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THE UNIVERSITY OF ALBERTA

THE INTERRELATIONSHIP BETWEEN SCIENTIFIC AND TRADITIONAL MEDICAL SYSTEMS. A STUDY OF GHANA

by

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A THESIS

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled THE INTERRELATIONSHIP BETWEEN SCIENTIFIC AND TRADITIONAL MEDICAL SYSTEMS. A STUDY OF GHANA submitted by Patrick Adubofour Twumasi in partial fulfilment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

The study was devoted to the investigation of a common phenomenon in developing countries - i.e., the co-presence of scientific and traditional medical systems. The aim was to explicate the nature of the interrelationship between scientific and traditional medical systems, to discover the continuing functions of traditional medical practice, and to elucidate some of the determinants of the pattern of articulation between the medical systems and the larger society. The focus of the study was directed to Ghana, with implications for other developing countries.

The study required a perspective which incorporated certain features of both a rational and a functionalist model. From the former the idea was developed that men plan consciously to take into account not only their successes but their recognized failures. From the latter, emphasis was placed upon the social system and its formally stated goals, considered as the main organizational ends. This perspective enabled us to focus upon one of the crucial problems in sociology: how a measure of integration, vis-a-vis the medical systems, is maintained in the face of inevitable changes from sources both external and internal to it.

Methodologically, the study was limited to examination of published data; no primary field research has been carried out. The available data have been subjected to preliminary analysis in terms of the concepts and problems of contemporary social science.

Four conclusions were reached: (1) that traditional medicine or its functional equivalent would never wholly disappear from the Ghanaian scene; (2) that the limited utility of scientific medicine in the area of psychosomatic disorders leaves a relatively permanent area of chronic ills within which traditional medicine may survive at least in the rural setting; (3) that an interaction occurs in the traditional setting between the two medical systems which tends to create a division of function between traditional and scientific medical practices; and (4) that a kind of pragmatism acts as a selective principle to help determine which method of treatment is chosen.

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However, I must emphasize, that I am solely responsible for any shortcomings, marginal or substantial, which may be found in the text of this dissertation.

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CHAPTER 1

INTRODUCTION

I. Introduction

The study is devoted to the investigation of a common phenomenon in the developing countries, the co-existence of scientific and traditional medical systems. However, the main focus of the study is directed to the examination of Ghana medical systems, which have implications for other traditional societies.

The study is conceived as a preliminary research. It is intended to make a beginning in bringing together the essential facts about contemporary medical systems in Ghana and to explicate the nature of the interrelationship between scientific and traditional medical systems. The study is limited to examination of published data; no primary field research has been carried out. The available data have been subjected to preliminary sifting and analysis in terms of the concepts and problems of contemporary social science.

II. The Problem

The principal incentive in undertaking this study stems from the promise it affords to raise and to re-examine a number of challenging problems about the nature and functioning of medical systems in a traditional society.

Illness we know is an inevitable factor in every social group,

with its social, psychological as well as biological implications. It is disruptive of social relationships and this fact of life must be explained and dealt with in some manner by each society, both pragmatically and philosophically.

In Ghana, there are at present two types of practitioners of medicine, the traditional medical practitioners and the scientific medical practitioners. Both deal with illness.[1] But these two institutions of medicine hold different, though not mutually exclusive, world views guiding their respective practices. Any conflict, therefore, which may arise between these two forms of medicine has a disruptive effect on the well-being of the people in their pursuit of medical attention, especially so in the contemporary setting of many rapid social changes.

In pursuit of the research problem it may be possible to discover what continuing functions traditional medical practices continue to serve, and to find out some of the determinants of the pattern of articulation between scientific and traditional medical practices and the larger society.

III. Objectives of the Study

In pursuance of the research investigation, it is necessary to indicate the nature of the interrelationship between both medical systems. What we consider of fundamental importance is to examine the manner in which the traditional medical system continues to serve needs of the society, and to be able to determine how far a changed

situation, as a result of western contact, has contributed to a modification of the traditional system.

The following questions are framed to guide the discussion in later chapters:-

(1) How does the traditional medical institution serve the present needs of the society?

(2) To what extent has the introduction of scientific medicine lead to changes in the practice of traditional medicine?

(3) What type or kind of organizational base supports either type of medicine and why?

(4) In what circumstances do the sick prefer one type of medical attention to the other?

(5) What are some of the social consequences arising from the introduction of scientific medicine?

IV. Theoretical Perspective

A study such as this, concerned with social change and with specific institutions requires a perspective that incorporates certain features of both a rational and a functionalist model.[2] From the former, the idea that men plan consciously and take into account not only their successes but their recognized failures. From the latter, skepticism about formal, stated goals as the main ends of organizational behavior, and the emphasis which is placed upon the integration of the social system.

Such a perspective should permit us to focus upon both cooperative

and conflicting actions as well as to incorporate the notions of unanticipated consequences of both medical systems, traditional and scientific. It should bear upon one of the crucial problems in sociology i.e. how a measure of integration is maintained in the face of inevitable changes from sources both external and internal to the medical systems.

Mead,[3] arguing for orderly and directed social change, remarked that the task turns about relationships between change and persistence. The question is how to bring about changes in an orderly fashion and yet preserve order? From a sociological point of view in this thesis we are looking at the interrelationship between two medical systems in a traditional society. In approaching this problem, the manifest objective is to formulate, at least in an exploratory way, an adequate sociological explanation of the nature of the interrelationship.

Such an approach as we are proposing may be best understood through a voluntaristic theory of action which is relevant to the thesis. Very briefly, this scheme involves a subjective process of orientation to an objective situation, the influence of various norms entering into the determination of ends or goals and governing the choice of means thereto, and an actor to whom the scheme imputes a limited "freedom" to choose between alternatives and to indicate action.

Action is thus teleologically conceived, as a process directed toward the realization of goals or toward the expression of values; and the individual uses his very limited powers of prediction and control in an attempt to bring some portion of the future into harmony with his ends and values.

It is an activistic model: action implies effort directed toward the overcoming of obstacles. Action carries with it the ever present possibility of frustration and failure. Outcomes are only meaningful in terms of some such teleological system. (Stressing the important role of affective and teleological orientations, this model provides a convenient tool for analyzing the actions of actors in situations of risk and uncertainty.)

The actor is thus forever involved in problems of "economizing" that is to say in counting costs of any given projected line of action in terms of the sacrifices the course he takes entails for other values he holds important.[4]

A. Institutional Theory

In sociological terms, medical practice takes place within an institution. It takes us to the area of a study of purposeful behavior. As pointed out by Talcott Parsons,[5] institutional theory is considered as a form of "action theory" in the sense that it involves all those cultural theories of human behavior which study the many ways in which men manipulate their environment in order to achieve their purpose.

But the central distinguishing criterion of the institutional approach is its emphasis on the postulate that human aims are achieved through organization. Therefore the culture of a group is seen in terms of the purposefully directed activities of specific groups.

The institutional approach is distinguished from utilitarian or other "positivistic" approaches which explain human behavior without

reference to the ultimate aims men have.

This is not to say that the institutional approach lacks all elements of determinism. It does assume that the general content of cultural knowledge determines the form of both purpose for which groups are organized and the activities by which they hope to attain the aims. Furthermore, the institutional approach assumes that there are certain instrumental imperatives which must be met if any organization is to persist in trying to achieve any purpose whatsoever. However, given these assumptions, the institutional approach places emphasis on the fashion in which organized groups select specific purposes for accomplishment and fashion specific norms for achieving those aims.

Three main elements are basic to the institutional approach. There is the concept of purpose, for the achievement of which members cooperate. There is the concept of an institutional group, the group of members cooperating to achieve the purpose. Then, lastly there is the concept of the institution, per se, the complexity of cultural expectations which are shared by the men of the given institutional groups.

Our aim is to analyze both the scientific and traditional medical institutions within the larger societal context, utilizing the institutional theory. As a cultural universal all institutions include prescriptions about the ways in which institutional purposes shall be obtained by the members of the group with which they are associated. For example, a basic decision which group members face is with the problem of recruitment, who shall belong to it. Personnel prescriptions arise from the decision group members make. These prescriptions define not only the criteria for admission to membership in the institution,

but also the criteria for the determination of what personnel, within it, should do in order to retain their membership, what method is to be used in assigning group members to duties, and in what relational capacity members are to be in, both as regards other personnel of the institution as well as to outsiders.[6]

This matter of determining relationship is necessary in institutional analysis because it means in practice we shall get at the variation in attitudes and influence of various personnel in the day-to-day operation of the institution. Individuals in the institution stand in a series of different relationships to each other. The structure formed by these relationships is social structure. This in itself is determined by the cultural expectations concerning the personnel, as well as by the rules found within the institution.

Bronislaw Malinowski[7] observed that human behavior and hence the institutions that organize the behavior of its members into meaningful patterned activities, arise in the first place because of the biological needs of men. He tried to develop a scientific theory of culture on this premise (of biological needs) arguing that all the manifold activities of men are directly or indirectly related to man's needs which he, as an organism, requires in order to survive. The whole area of medicine as an aspect of human behavior would seem directly to fit Malinowski's assertion that human institutions are based upon individuals biological needs.

It is within this vein of thought that Hertzler pointed out:

> "Social institutions are purposive, regulatory and consequently primary cultural configurations, formed unconsciously and/or deliberately, to

> satisfy individual wants and social needs bound up with the efficient operation of any plurality of persons. They consist of codes, rules and ideologies, unwritten, and essential symbolic organizational and material implementations. They evidence themselves socially in standardized and uniform practices and observances, and individually in attitudes and habitual behavior of persons. They are sustained and enforced by public opinion, acting both informally and formally through specifically devised agencies".[8]

B. An Approach to the Theory of Social Change

When one proposes to construct a theory of social change, the immediate question that comes to mind is whether the various social phenomena in the process of social change can be explained by a simple theory. Wilbert Moore claims that such an exercise is a "dubious enterprise".[9] However an attempt to arrive at pure descriptive generalizations is in any case of dubious value. This section then is an approach to construction of a theory of social change.

1. Social Change

The theory that we are seeking will have to explain the consequence of introducing a new idea into a traditional social system to produce changes in the existing social structure. A number of factors may cause the developmental trend, but we have to initiate the discussion from some point (from an observable phenomenon, such as scientific medical institution).

In this direction, a theoretical perspective for the analysis of social change, as pointed out by Firth,[10] must be concerned with

what happened to social structure. The concept of social structure must fulfil the following three conditions. First, it must be concerned with the ordered relations within a social unit. Second, these relations must be regarded as built upon one another. Third, these relations must be more than purely momentary significance. Regarding the first condition, the ordered relations imply certain rules or fixed lines of social behavior. This embodies a set of expectations regarding what the social group members will do in virtue of their social roles and ideas as to what they ought not to do.

Social change then is the significant alteration of social structure, that is of forms of social action and interaction, including both the manifestations and the consequences of such structures embodied in the rules of behavior. Until units or sub-systems are identified in their principal dimensions one does not become aware of what is changing or has changed. Until temporal and other dimensional specifications are made one may not be able to distinguish significant changes from what may be deemed insignificant.

