was cross-sectional and descriptive using both quantitative and qualitative methods. In this study a mixed method approach for data collection was necessary in view of the rather wide range of issues explored: First of all one needed to understand the point of view of diviners on one side and healthcare practitioners on the other side, how the practice of divination affects healthcare delivery. Secondly, there was the need to understand the community members' perspective of the practice of divination in relation to seeking health from orthodox healthcare facilities, and thirdly the socio-demographic profile of the study

population was needed in order to determine how these influenced the key dependent variable, i.e. whether or not one found divination useful in health seeking.

A mixed method approach has been adopted in several studies. For example, Agyarko et al (2003), in an in-depth assessment, used both quantitative and qualitative methods of data collection in their study to assess the trends of the use of Intra-Uterine contraceptive devices (IUD) in Ghana. Similarly, Denham et al (2010) in a recent study employed a mixed method approach combining ethnographic fieldwork and analysis of demographic data in their study of the "spirit child" phenomenon in the Upper-east region of Ghana. Also, Driscoll et al, (2007) advise that "researchers seeking associations between primarily quantitative biophysical and primarily qualitative data..." should use mixed method research designs. According to them 'mixed method research' refers to all procedures of collecting and analysing both quantitative and qualitative data in the context of a single study.

3.3 QUALITATIVE METHODS

The use of qualitative methods was informed by the fact that in dealing with individual life experiences, one cannot understand human actions without understanding the meanings that participants attribute to those actions – their thoughts, feelings, beliefs, values and assumptive worlds; therefore the researcher needs to understand the deeper perspectives captured through face-to-face interactions (Marshall & Rossman, 1999). The inclusion of qualitative-ethnographic methods was further inspired by the Adongo et al (1998) study which was conducted in an area with very similar socio-cultural characteristics (as documented by Cardinall (1920), Rattray (1932) and Fortes & Goody (1987)) as those of my study area. It was always borne in mind, however, that these data recording strategies should not intrude excessively in the ongoing flow of daily events; that will fit the setting and the participants' sensitivities and that these will only be used with participants' consent (Marshall & Rossman, 1999).

3.3.1 Focus Group Discussions

A focus group discussion is a research strategy which involves intensive discussion and interviewing of small groups of people, on a given 'focus' or issue, usually on a number of occasions over a period of time. This method enables the researcher to utilise group dynamics in order to study the breadth of experience of respondents, thereby gaining maximum variation of answers with adequate depth. According to Krueger (1988), the interaction between participants in a group can provide valuable, sometimes unexpected information and understanding; and for base-line information FGDs can indicate the range of a community's beliefs, ideas, opinions and attitudes. This method assumes that an individual's attitudes and beliefs do not form in a vacuum: people often need to listen to others' opinions and understandings in order to form their own. In this vein Marshall & Rossman (1999) advise that the interviewer must create 'a supportive environment, asking focused questions to encourage discussion and expression of differing opinions and points of view' (p. 114).

Groups of about 8- 12 clan/family elders were each selected for Focus group discussions in Dagliga, Nangode, Datuko, and Tongo. There were therefore a total of four focus group discussions that were done. The choice of clan elders for the FGDs was very much informed by the Adongo et al (1998) study in which lineage heads were interviewed on the basis of the fact that the rites of divination (soothsaying) were practiced by men who are compound heads and lineage elders, and that only the lineage heads had the right to perform such rites on behalf of the entire family. This had been confirmed by earlier studies by Fortes & Goody (1987), Cardinall (1920), and Rattray (1935), who all had extensive ethnographic documentations of the practice of divination in the study areas.

It is necessary that during focus group discussions an atmosphere of mutual respect and tolerance should be created to enable participants to express their various points of view and

opinions. We therefore craved the indulgence of the discussants that everyone should be allowed and not to be shy or intimidated to express his/her opinion during discussions. The assumption in using this method was that in listening to other people's opinions and understandings of a particular issue one would form better attitudes and beliefs that would enrich the discussions.

3.3.2 In-depth Interviews

According to Boyce & Neale (2006) in-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program or situation. They are useful when the researcher wants detailed information about a person's thoughts and behaviour, or want to explore issues in depth, most often to be used to provide context to other data to offer a more complete picture. In this case an in-depth interview is an open-ended, discovery-oriented method the goal of which is to deeply explore the respondent's point of view, feelings and perspectives. Qualitative researchers tend to rely quite extensively on in-depth interviewing. According to Patton (1990), interviews are categorised into three general types namely, the informal conversational interview, the general interview guide approach, and the standardized open-ended interview. In-depth interviews are much more like "conversations with a purpose" rather than formal events with predetermined response categories. The researcher explores a few general topics to solicit the interviewee's views but gives room for the interviewee to frame and structure the responses. The underlying assumption behind this approach is that the participant's perspective on the phenomenon of interest should unfold as the participant views it, and not as the interviewee views it (Marshall & Rossman, 1999).

A major advantage of using in-depth interviews is that they can provide much more detailed information than what is available through data collection methods such as surveys.

Additionally they provide a more relaxed atmosphere to collect data. On the strengths of this technique and against the fact that FGDs are limited in explaining complex beliefs of individuals, In-depth interview was used to augment the data.

In using this method however, its major disadvantages were noted: prone to bias, and not generalizable. The research made use of some purposely selected diviners and healthcare workers. The research was interested in exploring the perspectives of both diviners and health workers on the role of divination played as far as seeking care from modern health facilities was concerned. With each of these acting as 'professionals' in their own right, and probably as competing rivals in health delivery, it was possible for each of them to want to prove that its practice is more superior than the other. This was a potential source of bias. Boyce & Neale (2006) noted this bias and advised that special efforts should be made in designing a good interview protocol (the rules that guide the administration and implementation of the interviews) and a good interview guide, to minimise this bias.

There were two major in-depth interviews conducted: one with diviners and the other with health workers. A total of five diviners were interviewed. There were also a total of six senior health workers interviewed.

3.3.3 Observation

Observation is a fundamental and highly important method in qualitative inquiry (Marshall & Rossman, 1999), and indeed considered as basic to all scientific investigations (Kumekpor, 2002). It entails the systematic noting and recording of events, behaviours, and artefacts (objects) in the social setting chosen for study. It requires observation to discover certain complex interactions in natural social setting. During the in-depth interviews observation was

used with the aid of field notes to note the interviewees' body language and affect in addition to words.

The observations were carried out with the aid of field notes. Field notes are brief jottings of important points during a conversation or observations that are described and written in detail as soon as possible following the interview. They serve to supplement data that cannot be tape-recorded and would have gone unnoticed but for the observation. Field notes include what the researcher sees, hears, experiences, and observes and ideas arising during the process. They also include the description of the participant, recordings of the physical setting, who was present, what was said, how it was said and the tone of the voice, gestures, nonverbal communication (such as giggles or laughter); the researcher's impressions, and general reflections on what was happening at the time of the conversation or activity (Morse & Field, (1995); Richards, (2006); Speziale, (2003).

3.3.4 Ethnography

In order to appreciate in a more tangible manner the diviners' and community elders' perspectives of divinations as it is used in health seeking, it became not only necessary to conduct face-to-face in-depth interviews but also to observe the sessions of the divination process itself. In view of this a mini or focused ethnographic approach was adopted in order to understand the shared beliefs and practices regarding the art of divination.

Ethnographic approaches enable the researcher to understand the construction of order and reality and the necessary techniques and production and interpretation of meaning from the perspective of the participants (Jansen, 2006). By using this approach a deeper understanding of the beliefs and behaviours in their socio-cultural contexts is achieved.

3.3. 5 Methods used in selection of study participants

Generally convenient sampling methods were used to select the various study subjects for the Focus Group Discussions and the In-depth Interviews. The categories of subjects are shown in *Table 2*.

Table 2: Selection of participants for the Qualitatative study

Type of interview	Communities/health facilities sampled	Participants sampled
In-depth interviews with diviners	Dagliga Kongo Tongo Sakote Datuko	One from each community
Focus group discussions with clan heads/community elders	Dagliga Tongo Nangode	eight clan/community elders from Dagliga, ten from Tongo, eleven from Nangode
In-depth interviews with Healthcare practitioners	Tongo Health Centre Kongo (private-owned clinic) Datuko Health Centre Nangode Health Centre Sakote CHPS Compound	One Medical Assistant One Senior Nurse One Senior Nurse One Medical Assistant One senior Community Health Nurse

A total of five diviners, conveniently chosen on the basis of their popularity in the art, were interviewed. They were all married men aged between 45 – 65 years. Apart from being diviners they also engaged in peasant farming to supplement their living. The study engaged five groups comprising of 8 - 12 of community elders in FGDs. The community elders were chosen on the basis of their extensive knowledge in the tradition and in divination. A total of six healthcare practitioners were also interviewed. Three of them were Senior Medical Assistants (MAs) and the other three senior nurses. They were chosen on the basis of their extensive knowledge and experience in managing the activities of their respective healthcare facilities.

3.3.6 Recruitment of study participants

According to Patel et al (1990), recruitment is a dialogue, which takes place between an investigator and a potential participant prior to the initiation of the consent process. It begins with the identification, targeting and enlistment of participants for a research study. It involves providing information to the potential participants and generating their interest in the proposed study.

A recruitment strategy (plan for identifying and enrolling people to participate in the research a study was used. The strategy specified the criteria for screening potential participants, the number of people to be recruited, the location and the approach. In recruiting people for the FGDs the inclusion criteria was male clan heads in the communities that were sampled. With the aid of the Research Assistants who all had a fair knowledge of the social setting of the communities, a community elder was first approached by introducing ourselves and the aims and objectives of the study to him, then asking him to kindly participate in the study. It was further explained that participation was voluntary and that one was at liberty to withdraw from the discussions anytime one deemed it necessary. However a promise to keep the discussions as confidential as possible was also made. When this elder finally consented to participate, we got the other members through a kind of snowballing in which the participant with whom the contact had been made and agreed used his social networks to refer the team to other elders who could potentially participate in the study.

With the assistance of community members a diviner was recruited from each of the five communities sampled. The criteria for the selection of the diviners were on the basis of their popularity and effectiveness in divination as perceived by the community members. Initially three of such diviners were proposed and by consensus they then settled to one best to be

approached. Upon identifying this potential participant the team then visited him to solicit his participation. The aims and objectives of the study as well as the provisions as per the consent form were all explained to him in the local dialect after which he gave his consent by signing (by thump printing) the Consent Form.

In recruiting the health care workers the team first selected the five health facilities comprising two Health Centres, two clinics, and one CHPS zone. The In-Charges of these health facilities were contacted, with the assumption that they had sufficient knowledge and experience in dealing with health care delivery at their respective areas. The aims and objectives was explained and the health workers consented by signing the Consent Forms. In all the contacts that were made the date, time and venue for the discussions and interviews were negotiated and agreed upon.

3.3.7 Analysis of Qualitative data

Data entry and management

The qualitative raw data was in the form of verbatim transcriptions of all interviews and discussions. This consisted of audio-taped interviews with the healthcare workers and diviners, as well as discussions of the focus groups with community clan elders. Audio tapes of interviews with the healthcare worker were all in the English language and so were transcribed directly. However those of the diviners and community elders were done in the local Nabt and Talen dialects and therefore were first translated into the English language and then transcribed verbatim. Using Microsoft Word processor the transcripts were all typed and converted into a text-based electronic format and saved as separate files using the extension: .rtf (rich text format). Finally by using NVivo-7, qualitative data analysis software, a NEW PROJECT was then created and all files were imported for processing and analysis.

3.4 QUANTITATIVE METHODS

3.4.1 Study survey

A community survey was conducted using a questionnaire. There was the need to describe and explain statistically the variability of certain features of the population. The questionnaire was therefore included to obtain data on the socio-demographic characteristics and to obtain cross-sectional responses from the entire community on perceptions of whether or not divination was used to solve health problems.

3.4.2 Methods used in sample size calculation

In calculating the sample size for the study the Daniel (1999) formula (recommended by Naing et al (2006) was used. This was based on the fact that the survey was intended, among others, to estimate basically the prevalence of the practice of divination with respect to the socio-demographic characteristics of the study population. According to Daniel (1999) the appropriate formula for calculating the sample size of a known population of more than 50,000 is given by n, as:

$$\mathbf{n} = \frac{[\boldsymbol{NZ}(\boldsymbol{P}(\mathbf{1}-\boldsymbol{P})]}{[\boldsymbol{d}^{\mathbf{2}}(\boldsymbol{N}-\mathbf{1}) + \boldsymbol{Z}^{\mathbf{2}}(\mathbf{1}-\boldsymbol{P})]}$$

Where:

N = the total population

Z = Z statistic for a level of confidence (confidence interval)

P = the expected prevalence or proportion of the event to be measured

d = the precision level (p-value)

Using the conventional estimates of

Z = 1.96,

d = 0.05

P = 50% (i.e. 0.5)

And assuming

N = 100,000 (from Population and Housing Census, 2000 for the T-ND)

Then, n = $[(100,000)\ (1.96^2)\ (0.5)\ (1\text{-}0.5)]\ /\ [(0.05^2)\ (100,000\text{-}1) + (1.96^2)\ (1\text{-}0.5)]$

= 381.23471 (using STATA-11)

To adjust for possible loses the sample size was taken as 400 (200 for males and 200 for females).

3.4.3 Sampling method used to select survey respondents.

To administer questionnaires a probability sampling technique was necessary in order to obtain a representative and unbiased sample. Therefore every effort was to be made to ensure that each member of the population had an equal chance of being selected. The step-by-step guide for conducting immunization coverage contained in the WHO document *Training for Mid-level managers: the EPI Coverage Survey (WHO/EPI/91.10)* was adopted and used for sampling the respondents.This method involved a two-stage cluster sampling technique in which a random sample of sub-populations was done followed by the selection of each household to select the individuals.

The first stage involved identifying the clusters. To do this the study area was divided into six zones to coincide with the already existing six administrative sub-districts namely; Tongo Central, Tongo West, Nangodi-Kongo, Sakote-zolba, Tongo East and Datoko. Each of these sub-districts was made up of a number of communities which together totalled 21 communities, and therefore these were considered as the clusters. The population of each sub-district was known but those of the individual communities were not known. Each sub-district population was divided by the number of communities in it to obtain an average population for each community. In this case it was assumed that communities in each sub-district had equal populations. In order to systematically select clusters, a sampling interval or unit was calculated by dividing the total population by the number of clusters. By the use of random numbers the clusters were then systematically selected.

The second stage involved the selection of houses and the individual respondents. Since the list of houses was not available and there were at least 100 houses in each village and therefore not feasible to list them, the households were selected in the following manner. A

point judged to be the central location of the village was located. From this point a simple random method was employed by spinning a bottle on a smooth surface and determining the direction pointed by the opening of the bottle and subsequently choosing the first house in that direction. Then a count of the number of houses which exist along the directional line selected from the central location to the edge of the village was done. After this a random number between 1 and the total number of houses along the directional line selected was used to determine the first house to be selected. On entering the selected house a male and a female adult was selected for the administration of the questionnaires. In choosing subsequent houses it was assumed that the houses were single family dwellings. Therefore the second house visited was the one nearest to the first. The next nearest house was the one whose front door (entrance) was closest to the front door of the house just visited. The procedure was repeated till the total number of houses was obtained in each cluster chosen. In all a total of 210 houses were sampled to select 410 respondents. The sampling format showing the clusters selected, and the number of houses and individuals selected in each cluster is shown in *Table 3.*

In using this sampling method it was noted however that while it was convenient, time saving and generally satisfactory to use the method, the use of the method could decrease the precision of the sample result because there is usually the tendency for individuals within a cluster to share characteristics (Henderson & Sundaresan (1982).

Table 3: Cluster identification and sampling format

Sub-district	Clusters	Population	Cumulative Population	Population + S.I	Cluster chosen	Number of Houses chosen	Num of respondents chosen	Total population of sub-district
Tongo West	1. Pwalugu	5866	5866	5866	1	10	20	23462
	2. Awaredone	5866	11732	10620	2	10	20	
	3. Shia	5866	17597	15374	3	10	20	
	4. Yinduri	5866	23463	20128	4	10	20	
Tongo Central	5. Tongo	5569	29032	24882	5	10	20	16706
	6. Gorogo	5569	34601	29636	6, 7	20	40	
	7. Yamiriga	5569	40170	34390	8, 9	20	40	
Tongo East	8. Namologo	6354	46524	39144	10, 11	20	40	19062
	9. Kpatia	6354	52878	43898	12	10	20	
	10. Duusi	6354	59232	48652	13, 14	20	40	
Datoku	11. Datoku	3343	62575	53406	15	10	20	10030
	12. Gare	3343	65918	58160	-	-	-	
	13. Yogbare	3343	69261	62914	16	10	20	
Sakote-Zolba	14. Pelungu	3593	72854	67668	17	10	20	17969
	15. Zanlerigu	3593	76447	72422	-	-	-	
	16. Sakote	3593	80040	77176	18	10	20	
	17. Dagliga	3593	83633	81930	19	10	20	
	18. Logre	3593	87226	86684	20	10	20	
Nangoe-Kongo	19. Nangodi	4200	91426	91438	-	-	-	12602
	20. Dakio	4200	95626	96192	21	10	20	
	21. Kongo	4200	99826	100946	-	-	-	
Total						**210**	**420**	**99832**

S. I. = Sampling Interval = Total population divided by number of clusters = 4754

Random number = 1014.

3.4.4 Analysis of Quantitative data

Data management to ensure data quality

The objective of the data analysis was first to inspect, clean, and transform the data to ensure data quality and subsequently to model the data in order to highlight useful information. Two main data sets were obtained – quantitative and qualitative data. The quantitative data consisted of the survey data initially captured in Epidata and imported into Stata-11 software.

To ensure that quality data was obtained for the actual analyses the data was first inspected to identify and remove erroneous data. Checks were made for: missing observations- whether missing at random or systematic; non-response – in order to calculate response rates; and extreme values.

Secondly, to describe the structure of the data basic checks and manipulations were performed using Stata-11 software. This involved counts, summaries, listings, replacements, dropping duplicate observations, sorting, merging, and generation of variables and their properties. In all these, checks were done to ensure that there were no adverse effects on the distribution of the variables.

Statistical analyses

Basic statistical analyses of variables of interest were done by performing tabulations and cross-tabulations. The relevant tabulations yielded frequencies which were used to describe the basic summaries of the variables. The cross tabulations allowed for comparison between variables and so Chi-squares and P-values were obtained for testing the associations between variables. For this study the significance level was 0.05.

Logistic regression, the method most commonly used for the analysis of binary outcome variables (Kirkwood & Sterne, 2003) was used to analyse the data as it was obtained from a cross-sectional survey. It was used specifically to address one of the study questions that aimed at determining the extent to which people resort to divination to solve their health problems. To estimate this we made use of a key question in the questionnaire that solicited a categorical dichotomous response from respondents as to whether they utilized divination for the solution of their health problems or not. This response, which was a binary outcome (Yes=1, No=0) constituted the dependent variable. The independent variables (the covariates) were the socio-demographic characteristics – age, sex, marital status, and number of wives possessed by men, number of children, formal education level, religious affiliation, occupation, and income level. Results from the logistic regression were reported as odds ratios with corresponding 95% confidence intervals. The odds ratios between two groups was interpreted as the odds of utilising divination for one group divided by the odds of utilising divination for the other group. A test for the overall association of a variable was done using the Wald test. The aim of the analysis was to estimate the effects of these socio-demographic characteristics on the outcome i.e. the dependent variable (whether or not one has ever utilized divination to solve health problems). It was however noted that odds ratios when assumed to be equivalent to relative risks tend to overestimate real effects, because odds ratios approximate relative risk if the outcome of interest i.e. use of divination, is rare. In this study the use of divination was estimated to be high. But rather than using only bivariate analysis, logistic regression enables a fair prediction of whether a person will use divination based on the socio-demographic characteristics The effect of each of these socio-demographic characteristics could also be measured.

3.5 TRIANGULATION

Triangulation is using a combination of at least two or more theoretical perspectives, methodological approaches, data sources, investigators, or data analysis methods in a single study. The intent of using triangulation is to decrease, negate, or counterbalance the deficiency of a single strategy, thereby increasing the ability to interpret the findings (Thurmond, 2001). In this study the methodological approaches involved ethnographic in-depth interviews with diviners and community clan heads together with face-to-face interviews with health workers, as well as a community survey. Though the qualitative and quantitative data were analsed seperately, findings from both data were triangulated in the interpretation and discussion of the results to achieve coherent conclusions.

3.6 PREPARATIONS FOR FIELDWORK

3.6.1 Protocol/Community entry

As normal protocol procedures demand, some key healthcare administrators in the region, as well as in the District Assembly (DA) had to be visited first. An introductory letter from my Head of Department was very useful in confirming my mission in these visits. I visited a number of key persons in their respective offices to explain my mission and to solicit their approval and support for the exercise. Among them was the Regional Director of Health Services (RDHS) at the Regional Health Directorate in Bolgatanga, the District Chief Executive at the District Assembly in Tongo, the District Director of Health Services at the District Health Directorate in Tongo, the Sakot-daan (the Spiritual Leader of the Nabdam traditional area) at his residence in Sakote. Some other community elders, opinion leaders, assembly men/women of the various communities were also visited.

As part of community entry initial house to house visitation of clan heads to explain the aims and objectives of the research was carried out. Assembly Members and opinion leaders were consulted. Readiness to explain aims and objectives of the project to any member of the community was assured.

3.6.2 Recruitment and training of Research Assistants

A total of ten school teachers who all reside in the district were recruited to be Research Assistants. A day's training was given to them to enable them appreciate the aims and objectives of the study, and to assist in the administration of the questionnaires and the conduct of the FGDs and interviews. They were trained on how to use the sampling format to identify clusters, houses, and individuals for the administration of the questionnaires. They were also trained on the importance of respect for research participants and the maintenance of confidentiality.

3.6.3 Pre-testing

The questionnaires and interview guides went through three stages of pretesting. First, they were subjected to scrutiny by colleagues and some senior academic staff including my supervisors. The feedback from these helped tremendously in sharpening the validity and consistency of the instruments.

Secondly the instruments were assessed by the ten Research Assistants that were recruited to administer the questionnaires. During their training for the conduct of the fieldwork the opportunity was taken to allow them to assess the questions and seek clarifications from me. They were asked to point out any aspects of the questions that they thought will pose difficulties of understanding to the potential respondents. Their input in this regard was

invaluable as they were the very ones to administer the questionnaires, and clear understanding of the questions was important especially in assisting the illiterate respondents to answer the questionnaires.

Finally the instruments were piloted on some individuals randomly selected from a nearby community. The objectives of this exercise were to assess the thinking behind the respondent's answers so as to accurately assess whether the questions were being answered properly, and whether the questions were actually understood by respondents. It was also to assess whether the questions actually asked what is intended to be asked and, as well as whether respondents are able and willing to provide the needed information.

The combined feedback from these pretesting exercises offered not only opportunities to revise the instruments to better standards, but also some key lessons were learnt. For example, during discussions with the Research Assistants it was advised that the instruments should not be applied to women, the reason being that generally women were hardly involved directly in divination matters. This was confirmed by experiences during pretesting in the nearby community, as many women declined to answer the questions when they were told the questions were about divination. Furthermore some of the men in the pre-test group advised us not to 'waste our time' asking women about divination. In spite of these useful hints an attempt was made to recruit female respondents in order to explore and verify these assumptions.

3.7 ETHICAL CONSIDERATIONS

3.7.1 Introduction

A study of this nature will definitely involve some ethical issues as it borders on people's religious beliefs and practices. The fundamental tenet of ethical research enjoins the researcher to respect and protect the rights and welfare of those who volunteer to participate in the research. The core principles that form the universally accepted basis for research ethics (as originally contained in The Belmont Report) namely *Respect for persons, beneficence* and *justice* were carefully noted. According to The Belmont Report, *Respect for persons* requires a commitment to ensuring the autonomy of research participants, and, where autonomy may be diminished, to protect people from exploitation of their vulnerability. The dignity of all research participants must be respected and people should not be used merely as a means to achieve research objectives. The Report further explains that *Beneficence* requires a commitment to minimising the risks associated with research, including psychological and social risks, and maximising the benefits that accrue to research participants; and *Justice* also requires a commitment to ensuring a fair distribution of the risks and benefits resulting from the research.

Additionally, *respect for communities,* as suggested by some bioethicists as the fourth principle for research ethics was noted. This principle emphasises the obligation of the researcher to the values and interests of the communities in which the research is conducted, and to protect the communities from harm. As noted earlier this study does not intend to prove the efficacy or otherwise of the practices of divination. Hence throughout the entire process of data collection care was taken to abide by this. Sound training of the Research Assistants in this area was imperative.

3.7.2 Ethical clearance

The proposal for the study was presented to the Board of Examiners at a seminar at the School of Public Health at which valuable inputs were suggested. After incorporating inputs from the seminar approval was given by the School Board to subsequently submit the proposal to the Ministry of Health Ethical Review Board for ethical clearance. After reviewing the proposal the MOH ethics community issued the approval for the study to be conducted.

3.7.3 Consent for participation in the study

Informed consent is a mechanism for ensuring that people understand what it means to participate in a particular research study so they can decide in a conscious, deliberate way whether they want to participate. A written consent was obtained from the participants after carefully explaining the key issues to be considered before giving consent. The key issues included the purpose of the research; what is expected of the research participant, including the time likely to be required for participation; expected risks and benefits, including psychological and social; the fact that participation is voluntary and that one can withdraw at any time with no negative repercussions; and finally, that maximum confidentiality will be maintained and protected.

Additionally, my contact address as well as that of the Ethical committee was provided to enable the research participants make contacts if they had any further enquiries about the research. All participants of the study – the Health workers, the diviners and community clan elders who took part in the focus group discussions gave their consent for participation by signing the Consent form.

3.7. 4 Incentives for research participants

The ethical appropriateness of the use of incentives in research involving human subjects has been an issue of considerable sensitivity and controversy (Grant & Sugarman, 2004). While some authorities dismiss incentives as an outright unacceptable practice, other authorities regard the use of incentives as innocuous depending on certain circumstances. Examining the issue of incentives, the ethics of human subjects research, and the areas where the use of incentives either introduces ethical problems or aggravates already existing ethical problems, Grant & Sugarman (2004) found out that 'in the vast majority of situations, the use of incentives in medical research will not pose ethical problems.' They noted however that there are two serious ethical questions that can arise with the use of incentives: (1) can the use of incentives constitute "undue influence" or a coercive inducement to participate? And, (2) can the use of incentives compromise the dignity of the subjects? They therefore cautioned against the use of incentives in circumstances involving the combination factors such as where the subject is in a dependency with the researcher, where the risks are particularly high, where the research is degrading, where the participant will only consent if the incentive is relatively large because the participants' aversion to the study is strong, and finally, where the aversion is a principled one.

In this research some incentives were given, particularly to the diviners and participants of the FGDs. While noting the cautions in giving incentives to research participants it was nonetheless necessary to give some incentives. For example during the community entry phase of this research it was noted that custom demanded that one cannot convene a meeting of elders without offering some drink to refresh themselves at the end of the meeting. Therefore at the end of every FGD some money was given to participants to purchase the

drink of their choice. Additionally each participant was given Two Ghana cedis for cola or tobacco, also in accordance to local custom. Regarding the diviners, One Ghana cedi was given to each as consultation fee before the commencement of every interview. At the end of each interview Five Ghana cedis was given to each, also for cola and tobacco.

3.7.5 Limitations of the study

This study is not without both limitations particularly in relation to the findings and conclusions that have been made. Patton (1990) noted that "there are no perfect research designs. There are always trade-offs" (p. 162). This has been re-echoed by Marshall and Rossman, (1999) as "No proposed research project is without limitations; there is no such thing as a perfectly designed study" (p. 42). It is therefore in recognition and understanding of this reality that I discuss what I perceive as the limitations of the study which are summarised under the following headings:

Generalisation of findings

The study was conducted in just one out of the nine districts in the Upper-East region, which is also just one out of the ten regions in Ghana. Ghana is a multicultural country with several different cultural beliefs and practices. Also, the study population is a relatively homogenous sub-cultural group. For example, the district is predominantly rural with relatively fewer and less equipped health facilities. Generalization of findings to other cultural groups or across the entire country including urban areas is therefore limited, though the cultural homogeneity allowed for better understanding of the phenomenon being studied. However, in the entire northern part of the country, which is predominantly rural with similar socio-cultural practices and healthcare infrastructure, transferability of the findings may be possible.

Design and relevance of methods used

Focus group discussions were limited to only elderly clan heads who were men. No focus group discussions were done for women and children. This was based on the advice of some community members and on my personal common knowledge that women and children were not directly involved in the active practice of divination. However in the community survey questionnaires were administered to a relatively fewer women and on analyses of their views some quite useful insights were discovered, thereby suggesting that focus group discussions for women could have been helpful. Also, ideally focus groups require two interviews per group, but only one per group was done due to time and logistical constraints..

Sampling and selection of survey respondents

Another challenge faced was the practicability in using the adopted cluster sampling method. It should be noted that this method though theoretically the best in obtaining a truly random sample within the prevailing circumstances was tedious and fraught with problems of practicability. For example the assumption that the clusters of communities within each sub-district had equal number of people meant that not all the population really had equal chance of being selected. Also personal biases from the research assistants in strictly applying the technique could not be ruled out. Another limitation was the willingness of a selected person to participate by answering the questionnaires. This was particularly so when some of the women declined to answer issues on divination. This accounted for the reason why the number of female respondents was less than that of the men. In an attempt to compensate for this more men (above the targeted sample size of 200) were chosen.

Analysis of quantitative data

The logistic regression model was used to determine the socio-demographic predictors of divination for health. The interpretations of the odds ratios were based on the assumption that they were equivalent to relative risks. In using this model one has to be modest on the use of odds ratios because of the tendency to overestimate real effects. For example odds ratios approximate relative risk if the outcome of interest is rare. In this study however the use of divination in health seeking was found to be high (about 71%). On the basis of this caution we admit that the interpretations of the odds ratios may not have been very accurate. However since the survey was done to augment the qualitative study judgements based on this is unlikely to be in serious error.

It is humbly admitted that other data collected in the questionnaire were not presented and discussed. This is partly because of some shortfalls in the questionnaire design and also because of time and logistical constraints.