An example may clarify the issue relating to what is a significant change. Let us suppose that mortality rates are relatively low and temporally stable, and relatively uniform by the standard social categories of residence, occupation, income and so on. Let us also assume a fairly rapid rise in birth rates. Now such a change in the birth rate will have only minor repercussions for the structure of the family. These consequences are limited to the nuances of generational and sibling relations. But the overall effect of this change on the economy, on the density of population, occupational

structures, on the demand for schoolsand so on will be of major significance. All these concommitant changes will have significant impact on the traditional family structures.

For example if the traditional authority is vested in the lineage head, let us suppose then that he makes all the decisions which affect the lineage members; then if some members of the family are occupationally mobile and have access to income resources, and they decide not to obey the "commands" of the head of the family, this in itself is an indication of social change at least in the authority system.

2. The Society

The present society we are looking at is based upon a tribal system which had currency before and during the colonial rule, and may be called traditional to use Weber's term.[11] In examining traditional Ghana Apter was concerned with three orientational variables. The first we can call behavioral alternatives.[12] These are the systems of authority roles, particularly as they are legitimized in various clusters such as the family, the chieftaincy hierarchy, the state council, and other membership structures entailing the direct exercise of authority. The second we term goal orientation.[13] This refers to the type of expectations which are built into the traditional system by which individuals view their future and pattern their activities. The third we call social norms.[14] This refers to the sanctioned aspects of social action.

The norms are enshrined in traditional cosmological patterns. These have certain fairly well-defined maxims. Guides to social behavior are enunciated in proverbs, and usually interpreted by the head of the lineage or the traditional medical practitioner as part of the living code of behavior, through the process of socialization.

The best way to act in traditional system is, so to speak, the way ancestors have ordained. That which is legitimate is that which has been enshrined in the past.

The degree of behavioral institutionalization is intense. The level of affect is maintained at a high pitch in a context of vengeance, fear, magic, and exorcism. The non-empirical sources of behavioral criteria stemming from specifically religious sources grants rationality to the wisdom of the gods, and disobedience at the level of social order brings vengeance from the gods.[15] The repressive act against the deviant actor is thus to prevent vengeance from falling on the group.

The basis of traditional cosmology must be found in the philosophy of life which emanates from the traditional cultural material. The philosophy of life of the Ashanti, like most traditional people is aimed at perpetuation of life - life for the individual and for the group. It is this quest for life both for the individual and for the group which bolsters magico-religious beliefs and practices (the sine qua non of traditional medical theory).

If this belief develops in mankind what may be called a sense of dependence upon super-sensible powers, as Radcliffe-Brown[16] maintains, then the proper performance of magico-religious acts and observances must have as their goal the desire to increase one's hold on life, to

provide some kind of insurance against threats to life or disruption of the social unit.

Within the traditional context of the Ashanti cosmology, illness is not considered as just the result of pathological change. The supernatural is invariably invoked as the main causal factor. Within this framework the concepts of the etiology of health and illness are far more behavioral than biological. Health and illness are not isolated phenomena, but part of the whole magico-religious fabric. The traditional cosmology has no room for a purely naturalistic notion of illness, because there is no clear cut conceptual separation of the natural or physical world on the one hand and the supernatural or the magico-religious world on the other. Whereas in the world of Scientific Medicine there is a conceptual separation between the natural and the supernatural.

C. Key Concepts

1. Scientific Medicine

We use the term scientific medicine to indicate a view in which the rational explanation of natural events is in terms of cause and effect.[17] Cause in this sense, is viewed as natural in contrast to supernatural causation. In otherwords the causation by supernatural powers, we may say, has no place in scientific medicine *per se*. According to scientific methodology, facts in the system of belief are arrived at, whereby phenomena are observed, described and classified then by inductive reasoning, hypotheses are derived and from the

general principles, deductions or predictions are made about relationships between events. These predictions are verified or dismissed through experimentation. One of the premises of scientific medicine is that the results of new experimentation can change the basic principles. It depends on observation, experimentation, the seeking of natural causes, allowing in all cases for change when demanded by new evidence.

2. Traditional Medicine

A sine qua non of traditional medicine is that the service is performed through the utilization of magico-religious acts and concepts.[18] This is not to say that the practitioners of traditional medicine have no notion of physical cures and treatment. They have a stock of remedies with which to treat ills and some may have scientific validity. For example, wounds are bandaged and broken bones set and bound. Stimulants and sedatives are also found in the traditional pharmacopoeia. Most treatments however, are regarded as aspects of a total treatment which does include magico-religious ingredients.[19] The malefic action of another human being or intervention by a supernatural power may cause illness, which may be cured by resort to the appropriate magico-religious formula or application to the supernatural power. Tradition is important not in the sense of empirical experience, but through its validation of the power of the unseen world.

3. Supernatural

This term is used to include all that is not natural, inexplicable in concrete terms. For example the scientific medical practitioner does not seek supernatural causes but employs the germ theory vis a vis scientific method in his curative practices (natural causation), whereas the traditional medical practitioner qualifies under this usage of the term supernatural.

However Hsu[20] clarifies this idea by pointing out that man interprets his universe in two (but not mutually exclusive) ways and on the basis of the interpretation he is afforded patterns of behavior with relation to that universe so that he may know how to act. Naturalism and supernaturalism therefore are both ways of adjusting to the universe. The behavior of an actor is based upon both lines of the interpretation; the act of the individual is affected by "the definition of the situation".[21]

4. Magico-religious

The use of the concept "magico-religious" needs an elaboration. As exemplified in the scholarly works of Tylor,[22] Durkheim,[23] Frazer[24] and Malinowski,[25] all attempts at drawing a hard and fast distinction between religion and magic have not been able to produce consistent and universally valid results. For example according to Malinowski's classification, magic is a means to an end and religion is a "body of self contained acts"[26] which are "themselves the fulfilment of their purpose".[27] On closer scrutiny the Malinowskian contrast between magic

and religion is not clear, because whichever criterion one may use, he is led to the conclusion that magic and religion, instead of being treated as mutually exclusive entities, must be seen as mutually interdependent. A major criticism arises from the unequivocal fact that both magic and religion are often found to be intermingled in a simple rite. Ideally, sharp distinctions may be attempted but in practice only the rarest case in all aspects may meet the conceptual ideal. For this reason the use of religion embraces magic (magico-religious).

There is a considerable overlap between the utilization of magico-religious concepts on the one hand by the traditional medical practitioners and science, on the other hand as applied by the scientific medical practitioners. This is so, not because any one lacks any power of rationality, but because an element of faith is present in both. There is hardly any question of rationality, for a science oriented medical practice does not always differentiate or act accordingly in a distinctive way along the two lines. Just as a magico-religious oriented medical practice often utilizes real knowledge in its activities, so also do science oriented medical practitioners often mix magico-religious concepts in their activities.[28]

In either instance there can be correct as well as erroneous beliefs. For this reason, a discussion of magico-religious concepts versus science in human behavior is meaningless unless it is related to patterns of culture which are the prime mover of the behavior in question.

D. Proposed Theory

The Ashanti traditional society was an integrated one. New ideas, among new scientific medicine, came to impinge upon the social system of Ashanti traditional society, and helped to bring about changes in the system of medicine. (Other new factors include: changes in the policy, economy, formal education, rural-urban migration and changes in the extended family structure).

Changes in the system come about through mediating processes. New ideas, and their latent and manifest consequences, need to be explained and understood both by individuals and collectivities. As new understandings through the process of social interaction, are arrived at they may serve to erode the traditional world view. Three orientational variables are subsumed under the concept of traditional world view: i.e. role alternatives, goal orientation and social norms. The first concept is related to authority - roles classification, the second is the expected traditional behavior, and the third refers to the sanctions required to guide the rules of social behavior.

In such an integrated society, as was the case with the Ashanti, changes will come about in the system to the extent external influences erode the traditional world view. This erosion will in turn affect changes in the social structure of the society. For the purpose of this thesis, this is the theory of social change.

V. Methodology

Primary fact finding is not one of the goals of the present research. The objective is rather that of assembling and utilizing available facts in the interest of critical analysis.

Data related to our purpose have been conveniently assembled and adequately documented by social scientists as well as historians who have worked in the Ghanaian cultural setting since contact with the Western World. For example the Ashanti traditional society has received the most attention, in terms of greater documentary evidence, of the various ethnic groups in Ghana. This gives us some indication of reliability and validity to judge the adequacy and the quality of the information available. This material on Ashanti and on Ghana prove to be adequate.

In the discussion of the contemporary period (1950-1970) we have drawn our material mostly from the Ghana Government's documentary sources, from the offices of the Ministry of Health, Research Unit, Statistical Office and from the Offices of the Ghana High Commissioner in Ottawa.

As a Ghanaian Civil Servant, the author's work in the Ministry of Health, Ghana, has proved to be an asset because of the experience he has acquired. The author's work as a senior civil servant, brought him in contact with traditional medical institutions, as well as giving him knowledge and insights into the scientific medical system.

These processes of eliciting information afforded the author the opportunity to compare data in order to establish some measure of

consistency in the findings. Also the investigator's observation at the medical shrine of the traditional medical practitioners provided the possibility of assessing the quality of the data assembled. It provided the background for evaluating and understanding facts collected from the various documents. Personal observation also served as a basis which allowed us to judge what information may have escaped official documentation. In summary therefore, it was possible to obtain a great deal of pertinent material which forms the basis for the study.

The study is sociological rather than historical in its emphasis on the present. However the emphasis is also on how things came to be what they are; and an attempt to describe and analyze the present conditions. It is sociological rather than ethnographical in-so-far as it deals more with social structure than with culture. It is sociological rather than psychological in that it is concerned with the individual personality and motivations only where relevant to the structure of the group.

VI. Implications

As an exploratory study it is hoped that this work will make it possible to generate hypotheses from the investigation in order to arouse interest in this area for future field research. A study of traditional medicine and its contrasting elements may provide us, beyond satisfying mere curiosity, with a broader perspective and a deeper insight into the problem of contemporary medical systems and also the reasons for some of the successes and failures of scientific medicine.

It could, also, be viewed as assisting in the clarification and reconceptualization of the subject area. The questions pursued are of interest to the area of medical sociology in particular and,for that matter of interest to the body of knowledge of sociology. It may assist us to understand the raison dêtre of both traditional and scientific medicine in a developing nation. It is a pioneer study in this direction.

VII. Organization of the Dissertation

In accordance with the research objectives, the dissertation includes eight chapters. The first chapter sets forth the problem, the background theoretical information, the objectives of the study and the implications. Chapter two deals with the social organization of the traditional society of the Ashanti of Ghana, the reason being that it provides the background from which to view the ongoing discussion of the co-existence of the two medical systems. Chapter three looks at the institution of traditional medicine. Chapter four deals with some changes in the contemporary setting (1950-1970). Chapter five deals with the institution of scientific medicine. In chapter six we shall discuss some of the effects of scientific medicine upon the larger society. In chapter seven we shall look at the nature of the competing relations between the two medical systems. The last chapter deals with some of the conclusions, the implications and the recommendations of the study.

FOOTNOTES

[1]Before the advent of Scientific medicine, the traditional medical practitioner was the sole practitioner of medicine. He employed the aid of magico-religious acts and concepts to find the cause and the course of illness before treatment is initiated in terms of medication. But the real potentiality of the medication is sought in terms of its spiritual potency.

[2]See an appraisal of these two approaches from Herbert Simon, Organizations (New York: John Wiley and Sons, 1958), pp. 128-130.

[3]George H. Mead, "The Problem of Society" reprinted in Anselm Strauss (ed.), The Social Psychology of George Herbert Mead (Chicago: University Press, 1952), p. 18.

[4]F.H. Knight, Risk, Uncertainty and Profit (New York: Houghton and Mifflin, 1968).

[5]T. Parsons, Structure and Social Action (New York: McGraw Hill, 1951).

[6]Albert A. Wessen, "Social Structure of a Hospital" (Unpublished Ph.D. dissertation, Department of Sociology, University of Chicago, 1951).

[7]Bronislaw Malinowski, The Scientific Theory of Culture (Chapel Hill: University of North Carolina Press, 1944).

[8]On the Concept of Social Institutions, the author gained greatly from reading J.O. Hertzier, Social Institutions (Lincoln: University of Nebraska Press, 1964). See especially pp. 1-5, "Place of an analysis in Social Theory".

[9]W. Moore, Social Change (New Jersey: Prentice Hall, 1963), p. 33.

[10]R. Firth, Elements of Social Organization (Boston: Beacon Press, 1961), especially Chapter 3.

[11]Max Weber, The Sociology of Religion (Boston: Beacon Press, 1964).

[12]David E. Apter, Ghana in Transition (New York: Atheneum, 1963), pp. 1-83.

[13]Ibid.

[14]Ibid.

[15]Emile Durkheim, The Elementary Forms of Religious Life (New York: The Free Press, 1951).

[16]A.R. Radcliffe-Brown, "Social Sanction" Encyclopeadia of the Social Sciences (New York: Macmillan Company, 1934), pp. 531-534.

[17]This may be the scientific ideology but in terms of our analysis the scientific ideology will be subjected to sociological analysis.

[18]R.A. Lystad, The Ashanti: A Proud People (New Jersey: Rutgers, 1958). Also consult G.W. Harley, Native African Medicine (Cambridge: Harvard Press, 1944).

[19]J. Middleton, Magic, Witchcraft and Curing (New York: Doubleday Anchor Books, 1954).

[20]F.L.K. Hsu, Religion, Science and Human Crisis (London: Routledge and Kegan Paul, 1952).

[21]A pioneer American Sociologist W.I. Thomas points out that "if men define situations as real, they are real in their consequences". See W.I. Thomas, Social Behavior and Personality (New York: Social Science Research Council, 1951), pp. 226-231.

[22]E.B. Taylor, Primitive Culture (New York: Henry Holt and Company, 1889).

[23]Emile Durkheim, op. cit.

[24]J.G. Frazer, The Golden Bough (New York: Macmillan Company, 1922).

[25]Bronislaw Malinowski, Magic, Science and Religion (New York: Doubleday Anchor Books, 1954). This book has had a great intellectual impact on my thoughts.

[26]Ibid, p. 25.

[27] Ibid, p. 26.

[28] F.L.K. Hsu, op. cit.

CHAPTER 2

THE TRADITIONAL SOCIAL SYSTEM

I. Introduction

In this chapter we shall discuss the social system of Ashanti traditional society in order to provide background for viewing changes that have come into being within the contemporary setting. It is necessary to provide this background discussion of a traditional society because it gives an insight into some of the old institutional structures which once gave an all embracing support to the practice of traditional medicine. Furthermore it would be impossible to comprehend the interrelative aspect of the two medical systems (scientific and traditional) as well as the substance of medical institutions without some understanding of the indigenous social system upon which the medical institutions impinge.

We choose to discuss the Ashanti because they are the most numerous of the Akan[1] speaking people, whose culture has had profound effect on the present situation in Ghana. The ethnographic works of Rattray,[2] Fortes[3] and Busia[4] (to mention only a few of the social scientists who have worked in the area) indicate that in spite of more than a century of contact with the Western World, the Ashantis have kept tenaciously to their social system. Also it is convenient to select the Ashanti system because of its adequate documentation.

The discussion then, takes us into the following areas: the political system, the kinship system, marriage and the family, the

economic system, the concept of the individual[5] and finally a summary of the chapter.

II. The Ashanti Social System

A. Political System

During the eighteenth century Ashanti had emerged as a powerful national state consisting of a confederation of strong and semi-autonomous chiefdoms grouped round the kingship whose politico-religious symbol is the Golden Stool.[6] The story was told that the Golden Stool was miraculously created and delivered by the gods and the ancestral spirits through the religious priests, Okomfo Anokyi, under the aegis of the Ashanti King Osei Tutu.

The significance of the Golden Stool was seen in the unity it gave to the nation, for it was believed to contain the soul of the nation. In this day and age, the Golden Stool still symbolises the emblem of the authority of the Ashantihene,[7] the evidence of his unique, sacred ordination. The Ashantis were politically united under the Ashantihene before the colonial rule.

At the side of the Ashantihene stands the Ashantiman Council, composed of paramount chiefs of the member states of the Ashanti confederacy. The paramount chiefs assist the Ashantihene in the direction of the affairs of Ashanti nation. The paramount chiefs also hold positions in their own states. As paramount chiefs of their states, they govern their people with a council comprised of the elected representatives of the state. Similarly, subchiefs and

village chiefs serve their smaller communities with the help of elected representatives from the local communities.

Within these communities the town chief or village head serves the people as the leader of the community. But he consults with a council which is made up of the heads of the respective lineages who are resident in the village or the community. In otherwords the political structure of the Ashanti social system radiates the authority of the Ashantihene through to the level of the extended family network. This political structure reveals a logic and a degree of centralization that is capable of providing a stable government with the consent of the governed. For example, to be eligible to become a village chief, the person is selected only from among the members of the royal family. But the final choice, from the number of eligible persons, requires the approval of the constituent commoner groups in the community. A poor selection could be deposed by popular demand.

This political system is in evidence today in the traditional society. It is popularly known as an "indirect system of Government" meaning that at the Governmental level (central government of Ghana) the chiefs are given the authority to deal with traditional matters. In the final analysis the traditional person looks up to the elder of his lineage in cases of settlement of dispute, traditional marriage problems, litigations, land disputes and similar cases within the traditional jurisdiction. So in essence the Ashantihene's authority permeates throughout the length and breadth of the traditional society.

B. Kinship System

The key to the understanding of the kinship system of the Ashanti is through the rule of matrilineal descent.[8] Matrilineal descent is the foundation of the localized lineage organization which is generalized throughout the society by an organization of dispersed clans.

Every person is by birth a member of his mother's lineage and a member of the chiefdom in which this lineage is located. Through marriage or through migration (in terms of working in another area and/or establishing a neolocal residence), members of the matrilineage still find their real home in their original chiefdom. They still retain their rights of membership in their natal homes. Dispersal does not, in any way, deprive members of their lineage rights and statuses.[9]

In the matrilineage, the head of the lineage has real control over the individual. The individual's maternal uncle has jural rights over him. Marriage confers rights in uxorem but no rights in genetricem. A child's genitor is not necessarily his pater. In other-words whenever a man marries a woman, and brings forth offspring by her, the man is the biological father but does not necessarily mean that he is the sociological father. In terms of social relationship, the child's maternal uncle has rights of the socialization of the child. Furthermore the head is the lineage's representative with the chief's council as well as the intermediary with the child's ancestors. He is the administrator of the lineage's property, the

custodian of its traditions and the arbitrator of disputes among the lineage members.

The authority of the head of the lineage is supported by the spiritual order. Even though all the members of the matrilineage do not live together on the ancestral lands and households in the present time yet in various points in time many do come together to their natal homes, to perform funeral rites, to share funeral expenses and other rituals of such nature.

The Ashanti explain the principle of matrilineal descent by pointing out that the ancestors reckon descent that way. After four generations or so of this reckoning, the kinship system gets large and its branches tend to have less and less to do with each other in their day to day activities. Whenever such point is reached a kind of loose boundary line is drawn between two or more extended families: those family members who live in one village or community still consider themsevles as one extended family unit, while those who have moved elsewhere regard themselves as a separate though related part of the original extended family in the natal locality. In times of crisis and uncertainty all the members of the separate units of the matrilineage are consulted, through their respective heads or elders.

The ties between the separated extended families are not severed completely. Each unit regards itself as a member of a larger kin group which is called the lineage. When the common ancestry is traced even further back, a very large number of people, who are usually living in widely scattered areas but do realize their relationship, consider each other as belonging to the same clan.[10]

Leadership in the lineage usually falls to an older male member of the extended family, because of his superior wisdom, personal qualities and experience he has acquired during his lifetime. Before he is selected as the leader of the group other members of the various units of the extended family mustgive their approval. If he is selected he carries the greatest weight in making economic, political as well as social decisions which affect the group. He is the custodian of the morals of the group and the property rights are invested in his authority. He is the link between the living members of the group and the world of the ancestors. Politically he represents the group in the chief's council.

At the death of the lineage head, his authority is almost automatically bequeathed to the next in age of his brothers - unless the next person in line of succession is regarded as physically, intellectually or morally unfit for the office of the lineage head. When death has carried all the members of the elder generation to the ancestral world, from where it is believed that they continue to exert their invisible leadership, then the leadership may fall on a mother's brother's son: that is a maternal nephew may inherit the office and the authority of the lineage head, after the death of an uncle, when uncle's brother is not available.

C. Marriage and Family

In Ashanti, marriage between a boy from one lineage and a girl in another lineage is not a contractual relationship between the two

persons. The Ashanti attribute importance to marriage so it is not left in the hands of the boy and the girl. Marriage is less an agreement entered into by the two individuals than a social contract between two families. The potential in-laws first investigate each other and come to an agreement to establish new obligations of mutual respect and aid between the families; only then may the boy and the girl be allowed to marry. The families of both young people are active counselors during the courtship, and their wholehearted endorsement is essential to the success of the marriage.

The criteria applied by the respective in-laws are, for the most part, familiar. How old is she or he; has she been married previously; why did her earlier marriage fail; does she possess the personality of a "good" woman; is she educated in the womanly arts; will she work hard; will she be able to bear children; will she raise her children well; does she come from a good background; is the history of her family such as to give pride to anyone allied with it; is it a wealthy family; is her family free from the taints of indebtedness and witchcraft; is she from a royal family? The investigation, along these lines, goes on and it is conducted with great care and thoroughness. This is believed to be a job for the experienced old person who is attributed with the wisdom of the years, not for the young "empty heads" of a boy and girl who think they like each other. After all the enquiries and tests having been satisfactorily passed the bridegroom pays the customarily bride price following which the boy and the girld are considered married.

The crucial payment by the bridegroom by which a daughter is legally espoused goes to the lineage head and his concurrence is essential for marriage of any member of the lineage to be considered valid.

The Ashanti say "one lineage is one blood" (abusua baako mogya baako); and again they say that the lineage is "one person" (nipa koro). This, again, is not a question of physiological theories but a way of expressing the corporate unity of the lineage.

The Ashanti regard the bond between mother and child as the keystone of all social relations. Therefore childlessness is felt by both men and women as the greatest of all personal tragedies and humiliations. Prolific child bearing is honoured and the mother who bears ten children is congratulated with a public ceremony.