Possible biases

The 'positionality' of the researcher in qualitative studies can affect the quality of the findings (Kirby et al, 2006), and especially when the researcher is part of the culture, it is difficult to achieve neutrality (Werner et al (1987). By positionality Kirby et al refer to as the way that an individual's position in the social hierarchy compared to other groups potentially "limits or broadens" one's understanding of others. In this regard the researcher in this current study was born and raised up by parents belonging to the research area, and as such is part of the culture of the people – speaking the same language and quite conversant with the beliefs and practices pertaining in the area. Being aware of this "position" I constantly reflected upon my assumptions and the tendency to expect certain responses from participants

so as not to unduly bias my observations and findings. I might have not done this as perfectly as desirable and hence some unintended biases might have crept in. However my belongingness and apparent familiarity to the area was useful as it enhanced my ability to easily solicit their cooperation, especially during the recruitment of participants for the study.

CHAPTER FOUR

4.0 RESEARCH FINDINGS/RESULTS

4.1 INTRODUCTION

In this section I present the findings of the study under the themes and sub-themes that emerged as a result of a triangulation of analyses of both the quantitative and qualitative data. I first present findings pertaining to how divination is practiced in terms of how one can become a diviner, and the processes involved in consulting a diviner. Also presented in this section are the reasons why participants would consult diviners before, during and after seeking healthcare at modern health facilities. Perceptions of the role of diviners in mainstream medical care from the perspectives of the diviners themselves, community members and health workers, are also presented. Also, findings of the common types of illness conditions that are perceived to require divination are presented. Finally, descriptive statistics of the socio-demographic characteristics of the survey sample as well as the levels of significance between these characteristics and whether or not one used divination to solve health problems are presented. P-values, confidence intervals and odds ratios of logistic regressions employed to establish the predictors of divination practice with respect to these characteristics are also presented.

4.2 THE PRACTICE OF DIVINATION

The qualitative interviews involved in-depth interviews with health workers and diviners, as well as focus group discussions with community elders. The diviners were aged 45-65 years old. They were all married and also engaged in peasant farming. Community elders were also aged 50-70 years old.

4.2.1 Becoming a diviner

The diviners generally consider their profession to be sacred, claiming that no one ever wished to be a diviner, or decided on his own to be a diviner; but one could only become a diviner when chosen by the ancestors. According to them one is predestined from birth to become a diviner and this predestination comes through inheritance, normally from male grandparent to a male grandson. When the person who is ancestor-chosen grows to adult age certain signs such as some bizarre sickness will afflict the victim and in efforts to remedy the situation will prompt the parents or the clan head to consult a diviner for interpretation. So the eligibility to become a diviner is normally determined by divination. The following are the responses of all the five diviners when they were asked to tell how they became diviners:

> *It is my great grandmother who passed on this thing to me; it comes through the mothers' line and it is the gods who chose me to be a soothsayer. This came out of soothsaying. You cannot choose yourself or just decide that you want to be a soothsayer unless the ancestors choose you. [Diviner 1)*
>
> *It was through sickness. A strange sickness attacked me and when they went to the soothsayers it was revealed that the Bakolug is in me. I accepted it and I was then initiated into it. [Diviner 2]*
>
> *When they gave birth to me i was very sick for a long time. So my parents consulted the soothsayers who then disclosed that I was destined to be a soothsayer. They accepted it and offered the needed sacrifices. When I grew up I looked for the necessary items and I was then initiated into it I was a professional violin player, and it is this that turned into Bakolug, because the soothsayers revealed it. So I had to be initiated into it, and that's how i became a soothsayer. [Diviner 3]*
>
> *I was a professional violin player, and it is this that turned into Bakolug, because the soothsayers revealed it. So I had to be initiated into it, and that's how i became a soothsayer. [Diviner 4]*
>
> *What happened as I became a soothsayer was that I went into the bush and saw an animal called "Dee" (antelope) very difficult for a human being to chase this animal and catch it but because it was destined for me to be a soothsayer, I had to run "karikarikari" to catch it and I caught it. [Diviner 5]*

4.2.2 The consultation process

All the diviners who were interviewed used generally very similar items for their art. The basic items used consisted of a goatskin bag with its content, a stick, a musical instrument, and two or more vertebral bones of an animal. The contents of the bag consist of several and various code objects each of which represents some phenomenon or something about the life situations of people. Fortes & Goody (1987) described these objects as 'standard code symbols' or '*materia oraculosa'*. The items also fit very much Cardinall's (1969) description of the content of the diviner's bag as:

> *Inside the bag are all kinds of apparent rubbish, some old bones, dirty little rags containing 'medicine,' weird-shaped stones, bits of iron, broken pottery, feathers, bits of skin, horns – a regular rag-and-none merchant's collection* (P. 30).

Figure 4 is a picture of the objects contained in a typical diviner's bag ((taken with permission from one of the diviners).

Figure 4: The items in a diviner's bag.

The diviner's stick is about a meter long and is forked at the upper end. It is called *bakolug-dore,* which literally means the diviner's stick. During a divination session it is this stick (when held at its lower end by the client and supported loosely at its upper end by the diviner) that points to the objects or makes certain signs that are interpreted by the client. For example when the stick points to a red object such as a red piece of cloth it is interpreted to mean danger. Then the client would ask, 'danger from where?' the answer could be given by the stick pointing upwards, which is interpreted to mean 'from the gods or ancestors'. The client would then ask, 'so what should I do?' The stick could then point to a fowl's leg which would mean 'offer a fowl to your god'. The client could ask further – 'what type of fowl?' The stick may then point to a piece of white cloth which is interpreted as 'white fowl'. [This illustration is from personal observation I made during a consultation process a client had with one of the diviners].

The musical instrument is a bottle-shaped gourd with seeds or little pebbles inside it (called *bagre-siyak*), a violin, or a long horn used to produce some musical sound. The diviner would normally use this item to produce some sound or music to inform the spirits or ancestors to be on the alert and consider a matter brought before them by a client for their consideration and interpretation.

The small vertebral bones are called *bakolug-kuga* (*bakolug-kugri*, singular). These are used to confirm the outcome of a divination. This is done by the diviner throwing them down and the positions on which they lie (either convex or concave up) are then interpreted.

A typical consultation session would normally involve the client who may be accompanied by one or two persons, and the diviner himself. The divination is done in the diviners' office (*bakolug-zong*), which is usually a small hut with a very narrow entrance, located in a corner of the house of the diviner. When it is the turn of a client he goes into the hut with his companions and the consultation starts. They all sit on the floor and after the client has offered a 'consultation fee', the content of the bag is poured onto the floor in front of them. The diviner calls on the spirits/ancestors with his musical instrument together with some verbal incantations. Both client(s) and diviner now assume that all ancestors relevant to diagnosing the problem are present and are ready to listen to them. One would expect that during consultations there must be a solemn atmosphere, but it is interesting that during the session there can be interruptions. For example the diviner can be greeted by someone from outside if it is urgent enough to do so. Also, other conversations on unrelated issues could come in, or they could laugh at a joke delivered by any one of them. Moreover the consultations need not be strictly private or secret, for voices could be loud enough for even the other waiting clients outside to listen to. This confirms Fortes & Goody (1987) comment that "divination sessions are never secret – private consultations can be listened to and even interrupted by callers or friends of either party" (p. 13).

The main diagnosis of the situation is determined by the movement of the stick, normally held loosely by the diviner at the upper end and by the client at the lower end. The client would ask a question or make suggestions about the problem he has come with and the stick will point to the objects and the interpretations are done accordingly. Normally a client is supposed to have learned the skill of divination in terms of knowledge of the code objects, and so would not need the diviner to interpret to him. However, whenever the client is in doubt the diviner could help in the interpretation.

In questioning whether there could be manipulation of the movement of the stick, two of the diviners offered for me to simulate a consultation. On the basis of this personal experience I can testify that the stick indeed is not manipulated, it moves and points to the objects and makes other kinds of movements without the control of both the diviner and the client. Regarding this procedure the following responses were given by the diviners:

> *It's from the gods and not me. The only thing you have to do is to hold this stick and it will direct you to whatever you came purposely for.... and whatever you came here to ask for the gods will tell you and not me because everything here has a meaning. [Diviner 1)*
>
> *It is the Bakolug-dore that will point out the items for you. But it is better you learn the art so that you will be able to ask the necessary questions to the Bakolug for clarification. [Diviner 2]*
>
> *I have absolutely nothing to do with the movement of the stick. The Bakolug controls the movement because it is only the Bakolug that knows why you came and what you should do next to solve your problem. I don't know what problem you have, how can I control things? Only the Bakolug can see and tell by pointing at the items. [Diviner 3]*
>
> *... as for me, and for every diviner, we don't "see" anything. It is the Bakolug that "sees" the issues and points the stick (Bakolug-dore) to the items for you to make the interpretation. My duty is to hold the stick, I have no influences as to what it will touch or point to. [Diviner 4]*
>
> *If the person comes, the person does not tell you what is wrong with him/her; you collect whatever the person brings and tell the gods to collect it, and try to diagnose the problem. You ask the gods and not the person. It's only the gods that can tell the problem with the person. [Diviner 5]*

All the diviners believed that they have been chosen by the gods/ancestors to perform their functions in society. They claim they have no influence whatsoever on the outcomes of divination consultations: the gods reveal whatever is required of men through the *bakoluk-dore* and this is interpreted and understood by the client. This confirms Rose's (2003) explanation that those who divine by mechanical means such as *coscinomancy* normally explain that the movements of the instruments are 'caused by some spirit which controls the instruments' (p.779). The diviners also revealed that every diviner is chosen through divination and subsequently initiated into the profession.

Figure 5 is a picture showing one of the diviners explaining the functions of the items in the diviner's bag.

Figure 5: A diviner explaining the functions of the items

4.2.3 Consultation fees

All the diviners said no client was required as a matter of compulsion to pay consulting fees for the services of diviners. To begin the consultation, the client would normally deposit anything he/she has to offer after which the diviner would announce to the *Bakolug* to accept the offer and "wake up" to try to find out the problem. The offer is never specified; it could be money, foodstuff, pepper, salt, or even a stone. A client could be given audience by the *Bakolug* even if he or she has nothing to offer. Another common finding from of all of the diviners is that the consulting fees and other items given by clients do not necessarily become the property of the diviner but strictly that of the *Bakolug*. A diviner could use these for his personal gains only with permission from the *Bakolug*, and this permission could only be ascertained through divination.

The following are their responses regarding consultation fees:

> *We don't have fees. Whatever you give we take. But when you come and go back and everything goes on well with you, you have to bring grass (as evidence) as you can see. Yes whether salt, sugar, millet, money or anything. [Diviner 1]*
>
> *It could be millet, corn, salt, money, anything you bring is acceptable. If you have nothing you also consult, or you can consult and later bring something, it is acceptable by the Bakolug. [Diviner 2]*
>
> *No we don't have any amount, whatever you have we collect. It can be millet, money, etc. [Diviner 3]*
>
> *As for we diviners we don't charge fees. The clients would normally bring millet, corn, money, anything. We accept anything, and even if you bring nothing (Laughs) we will soothsay for you. [Diviner 4]*
>
> *If it is hard for someone the person can even bring a stone as consultation fee and i must soothsay for that person. But if you come in your cool condition you must have something to give to the soothsayer and he will collect if someone even brings money, you take it. Someone can even have plenty money and come but someone might not have and if the person has even thousand (GH¢1) you will have to help the person. [Diviner 5]*

4.2.4 Referral of clients

Another striking revelation was that all the diviners said they were not required to refer or suggest that the client consult other diviners for further consultations. A question was asked to this effect and the following were responses from them:

> *It is the bakolug that does referrals. If the bakolug cannot see anything when you come, you just have to try somewhere else. The bakolug can only refer you to a herbalist, but cannot refer you to another bakolug [Diviner 1]*
>
> *Not at all! We don't do that. If you come and the bakolug fails to diagnose your problem it is you who will advise yourself who to go to next [Diviner 2]*
>
> *It's true we soothsayer's can't tell somebody to go and see another soothsayer. If the person comes to you and the bakolug fails to see anything wrong in terms of your gods' demands, then that is it. Because if you throw the stones and nothing shows up you will give the person's money back to him and tell the person that there is something going wrong in his house that cannot be seen clearly by the bakolug, and If the person goes away and thinks that he needs to consult another soothsayer it is up to him [Diviner3]*
>
> *No. We never do that. You the client will decide to see another soothsayer. [Diviner 4]*
>
> *When you come to me and nothing is seen, it is left onto you to decide what to do next. You can see another soothsayer, but we cannot direct you to other soothsayers [Diviner 5]*

Generally, the diviners perceive themselves in society as instruments or handmaids of the gods and ancestors through whom community members can find divine answers to their predicaments. Regarding health, they see their role as basically custodians of the spiritual means by which people can find out the causes of diseases and the course of action for these diseases. They maintain that as their clients come to them (the diviners) their only duty is to determine from the ancestors and gods (and not by the diviners themselves) the cause of their predicaments and to give advice on the mode of therapy. They claim that through divination it can be determined whether a patient's sickness is "doctors' sickness" (*yerib*) or supernatural sickness (*ba-nam*). In the case of a diagnosis of *ba-nam*, the reasons for the client's affliction are revealed and these would normally be related to certain misconduct of

the client or his close relations, or the breach of certain taboos or social norms. The divinatory 'prescription' would normally require the client to offer some sacrifices to the gods or ancestors. It could also require the client to perform certain rituals. However if the sickness is diagnosed as relating to *yerib*, the client would normally understand that he has to go to some herbalist or seek orthodox (modern medical care) at the most convenient health facility.

4.3 SEEKING HEALTH AT MODERN HEALTHCARE FACILITIES: INFLUENCE OF DIVINATION

Results from the qualitative study revealed that there is the general belief that diseases are either physical or spiritual. The predominant cause of disease in the individual was perceived to be poor personal hygiene. This is within man's physical and personal control and therefore natural means and methods could be applied; the spiritual are believed to be caused by supernatural forces such as the gods and the ancestors, and therefore can be diagnosed through supernatural means and subsequently treated by supernatural methods. It is therefore mainly for this reason that people would visit the diviner especially when they suspect supernatural causes. For example, a participant in a FGD summed up reasons for visiting diviners in the following manner:

> *The reasons why we in particular we like consulting the soothsayer whenever we are sick or any of our household is because, in this world nothing is caused without a reason. So first of all we have to find the root of the sickness, is it caused out of disobedience or what? Maybe you have been disobedient to your forefathers/ancestors or let's say the gods may be the actual cause of the sickness. So it is good and advisable to consult the soothsayer before even an attempt to cure it so that after curing you wouldn't go back to commit some crime, and to add, may be finding out the cause it can be a spell cast on you and the soothsayer can show you what to do to be free. (Community elder at Tongo).*

From Focus Group discussions participants gave many and varied reasons why some patients would visit the diviners while they were being treated or admitted at the hospital or clinics. The reasons given tend to emanate from a general belief and practice that while seeking medical care from modern healthcare facilities like hospitals and health centres, it is advisable and prudent to seek "other" causes of the patient's disease because the doctors do not know it all. Some specific reasons were given for this health-seeking behaviour. First of all patients wanted to be sure whether their condition was of natural or supernatural cause. This was necessary to be able to determine the therapy options to choose. This was especially so in chronic protracted cases and in conditions such as burns, snakebites, boils, and

fractures. Patients with these conditions tend to attribute the conditions to supernatural causes and would therefore want to verify this, hence the resort to divination.