In Ashanti all mothers expect obedience and affectionate respect from their children. If a child shows disrespect towards his mother it is tantamount to sacrilege.[11] It is expected of a mother to be the mistress of her own home. It is honourable for a mother to surround herself in her own home with her children, and daughter's children. It is believed to be the highest dignity an ordinary woman can aspire to.

The family is not a small single unit of the man, wife and offspring type. It is a unified, cooperate group. The total group consist of a number of integrated parts, each of which functions in its own sphere. The smallest unit, the "nuclear family", is made up of a man, his wife, and their children. Within this group, the husband is responsible for providing shelter and food. As the children grow older,

their father's responsibilities to them decrease, but during their childhood the father is the person upon whom the children may depend. As the children belong to the matrilineage, the jural right is invested ideally in the maternal uncle, he is the de facto head.

The members of the nuclear family usually reside together, although many husbands prefer to live separately from the wife and the children. Living apart is frequently the arragement made, so that if a man has more than one wife, he is able to keep the wives in separate households to avoid immediate quarrels and household friction. It goes without saying that not all husbands are diplomatic enough to care for several wives and their respective children in a single household. The reason for the division in residence is to be found in the Ashanti principle of reckoning family membership by the matrilineal descent principle.

The traditional family is a social and administrative unit, differentiated in functional roles, in which the head of the family is responsible for the general well-being of the group. The aged, have a place of honour, in the sense that, they are the cultural link between the dead and the living. They are the transmitters of myth and custom and in many ways arbiters of proper conduct.

The family unit is a personalized unity of a high degree of solidarity (nipa bako).

Class distinction is rudimentry. The limited division of labor, and consequent social differentiation by economic class, is of only slight relevance. Almost everyone does roughly the same kind of work. The basic differentiation is found in terms of male's

work as opposed to female's work.

Status grouping on the basis of lineage and more formalized roles carry certain privileges. Yet status does not involve a personal set of qualities involving superiority or inferiority, but rather impersonal relationships having ritual antecedents which all members are obliged to sustain. Emotional feeling runs high if participants attempt to break out of this social pattern. It requires an independent cast of mind, therefore, for the individual to break loose from the system.

D. Economic System

Members in a given matrilineage are expected to farm on ancestral lands. Land is held for members use but not for sale. It is the right of a lineage member to use and enjoy the advantages and profits of a given lineage property of another without altering or damaging the substance (usufructuary). Property is held subject to the obligation to use it generously for the benefit of lineage members. There are norms for conduct which are designed to protect the social order. Members who are dependent on the use of ancestral lands are expected to obey the "commands" of the lineage head. To avoid injury to the spiritual world, rules of conduct are laid down; violation is believed to bring illness or accident to the individual or disaster to the lineage members. So long as the member of the kinship unit conforms to the expectations of the group, he is looked after by the cooperate unit. Whenever an individual incurs a debt it is the

responsibility of the lineage head to assist him in the payment of the debt.

Thus a system of prohibited norms of fairly clear content and third-party decision making has developed for the control of deviant conduct. Once again it requires an independent cast of mind for the individual (who depends on the goodwill of the family property for his living) to break loose from the system. Furthermore magico-religious beliefs and practices validate the social and the economic order.

The living, it is strongly believed, receive from their ancestors the permission and the right to use the land. The ancestors, in spirit form, are believed to watch the living for the proper utilization of the land. The ancestors ensure through their power over the living members of their respective lineages that the land is used in a proper manner, that is to allow lineage members the right to farm on the land.

E. The Concept of the Individual

The Ashanti view the individual as a compound of both the physical and spiritual entities. He is seen as a product of the union of male and female, the male spirit (ntoro) with the female blood (mogya). The ntoro is tramsmitted from the father to his children and this is shared by them as members of the ntoro group. Members of the ntoro group observe certain practices in common and they are not allowed to marry other members of the same matrilineal group. Members of the matrilineage perform certain rituals in common and they observe taboos and totemic practices together on certain festivals.

The mogya which is inherited from the mother is the basis of lineage membership. The mogya is therefore synonymous with the lineage (abusua) and it provides the child with its lineage identity and membership. According to the Ashanti's world view, it is the presence of mogya that makes the child a human being. The female child receives the ntoro from her father but she is unable to transmit it when she is of age and she is able to bear children of her own. It is believed that only the male child, when he is of age and is able to reproduce, can pass on the ntoro to his offspring.

The combination of the ntoro and the mogya gives the individual okra, which is equivalent to the person's temperament. This okra is inborn, that is, the inborn characteristics of the child. The okra is also derived from the day of the week on which the child is born, and is the spirit or the soul of the child. It is believed to be determined by the gods who are associated with the day on which the child is born, and the okra comes to the infant on conception, through the union of the ntoro and the mogya. After birth, it is the okra which is assumed to be the guiding spirit for the life's journey of the individual.

The okra leaves the person on his death to become a part of the world of the spirit. It is also believed to be subject to reincarnation in another life.

These three elements of one's personality, the ntoro, mogya and the okra, are ineluctable, and are thought to be beyond the individual's control. Therefore, the individual becomes a member of his matrilineage. As spiritual elements they are made manifest in

the individual's life. The child is identified by these three elements which place the child firmly in the sphere of his lineage, and the spiritual world.[12]

The spiritual world is comprised of ancestors and gods. The gods are related to the lineage stools. The ancestors are believed to exert influence upon the lineage members who are living. They must be communicated with accordingly. As given elements of the individual's personality, the ntoro, mogya and the okra are not amenable to individual control. They are the individual's link with the world of the spirit. They make it possible for him to come into this world, it is believed, and they are responsible for guiding him throughout life till death calls him back into the world of the spirit.

Upon his death, he becomes an ancestor for his descendants. In spirit form he is able to influence the fortune of his descendants and to bring ill to them if they are not in good communication with him.[13]

As the child is being socialized to become an Ashanti, he acquires the sunsum which is his character (it may also resemble the ego and the superego concepts of Sigmund Freud in that it embodies the individual's distinctive personality and character).[14] The sunsum dies with the person. It can leave the body during sleep, while the okra cannot. The sunsum is educable and has a moral system of reward and punishment. Failure to observe the usages of the lineage entails a negative sanction.

On the concept of social sanction, Radcliffe-Brown points out that:

> "the sanctions existing in a community constitute motives in the individual for the regulation of his conduct in conformity with usage. They are effective, first, through the desire of the individual to obtain the approbation and to avoid the disapprobation of his fellows, to win such rewards or to avoid such punishments as the community offers or threatens and second through the fact that the individual learns to react to particular modes of behavior with judgments of approval and disapproval in the same way as do his fellows, and therefore measures his own behavior both in anticipation and in retrospect by standards which conform more or less closely to those prevalent in the community to which he belongs".[15]

In essence we may say that what is termed the individual's conscience is thus, in the general sense, the reflex in the individual of the sanctions of society in which he lives.

In describing the behavior of the individual, therefore, these unifying themes stand out: (1) the supremacy of the spiritual world; (2) the assumption of a particular form of political and social order because it links the individual appropriately with the spiritual world; and (3) the universality of a model of action which is provided by the individual's family or his lineage as a means for organizing his action. The authority of the lineage rests precisely on the logic of the spiritual support received from the ancestral world. This is not a question of physiological theories but a way of expressing lineage solidarity in pure and simple terms.

The Ashanti exhibits a sense of order and depth of perception in his concept of the elements of the personality, his relationship with others in the world of human organization and the world of spirit.

III. Summary of Discussion

The individual Ashanti finds help in his faith in the hidden forces and in the personal ancestral spirits, guiding the world view of the traditional social setting. The individual, in such a setting, is also aware of his dependence upon other members of his kin groups and upon his ancestors. He is made aware of the fact that any deviant behavior may be subjected to sanctions from the spiritual world; and ill-health is one of the devices which may be inflicted upon the traditional deviant.

In such an integrated social setting, a breach in social relations threatens almost the very survival of the group. In any social setting, we are aware of the fact that, occasions do arise in which hostility and conflict threaten the harmony and the solidarity of the unit. It is even more serious in a traditional social setting where almost always relatives interact with one another in various aspects of their day to day activities. In such a setting when ill feelings develop and when they are accompanied as they often were in the past, by certain kinds of prolonged illness and/or uncertainty, it seems obvious for the members of the group to trace them to the action of the supernatural world or an ill will which had wormed its way into the group.

To enjoy good health and prosperity, members of the kin group are made aware of the fact that they have to keep in good standing with other relatives of the matrilineage. Litigation, for example, among lineage members is a taboo strongly disapproved of by the gods

and the ancestors.

Whenever the spiritual world manifests itself, an intermediary is needed to communicate with the spirit. An elder of the lineage, the chief of the community and/or the traditional medical practitioner is needed to bring its favour and/or to avert its misfortune. A ritual ceremony is performed, to express the linking of the group, or the individual, with the world of spirit and to bring about a good omen in the intervention of the spiritual into the temporal world.

Thus health and long life provide some of the specific rewards of the ancestral practice of the Ashanti traditional society. These are also the indices of life and of the group continuity.

In recapitulation we have pointed out that the society we are describing is based on "mechanical solidarity".[16] The day to day social relationship is based on a closely knit kin group. Members of a given extended family unit are expected to relate daily on the personal, affective level, a Gemeinschaft as opposed to a Gesellschaft setting. The unit is based on friendship, on neighborliness and on blood relationships.[17] Group feeling is almost always high providing a situation charged with high emotional content.

As claimed by Middleton[18] in such a traditional setting, the threat to the belief system, that is traditional cosmology, does not lie in the growth of Christian religion alone but rather in the development of a society in which a large proportion of the day to day relationships are impersonal and segmental (see the discussion on the changes in the contemporary setting in Chapter 4).

The relevance of this point is that, with recent contemporary social changes, many kinship members have taken advantage of new opportunities and have moved to areas where job opportunities are available. In short many of them have ceased, at least in the urban areas, to relate in close relationship as it was before. Now a large proportion of the urbanites day to day activities are impersonal and segmental. These have implications for traditional social structures which in a historical point in time did give support to traditional medical theory. (For further elaboration on this point see Chapter 4 and especially Chapter 6.)

FOOTNOTES

[1]The word Akan represents a culturally homogeneous group of people who share the same culture, matrilineal descent group, and speak the same group of language. There are slight variations, viz-a-viz dialects but invariably an Akan is understood by another Akan. Among the Akan the Ashanti are the most numerous. The Akan represents about 40 per cent of the Ghanaian people. See the Statistical Year Book, Central Bureau of Statistics Accra, Ghana, 1963. Also see E.A. Boateng, A Geography of Ghana (Cambridge: University Press, 1966), pp. 3-10.

[2]Refer to R.S. Rattray, Ashanti Proverbs (London: University Press, 1923). Rattray's works were based on intimate contact and knowledge of the people of Ashanti. He stayed with the Ashanti for almost twenty years.

[3]Meyer Fortes' work among the Ashanti also confirms the good quality work of Rattray's ethnography. See M. Fortes, "Kinship and Marriage Among the Ashanti" in A.R. Radcliffe-Brown and Daryll Forde (eds.), African Systems of Kinship and Marriage (London: Oxford University Press, 1950), pp. 253-284.

[4]K.A. Busia, The Position of the Chief in the Modern Political System of Ashanti (London: Oxford University Press, 1951).

[5]E.A. Boateng, A Geography of Ghana (Cambridge: University Press, 1966), pp. 3-5. It is customary to discuss the concept of the individual last because in Ashanti the collectivity is more important.

[6]R.S. Rattray, Ashanti (London: Oxford University Press, 1927), pp. 1-91.

[7]K.A. Busia, op. cit. Ashantehene is used to stand for the King of Ashanti.

[8]R.S. Rattray, Religion and Art in Ashanti (London: Oxford University Press, 1930). Also see K.A. Busia, op. cit.

[9]Ibid.

[10]In essence there are eight clans in Ashanti. These are: Oyoko, Ekoona, Asona, Asense, Agona, Brentuo, Tena and Aduana. Members of each clan are believed to be related by blood: marriage or sexual relations among members are defined as incestuous and therefore forbidden. (A clan is a large lineage group.)

[11]Meyer Fortes, "Totem and Taboo" Presidential address 1966 from Proceedings of the Royal Anthropological Institute of Great Britain and Ireland 1966, pp. 5-7.

[12]Ibid, p. 7.

[13]Ibid, p. 13.

[14]P. Twumasi, "The Ashanti Personality", West Africa, I (August, 1970), pp. 861-863.

[15]A.R. Radcliffe-Brown, "Social Sanctions", Encyclopaedia of the Social Sciences, New York: Macmillan Company, XIII (1934), p. 531.

[16]Emile Durkheim, The Division of Labor in Society (New York: The Free Press, 1966). See especially Chapters 2-3.

[17]Ferdinand Tonnies, Community and Society (New York: Harper Books, 1957). This book was translated and edited by Charles P. Loomis.

[18]J. Middleton, Magic, Witchcraft and Curing (New York: Doubleday Anchor Books, 1954).

CHAPTER 3

TRADITIONAL MEDICINE

I. Introduction

The discussion in this chapter shall take us into these areas: the training of traditional medical practitioners, the routine practice of traditional medicine at the shrine, the diagnostic and the treatment of illness as it was in the traditional society and lastly we shall summarize the salient features of the discussion.

It is hoped that this chapter will give an insight into the raison d'être of traditional medical practice, in order to facilitate the discussion in later chapters of the interrelative aspects of the two medical systems, the traditional and the scientific.

The potentiality of traditional medical practice is derived from the supernatural assumptions underlying the practice. This is not to say that traditional medical practice did not, within this historical point in time, prescribe herbs or bandaged wounds. Traditional medicine utilized medical herbs, but the potentiality of herbal treatment was sought in terms of the powers of the spiritual world.

As an institution, traditional medical practice has its own set of established patterns of behavior, its purpose and its group members. It is the intention of this chapter to provide an insight into this medical institution.

II. Training of Traditional Medical Practitioners

The novice who enters the training school to become a traditional medical practitioner will say he chose the profession because he has experienced possession by some spirit influence. He may have been going about his ordinary daily duties, but more often was attending some religious ceremony, when suddenly and without previous warning he heard "a voice". Subsequently he fell down in a fit or went into a trance.

His relatives may call in a qualified traditional medical practitioner to interpret the episode. The latter would say that it is the spirit of a particular god in the lineage who wishes the possessed individual to enter into the practice. Christensen[1] claims that the primary requisite to become a traditional medical practitioner of a particular god or shrine is possession by a deity (abosom).

The final decision to permit a person to enter into training is left to his relatives. Then the individual decides to enter into the particular institution of his choice in order to train for the job. In other words, he would enter the service of some fully fledged practitioner of the particular god, whose spirit he has been told has manifested itself in him.

Both men and women are accepted as traditional medical practitioners and are trained separately at appropriate shrines.

It is within the traditional medical institution that the aspiring novice receives his formal medical education. Throughout his medical socialization, the school provides him with his professional knowledge, skills and the identity, so that at the end of his training,

it is expected that he will think, act, and feel like a traditional medical practitioner.

In the institution, the new entrant is taken to the cemetery for a ritual bath in order to get into contact with the samanfo, the spirits of his ancestors. This is a complex supernatural organization centered around ancestor worship, in which the institution is a part. The essential fact is that inanimate objects - fetishes, shrines and things become invested with magico-religious powers. These ancillary beliefs play a great part in the everyday life of the traditional society.[2]

In training the novice observes many taboos. He must not break the vow of celibacy; but if he does he must make a sacrifice to the god at the shrine, and begin his training all over again. Besides the taboo on sexual intercourse, he must observe the taboos of his own god. He is admonished: (1) not to drink alcoholic beverages; (2) not to gossip; (3) not to quarrel or fight; (4) to salute his elders by bending the right kneed and touching the ground with the right hand; (5) never to adjure his god to kill anyone; (6) never to attend the chief of the village or any chief's court on his own accord; and (7) not to go out at night to join other young men or women.

The period of training is three years; and during this period the novice lives in the house of the trainer on the compound of the shrine.[3] He helps him on his farm, and at night he sleeps in the temple beside the shrine of the god he serves. Thus he is under constant observation during the period of training.

The first year is a period of orientation during which he is not told anything of crucial significance. It is a period in which both the

trainer and the trainee get to know each other, but when nothing very secret is told. If the novice proves disobedient or inattentive to instruction, his family is informed that the novice is not likely to make a "good" medicine man and his training will cease. The medicine man does not loose face when he gets rid of an inattentive or disobedient pupil.

During the first year of training, the novice is not paid but is required to do any duties his trainer may set before him. Although he is not isolated from the entire village community, he must observe many restrictions and fulfil many obligations. In essence he is in a new community within a community.[4] On ceremonial days he is asked to fast all day. On ordinary days he must never eat too much. He must have white clay on his face and shoulders on the days of the week sacred to his deity and wear as his primary garment a special rust-colored cloth which designates his calling. He is not allowed to have a hair cut. His long hair sets him apart from his relatives or other non-members of the medical institution. He acquires a distinctive appearance. He is instructed and interrogated from time to time by other medicine men in the community. He is told in no uncertain terms that the violation of a taboo would cause the "powers" he is developing to fly away from him. He must give automatic obedience to the rules and regulations of the institution.

In the second year of his training he learns the names of trees and plants and ferns and the spiritual properties of each. This aspect of the training deals with therapeutic techniques, including the instruction about properties of various plants and herbs and their

location. Also much of the instruction concerns the "god" or deity the candidate is training to serve, for he will be the intermediary between the people and the god. He is instructed in the dancing used to call his deity. The construction and the use of charms are also emphasized in this part of his training.

The trainee is made intimately acquainted with the haunts and habits of animals, birds and insects. The forest area, with their sights and sounds, are familiar ground during this period. He finds out through his learning experience and also through discussion with the trainer that some leaf or plant or root is specific for some particular curative purposes of an illness. He is now introduced to Suman. They are charms which are fastened on his wrist, ankles, and in his long hair. He is taught how to perform propitiation by laying the fetish upon the ground and kneeling in front of it holding a live fowl. He is then told to cut off its head and allow the blood to drop upon the fetish, repeating certain words he has learned from his trainer.

When the novice enters the third and final year, he is instructed in the technique of water-gazing and the art of divination. He is taught how to impregnate charms with various spirits, how to understand and to interpret the "voices" he hears. He is instructed to respect certain trees and animals. He is instructed to differentiate between certain animals; those which are supposed to possess "powers" or charms and those which do not. He is taught what lies within "water". For many weeks, during this period, he will be unable to look into water without seeing the faces of spirits or ancestors and as long as this happens he will not be able to do any water-diving, (hwe nsum) which literally means gazing into water.

At the end of this training, he enters into the status of a fully trained traditional medical practitioner. On that day, he will be asked to dress in his full robe (doso), with all his charms upon him. He dances all day to the accompaniment of drums and singing. At the ceremony he must perform specified feats under possession.

Akesson[5] points out that throughout his training the would-be medicine man is instructed in the art of possession or akom. This phenomenon of possession is a special attribute of the traditional medical practitioner. His behavior is sometimes not unlike that of the epileptic, for he may twitch, jerk, appear to run or dance aimlessly, and to talk in unintelligible utterances. Possession, in this context, is socially patterned, institutionalized and required on these ceremonious occasions. It is, in fact, a predictable behavior regarded as normal under these conditions.

A medicine man cuts a piece of the root of the tree called akakapempe, washes it, scrapes off the thin layer, puts it in a piece of linen cloth or towel, wets it with water, and then he squeezes it to allow the juice to drop in his eyes. He does this in secret before he comes into public view. This makes the eye balls look red. The juice (from the herb) is very powerful and makes the medicine man incapable of holding up his head. But adherents ascribe the change of the color of the eye balls and the shaking of the head to the power of the spirit of the particular god.

The medicine man has a spokesman or okyeame. He is his helper, a general factotum. He is instructed to serve the fully fledged medicine man. On this occasion, the medicine man picks the leaves of the

aseresere plant, rubs them between his palms, dips the result in white powdered clay, and rubs it carefully in the soles of his feet and the back of the legs up to the knees. This herb makes his legs shake because of the reaction of the juice on the nerves. These effects together with the music make possession possible.

On this day the final rite is a covenant performed before the god of the shrine. It is a secret rite performed only in the presence of the trainer and the outgoing trainee. They enter into a covenant of blood, after his trainer is satisfied that he has mastered all that he has been taught. The okyeame does not accompany them on this occasion.

The trainer asks the trainee to bring a pen-knife and a bottle of gin, or rum. A trainee's account is as follows:

> "The two of us entered the temple of the god. My trainer sat down by the shrine and stirred a big bowl with a wand and called upon the praise - titles of the god. After he had stirred it, he told me to stir it too. I stirred it three times in succession, but I neither saw the god nor heard him speak. When my trainer stirred it again, he spoke and made responses as if someone had asked him questions. He gave the wand to me again but, as before, I could not see any shadow or spirit nor did I hear any spirit speaking at all. My trainer became impatient and said: 'gyese me ne wo anom abosom. Ogyina ho kasa yi wonhu' (unless I drink abosom with you - a potion drunk when swearing an oath of allegiance or mutual fidelity). My trainer went on to enquire don't you see him standing and talking? I asked: How are abosom drunk? My trainer replied 'wait a moment'. He opened the pen-knife and made seven small incisions on the front part of my right wrist and said, if it is not the soothsaying of the forefathers which I was taught that I am imparting to you, may the god kill me (nye nananom akom a wode a kyere me na mede bi rekyere woa bosom nkum). He rubbed black powdered medicine in the incisions and licked

> the blood immediately he had uttered the above. He asked me too, to make the same number of incisions in his right wrist after he had said the following: 'if you tell your linguist that we have entered into a covenant, you disgrace akom if you happen to tell anybody may the gods kill you. (woka kyere obiara a abosom nku wo. wo ka kyere o'kyeame ana obiara se yeanom yen ho abosom a wagu akom anim ase). The trainer rubbed the black powdered medicine in the incisions and asked me to lick the blood. I did and both of us drank some of the gin. This done, my trainer claimed his fee of Preguan (eight pounds), one sheep and a bottle of gin".[6]

The new traditional medical practitioner then dances all night to the accompaniment of the drums and the singing. He then cuts a sheep for his god saying as he does:

> "abosom asumasi gye 'gwan yidi, nne na wa ware me wa wie; me nsa m'gwan ni, gyina m'akyi, akyigyinapa" (God so and so accept this sheep and eat; today you have completed marriage with me; this is a sheep from my own hands, stand at my back, during my professional life, with a good standing).[7]

After this ceremony he may marry, or if he is already married before he embarked on the training he may resume cohabitation with his wife.