In all these instances it is believed that a disease that has supernatural causes can never be successfully treated by doctors and nurses, and that diviners can give clues as to how supernatural diseases can be best treated. This is exemplified in the following responses of participants in FGDs involving community elders in Nangode and Dagliga respectively:

> *Yes, sometimes if you are admitted in the hospital sometimes the doctors tell you that this your sickness is a 'house sickness' so you have to go to the house for treatment or is a spiritual sickness, and if you don't send it to the house you may die (Community elder in Nangode).*
>
> *Your relatives, what would be their function at home? (while you are in hospital). They must also be doing something to complement the efforts being made at the hospital by visiting the diviners to find out the real reasons for your sickness. This is especially so if your recovery is very slow or if we think the doctors are failing (community elder in Dagliga).*

Responses from the diviners corroborated those from the clan elders. For example, some of the diviners and community elders stated that it was advisable and reasonable to first rush any acute disease or symptom to hospital or clinic, explaining that while the doctors were attending to the patient the relatives also had the responsibility of finding out other possible modes of treatment; for that matter divination was important. In a response to a probing question whether there are some conditions that necessarily require that the patient must see the diviner first before going to hospital or clinic, one of the diviners had this to say:

> *Truly, in these modern times no one should rush the sick person to the diviner first; you should rather first send the person to hospital immediately and leave some money for the doctors to attend to him. You the relatives what is then your duty at home? You must do the necessary sacrifices at home. You then run to the diviner to find out whether your patient will survive or not. In my opinion anyone who rushes the patient first to the diviner is only a fool (Diviner 1).*

In answering a similar question this was re-echoed by another diviner as follows:

> *For me I always advice that they should always take the person to hospital first before later they can consult we the soothsayers (Diviner 3).*

Reasons for people visiting diviners even after being treated and discharged from hospital were related specifically to conditions such as fractures, burns, suspected case of poisoning, and snakebite as indicated by various participants as follows:

> *Ok, let's say you had an accident and you had a broken bone, for here in Upper – East region they can't do anything with it, in the hospital unless they transfer you to the southern hospitals, so with this the doctors themselves will tell you that they will look in the broken part of the body and see if there is any sorer so that they can give some drugs for the sore to heal and then the family will now take their patient to the house for local treatment. And with this the local people will re-break it and now straighten it. And sometimes if the hospital people put the broken part in a P.O.P we will cut of all the P.O.P and now do our sacrifices for the broken part to heal.* (Community elder in Tongo).

> *Yes, let's say in the case of poisoning, if they poison you to die you have the right to tell the doctors that with this, we need our patient back to the house for treatment because is like this and if they now allow you to take the patient to the house, then you will now go to the one who has that poisoning medicine locally or let say the herbalist, he/she will now give the patients some herbs and he/she will vomit all the poison out and be save.* (Community elder in Nangode)

> *Yes, they are two things if let say the sickness was malaria you have to go to find some herbs like neem tree, and if it is a snakebite after the hospital treatment you have to go to the one who can traditionally remove the teeth of the snake so that you never be shivering when it rains.* (Community elder in Dagliga)

A health worker confirmed that the belief that there are always supernatural forces behind any disease or mishap that happens to a person was pervasive and explained the reasons why the people must find out from the ancestors or gods through the diviners. This health worker indicated how this belief and practice manifest as he attends to patients in his clinic, in the following manner:

> *They (the patients) will still visit the soothsayer because they believe that accident should not come at all except when you have wronged your god. So for every sickness, whatever it is, after it has been cured they will still go to the soothsayer to say this thing happened to me. Well, they fear, you don't know when it will happen and so he has to find out whether this thing that happened to me and I don't know whether it's ok and I want to find out if there are some sacrifices I have to make to prevent future ones. So they still go to the soothsayer. So how you will get to know that they still gothe soothsayer is that some might still even be on admission and you want them to stay a bit longer to take some medications and*

> *they will be urging to let them come home because there are some sacrifices they have to make and they have to be there [at home] and that has been determined through the soothsayer. It means that someone might have told him, so that will tell you that they are going to a soothsayer. That tells you the reasons for discharge against medical advice (Health worker at Tongo).*

4.4 THE USE OF DIVINATION FOR HEALTH SEEKING FOR SUPERNATURAL ILLNESSES

It was found out that the respondents had 'fixed' notions of the aetiologies of certain diseases or conditions as emanating from supernatural forces and for that matter would invariably seek supernatural explanations through divination irrespective of whether they visit a modern health care facility for remedy or not. The specific diseases mentioned were boils, burns and scalds, anthrax, fractures, snakebites and poisoning.

4.4.1 Burns

This condition is believed to be associated with some spiritual complications even if it is treated at the hospital. The belief is that whatever mode of treatment used to treat this condition, the condition can only be fully cured if certain deities are identified and certain sacrifices offered. Thus, in all cases of burns the diviners are consulted ultimately to determine the final cure. A health worker confirmed this with the following response:

> *Like burns due to fire, it is believed that when you are cured in the hospital you still need to go to the herbalist to perform some rituals. Though the sores are no longer there but you need to get to a herbalist or someone who have that spiritual power to perform those rituals to prevent you from getting another burn in the future. (Medical Assistant)*

4.4.2 Boils

A person with a boil of any kind is often strongly advised not to seek hospital or allopathic treatment. This stems from the belief that metallic objects should not be introduced into the body while there is a boil that has not been resolved, and that when such thing is done for instance by giving an injection the result will be fatal. Because of this, most patients even if

on admission at the hospital would vehemently resist an injection when he/she discovers there is a boil in the body. This notion is consistent with Bierlich's (2000) findings regarding fear of injections among the Dagomba of Northern Ghana. A nurse had the following to say about this issue:

> *They also had the belief that with the boil, if they come and we inject them they will die. So because of that any little boil they get they don't come until they see that the boil is burst and after that even if they come and we inject they can now survive.*

This nurse's view was corroborated by two of the diviners as follows:

> *Why, because if you go to the hospital and they don't assess you well and inject you, you may die. That is why locally we treat it [the boil] and after it has burst and turns to sore you now take it to the hospital for them to wash it. Another one is anthrax; it can turn to a boil in your body (Diviner 2).*
>
> *... in conditions such as epilepsy, boils and carbuncles. In boils and anthrax for example they will tell you these do not need injections, if you inject them they will die (Diviner 1).*

4.4.3 Anthrax

This disease is normally contracted when people handle or consume carcasses of infected animals. The notion of mode of treatment of this disease is closely related to that of boils, for it is believed that anthrax invariably produces a boil in the body and therefore will produce similar consequences when the patient is injected. This was confirmed by a nurse and a diviner in the following words:

> *(A condition like) anthrax. This they (the patients) will tell you it is not good for injection (Nurse).*
>
> *... In boils and anthrax for example they will tell you these do not need injections, if you inject them they will die. (Diviner 4)*

4.4.4 Snakebite

Both local and allopathic modes are utilised in the treatment of snakebites. They would usually commence treatment with local concoctions prescribed by herbalist. However in severe cases where the patient is bleeding profusely accompanied with obvious signs of weakness they would rush the patient to hospital. The diviners are always consulted while these are going on. The outcome of such divinations always however point to supernatural causes and hence the tendency to resort to supernatural modes of therapy. There is the general belief that once bitten by a snake the patient will from time to time (even if treated) experience some symptoms, normally seasonal in nature. A diviner explained this in the following manner:

> *There are the traditional treatment and the orthodox treatment (for snakebite). The traditional doctor can give you some herbs and you will vomit all the poison and he will rub some on your leg. He will also remove all the snake teeth in your leg. You can go to the doctor and they will give you medicine to take and it will stop but when rain clouds begin to gather it will show in your eyes (Diviner 2).*

4.5 HEALTH WORKERS' VIEWS ABOUT THE ROLE OF DIVINERS IN MODERN HEALTHCARE DELIVERY

Analyses from in-depth interviews with all health care professionals (Medical Assistants and Nurses) revealed that these professionals were ambivalent on how diviners could play a positive role in health delivery: while some of them were very sceptical about the role of diviners in health delivery and generally regarded their role as negative, others had strong views that diviners could play positive roles in health delivery.

Some of the health workers generally perceived diviners to be the first line of contact for patients and for that matter served as important links between them (health workers) and the

diviners. These links, according to them, could be exploited positively by the Ghana Health Service to enhance health delivery. For example, while acknowledging that he will not dispute nor acclaim the assertions made by diviners regarding their ability to foresee the future and outcomes of people' predicaments, a health worker nonetheless stressed the need for healthcare practitioners and the Ghana Health Service to work in collaboration with diviners since they (the diviners) were not only the first most often to be consulted by patients but also they direct patients as to the next steps to take regarding mode of therapy. He summed up the role of diviners in the following response to the question on how he perceived the role of diviners in healthcare delivery:

> *...Their role is very important because they are the first to see the patient. What we need to do is not to shun them. Beliefs and values of our people are something they can never forget in their lives. The Ghana Health Service should recognise them and accept them to be part of us, and we will be able to agree on how to manage certain conditions together. The fact that they will always see the patient first before us is very important.... because they are with them and they will never, never say they don't know them. We need to also give them our knowledge. Health workers also need to know a bit about what they are doing. If we don't interact with them more they can keep the patient till things get worse (Medical Assistant).*

Another health worker revealed (in the following words) that diviners' activities could be considered largely to be positive because they can give some clues to health workers and herbalists to be able to arrive at proper diagnoses of some of the clinical cases that they deal with.

> *They [the diviners] could help in diagnosis. In my view they help in diagnosis. For example, when the diviner says you have "kugri" [a local name for stone, used to denote the condition of a very hard mass felt on the abdomen], he is giving a hint on diagnosis. When the patient comes and says he has "kugri", when you do a thorough palpation of the abdomen, you will find out the patient has a very hard mass which could indicate an enlargement of the liver or the spleen. This can help in the final diagnosis. (Medical Assistant).*

This health worker also stated diviners' social role, which he regarded as positive, as follows:

> *Socially in a way they try to control our behaviours and values, because if you doubt something the soothsayer can separate the truth for you, so you try to*

> *control that type of behaviour. For example in the case of adultery the soothsayer is the first to detect. When the woman is confronted she will normally not deny because it is true. Also there might be a quarrel between two people about a certain thing or about who might have been the culprit in the case of a theft case, the soothsayer can separate them... so you see they help in dispute resolution as well.*

In spite of these, other health workers were of the view that the negative role of diviners far more out-weighed the positive role in mainstream healthcare. Their main concerns bordered on some negative attitudes of patients in health seeking which they blamed on the advices and activities of diviners. These include delays in reporting for medical attention, taking concoctions while on admission, lack of confidence in medical treatment, and asking for discharge against medical advice. These health workers were of the view that diviners had nothing to offer in terms of treatment of any disease or condition except to prescribe concoctions or ask them to offer sacrifices to their gods/ancestor, and therefore it was absolutely unnecessary and a waste of time to consult diviners when one is sick. They explained that most of the cases that are brought to the facilities for attention were complicated cases because the victims had wasted time consulting diviners before seeking medical attention.

The health workers also attributed some non-compliant behaviour of some patients such as the taking of concoctions by patients while undergoing medical treatment, and asking for discharge against medical advice, to the influence of diviners. They explained that some diviners would advice their clients that the conditions for which they are in hospital were not really conditions meant for hospital and as such those conditions could never be treated successfully by medical staff. Therefore when such patients are in hospital they do not have confidence in the treatment being given to them by the medical staff, instead they would adhere to the prescriptions of the diviners. Such patients, they further explained, had the tendency to ask for discharge in order to comfortably treat the condition at home. Because of

these, the health workers believed that diviners can contribute to complicate patients' conditions in terms of their influence on patients' attitude in seeking appropriate therapy. For example, a nurse was concerned that the diviners' activities in the community in which she works largely contribute to complications of patients' conditions thereby creating further problems when the patients eventually come for treatment at the health facility. This was expressed in the following manner:

> *Regarding the health role of diviners, at times they do worsen cases before they come. Because they [the patients] keep taking these concoctions and before they come the condition is worse. If they are lucky and it is not any serious condition and they take some treatment and it subsides, fine. But when they fail and come it becomes a problem. Some of the diviners give treatment. If they don't give treatment, they link the patient to the herbalist. This link is hindering our services. When they come we don't know where to start from, because the extent of the concoctions they have taken goes to affect other parts of the body then you will diagnose something else; meanwhile the main problem is there.*

In addition this nurse said that it was also not economically prudent to adhere to diviners' prescriptions though they claimed they do not charge for their services, in the following words:

> *They [the diviners] feel they don't charge. But they tell you buy this, buy that goat or sheep or other animals for sacrifice. With this they [the patients] don't see any cost, but in reality at the end they spend more than they would have spent in the hospital.*

Another nurse at a different health centre could hardly imagine that diviners could have any positive role in health delivery. This nurse blamed particularly the delay of pregnant mothers in seeking supervised delivery at her Health Centre on the prescriptions of diviners, and portrayed the activities as totally inimical to health in the following words:

On the part of health they play a negative role. When you have malaria and you go to the soothsayer what are you going to do, and somebody having bridge or transverse in labour and you go to the soothsayer what are you going to do? Maybe going to the soothsayer for juju and other things, as for that they can do that. But on the part of health, can the soothsayer give you para or chloroquine? Me I don't believe in them, I don't think my pesewa will ever go to them for anything.

4.6 SOCIO-DEMOGRAPHIC PROFILE OF SURVEY RESPONDENTS

From the quantitative survey the respondents were made up of 258 males and 126 females, representing approximately 67% and 33% respectively, of the total sample. Their ages ranged between 18 years to 60 or more years, with a modal age group of 31 – 45 years. Those in the youngest age group (18-30) and those in the oldest age group (60+) constituted about 29% and 13.0% respectively of the total sample. Of the total sample about 69% are married, 22% are single, and 2.3% divorced, while about 6% of them are widowed or are widowers. Approximately 73% and 62% of the males and females respectively are married. Twenty percent of the men (55) had at least two wives and 56% of them had only one wife, suggesting a basically polygynous society. Of the women 61.9% (78) of them are also married. Proportionately more of the women are widowed than the men, reflecting a lower sex ratio at older ages. About 41% of the sample had at least four children, reflecting the generally high fertility rates in the area.

About 51% of the respondents had no formal education at all, while about 16 % attained tertiary level education (i.e. training college level and above). Those with JSS/MSLC and SSS/GCE/Technical constituted 10% and15% respectively. Regarding religious affiliations of the respondents, African traditional believers constituted about 60% (majority), while Christians were about 32%. Moslems and other religions were 6.7% and 1.3% respectively.

Income levels were found to be generally low: Less than 15% of the respondents had annual income levels above 500 Ghana cedis, while about 35% had annual income less than 100 Ghana cedis. The predominant occupation of respondents is farming or agricultural activities. About 55% (211) of them are involved in this activity for their livelihood, of which 67% and 29% of the men and women respectively are involved. The socio-demographic characteristics of the respondents are summarised in *Table 4*.

Table 4: Distribution of socio-demographic characteristics of survey respondents by sex

SOCIO-DEMOGRAPHIC CHARACTERISTICS	MALES	FEMALES	TOTAL FREQ	TOTAL PERCENTAGE (ROW)
Age				
18 30	72 (27.91)	41 (32.52)	113	29.43
31-45	86 (33.33)	45 (35.71)	131	34.11
46-60	63 (24.42)	28 (22.22)	91	23.70
60+	37 (14.34)	12 (9.52)	49	12,76
Total	258	126	384	100
Marital status				
Married	188 (72.87)	78 (61.91)	266	69.27
Single	58 (22.48)	28 (22.22)	86	22.40
Divorced	5 (1.94)	4 (3.17)	9	2.34
Widowed/widowed	7 (2.71)	16 (12.70)	23	5.99
Total	258	126	384	100
Number of wives (for males)				
None	58 (22.48)	-	58	22.48
One	145 (56.2)	-	145	56.20
Two	40 (15.50)	-	40	15.50
Three	6 (2.33)	-	6	2.33
Four	6 (2.33)	-	6	2.33
>four	3 (1.16)	-	3	1.16
Total	258	-	258	100
Number of children				
none	0 (0.00)	1 (0.79)	1	0.26
One	56 (21.71)	28 (22.22)	84	21.87
Two	48 (18.60)	26 (20.63)	74	19.27
Three	42 (16.28)	21 (16.67)	63	16.41
Four	39 (15.12)	26 (20.63)	65	16.93
>four	73 (28.29)	24 (19.05)	97	25.26
Total	258	126	384	100
Educational level				
No formal education	130 (50.39)	67 (53.17)	197	51.30
Primary	23 (8.91)	10 (7.94)	33	8.59
JSS/Mid School	35 (13.57)	22 (17.46)	57	14.84
SSS/GCE/Technical	24 (9.30)	13 (10.32)	37	9.64
Tertiary	46 (17.83)	14 (11.11)	60	15.63
Total	258	126	384	100
Religious affiliation				
Traditional	173 (67.05)	56 (44.44)	229	59.64
Christian	66 (25.58)	58 (46.03)	124	32.29
Moslem	15 (5.81)	11 (8.73)	26	6.77
Other	4 (1.55)	1 (0.79)	5	1.30
Total	258	126	384	100
Occupation				
Farming	174 (67.44)	37 (29.39)	211	54.95
Housewife	0 (0.00)	29 (100.00)	29	7.55
Self employed	25 (9.69)	24 (19.05)	49	12.76
Salaried worker	47 (18.22)	19 (15.08)	66	17.19
Unemployed	12 (4.65)	17 (13.49)	29	7.55
Total	258	126	384	100
Annual income				
Less than Ghc 100	87 (33.72)	49 (38.89)	136	35.42
Ghc 100-200	78 (30.27)	43 (34.14)	121	31.51
Ghc 250-500	49 (18.99)	22 (17.46)	71	18.49
More than Ghc 500	44 (17.05)	12 (9.52)	56	14.58
Total	258	126	384	100
Percentage	**67.19**	**32.81**		

4.7 THE USE OF DIVINATION IN THE COMMUNITY

About 95% of the respondents indicated they were aware of the existence of diviners in their communities. Approximately 90% of both men and women were aware of the practice of divination with more than 85% estimating that there were at least five diviners in each of their communities. The majority (53.3%) of the respondents indicated that men alone were allowed to consult diviners, while 25% and 38% indicated it was women and family heads respectively.

Out of the total respondents 94.9% of them attested to the fact that the practice of divination was widespread in the area. This consisted of 97% of the males and 90% of the females. *Table 5* shows the distribution by socio-demographic characteristics of the proportions of respondents who utilized divination for their health problems. About 71% of the respondents mentioned that they have ever utilised divination to solve a health problem, and this is made up of 75.6% of males and 59.5% of females.

***Table 5*: Proportions of respondents who use divination for health**

Socio-demographic characteristic	Number	Proportion	Chi square	P- value	Degree of freedom
Age			42.17	0.000	3
18 – 30	55	48.67			
31 – 45	96	73.28			
46 – 60	79	86.81			
60+	41	83.67			
Sex			11.02	0.001	1
Male	196	75.97			
Female	75	59.52			
Marital status			31.74	0.000	3
Married	209	78.57			
Single	43	50.00			
Divorced	3	33.33			
Widow/widower	16	69.57			
Number of wives			31.77	0.000	5
None	29	50.00			
One	116	80.00			
Two	36	90.00			
Three	6	100.0			
Four	6	100.0			
>four	3	100.0			
Number of children			50.64	0.000	5
None	0	0			
One	36	42.86			
Two	51	68.92			
Three	46	73.02			
Four	54	83.08			
>four	84	86.60			
Educational level			52.14	0.000	4
No education	168	85.28			
Primary	25	75.76			
JSS/Mid.	32	56.14			
SSS/GCE/Technical	19	51.35			
Tertiary	27	45.00			
Religious affiliation			107.44	0.000	3
Traditional	207	90.39			
Christian	52	41.94			
Muslim	10	38.46			
Other	2	40.00			
Occupation			55.76	0.000	4
Farming	181	85.78			
Housewife	18	62.07			
Self-employed	28	57.14			
Salaried	30	45.45			
unemployed	14	48.28			
Income level			3.50	0.320	3
< 100	103	75.74			
101 – 200	80	66.12			
201 – 500	51	71.83			
500+	37	66.07			

With respect to the different age groups and the different levels of education, the use of divination showed an increasing and a decreasing trend respectively. The use of divination is lowest (49%) in the age group 18-30 years. It increases to about 73% in the next age groups (31-45 years), then increases further to about 90% in age group 46-60, and finally decreases slightly to about 84% in the last age group (60+ years) to the highest in age group 46-60 year and decreases slightly for age group 60+. Thus it appears the older generations have more propensities to use divination than the younger ones. It also appears the tendency to use divination decreases with higher levels of formal education (lowest for those with tertiary level education (45%) to highest with no formal education (85%). Similarly the propensity to use divination shows increasing trends with respect to the number of wives possessed by men and the number of children one had. The more the number of wives and children they have, the more the tendency to use divination. Regarding marital status those married had the highest proportion (about 79%) of those who use divination than the rest.

About 90% of those who practice traditional religion said they would employ divination for their health problems. However about 42% and 38% of the Christians and Muslims also used divination respectively. However, the tendency to use divination does not appear to vary among those in the various occupations and income levels.

χ^2 analyses were done to determine the statistical significance of the associations between the various socio-demographic characteristics and the use of divination. It was found that all the characteristics except income levels were statistically significant.

Using the socio-demographic characteristics (age, sex, marital status, number of wives, number of children, educational level, religious affiliation, and occupation) as independent variables and use of divination (Yes=1, No=2) as the dependent variable a logistic regression was done and results obtained as depictured in *Table 6*.

Table 6: Logistic regression of socio-demographic characteristics on use of divination

Socio-demographic Characteristics	Logistic regression (without Interaction)			Logistic regression (with interaction)			Wald Test
	OR	P-value	C.I	OR	P-value	C.I.	$P > \chi^2$
Age	2.12	0.000	1.62 – 2.76				0.000
18 – 30				Ref			
31 – 45				2.90	0.000	1.70 – 4.94	
46 – 60				6.94	0.000	3.41 – 14.13	
60+				5.40	0.000	2.33 – 12.55	
Sex	0.47	0.001	0.29 – 0.73				0.001
Male				Ref			
Female				0.47	0.000	0.29 – 0.73	
Marital status	0.64	0.001	0.50 – 0.83				0.000
Married				Ref			
Single				0.27	0.000	0.16 – 0.45	
Divorced				0.14	0.006	0.03 – 0.56	
Widow/widower				0.62	0.322	0.24 – 1.59	
Number of wives	3.52	0.000	2.12 – 5.85				0.000
None				Ref			
One				4.00	0.000	2.08 – 7.71	
Two or more				9.00	0.000	2.83 – 28.54	
Number of children	0.14	0.000	1.45 – 2.02				0.000
None				Ref			
One				0.12	0.000	0.06 – 0.24	
Two				0.34	0.006	0.16 – 0.74	
Three or more				1.18	0.034	0.19 – 0.94	
Educational level	0.60	0.000	0.52 – 0.69				0.000
No education				Ref			
Primary				0.54	0.173	0.22 – 1.31	
JSS/Mid.				0.22	0.000	0.11 – 0.43	
SSS/GCE/Technical				0.18	0.000	0.09 – 0.39	
Tertiary				0.14	0.000	0.07 – 0.27	
Religious affiliation	0.19	0.000	0.13 – 0.28				0.000
Traditional				Ref			
Christian				0.08	0.000	0.04 – 0.14	
Muslim				0.07	0.000	0.03 – 0.16	
Other				0.07	0.005	0.01 - 0.45	
Occupation	0.57	0.000	0.49 – 0.67				0.000
Farming				Ref			
Housewife				0.27	0.000	0.12 – 0.63	
Self-employed				0.22	0.000	0.11 – 0.44	
Salaried unemployed				0.14	0.000	0.07 – 0.26	
				0.15	0.000	0.07 – 0.35	

OR = Odds Ratio, CI = Confidence Intervals

Without controlling for the effect of the various strata of the independent variables all the independent variables were found to be statistically significant with odds ratios as follows: Age (2.12), sex (0.47), marital status (0.64), number of wives (3.52), and number of children (0.14), educational level (0.60), religious affiliation (0.19) and occupation (0.59). This means that age accounted for two times and number of wives almost four times the odds of using divination. Also sex, marital status, educational level, and occupation accounted for 47%, 64%, 60%, and 59% respectively the odds of using divination. Number of children and religious affiliation accounted for only 14% and 19% respectively the odds of using divination.

However, on controlling for the effects of the various strata it was found that among the various age cohorts those in 31-45, and 46-60+ were about three and seven times respectively more likely to use divination than those in 18-30 (referent group). Also those in 60+ were five times more likely than the referent group. This means that the older generations tend to use divination much more than the younger generations. This finding seems to corroborate findings from interviews with some diviners regarding who consults diviners. For example, a diviner had the following to say regarding who qualifies in the community to consult a diviner.

> *Normally anybody can come to us to consult – children, young men, old men, but usually no children. It is the parent, the elderly person, or the family head that come to us to find out about what issues concern children's health. (Diviner 5))*

Meanwhile some other responses indicated that there is no hard and fixed rule as to who can consult diviners. For example this diviner from Dagliga had this to say:

> *When you think of consulting a diviner you normally inform the father of the house that there is a problem and you want to see the diviner. He will normally give you permission to go. Bakolug (divination) matters have nothing to do with seniority or whether one is elder or not. It depends on you knowing the art of soothsaying, if you know how to do it you can go without consulting anybody. In fact it is in the case of offering sacrifices that an elder or the senior must be involved (Diviner 2).*

This finding is also consistent with the customary and cultural practices that pertain in the area-that in matters regarding critical decision-making the older generations has more power as household headship and clan headship is normally associated with the more elderly. Thus in a patriarchal society one would expect that women and children voices to be heard only through the sanctioned hierarchy of communication. Gaining permission to seek health care from a gate keeper – either husband or compound head – was an accepted cultural norm (Ngom, et al. 2003).

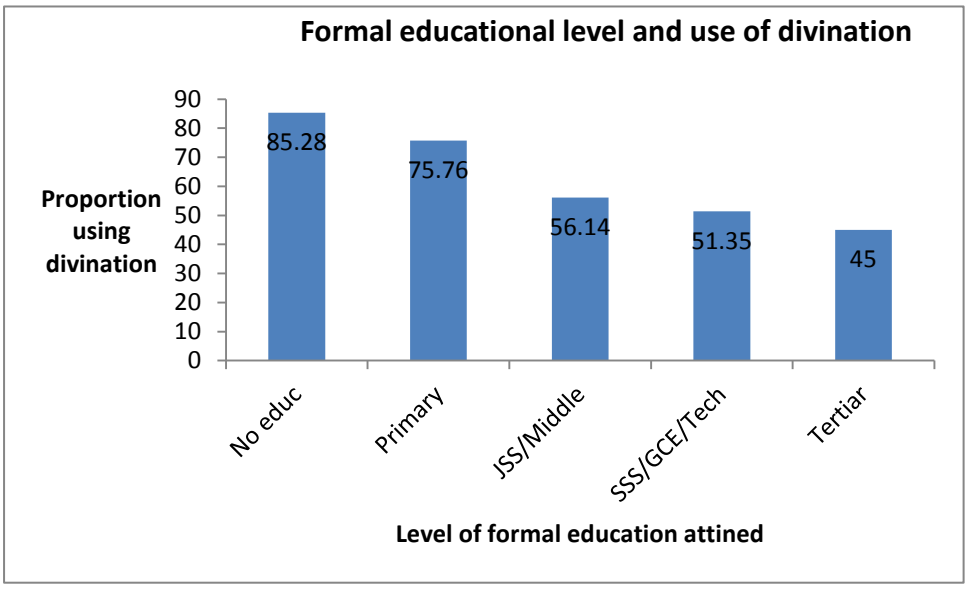
Females were 47 percent less likely to use divination than males (males as referent group). This is rather surprising in view of the general impression that women had not much to do with divination matters (as revealed in the pre-test). Perhaps women may not consult the diviners directly in matters involving their ill-health but would ask their husbands to consult on their behalf and would generally endorse such consultations.

With the married as referent, singles were 27 percent and the divorced 14 percent less likely to use divination. Being married made one 64% more likely to use divination. For the men those with one and two wives were respectively four and nine times more likely to utilise divination than those without wives. However in controlling for the effect of the different strata (married, single, divorced, and widow/widower) widowed/widower was found to be insignificant, while single and divorced were significant. It is noted that the common factor among the three categories - singles, the divorced and the widowed - is the fact that they all have no spouse present, and on the basis of this one would have expected the category widow/widower to also be significant. A possible explanation is that while only 7.4% of both the singled and the divorced are 45 years and above, 82. 6% of the widowed/widowers are also in the 45 years and above group. Statistics on the number of wives were limited only to

male respondents as the assumption was that women did not have wives. Thus only 258 (total number of males) observations were recorded for this variable. The interpretations here can only be made of males. The results of logistic regression of this variable on the use of divination revealed that the number of wives possessed by men accounted for 3 ½ times the likelihood of using divination (OR=3.52, CI: 2.12-5.85.) Having one wife made a man four times more likely to use divination while those with two or more wives also were 9 times more likely (the referent being those with no wife). Perhaps the number of wives possessed by a man invariably imposes more responsibility as more wives could also bring along more children. Thus the men with more wives would consult diviners more especially as they have to consult on behalf of children and wives. This is consistent with the above analysis on spousal status.

On educational level those who had attained Primary school level were found to be insignificant with respect to the use of divination. However, with no 'formal education' as referent, those who had attained JSS/Middle and SSS/GCE/Technical were 22% and 18 % less likely to use divination, while those with tertiary level education were 14% less likely. Thus level of education and use of divination shows a trend that suggests that the higher the educational level the lower the likelihood of using divination. This is illustrated in *Figure 6*.

***Figure 6*: Educational level and use of divination**



Even though religious affiliation was significantly associated with the use of divination, Christians and Muslims did not vary in their tendency to use divination. However with reference to those of traditional religion both were averagely seven percent less likely to use divination.

Similarly housewives, the self-employed, salaried workers and the unemployed were 27%, 22%, 14%, and 15% less likely to use divination than those engaged in farming.

A Wald Test statistic on all subgroups revealed statistically real differences among them.