III. Routine Shrine Procedure

At the medical shrine, women are employed to look after the domestic duties. They look after the daily activities such as cooking, washing and keeping the place tidy. They are not specifically concerned with the professional activities at the shrine. They are carefully instructed on the taboos and all the avoidances observed at the shrine by the professionals and the trainees. This adds very considerably

to the women's ordinary housework. Because of the difficulty involved in remembering all these "avoidances", they are made to wear a special little bracelet on their left wrist called nkae which means remembrance.

No two shrines are alike in details of ritual and priestly technique. The following is an account of a typical procedure at one of the medicinal shrines. After dark on the evening before a shrine working day, of which there are three every week (Sunday, Wednesday and Friday), the drums will beat to remind the entire village or the community to prepare for the healing day. This means that the shrine officials are to eschew sexual intercourse till after the day of healing. Soon after dawn the next morning the drums are beaten again and the women members in the medicinal compound start to sing, and to beat their rattles.

About nine in the morning of the healing day, the drums are beaten again to summon all the officials. The elders, spokesmen, drummers, singers and the wives of the officials assemble in the big compound, the gates being as yet unopened to the public.

Within the big yard is the circular sanctuary with its door opening onto a fenced dais which extends out like an apron stage. The elders take their seats under a sheet looking towards the side of the dais. Between them and the sanctuary stands the smaller orchestra, consisting of two drums, two tonal drums and one stumpy wooden drum. Sitting on the ground to one side of the sanctuary door with his back leaning against the sanctuary wall is the drummer, reiterating a little motif saying "mmere dane, dane" (time change, change).

Amidst the drumming and singing, the medicine man emerges

from his house. He is clad in thigh-length tunic of white calico. He wears no beads, only his uncut hair and his white calico mark him out from other people. At the foot of the steps he kicks off his sandals; then he mounts, hands the key of his private living room to the okyeame and holds out his hands to receive an egg. This he flings onto the flat top of the shrine. If it breaks unpropitiously (with the concavities of the shell fragments downwards) he looks worried; if satisfactorily, he looks pleased and bows in reverent gratification over the act. Then, he stoops while entering the low door of the sanctuary. Immediately the orchestra begins to play furiously to call the god (obosom) to possess him. After a few minutes of mounting expectancy the calico curtain at the sanctuary door is suddenly flung aside and out dart the attendants, two spokesmen, and lastly the possessed and quivering medicine man. The latter takes his stand with his back to the sanctuary door and facing the shrine.

He never varies his style. He stands upright on one spot with folded arms but with his head increasingly shaking from side to side, his long (mpese - mpese) hair flicking like whips round his head, his face mask-like, but his expressionless red eyes rolling from side to side and his eyebrows flickering up and down as though they are worked by machinery.

The drums redouble their frenzied beating, the gong-gong its iron clatter and the horn its piercing cries. After another minute or two the medicine man again holds out his hand for an egg and then smashes it. Then after a further minute or so he raises a hand to

silence the drums. Work now begins.

The public visits the shrine for two purposes. (a) It offers protection from all evil factors and (b) it offers curative rituals. All types of people come to seek help from the medicine man. The mentally ill comprise a portion of the people who come to the shrine not only from within Ashanti but from other parts of the country; some are healthy people who need protection from evil spirits. Financially successful men are fearful lest envious kinsmen should, by means of witchcraft, bring about their ruin. Unsuccessful men are of the conviction that envious malice is the cause of their failure. Thus a strikingly 'paranoid' attitude is normal among the pilgrims or patients.

The typical pilgrimage is made to the shrine to ask the deity, through the medicine man for a year's protection; and promise is made, offering a sheep and a bottle of rum at the end of the year. The deity's protection and blessing is granted conditionally on the supplicant's keeping of the prescribed rules of the society such as ethical conduct. He must not steal, commit adultery, bear false witness, nor curse another person. If he breaks any of these rules, the deity may punish him with sickness and/or death.[8]

Every hour or so it is alleged the "god" leaves the traditional medical practitioner and "goes to sleep". The practitioner suddenly turns on his heels, rushes at the sanctuary, flings himself at the wall, to cool down; then he begins to eat and sits around chatting with shrine officials. After a few minutes he resumes work again, always going first into the sanctuary while the drums call the "god" to come

to possess him again.

The traditional medical practitioner is familiar with the cultural traditions, the fears and the wishes of his clientele, so he utilizes such knowledge in his curative practices, in a form of psychotherapy with a strong element of suggestion in his act. Debrunner[9] describes a case of the young married man, who after a few years of married life had no children because he was impotent. The young man came to see the practitioner at his shrine. After consultation the practitioner told him that his sister, whom he has previously quarrelled with, was a witch so she had removed his testicles, symbolically, rendering the brother impotent. Unless these testicles were returned to him, he would be unable to father children.

The practitioner summoned the young man's sister to come to his shrine, to patch up the quarrel. The sister arrived at the shrine, and was interviewed by the practitioner in his consultation room. There the sister readily confessed her guilt and informed those present that she had buried her brother's testicles in an ant hill. When she was challenged whether the ants would not have eaten the testicles she replied that she hid them in an empty cigarette tin. Thereupon, the traditional medical practitioner and his group went to the ant hill and started to dig for the crucial cigarette tin. Eventually an empty cigarette tin was found. This was presented to the patient by the practitioner; and although it was found empty, the patient gratefully accepted the return of the invisible testicles; a year from this incident, his wife delivered a son.

It may be relevant to remark that in the traditional society,

health hazards loomed large in the lives of the inhabitants and took a heavy toll in death and disability. To deal with the burden of recurrent sickness, they built up a system of traditional medicine. There are three themes in the system: (1) the social organization of the people from which arises the nature and the degree of mutual dependence of group members, together with the respect accorded to those who are recognized as possessing the art and the skills of healing; (2) the method of treatment and the measures taken to prevent and to ward off accidents and illnesses; and (3) the concepts of supernatural world, which provide the inhabitants with some basis for their beliefs.

Evans-Pritchard[10] and Kluckhohn[11] have pointed out in their studies that beliefs are integral parts of the cultural life of a people and can therefore be understood only in their own total social context. What in effect they say is that any point in time, what a given society believes in has a coherent logic of its own. When one accepts the basic premise of their thought system, what flows from it is consistent with their world view.

The belief system provides explanation for coincidence and disaster. Malinowski has shown that belief in the supernatural fills a gap in man's pragmatic pursuits. It acts as a means of expressing thwarted human desires, in instances of coincidence and disaster.

As noted earlier the practitioner has a stock of remedies with which to treat ills and some of these have some scientific validity.[12] However most treatments are regarded as aspects of a total treatment which include magico-religious ingredients. The distinction between physical cures and magico-religious (supernatural) cure is not usually

made at the shrine. The society relies upon the supernatural theories of disease, and its identification of magico-religious prescriptions is quite in keeping with their world view. Germs, viruses, and the concepts of protein and vitamin deficiencies, (to name only a few of the natural causative agents) do not figure in traditional medical thoery.

IV. Diagnosing and Treating of Illness

In this section the author is referring to a traditional situation in which the only available institutionalized medical technology is in the hands of the traditional medicine man. There are several ways in which the sick person may receive assistance. He may appeal directly to the ancestral spirits, to his god, or he may travel to the medicinal shrine to "see" the medicine man. The nature of his illness may influence the decision.[13]

The person who is ill, may recognize that he is not feeling well. The next stage is for him to communicate this feeling of illness to others, which may be achieved verbally or non-verbally. Once the symptoms have been recognized, not only by the sufferer but within the primary group, an implicit or explicit decision has to be taken collectively as to whether the situation is serious enough to justify the disturbance of normal social relations by the adoption of what has come to be known following Sigerist and Parsons, as the sick role.[14]

Implicit in this are other decisions as to how such a role is to be legitimated, and how other social interaction is to be adjusted

to minimize social disturbance. The characteristics of the sick role in the society are that in so far as he is legitimately recognized as a sick person, he is temporarily relieved of his obligations of his work activities. If he is a father he is not obliged to attend work to support his family or take part in the decision making processes of his various social groups. This role is legitimated by the elders of the family and it is reinforced by the traditional medicine man, when the case comes to him at his medicinal shrine.

The sick-role principle, therefore, is not the invention of modern society. The sick in traditional Ashanti are under social pressure to call in a traditional medicine man or other outside authority such as an elder who, in return for obedience to his request, legitimates the non-fulfilment of obligations, because the sick are not relieved of normal obligations without social cost.

To be legitimately ill first requires the approval of an elder of the extended kinship group or the family and/or the medicine man; second it implies the obligation or the determination to get well and to return to normal daily activities. This implies that while the social unit on its part mobilizes (through the medicine man) its resources to restore health, so the sick must do as he or she is ordered to do. The sanctions are withdrawal of legitimation.[15] Once the signs and the symptoms have been socially recognized, both the illness and the sick exist within the social situation. The traditional medicine man, when he is called in or is approached, sees the social situation as causing the disease.

Diagnosis of illness is deeply embedded in the whole magico-religious system. The medicine man performs acts which give the sick inspiration and restoration of confidence. He works with the strength of his own personality and with that of the magico-religious ritual which is part of the common faith of the society of which he is a part. In other words, the whole weight of the community, its religion, myths, history and spirit enters into the therapy.

The medicine man does not differentiate between illnesses of the physical type and that of the psychological in origin. He is no dualist, for he knows only one kind of disease and one kind of therapy.[16] His modus operandi follows directly from his idea concerning the causation of disease. This idea about disease is understood by the general public of which he is a part; there is unity of thought.

In treatment, the sick may be denied rest and quiet for the simple reason that the causative agents (disease demons) must be allowed no peace. At times the demons are frightened away by terrifying masks and grimaces, by noices and dancing. The demons must also be smoked out by unbearable smells and fumigations. If they are strong enough to endure all these hardships, then by sorcery they must be lured elsewhere to take their abode in some scapegoat, or an inanimate object. If the demons are "too clever" to be fooled, they must be appeased with sacrifices and precious gifts. The medicine man's therapy may be so heroic that at times he looks as ill and gaunt as his patient, but he rarely gives up. Essentially, the patient's faith and the medicine man's personality are important factors in the therapeutic milieu.

At the shrine medicine may be taken orally or by enema. However the medicine man may either on his own volition or at the request of the patient, consult his god and through divination ascertain the cause of the illness. He practices major techniques of divination, possession, and casting lots. While possession as a public ceremony is induced by drumming, it is achieved in private treatment by having an assistant rhythmically beat a gong. It has a "magico-religious" effect. The medicine man is a passive medium, for while he is possessed, his god or deity speaks through him, and on recovery he claims no knowledge of what he has said or experienced. The guttural speech of the medicine man is unintelligible to all present but the okyeame, who serves as the translator.