4.9 SUMMARY OF RESEARCH FINDINGS

The practice of divination in health seeking is generally widespread. About 71% (i.e. 75.6% of males and 59.5% of females) of respondents would consult diviners in the course of health-seeking. However, divination is often practiced as a prelude to treatment rather than for treatment itself. It is done to pin down supernatural and other causes of ill health and to determine proper patterns of resort.

The general belief that the causes of diseases are either physical or supernatural, or both, accounts for why some patients would visit a diviner before seeking a particular therapy. This is to first confirm or rule out supernatural causes. People would consult diviners while being attended to at modern healthcare institutions mainly because of the belief that medical staff are unable to deal effectively with the supernatural and spiritual aspects of their illnesses. After attending a health care institution for health care, or after being discharged from admission, patients would still consult diviners to satisfy the need to tackle the spiritual aspect of their illness.

Modern healthcare practitioners generally tend to view diviners as healers who play a role in the treatment of patients. They are however ambivalent about the efficacy of the diviners' therapies - while some of them were very sceptical about the role of diviners in health delivery and perceiving them as contaminants of healthcare delivery, others had strong views that diviners could play complementary roles in health care delivery. Diviners, on the other hand do not consider themselves as healers. Rather, they perceive themselves as merely custodians of the spiritual conduits by which people can determine the causes and course of action for their ailments, and not as therapist themselves.

Socio-demographic characteristics such as age, sex, marital status, and number of wives of men, number of children, and level of formal education, religious affiliation, and occupation have significant correlations with the use of divination in health seeking. These are determined as follows: Age accounted for two times the likelihood of using divination while having a wife made one three times.

Patients attending modern health institutions with conditions such as boils, snakebites, burns, anthrax, fractures have a potential for request for discharge against medical advice because of the beliefs they hold about such conditions.

4.10 CONTRIBUTION OF THE STUDY TO KNOWLEDGE

The study attempted to explore why people resort to divination in times of ill-health. This study has contributed to knowledge by bringing to the fore the role divination plays in the health-seeking matrix. The study has demonstrated that divination, when used in health seeking, is purely a diagnostic procedure by means of symbolic interpretations to determine whether an illness or disease condition is of natural and/or supernatural causes. This is contrary to the perceptions that diviners provide cure for patients. Hence consulting diviners for health could be complimentary since the modern health care system has not much capacity to diagnose conditions believed to be of supernatural origin. 'Prescriptions' accompanying divinatory outcomes often require the client to offer sacrifices to the gods and ancestors. The performance of these rituals may not be necessarily incompatible with modern healthcare treatment regimens.

It was found out that those patients with illnesses or disease conditions such as boils, snakebite, burns, anthrax and poisoning have fixed notions that their condition is of supernatural causes and would invariably consult diviners for confirmation to decide on treatment options. For such patients diviners are in most cases their first line of contact, or even if they are undergoing allopathic treatment efforts will be made to consult diviners for further interpretation of the situation.

The study also revealed that socio-demographic factors such as age, sex, marital status, number of children and wives, and educational level of people are strong predictors of the use of divination in health seeking. Thus the aged non-educated polygynous males are more likely to use divination in the course of ill-health. This is attributed to the fact that in such a community the level of education is low, fertility rates are high with a high tendency to marry

more than one wife, and the responsibility of securing health for family members is culturally vested in household heads who are invariably adult males.

The study also sought to advance the current paradigm shift in health policy that seeks to build a pluralistic healthcare delivery system that recognizes allopathic, traditional and alternative providers. It adds to this multi-sectoral approach by attempting to focus on divination which is an integral part of the social, cultural and spiritual dimensions of health.

CHAPTER FIVE

5.0 DISCUSSION OF RESEARCH RESULTS/FINDINGS

This study has demonstrated that diviners' role in the health-seeking pathway is merely diagnostic rather than curative, i.e., divination determines whether a patient's condition is of supernatural causes or otherwise. Upon knowing this the patient then decides the therapy options to be taken in order to remedy the situation. For example, the study revealed that patients with such conditions as boils, snakebites, burns and anthrax have very high tendency to consult diviners first even before they resort to modern medical treatment. In such cases therefore the diviners constitute an important locus for critical health decision and this has implications for public health practice especially in health education and health promotion activities. The study further suggests that belief in the supernatural and spiritual causes and consequences of ill-health is pervasive and endemic in the area. In as much as people would believe in supernatural causes, they would always seek supernatural means of dealing with their ill-health, including the use of divination. This has implications especially for timely utilization of the healthcare services being rendered at our healthcare facilities such as CHPS Compounds, clinics, health centres and hospitals. For example patients with acute severe conditions which might require urgent medical and/or surgical interventions could engage in consulting one diviner after another resulting in delay in obtaining the much needed urgent care and further resulting in worsening or complications of the condition. This has been alluded to by some of the health workers interviewed in this study. Yet belief in the supernatural causation of illness, especially in ancestors' role in any misfortune that befalls a person is so much entrenched that one cannot rule out the consultation of diviners. Perhaps the way forward is to consider the suggestions from the other healthcare practitioners (respondents) that the Ministry of Health and the Ghana Health Service could collaborate with diviners and other indigenous healers, and that this collaboration could offer a route

through which the diviners could be educated to advise their clients to seek medical attention first even if divination outcome points to supernatural causes. This we think is feasible in view of the fact that some of the diviners interviewed in this study have indicated that they would not require their clients to necessarily consult them first in time of sickness.

Indeed some studies have found evidence that the use of indigenous traditional remedies for certain disease conditions have no significant effect on diagnostic delays. For example, Makundi et al (2006) showed that traditional healthcare is not necessarily a significant impediment or delaying factor in the treatment of severe malaria in Tanzania. Oeser et al (2005) also found no evidence that the use of traditional remedies for tuberculosis in Lima has an appreciable effect on diagnostic delay. Recommendations from both studies centred on the need for collaboration between traditional healers and modern healthcare providers.

This notwithstanding the findings also suggests that consulting diviners for health is not medically harmful per say. Divination merely draws the attention of the patient to the spiritual and/or supernatural causes of his ailment, and 'prescriptions' from divination outcomes have invariably instructed the offer of some sacrifices or performance of some rituals to appease the gods and ancestors. In our opinion offering sacrifices or performing certain rituals with the intention to appease the gods or ancestors is not necessarily incompatible with medical treatment regimen since the two can be concurrently administered.

The results also indicate that even while the patient is undergoing orthodox medical care the desire to consult diviners is high because of the reason that he/she may not believe in the doctors' capacity to ably handle the condition. As Kleinman (1980) has explained patients who come to hospital with entirely different explanatory models about their illness may pose

problems of non-compliance to treatment regimen (including 'discharge against medical advice') as they may not perceive the medical staff as competent enough to tackle their problems especially those problems related to their cultural and belief systems. After all, the patient does not go to hospital leaving behind his/her spiritual and cultural beliefs and needs.

As the study has shown more that 70% of the respondents indicated they use divination in health-seeking. This is consistent with Mendonsa's (1975) finding among the Sisala that over 50% of persons who consult diviners do so because of health problems: thirty eight percent of the sample he interviewed said illness was the main motivation, while another 15% of the reasons (e.g. insomnia, childbirth, infertility and death) were health-related. Results of the current study also indicate that, age, sex, marital status, number of wives and children that a man has, educational level and religious affiliation, are significant predictors of the use of divination in health-seeking. This means that generally, the aged non-educated polygynous males who are traditional believers have higher odds of using divination for health. This is consistent with the customary and cultural practices that pertain in the this study area - that in matters regarding critical decision-making the older generations have more power as household headship and clan headship is normally associated with the more elderly. Thus in a patriarchal society such as the one under this study one would expect that women and children voices to be heard only through the sanctioned hierarchy of communication. Gaining permission to seek health care from a gate keeper – either husband or compound head – was an accepted cultural norm (Ngom, et al. 2003). This has implications for clinical care of patients, particularly the non-literate aged males who believe in traditional religion. In clinical medical care situations providing comprehensive care for such patients, and indeed for all patients, would therefore require cultural competence skills from medical staff that

would enable them provide care that is effective, understandable and respectful in a manner compatible with the patient's cultural health beliefs and practices.

This underscores the need for health workers especially doctors and nurses to understand and appreciate the explanatory models that their patients may hold about their health and disease conditions. The ambivalence with respect to responses from the health workers regarding the role of diviners probably reflects the deficiency of knowledge about some of the indigenous healthcare resources that abound in the socio-cultural environment. This study has provided a baseline understanding of the practice of divination and provides insights into how health workers could begin to appreciate the work of diviners and begin to collaborate with them. This could complement recent efforts of the Ministry of Health and the Ghana Health Service to integrate orthodox and traditional medical practices with the view of obtaining maximum benefits. Rather than the mutual disregard, distrust and suspicion that usually characterise the relationship between modern health workers and folk/ traditional medical practitioners, there should be cooperation and collaboration between them to enable both tackle the myriad of health problems confronting the people. In this vein it is worth noting the Adongo et al (1998) study that demonstrated that the activities of diviners were not inimical per say to healthcare delivery with regards to the implementation of a planned Family Planning programme in the Kassena-Nankana area in Northern Ghana.

Our analysis in this study show that diviners generally do not consider themselves as healers or therapists as such, but as the spiritual conduits by which members of the society can determine the causes and course of action for their ailments. In fact, all the diviners interviewed in this study are consistent with this stand. This suggests some doubts as to whether we can call the diviners 'traditional healers', as they have been labelled as such in most studies elsewhere. For example, Golooba-Mutebi & Tollman (2007) and Truter (2007)

have labelled diviners as traditional healers. From the analysis of their practices and their role as in this study they can rather be best described as 'diagnosing agents' in the pathway to healing. Hardly do they prescribe any object or substance in the form of traditional medicine (defined in traditional health practice as "an object or substance used in traditional health practice for- (a) the diagnosis, treatment or prevention of a physical or mental illness; or (b) any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings". The diviners here rather do a socio-spiritual diagnosis of the situation to discover the social and spiritual antecedents of the illness, and thereafter provide clues to the patient as to the appropriate therapist to resort to. All diviners insisted that they as persons have no any direct role, or do not manipulate anything, during divination consultations; instead it is the spirits and ancestors who determine the situation and communicate their findings through the divinatory process which is interpreted by the patient himself. Furthermore, the outcomes of divinations that point to supernatural causes always prescribe sacrifices or some rituals to appease the gods and ancestors, and not specific treatment regimen.

It might appear quite contentious whether the activities of diviners constitute some nuisance in healthcare delivery. As the findings in this study suggest the mainstream health workers are ambivalent about the role of diviners: while some perceive diviners as healers whose activities largely tend to complicate patients' conditions, others perceive them as 'first contacts' for most patients as well as those who can assist medical practitioners to make diagnoses. In a related study in Abeokuta in Nigeria, Pearce (1989) assessed 200 civil servants to assess their evaluations of diviners and their knowledge claims. It was discovered that diviners are believed to have access to supernatural knowledge and that this knowledge is seen as medically useful. Seventy percent of the sample endorsed further development of the diviners' knowledge. They were however ambivalent/sceptical about diviners as they

perceived them to have become unduly materialistic and prone to dubious activities. Perhaps the ambivalence with respect to the role of diviners from the healthcare practitioners' perspective in the current study might be explained by gender and experience differentials in the responses. The health workers who had a positive view for the role of diviners were males while those with the negative view were females. Also, level of training and length of years of experience seemed to play a role. Those with the positive views were the Medical Assistants who had higher levels of medical and nursing training. They also had more years of experience working with patients in their health facilities. On the other hand those who expressed scepticism were the nurses who generally had lower level training and who had fewer work experience.

Data from this study suggests a linkage between certain disease conditions and supernatural notions of aetiology, diagnosis, treatment and prognosis of those conditions. The study findings suggest that for certain types of illnesses for which patients may seek modern healthcare from hospital or clinic, they could equally seek care from other providers especially depending on the prognosis of their conditions and their explanatory models about the illness. The study identified specific disease or illness conditions such as boils, snake bites, burns, fractures, and anthrax for which patients may have fixed notions about their aetiology and mode of treatments. Though the study did not probe further into these beliefs we nonetheless posit that patients attending modern healthcare facilities with such and similar conditions have greater potential of non-compliance and a high tendency to seek for discharge against medical advice in order to seek and apply alternative treatments, including turning to diviners for interpretations. This has been observed to be so especially in protracted illnesses where the doctors and nurses might declare very little hope for the cure of such patients. For example Nukunya (2003) has noted that even for some Ghanaian Christians who profess the Christian faith which includes the rejection of spiritual and

ancestral powers, but when faced with certain critical situations would seek supernatural explanations. In most cases when the sickness of a patient is protracted in hospital and doctors declare the condition as hopeless, the victim or his relatives will ask for discharge "against medical advice" to seek solace in the traditional healer. These observations are consistent with the observations of Mendonsa (1975) in studying the role of divination in the management of misfortune and afflictions among the Sisala of Northern Ghana.

Some studies conducted on issues of Discharge Against Medical Advice (DAMA) suggest that patients who ask for discharge against medical advice may subsequently resort to divination. For example, Solagberu et al (2005) examined the epidemiology and management of GSI (Gunshot Injuries) in an urban settlement in Nigeria. Out of the 107 GSI that were seen 27 patients (i.e. 34.2%) were successfully treated while on admission. However, the majority (39 patients, 45.4%) were discharged against medical advice in order to consult traditional healers for bullet extraction, thus portraying the beliefs of patients about GSI. In another study Ogbera et al (2006) found out that DAMA is a common occurrence among patients with DFU (Diabetic Foot Ulceration) in Nigeria. Twenty percent of the patients with DFU they studied in a hospital asked for DAMA while indeed they had poorly healed wounds with varied reasons as financial constraints, undue delays while awaiting surgical procedures, and refusal of medically advised amputation. Other reasons discovered for DAMA in other similar studies (Jeremiah, et al. (1995) were not having a primary physician, a history of previous DAMA, the patients claiming they were feeling better or had personal financial obligations. Genuine as these reasons may be, one can postulate that DAMA could be motivated by the patient's explanatory model about the condition, and that one cannot rule out the patient resorting to supernatural means such as divination after seeking DAMA.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

Using a combination of quantitative and qualitative methods this study assessed the role of divination in the health seeking practices of the people of the Talensi-Nabdam district of the Upper-East region of Ghana, with a view of finding some clues to barriers to rural healthcare delivery and utilization. On the basis of the findings of the study and the discussions made some conclusions can be deduced.

The implications of the findings of this study with regard to seeking and utilizing healthcare services seem to be two-fold. On the one hand, the use of divination in health seeking could result in patients delaying to seek modern healthcare services at the health facilities, especially in cases that would need immediate medical/surgical intervention. This is because for patients who would want to visit the diviner first to ascertain whether his/her illness is supernatural, spiritual or natural, timeliness in obtaining medical care may be compromised. Also, when patients who have belief in divination are undergoing care at health facilities, such patients may pose problems of non-compliance since they have the tendency to ask for "discharge against medical advice" to enable alternative treatment at home.

On the other hand, divination provides the client the opportunity to know whether there are supernatural antecedents to his/her ill-health and to determine the next line of action in health-seeking. This could complement orthodox medical care that does not yet have the means to deal adequately with supernatural causes of ill-health. In spite of the ambivalence of healthcare practitioners about the efficacy of divination in health seeking the practice of divination need not interfere with orthodox medical care. The two could be administered

concurrently. People can be made to understand that since divination is purely a diagnostic phenomenon that rules out supernatural causation it could be done even when the patient is admitted at a health facility for care. This is important because, after all, our modern health care system has not found a proven way to diagnose and subsequently treat spiritual and supernatural diseases.

The study also raises issues for further research. In so far as people would believe in supernatural causes of ill health they would resort to supernatural means of seeking therapy/remedy and therefore research into such issues is imperative. Findings in this study suggest links between certain disease conditions (such as boils, anthrax, snakebite, and burns) and the use of divination. Further study is therefore necessary in this regard. A study of this kind could provide medical staff with additional socio-cultural knowledge on the management of such conditions.

6.2 RECOMMENDATIONS

This study set out to assess the influence of the activities of diviners on the health-seeking behavior of the people of a relatively rural district in the Upper-East region of Ghana with a view of uncovering some of the socio-cultural determinants of seeking healthcare at modern health facilities. On the basis of our current findings and discussion and within the confines of the limitations of the study referred to in earlier discussions we hereby propose the following actions within the healthcare delivery system.

6.2.1 Recommendations for clinical practice

1. Clinical assessment and care of patients should be based on a Bio-Psychosocial-Spiritual model.

Assessing patients especially in clinical settings using the Nursing Process should not only be the routine biological, physical and psychological assessments, but also the social and spiritual assessments. Social assessment should include an assessment of the patient's social support system, relationship with important figures, work environment, and financial circumstances. Spiritual assessment of the patient should also include the patient's belief system and practices; whether he thinks his illness is physical/natural, supernatural or spiritual, and how he thinks spiritual and supernatural forces could play a role in his treatment. These assessments would provide comprehensive information upon which the doctors and nurses could make accurate diagnosis subsequently made make effective intervention or treatment regimens.

2. Acquisition of cultural competence skills should be incorporated into the Nursing and Medical training curricula.

The acquisition of cultural competence skills by medical and nursing staff would enable them provide care that is effective, understandable and respectful in a manner compatible with the patient's cultural health beliefs and practices. Issues of the use of divination and traditional rites and rituals in health seeking should be incorporated into the already existing courses in the social and behavioral sciences for doctor and nurse trainees to enhance their appreciation of the behavioral aspects of health. This should be reinforced with community-based field practical experience while they are on training. Appreciation of these issues regarding health seeking behavior of people by medical staff while being trained will go a long way to enhance their interpersonal relationships with their patients when they are finally certified to practice.

6.2.2 Recommendation for public health practice

Diviners could be educated through health education and health promotion programmes to encourage their clients to seek immediate health care before tackling the supernatural aspects of their ailments.

Public health programmes aimed at educating and encouraging people to report symptoms as early as possible at health facilities should recognize also that the need for some people to rather consult diviners first at the onset of symptoms cannot be underestimated. Therefore such public health programmes should also specifically target diviners with the objective of educating them (the diviners) to in turn educate their clients. Caution from diviners to their clients to seek medical care would be taken much more seriously.

6.2.3 Recommendation for health policy makers

Current efforts in the Ministry of Health to integrate traditional medical practitioners into the mainstream health delivery should also include diviners.

By recognizing the role that diviners could play in diagnosis doctors could advice their patients to consult diviners in order to assist whenever there are no clear tangible means of establishing diagnosis.

6.2.4 Recommendation for further research

Studies should be conducted by the Ministry of Health/Ghana Health Service to establish the link between conditions such as snake bite, burns, boils, fractures and anthrax, and compliance to medical treatment regimens.

Data from this study suggests linkage between certain disease conditions and supernatural notions of aetiology, diagnosis, treatment and prognosis of those conditions. Respondents in this current study mentioned boils, burns, snakebites, fractures, anthrax as some of the conditions they are sceptical about the ability of modern healthcare system to handle successfully. Reasons behind this scepticism include the belief that there are always

supernatural forces behind the causes of such conditions and therefore supernatural means of diagnosis and treatment are imperative if cure is to be achieved. Though the study did not probe further into these beliefs we nonetheless posit that patients attending modern healthcare facilities with such and similar conditions have greater potential of non-compliance to treatment. We therefore propose to examine this hypothesis in a study under clinical settings, the objectives of which will be to discover reasons for patients' non-compliance including discharge against medical advice. This study could provide evidence-based data for carving out more comprehensive patient-centred clinical care protocols.

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APPENDIX 1:

INTERVIEWER-ASSISTED QUESTIONNAIRE FOR SAMPLED MEN AND WOMEN IN THE TALENSI-NABDAM TRADITIONAL AREAS

Introduction

Thank you for taking time out off your daily busy schedule to respond to me at this moment. My name is Thomas Bavo Azongo. As part of my studies for the award of a PhD degree I want to study the practice of divination/soothsaying and how it affects our behaviour as we try to get treatment when we are sick. I would kindly ask you to answer the following questions as objectively as possible to enable me get ideas towards this study. Your responses will be kept in confidence.

A. <u>Personal Demographic data</u>

1. How old are you?
   a) 18 -30
   b) 31 -45
   c) 46 -60
   d) 60+

2. Are you male or female?
   1. Male
   2. Female

3. What is your marital status?
   1. Married
   2. Single
   3. Divorced
   4. Widow/widower

4. How many wives do you have? (if you are male)

   1. None
   2. One
   3. Two
   4. Three
   5. Four
   6. More than four

5. How many children do you have?

   1. None
   2. Two

3. Three
4. Four
5. More than four
6.

6. How many other dependants do you take care of?

1. None
2. One
3. Two
4. Three
5. Four
6. More than four

7. Which part of the district do you live?
1. Tongo Central
2. Tongo-East
3. Tongo-West
4. Datoku
5. Sakote-Zolba
6. Nangode-Kongo

8. What level of formal education have you attained?

1. No formal education
2. Primary school
3. JSS/Middle School
4. SSS/GCE O Level/Technical
5. Tertiary

9. What is your Religious affiliation?

1. Traditional
2. Christian
3. Muslim
4. Other (specify)

10. What is your Occupation?

1. Farming
2. Housewife
3. Self employed
4. Salaried worker
5. Unemployed

11. How much would you estimate your annual income?

1. Less than GH. ¢100

2. GH. ¢100 -200
3. GH. ¢ 250 -500
4. More than GH. ¢500

B. Concept of health and ill-health

12. What would you say constitutes good health? (tick as many as appropriate, starting with the most important)

1. Being happy
2. Being rich
3. Having no pain
4. Can eat well
5. Having no worries
6. Can perform normal work
7. Others specify……

13. What would you say constitutes ill-health/sickness? (tick as many as appropriate, starting with the most important)

1. Being happy
2. Being rich
3. Having pain
4. Being poor
5. Can't perform normal work
6. Can eat well
7. Others specify……

C. Causes of ill-health

14. Which of the following categories of causative factors of disease do you think is important in disease/illness causation? (tick as many as possible, starting with the most important)

1. The individual/the patient
2. The physical environment
3. The social world
4. The supernatural world

15. What factors in the individual can cause disease? (tick most important)

1. Poor personal hygiene
2. Poor nutrition
3. Misconduct
4. Breach of taboo
5. Other (specify)…….

16 What factors in the physical environment can cause disease? (tick the most important)

1. Poor environmental hygiene
2. Poor housing
3. Polluted water
4. Air pollution
5. Other (specify) ……

17. What factors in the social world can cause disease? (tick as many as appropriate, starting with the most important)

1. Witchcraft
2. Relatives/friends
3. Enemies
4. Curses
5. Evil eye
6. Other (specify) ……..

18. What factors in the supernatural world can cause disease? (tick as many as appropriate, starting with the most important)

1. God
2. Nature gods
3. Ancestors
4. Evil spirits
5. Magic/sorcery
6. Other (specify) ……..

D. Presentation/ manifestation of ill-health

19. Which of the following signs/symptoms do you think indicates ill-health/disease (tick five most common symptoms)

1. Swelling
2. Rise in body temperature
3. Difficulty in urinating
4. Difficulty in passing feces
5. Convulsions
6. Vomiting
7. Loss of appetite
8. Paleness
9. Growing lean
10. Paralysis
11. Chronic sores

20. For the following sign/symptoms indicate your perception of the severity of the disease (mild or severe); and what mode of therapy you would resort to first when you experience the sign/symptom:

Sign/symptom	Severity: mild= 1, severe=2	Mode of treatment: 1= traditional, 2= orthodox
1. Swelling		
2. Rise in temperature		
3. Difficulty in urinating		
4. Difficulty in defecation		
5. Convulsions		
6. Vomiting		
7. Loss of appetite		
8. Paleness		
9. Loss of weight		
10. Paralysis		
11. Headache		

21. Which of them will you give prompt attention? Indicate in order of promptness of your action

Sign/symptom	Order of promptness (1,2,3,4, etc)

1.	Swelling	
2.	Rise in temperature	
3.	Difficulty in urinating	
4.	Difficulty in defecation	
5.	Convulsions	
6.	Vomiting	
7.	Loss of appetite	
8.	Paleness	
9.	Loss of weight	
10.	Paralysis	
11.	Headache	

22. Why you think it is mild or severe?

Mild

.....
.....
.....

Severe

……
……
……..

E. Diagnosis and Prognosis of ill-health/disease

23. How are you able to know the specific type of disease you have when you are ill?

1. Through divination
2. By experience
3. When more than one person identify the same disease
4. the herbalist would tells me
5. consult household member
6. consult a friend or relative
7. others (specify) …….

24. Can certain diseases easily be cured?

1. Yes
2. No

25. Mention the diseases you think can easily be cured
……
……

26. Which diseases do you think cannot be cured at all?
……
……

27. Why do you think those diseases can never be cured?

1. Because they are caused by ancestors
2. They are caused by evil spirits or spells
3. They are caused by witches and wizards
4. They are caused by accidents
5. Others (specify) ……

E.Utilization of health care facilities

28. When you notice you are sick or unwell what first aid measures do you take?

1. consult a diviner
2. consult the herbalist
3. visit the shrine
4. say some prayers
5. obtain some medication from a druggist
6. visit the nearest clinic/health center
7. other 9specify)

29. If symptoms do not subside after the first aid measures, what do you do next?

1. consult a diviner
2. consult the herbalist
3. visit the shrine
4. say some prayers
5. obtain some medication from a druggist
6. visit the nearest clinic/health center
7. other (Specify) ……

30. For which type of illnesses would you resort to the following health facilities first?

Health facility	**Type of illness**
1. Hospital	
2. Health center/clinic	
3. Druggist	

4.	Traditional healer/herbalist	
5.	Quack doctor	
6.	Faith healer/prayers	
7.	Shrine/spiritualist	
8.	Diviner/soothsayer	
9.	Self medication	
10.	Nature (do nothing and allow nature to heal)	

31. When a child is sick, who decides which type of therapy to resort to?

1. The mother
2. The father
3. The grandfather
4. The grand mother
5. The in-law
6. The siblings

32. How would you describe the attitudes of the care givers when you visit any of the following health facilities?

Health facility	Attitude: 1= Excellent. 2= Good. 3= satisfactory. 4= bad
1. Hospital	
2. Health center/clinic	
3. Druggist	
4. Quack doctor	
5. Traditional healer/herbalist	
6. Faith healer/prayer	
7. Shrine/spiritualist	
8. Diviner/soothsayer	

33. What is your status regarding the National Health Insurance Scheme (NHIS)?

1. Ever Registered
2. Registered now
3. Renewed registration
4. Expired registration
5. Not registered

34. How many of your dependants have valid registration with the NHIS?

1. Some
2. All of them
3. None of them
4. State exact number ……

F. <u>Practice of divination/soothsaying</u>

35. Are there any soothsayers or diviners in your community?

1. Yes
2. No

36. Can you estimate the number of diviners/soothsayers you have in your community?

1. One
2. Two
3. Three
4. Four
5. Five
6. More than five

37. What do you think are their general functions in your community?

1. Determine causes of misfortune/disease
2. Determine causes of fortune/good omen

3. Determine what the ancestors expect of you
4. No function

38. Who in the community are qualified to consult a diviner?

1. Men
2. Women
3. Elders
4. Family heads
5. Other (specify)

39. Who normally are not allowed to consult diviners?

1. Children
2. Women
3. Other (specify)

40. Who consults diviners on behalf of those not allowed to consult?

1. Men
2. Elders
3. Family heads
4. Other (specify)

41. For which reasons would you consult a diviner? (tick as many as appropriate)

1. To determine cause of misfortune/disease
2. To determine cause of fortune/success
3. To determine what the ancestors expect of me
4. To find out your enemies
5. To predict the future
6. For child birth
7. For marriage
8. For business plans
9. Other (specify)

42. Who decides for you to visit a diviner?

1. Clan head
2. Family head
3. Husband
4. Wife
5. Friends
6. Myself
7. Father in-law
8. Mother in-law
9. Other (specify)

43. Can you tell me the specific outcome of any of the divination that you have ever consulted?

1. Asked me to offer sacrifices
2. Asked me to take some herbs
3. Asked me to fast
4. Asked me to consult other shrine
5. Asked me to ignore my condition
6. Other (specify)

44. Has divination ever solved any health problem for you?

1. Yes
2. No

45. Which problems has divination ever solved for you?

……..
……..
……..

46. List the specific problem(s) that you have been satisfied or not satisfied with, and the frequency:

Specific problem taken to divination	1= satisfied, 2= not satisfied

47. What are some of the benefits of abiding by the advices of the diviner?

1. Feel the ancestors are pleased
2. Solution of my problem
3. Other (specify)

48. What are some of the consequences of not abiding by the advices of the diviner?

1. Worsening of my condition
2. Other misfortunes happen to me
3. Other family members adversely affected
4. Death
5. Other (specify)

We wish to thank you sincerely for the time and patience you devoted in answering the questions. Once again we assure you of maximum confidentiality of your responses to this questionnaire.

APPENDIX 2:

IN-DEPTH INTERVIEW FOR DIVINERS: INTERVIEW GUIDE

Introduction

(As I mentioned,) My name is _____. I am a student from the School of Public Health in Accra. We are trying to learn about your profession as a diviner and how divination plays a role as people employ it in the course of trying to find out more about their problems especially health problems. I will be asking you some questions about how you conduct divination and how and why your clients consult you.

First, I want to thank you for speaking with me today. We are grateful that you are taking the time to help us with what we believe is very important research.

Before we start, I'd like to remind you that your participation is voluntary. You may stop at any time, and you can skip any question you do not want to answer. We will be audio taping your answers, but we will NOT record your name or any identifying information in our research record.

Your privacy, and the privacy of your fellow colleagues is very important to us, so we will maintain maximum confidentiality of all information we will get from you.

By participating in this interview, you are agreeing to let us use your information to guide our research. That means your information may be used in published research, although they will not be attributed to you by name.

Finally, this study has been reviewed and approved by the GHSIRB.

Do you have any questions you wish to ask before we begin? Thank you.

Questions

A. First I want to find out about your profession

Probes:

1. How did you become a diviner?
2. How long have been practicing as a diviner?
3. What are the tools you use?
4. Can you describe the various tools?
5. What does each tool/item represent?
6. How often are you consulted? Daily, monthly, yearly?
7. What constitutes the consultation fee?

B. Now tell me about your clients

Probes:

1. What categories of people consult you? Men, women, children?
2. Do they have to have some special skills to be able to consult?

3. What special skills do they have to possess?
4. Where do your clients come from? Within the community? Outside the community? Come from very far places?