There is no question that a positive psychological value is present in the role of the medicine man as a medium, which makes it possible for the patient to believe that he has established rapport with the "god" that controls him and contributes to his feeling of security. As pointed out by Herskovits:

> "although the herbs or other medication administered may be only a placebo, the belief that he is being helped through the attention of a skilled practitioner will thus have a positive psychosomatic effect on the patient".[17]

If he decides to treat the patient, after the diagnosis, the patient's relatives appoint an okyigyinafo (patient's supporter) who will remain with the patient during the course of treatment at the medical shrine. Literally the supporter is the person who stands behind the sick man. He discusses with the medicine man all matters

concerning the treatment. He is responsible for any fees to be paid and for providing any supplies of household equipment that may be required. He must discuss with the medicine man all matters concerning the nursing of the patient. No family will ever fail to support a sick relative, for to do so would be a standing reproach to the whole extended family unit.

If a young person who is known to be disrespectful or insulting dies at the shrine, an adequate explanation is offered by his misconduct. Either it is argued that his ancestors had punished him with death because of his misconduct, or it may be said that his own soul had killed him because it felt disgraced by his conduct. In other words the ancestral gods or spirits are believed to punish their living descendants for sins both of commission and omission, because they are known by the people to be guardians of the society's morality and they are known to chastise those who fail in their duty. The explanation often heard in the villages of Ashanti is:

> "he told lies about the property, and the spirits killed him or his uncle's ghost killed him because he failed to look after his relatives or his ancestors felt disgraced by his conduct so they killed him".[18]

The test of the medicine man's qualifications is his known effectiveness in treating illnesses. If he has proved his ability to communicate with the supernatural in such a way as to diagnose and to prescribe cures, he is obviously the man to consult. This method of handling disease, through the medium of magico-religious acts and concepts, satisfies the traditional Ashanti because it provides an explanation of what is happening.

The explanation for many illnesses are found in some antisocial behavior on the part either of the victim or of some persons closely related to him in the family. To cure such ills, therefore, requires the righting of some social wrong.

A breach in social relations threatens the very survival of the traditional society because of mutual interdependence. So numerous devices for the maintenance of the group are found; health and illness are means for detecting threats to social unity and for re-establishing the harmony of social relationships essential to their life.

The medicine man is constantly in touch with the news of the community and he knows what is going on in terms of cooperative efforts as well as conflicting situations. He visits the community during the night incognito to listen to the "gossip" of the men who gather in public places to talk about their daily activities. If he does visit during the day, he will be seen, and people who may happen to be there may not discuss their grievances or the news in the village. For this reason, he chooses the night for the purpose, and goes without carrying a light. He will remember, too, to disguise himself by changing the clothes he wore during the day. To avoid detection he will squat at a distance. There he sits in apparent stillness, calm and silent listening to all the discussions that go on.

He has yet another method of obtaining news. When the adults in the village have gone to their farms, he invites the children in the village to eat with him. There he leads them with various questions for news. He stores the news in his mind, to reveal the secrets of those who come to consult him at his medicinal shrine. His knowledge

about what goes on in the village gives him "a good local press", because his clientele believes that he intimately knows about them through his contact with the ancestral spirits or gods. The rest depends upon his skill, and his knowledge of roots and herbs, no less than his acquaintance with the psychology of his patients.

In the society, when occasions arise in which hostility and conflict threaten the solidarity of the social unit, and when they are accompanied as they are, by certain kinds of prolonged illness and/or by the barrenness of women or impotency of men, the extended family traces such ills to the act of a spirit or an ancestor which has wormed its way into the unit. The supernatural theory of medicine, then, serves as a form of social concept which helps to reinforce the mental and physical well-being of the social group.

The diagnosis of illness is largely viewed as a diagnosis of a social offense and the curing of the illness requires the establishment of normal social relationships. Viewed in this light, the threat of suffering becomes a powerful incentive for moral behavior, and the cure of suffering becomes a sign denoting that the gods and the ancestors are pleased once more in restoring the social unit to good health.

This is the relationship between the medicine man and his patient. What goes on in the interaction, what satisfactions each derive from the relationship, and what other situations materialize are determined not only by what the medicine man brings to the relationship, but also by what the patient brings. It is the patient or some member of his extended family who initiates contact with the

medicine man; frequently he approaches the medicine man only after alternative procedures have been considered or tried in his immediate family.

It is evident from the above discussion that the traditional medical practitioner had a place in the traditional society because he was the intermediary between the spiritual world and the people. In many instances the anxiety level of the patient was reduced when he was confronted with the traditional medical practitioner who understood him as a person. The traditional medical practitioner assumed the responsibility to advise the patient on his personal problems as well as on the specifics of the illness which was the object of the consultation. For example the patient must be told: "to be less arrogant" or "to be kinder to his wife" and so on. He considered it important to create an atmosphere of confidence and trust in order to allay the anxiety felt by the patient and his relatives and he establishes this atmosphere by an unhurried process of questioning as well as by the kind of inquiries he made about the illness and its symptoms. He spoke to the patient and his relatives in language and concepts that were familiar to them and which they could accept.

Ackerknecht[19] emphasizes that traditional medicine is not a queer collection of errors and superstitions, nor is it to be explained by simply stating that in this field the medicine man is living on the "anxieties of his people". What counts is not the forms he employs, but rather the place medicine occupies in the life of the people, the spirit which pervades its practice and the way in which it merges with other traits from different fields of cultural experience.

We may deduce from the above discussion that the success of traditional medicine lies in its psychotherapy. Opler[20] shows this clearly in his research, when he systematically compared the treatment of functional disorders of the Apache shamans with the modern psychiatrists. Cannon[21] also, shows the psychotherapeutic effect by traditional medicine through his physiological analysis of "voodoo death". Cannon observed the physiological reactions of men in traditional societies who have thought themselves supernaturally stricken. He gave a description of the physiological processes involved that culminate in death of the patient. The conclusive part of his research brought out the point that under the stimulus of fright the sympathetic nervous system supplies the body with unusual amount of adrenalin and this causes other physiological changes to meet with the emergency. Continued stimulus from fright and continued response of the nervous system without any physical action to relieve the bodily state of emergency results in multiple harmful effects which include low blood pressure; detereoration of the heart and serious disturbance of normal circulation of the blood. The patient is rendered incapable of carrying on normal and necessary metabolic processes. The end result is death. Lambo[22] also points out that the traditional medicine man's strength comes not only from the interpersonal ties but also from the reinforcing effect of the frequent participation of the entire community in the treatment. Customs related to illness are part of the projective systems of the culture of which the patient is a part. Here the medicine man stands at a strategic point in the balance of forces in society. It is only

logical that disease caused by supernatural agencies can be diagnosed and cured only by supernatural techniques. Medicine or herbs may be applied but are thought to be effective only because of its magico-religious potentiality. Intruding spirits have to be driven out by magico-religious formulae by noises, by dancing and sometimes by bloodletting. All these therapeutic measures, objective as well as subjective in content, are elements of magico-religious acts and concepts. This is not to argue that the medicine man is not sincere. Research of the last fifty years has shown that the average traditional medicine man is just as sincere as any practitioner elsewhere. The difference between him and the "scientific community" elsewhere lies fundamentally in the supernatural assumption about "reality" from which his thinking proceeds.[23]

V. Summary of Discussion

In the traditional society, traditional medicine was (and is) much more than just the art of curing ills; it performed an integrative function as well. The various research studies done in this area by social scientists and psychiatrists confirmed also to this claim; for example the traditional practitioners performed social analysis in order to restore harmony to the group.

The explanations for many ills for example, were found in some antisocial behavior on the part either of the victim or of some persons closely related to him in the family unit. To cure such ills required the righting of some social wrong. Members of the social unit realized

their intricate interdependence on their fellow relatives; therefore a breach in their relationships threatened almost the very survival of the social unit so health and illness became the means for detecting threats to the social unity of the group and for the re-establishment of the harmony to the group.

In such a society when situations did arise in which hostility and conflict threatened the harmony of the group, and when people were stricken with prolonged illness such disasters were traced to the theory of supernatural causation; or it was traced to an ill will which had wormed its way into the group. The function of social integration was therefore served via the traditional medical theory. And this function was one of the social control mechanisms which helped to reinforce the mental, the social and the physical growth of the people.

The point however is that in the traditional Ashanti society, under conditions which are basically dependent upon the natural environment and in the absence of a coherent body of scientific theory so much more lies beyond the reach of naturalistic explanation. The practitioners of traditional medicine go beyond empirical explanation; they elicit interpretation and action in terms of the supernatural agents. These agents are called into being by them in responses to the hopes and needs, of their clients. Beliefs of this nature are not capable of empirical verification and within the social context of the traditional system, they do not require it.

It may be necessary to point out that beliefs and attitudes of any given social group toward disease is held with tenacity and assurance

so that they are adequate to explain and to handle illness. Practitioners of medicine be it scientific practice or traditional find it helpful when the patient shares enough of their beliefs and attitudes to make acceptable a professional or logical explanation of disease. Likewise, they find it frustrating when a patient cannot understand or accept their explanations or orders because they are found to be inconsistent with his beliefs and attitudes. Thus a practitioner's effectiveness in treatment varies with his understanding of how the patient perceives the situation.

The threat of suffering became a powerful incentive for moral behavior and the cure of suffering became a sign denoting that the gods and the ancentral spirits were pleased once more and that the society was to be restored to moral good health.

To the traditional Ashanti, the traditional medical theory was satisfying because it provided an explanation of what was happening and the traditional social structures gave support in terms of the dependence on the supernatural causation of ill health and misfortune. It goes without saying that each society develops what appears to it as a reasonable explanation; not to provide such an explanatory model would result in an intolerable existence. But at this juncture the question we would pose is: in the face of recent social changes what aspects of this traditional system will persist

or change? Put differently we would inquire whether in the face of recent changes the functional prerequisite of traditional medicine will be circumscribed. Before we make an attempt to pursue the question we shall discuss some of the relevant recent contemporary social changes.

FOOTNOTES

[1]James Boyd Christensen, "The Adaptive Functions of Fanti Priesthood" in William R. Bascome and Melville J. Herskovits, Continuity and Change in African Cultures (Chicago: University Press, 1959), p. 257.

[2]Geoffrey Tooth, Studies in Mental Illness in the Gold Coast (London: His Majesty's Stationery Office, 1950), p. 28.

[3]The concept "shrine" is used to indicate the medical institute of traditional medical practice, where the god of the particular institute resides. It is the center of the healing practice. It is the place where the clientele visit when treatment is in progress. (Please note that we shall refer to traditional medical practitioner also as medicine man, in this work. The concept medicine man is in popular usage.)

[4]William Goode, "Community Within A Community", American Sociological Review, LX (1954), pp. 54-57. (A very insightful discussion on medical socialization.)

[5]Sammuel K. Akesson, "The Secret of Akom", African Affairs, LX (Devember, 1936), p. 339.

[6]Ibid, pp. 332-333.

[7]Ibid, p. 339.

[8]Margaret J. Field, Search for Security (Evanston: Northwestern University Press, 1960).

[9]R. Debrunner, Witchcraft in Ghana (Accra: Methodist Press, 1961).

[10]E.E. Evans-Pritchard, Witchcraft, Oracles and Magic Among the Azande (Oxford: Claredon Press, 1937).