C. what are some of the reasons why people consult you?

Probes:

1. To determine cause of misfortune/failure
2. To determine cause of fortune/success/
3. To find out what the ancestors expect?
4. To find out your enemies?
5. To predict the future?
6. To determine the cause of death of a family member?
7. To find out the cause of sickness/illness
8. For marriage
9. For child birth?
10. For business plans

D. Can you tell me the process of a typical divination session?

Probes:

1. Can you describe how a typical consultation is carried out?
2. How do you arrive at your conclusions/prescriptions?
3. How does the client know what the outcomes are?

E. what role do you play in relation to illnesses/ailments of people?

Probes:

1. What are the sicknesses the people consult you with?
2. What are some of the outcomes of these consultations in terms of the remedies you prescribe?
3. Do you sometimes refer your clients to other diviners or traditional healers? Under what circumstances would you do that?
4. When one is sick would you prefer he/she consult you first of the health professional at the clinic/hospital? Why?
5. Do people consult you first before they visit the clinic or hospital? Why do they do that?
6. Do people consult you even after they attend clinic or hospital? What are their complaints?

F. Finally, can you tell me the extent to which people comply with your prescriptions?

Probes:

1. Are there instances where some of your clients disagree with your recommendations/remedies?
2. What do you do about such cases?
3. What happens if people do not abide by your recommendations/remedies?
4. Can you (without disclosing identities) give specific instances of these

We have reached the end of the questions I had prepared for you today. Do you have anything else you'd like to tell me about divination and its role in the health of people in your community?

Again, thank you for your time today. Your insights have been very helpful. Feel free to contact any of us if you have any concerns, questions, or issues to raise about our study after you've had a chance to go home and think about these issues.

Again, thank you for your time!!

APPENDIX 3:

IN-DEPTH INTERVIEW GUIDE FOR HEALTH CARE PRACTITIONERS

INTERVIEW GUIDE

Introduction

(As I mentioned,) My name is _____. I am a student from the School of Public Health in Accra. We are trying to learn about your profession as a diviner and how divination plays a role as people employ it in the course of trying to find out more about their problems especially health problems. I will be asking you some questions about how you conduct divination and how and why your clients consult you.

First, I want to thank you for speaking with me today. We are grateful that you are taking the time to help us with what we believe is very important research.

Before we start, I'd like to remind you that your participation is voluntary. You may stop at any time, and you can skip any question you do not want to answer. We will be audio taping your answers, but we will NOT record your name or any identifying information in our research record.

Your privacy, and the privacy of your fellow colleagues is very important to us, so we will maintain maximum confidentiality of all information we will get from you.

By participating in this interview, you are agreeing to let us use your information to guide our research. That means your information may be used in published research, although they will not be attributed to you by name.

Finally, this study has been reviewed and approved by the GHSIRB.

Do you have any questions you wish to ask before we begin? Thank you.

Questions:

A**. What range of services/care do you offer at this facility?**

Probes:

1. Medical
2. Surgical
3. Obstetric/delivery
4. Gynaecological
5. Ante-natal
6. Post-natal/maternal & child welfare
7. Paediatric
8. Psychiatric/mental
9. Eye
10. Ear, Nose & Throat
11. Others

B. What categories of people come to your facility for services?

Probes:

1. Children
2. Women
3. Pregnant women
4. Adolescent girls
5. Adolescent boys
6. Men
7. The aged men
8. The aged women

C. Now let's talk about the emergency cases that come to your facility

Probes:

1. What are the most prevalent emergencies that come to you?
2. How early do they report those cases?
3. What first aid measures do they usually employ before coming to you?
4. Which health care providers do they usually consult before coming to you?
5. How do these prior consultations affect your treatment outcomes

Further probes on question 4:

1. Traditional healers?
2. Faith healers?
3. Druggists?
4. Diviners
5. Self medication

D. What about the chronic cases you get?

1. What are the most prevalent chronic cases that come to you?
2. How early do the report such cases?
3. What measures do the employ prior to reporting to you?
4. Which other health care providers do they visit before coming to your facility?
5. How do these consultations affect your treatment outcomes?

Further probes on question four:

1. Traditional healers
2. Faith healers
3. Druggists
4. Diviners
5. Others
6. Self medication

E. Now tell me about some of the cases who visit diviners before coming to you

Probes:

1. How do you know whether they visit diviners before coming to your facility?

2. Do you normally find out what sorts of remedies the diviners offer them? What are some of the remedies?
3. What type of conditions do they normally present at your facility?
4. What do you think are their reasons for visiting the diviners before coming to you?
5. Do you encounter patients who say they were specifically referred by the diviner to come to your facility? What specific cases do such patients present?

F. What about the possibility of patients visiting diviners after they have been treated at your facility?

1. Under what circumstances do you think a patient will visit the diviner after he/she has received treatment from your facility?
2. If they do so will they continue with the treatment regime you have prescribed? Why?

G. What generally do you think is the role of diviners in healthcare delivery in the community?

1. What social role?

2. What religious role?

3. What economic role?

4. What health role?

5. What other role?

We have reached the end of the questions I had prepared for you today. Do you have anything else you'd like to tell me about divination and its role in the health of people in your community?

Again, thank you for your time today. Your insights have been very helpful. Feel free to contact any of us if you have any concerns, questions, or issues to raise about our study after you've had a chance to go home and think about these issues.

Again, thank you for your time!!

APPENDIX 4:

FOCUS GROUP DISCUSSIONS WITH CLAN HEADS/COMMUNITY ELDERS (DISCUSSION GUIDE)

Introduction

(As I mentioned,) My name is _____. I am a student from the School of Public Health in Accra. We are trying to learn about your profession as a diviner and how divination plays a role as people employ it in the course of trying to find out more about their problems especially health problems. I will be asking you some questions about how you conduct divination and how and why your clients consult you.

First, I want to thank you for speaking with me today. We are grateful that you are taking the time to help us with what we believe is very important research.

Before we start, I'd like to remind you that your participation is voluntary. You may stop at any time, and you can skip any question you do not want to answer. We will be audio taping your answers, but we will NOT record your name or any identifying information in our research record.

Your privacy and the privacy of your fellow colleagues is very important to us, so we will maintain maximum confidentiality of all information we will get from you.

By participating in this interview, you are agreeing to let us use your information to guide our research. That means your information may be used in published research, although they will not be attributed to you by name.

Finally, this study has been reviewed and approved by the GHSIRB.

Do you have any questions you wish to ask before we begin? Thank you.

Questions

A. What generally do you think are the functions of diviners in this community?

Probes:

1. What are their social functions
2. What are their economic functions
3. What are their religious functions?
4. What are their health functions?

B. Now we want to dwell on their health functions?

Probes:

1. Why would you consult a diviner when you realize you are sick?
2. What type of sickness of a child would make you consult a diviner?
3. What type of sickness of a woman would make you consult a diviner?
4. What type of sicknesses do you think you must first consult a diviner with?

5. Can you mention the critical signs and symptom of disease that mandates consulting a diviner?
6. What types of remedies do you expect from a diviner when you consult with sickness
7. What type of sicknesses do you think are sole for the diviner's advice?

C. How are decisions made in the family when to consult a diviner?

Probes?

1. When a child is sick who makes the decision to consult a diviner
2. When a woman is sick who makes the decision to consult a diviner?
3. When other members of the family are sick who makes the decision to consult a diviner?
4. Who in the family consults the diviner? Who provides the consultation fee?

D. **under what circumstances regarding sickness would you prefer rather visiting the clinic/hospital first?**

Probes:

1. What would you consider as emergencies for the clinic/hospital?
2. What types of sicknesses do you think you should report to clinic/hospital first?
3. What critical signs/symptoms are associated with these sicknesses?
4. Which of these associated with children/
5. Which of these associated with women?

E**. Under what situations would you still visit the diviner while you are undergoing treatment from the clinic/hospital/**

Probes:

1. Would you find it necessary to visit the diviner while you are being treated at the clinic/hospital? Why?
2. What would you do when the treatment given from the clinic/hospital conflicts with that prescribed by the diviner?
3. What would make you visit the diviner even when you have been treated at the clinic/hospital?

APPENDIX 5:

CONSENT FORM FOR PARTICIPATION AS A DIVINER

IN IN-DEPTH INTERVIEW

Title research project: The Role of Divination in Health-seeking Practices in the Talensi-Nabdam District of Northern Ghana

Principal Investigator: Thomas Bavo Azongo

Address: School of Public Health, University of Ghana, Legon

Introduction

This Consent Form contains information about the research named above. In order to be sure that you are informed about being in this research, we are asking you to read (or have read to you) this Consent Form. You will also be asked to sign it (or make your mark in front of a witness). We will give you a copy of this form. This consent form might contain some words that are unfamiliar to you. Please ask us to explain anything you may not understand.

Reason for the Research

You are being asked to take part in a research to assess the effects of divination on the health-seeking behaviour of the Nabdam people.

General Information about Research

Specifically the study will identify the types of illnesses that mostly require consultation with diviners, examine how socio-religious factors influence the choice of therapy for management of illnesses and examine how the choice of therapy for management and prevention of disease is influenced by divination.

Your Part in the Research

If you agree to be in the research, you will be asked some questions about how you conduct your practice as a diviner.

Your part in the research will last about one hour at a location of your convenience.

Possible Risks

We do not anticipate any risks to you during this research except for your time we will take to interact with you.

Possible Benefits

We do not have any material reward to offer you except for the customary fee you may require of us.

If You Decide Not to Be in the Research

You are free to decide if you want to be in this research.

Confidentiality

We will protect information about you and your taking part in this research to the best of our ability. You will not be named in any reports. However, the staff of the School of Public Health and the University of Ghana may sometimes look at your research records. Someone from the IRB might want to ask you questions about being in the research, but you do not have to answer them.

Compensation

You will not be paid, since you do not have to take part in this research.

Leaving the Research

You may leave the research at any time. If you choose to take part, you can change your mind at any time and withdraw.

If You Have a Problem or Have Other Questions

Please call Thomas Azongo on telephone number 0244853578 if you have questions about the research.

Your rights as a participant

This research has been reviewed and approved by the IRB of The Ghana Health Service. An IRB is a committee that reviews research studies in order to help protect participants. If you have any questions about your rights as a research participant you may contact the Ghana Health Service.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "the role of divination in the health-seeking practices of the Nabdam of Northern Ghana" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Date Signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____ _____

Date Signature of Witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____ _____

Date Signature of Person Who Obtained Consent

APPENDIX 6:

CONSENT FORM FOR PARTICIPATION AS HEALTH PRACTITIONER IN IN-DEPTH INTERVIEW

Title research project: The Role of Divination in Health-seeking Practices in the Talensi-Nabdam District of Northern Ghana

Principal Investigator: Thomas Bavo Azongo

Address: School of Public Health, University of Ghana, Legon

Introduction

This Consent Form contains information about the research named above. In order to be sure that you are informed about being in this research, we are asking you to read (or have read to you) this Consent Form. You will also be asked to sign it (or make your mark in front of a witness). We will give you a copy of this form. This consent form might contain some words that are unfamiliar to you. Please ask us to explain anything you may not understand.

Reason for the Research

You are being asked to take part in a research to assess the effects of divination on the health-seeking behaviour of the Nabdam people.

General Information about Research

Specifically the study will identify the types of illnesses that mostly require consultation with diviners, examine how socio-religious factors influence the choice of therapy for management of illnesses and examine how the choice of therapy for management and prevention of disease is influenced by divination.

Your Part in the Research

If you agree to be in the research, you will be asked some questions about your opinion on whether your clients have prior consultations with diviners and how you think these consultations affect the timely utilization of your services. Your part in the research will last about one hour at a location of your convenience.

Possible Risks

We do not anticipate any risks to you during this research except for your time we will take to interact with you.

Possible Benefits

We do not have any material reward to offer you for this interview. However you may have access to the final report of this exercise in the form of a dissemination forum we shall organize at the end of the research.

If You Decide Not to Be in the Research

You are free to decide if you want to be in this research.

Confidentiality

We will protect information about you and your taking part in this research to the best of our ability. You will not be named in any reports. However, the staff of the School of Public Health and the University of Ghana may sometimes look at your research records. Someone from the IRB might want to ask you questions about being in the research, but you do not have to answer them.

Compensation

You will not be paid, since you do not have to take part in this research.

Leaving the Research

You may leave the research at any time. If you choose to take part, you can change your mind at any time and withdraw.

If You Have a Problem or Have Other Questions

Please call Thomas Azongo on telephone number 0244853578 if you have questions about the research.

Your rights as a participant

This research has been reviewed and approved by the IRB of The Ghana Health Service. An IRB is a committee that reviews research studies in order to help protect participants. If you have any questions about your rights as a research participant you may contact the Ghana Health Service.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "the role of divination in the health-seeking practices of the Nabdam of Northern Ghana" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Date Signature or mark of volunteer

APPENDIX 7:

CONSENT FORM FOR PARTICIPATION IN FOCUS GROUP DISCUSSIONS WITH CLAN HEADS/ COMMUNITY ELDERS.

Title research project: The Role of Divination in Health-seeking Practices in the Talensi-Nabdam District Northern Ghana

Principal Investigator: Thomas Bavo Azongo

Address: School of Public Health, University of Ghana, Legon

Introduction

This Consent Form contains information about the research named above. In order to be sure that you are informed about being in this research, we are asking you to read (or have read to you) this Consent Form. You will also be asked to sign it (or make your mark in front of a witness). We will give you a copy of this form. This consent form might contain some words that are unfamiliar to you. Please ask us to explain anything you may not understand.

Reason for the Research

You are being asked to take part in a research to assess the effects of divination on the health-seeking behaviour of the Nabdam people.

General Information about Research

Specifically the study will identify the types of illnesses that mostly require consultation with diviners, examine how socio-religious factors influence the choice of therapy for management of illnesses and examine how the choice of therapy for management and prevention of disease is influenced by divination.

Your Part in the Research

If you agree to be in the research, you will be asked together with other community elders some questions about your opinion on the functions of diviners, who consult them, why they consult them. We also want to know how your consultations with the diviners influence your consultation with medical practitioners when you are sick. Your part in the research will last about two hours at a location of your convenience.

Possible Risks

We do not anticipate any risks to you during this research except for your time we will take to interact with you.

Possible Benefits

We do not have any material reward to offer you for this interview. However you may have access to the final report of this exercise in the form of a dissemination forum we shall organize at the end of the research.

If You Decide Not to Be in the Research

You are free to decide if you want to be in this research.

Confidentiality

We will protect information about you and your taking part in this research to the best of our ability. You will not be named in any reports. However, the staff of the School of Public Health and the University of Ghana may sometimes look at our research records. Someone from the IRB might want to ask you questions about being in the research, but you do not have to answer them.

Compensation

You will not be paid, since you do not have to take part in this research.

Leaving the Research

You may leave the research at any time. If you choose to take part, you can change your mind at any time and withdraw.

If You Have a Problem or Have Other Questions

Please call Thomas Azongo on telephone number 0244853578 if you have questions about the research.

Your rights as a participant

This research has been reviewed and approved by the IRB of The Ghana Health Service. An IRB is a committee that reviews research studies in order to help protect participants. If you have any questions about your rights as a research participant you may contact the Ghana Health Service.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "the role of divination in the health-seeking practices of the Nabdam of Northern Ghana" has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Date Signature or mark of volunteer