[11]Cylde Kluckhohn, Mirror for Man (New York: McGraw Hill, 1956), pp. 11-24.

[12]Robert A. Lystad, The Ashanti: A Proud People (New Jersey: Rutgers Press, 1958).

[13]Ibid, p. 121.

[14]For a discussion of the "sick role" concept refer to H.E. Sigerest, "The Special Position of the Sick" in M.I. Roemer (ed.), Henry Sigerist on the Sociology of Medicine (New York: Free Press, 1929). Also see chapter 10 of Talcott Parsons, The Social System (New York: The Free Press, 1951).

[15]Ronald Frankenberg, "Man, Society and Health: Towards the Definition of the Role of Society in the Development of Zambian Medicine", African Social Research, VIII (December, 1969), pp. 573-587.

[16]W.H.R. Rivers, Medicine, Magic and Religion (New York: Harcourt Brace and Company, 1924). Also see E.H. Ackerknecht, "Problems of Primitive Medicine", Bulletin of the History of Medicine, XI (1942), pp. 503-521.

[17]M.J. Herskovits, Man and His Works (New York: Alfred A. Knopf, 1948), p. 374.

[18]R.S. Rattray, Religion and Art in Ashanti (London: Oxford Press, 1927), p. 148.

[19]E.H. Ackerknecht, ibid, pp. 503-521.

[20]M.K. Opler, Culture, Psychiatry and Human Values (Springhill: Charles C. Thomas, 1956). Opler makes this point of "psychotherapeutic potential of the traditional medicine man" explicit in his study among the Apache shamans.

[21]W.B. Cannon, "The Voodoo Death", American Anthropologist, 44 (1942), pp. 169-181.

[22]T.A. Lambo, "African Traditional Beliefs, Concepts of Health and Medical Practice", A paper presented at Ibadan University (Ibadan: University Press, 1963).

[23]If the medicine man contracts disease himself, he willingly undergoes treatment by another medicine man.

CHAPTER 4

GHANA IN TRANSITION: CHANGES IN THE SOCIAL SYSTEM

I. Introduction

In this chapter we shall deal with some of the social changes, during the period 1950-1970, which have had an impact upon the medical institutions in Ghana. We choose to discuss this period because during 1951 Ghana was permitted by the British, to have internal self-government which culminated in the granting of full independence in March 1957.

Specifically in this chapter we shall discuss some of the recent government programs of social changes which have had specific ramifications for Ghanaian medical services. We shall provide: (1) an introductory remark; (2) the change in government from colonial to independent status; (3) deal with some of the effects of economic changes on the health needs of the people; (4) discuss changes in levels of formal education; (5) analyze some of the effects of rural-urban migration; and (6) discuss some of the concommitant effects these changes have had on the extended family system. Lastly, we shall provide a summary of the salient features of the discussion. The purpose of this chapter therefore is to indicate the areas of social change which are potentially significant for medical practice. It is necessary to point out that although we are interested in the period 1950-70 yet as adequate statistics covering the period were not available, we have used only the available statistical compilation.

II. Change in Government: From Colonial to Independent Status

During the 19th Century the British signed the Bond of 1844[1] with the traditional chiefs in which the former was granted the permission to impose its rule on the country. The chiefs however were, given the mandate to rule their peoples within the traditional jurisdiction. (See Chapter 2: Traditional Political System.)

Since coming into contact with the British colonial system, there have been many indications of the Ghanaian people resenting the limitations imposed. For example as early as 1868 a traditional confederation[2] was formed to resist the imperial rule. In 1897 the Aborigines Rights Protection Society[3] came into being. Its aim was directed towards the democratization of the colonial legislature and the eventual introduction of "native" government in which the Executive Council would be responsible to the elected representatives of the people of the country. These movements kept alive a nationalist awareness, but did not achieve much else nor did they become popular movements until the formation in 1947[4] of the United Gold Coast Convention and the Convention Peoples Party in 1949.[5] These movements were assisted by the grievances resulting from the Second World War.[6] The end of the war led to the repatriation of thousands of the country's ex-servicemen whose experience abroad in Europe and elsewhere had been "an eye opener" to the gross inequalities of the country's colonial status. The sense of disillusion caused mainly by a lack of employment, health care facilities and inadequate pensions made the ex-servicemen the prime source of strength to the new parties.

The point in this discussion is that during the colonial rule, the chiefs were given a quarter share of managing their own people while the "national interest" was taken care of by the British administrators. It meant that the tribal structure[7] was left undisturbed until the advent of the indigenous political parties, and government.[8]

On March 6, 1957, under the leadership of Nkrumah, Ghana was granted independence by the British. In the Weberian sense of the term,[9] Nkrumah the head of the independent government was a charismatic leader. Weber used the term "charisma" in his analysis of authority and leadership to denote a certain quality of an individual personality by virtue of which the leader is set apart from ordinary men. This helps to explain why Nkrumah's government received tremendous support from almost all the people in the country. He was seen in the nation's eye as a man who could improve the social conditions of the time. He was a unifying force.[10]

The point to be remembered however is, the British left Ghana when they had laid the basic infrastructure of the country. Compared with other African countries south of the Sahara, Ghana's position was unique: its per capita income was the highest in tropical Africa.[11] It is within this context that we shall view the new government's attitude towards health needs of the country.

III. The Effects of Economic Change on Medical Practice

The relevance of the economic change is that prior to 1950 job opportunities were very limited. With only limited alternatives a young

man in pursuit of a job had little choice but to remain in the rural areas and work on the ancestral lands. It may be remembered in this regard that lack of job opportunities led ex-servicemen to rebel against the then colonial administration immediately after the Second World War.[12] Busia[13] had claimed that there were few job opportunities before the national government came into being. Acquah also made reference to "an absence of heavy industries and the small number of secondary establishments".[14] She claimed that in 1948 there were only 83,089 employed people over the age of sixteen. Of these only 29 per cent were female.[15] Due to paucity of employment data prior to 1950-1970 we are cautious in our generalizing. However on the basis of Busia and Acquah's contentions we could infer that prior to the period under discussion few job opportunities were available even in the urban or the municipal areas. If this is so then we could argue that many Ghanaians had to remain in the rural areas where they worked on the ancestral lands.

Since independence, there has been rapid economic development in the country. The young man with the necessary skills has been able to move away to attractive places[16] such as the cities and towns, to work. (It is interesting to note that in government services as well as in the large industrial concerns of foreign origin, the worker as part of the job contract, is frequently expected by his employers to seek medical aid from the services of scientific medical institutions. It is often incumbent upon him to return to work, when he is cured from his malady, with a medical certificate. Thus the new economic system has helped to challenge the raison d'être of traditional medical practice.) Let us examine some of the details of the new economic system.

The foundation of economic and social development was already laid with the well established cocoa farms and the spread of government and mission schools. This helped to provide the material and human elements on which later progress was built. For example during the 1920's Sir Gordon Guggisberg, the then Governor of the Gold Coast gave the country its first experience of planned development when he inaugurated the Ten Year Development Plan which specialized, above all in transportation, education and social and health services.[17]

Following the depression years of the 1930's, and during World War II, a stimulus was provided in economic and social life in the sense that the government made every effort to provide both the urgently needed raw materials and the internal communication system which the allied war activities demanded. At the beginning of the Second World War the British Government passed the first Colonial Development and Welfare Act (1940)[18] which promised financial aid for the various needs of the country. This new program was an additional stimulus to the interest, which the war had already created, in further economic and social development.

In 1944, Sir Alan Burns published a sessional paper which outlined a five year development plan,[19] but postwar shortages hampered its full completion. However the plan did succeed in providing for certain needs in the areas of medical and social services. It also made an attempt to encourage industry by setting up the Industrial Development Board, which was the forerunner of the subsequent Industrial Development Corporation.

Since the country's progress has depended to such an extent on

cocoa earnings, it is wise to look briefly at the cocoa industry.

A Cocoa Marketing Board was established in the country in 1947. The board's greatest influence lies in its power to fix the price paid to the farmer. By limiting this price within a narrow range the board has been able to accumulate substantial reserves which amounted to over 53 million pounds in 1958.[20]

Originally these reserves were set aside for two main reasons: (1) for price stabilization to enable the board to pay the farmers a fairly steady price regardless of fluctuations in world prices, and (2) to provide funds for the rehabilitation of the cocoa industry. Some time later in the 1950's the board also began to give grants for various purposes of general benefit to the cocoa farmers or to the industry as a whole. During this period it supplied scholarship funds for the children of the farmers to study abroad in disciplines which would help the social development of the country. Many went to countries such as England and Germany to study as doctors.

In the field of agricultural progress the government put much emphasis on the improvement of food crops for local consumption and to avoid undue reliance on cocoa. The government has been experimenting with the development of alternative export crops. For example in 1951, the Agricultural Development Plan aimed at setting up a chain of agricultural stations throughout the length and breath of the country to demonstrate "better" methods of husbandry.

Following agriculture, mining exports rank next in importance to cocoa in Ghana's external trade.

The timber industry has also grown rapidly in these years so that it now ranks next in value to cocoa and gold in export trade.

As far as manufacturing industry is concerned, Ghana is still in its infancy. In 1953 Professor W.A. Lewis, at the request of the Government, undertook an investigation into the possibility of starting successful industries in the country. After a careful study of the resources and the problems involved, his report concluded that the country at the point in time was not ready for any major experiments in industrial expansions.[21] He pointed out "a small program is justified but a major program in this sphere should wait until the country is better prepared to carry it".[22] Furthermore he recommended that the first priority should be given to the improvement of agriculture. The second priority was to extend the basic service of the country to provide adequate and cheap supplies of electricity, water, gas, and transport facilities so that factories could function efficiently.

The Arthur Lewis Report has had much impact upon governmental policy. For example in line with the Report, the government has accelerated its earlier efforts at extending the country's basic services. This has been particularly striking in the field of communications. Since the war, more than 1,000 miles of all-weather roads have been built in order to facilitate movement within the country. The country now has altogether over 1,645 miles of tarred roads including the Accra-Kumasi-Tamale-Bolga-Tanga route, serving as the main arterial road of the country. The completion during this period of the Adomi Bridge has also improved communication between Accra and the hinterland.

In line with the claims made earlier by Busia and Acquah about the lack of job opportunities the 1960 figures would show a wider variety of job opportunities. In Table 4.1 is found persons employed in industries, by sex categories, during 1960. If we compare these figures, in terms of total number of employees with Acquah's estimate it is evident that in 1960 there was a great increase in the number of employed persons in Ghana. The point however is that many people who possessed the necessary skills have been employed in this widening variety of jobs. We see from this table the varieties of jobs in which the individual is offered if he possesses the right skill. In 1948, according to Acquah, the employed persons in Ghana numbered 83,089. In 1960 (refer Table 4.1) the total number of employed persons was 2,561,000. In interpreting such figures one must take into consideration the inadequacy of statistical compilation before 1960. Secondly, in the 1960 figures 62 per cent of employed persons worked in agriculture, forestry, hunting and fishing. Acquah did not take this category of employees into consideration. However the evidence is clear that a significant increase has been indicated. With independent means of support it could be inferred that the individual is more free from the "control" of his traditional elder. Thus the new economic development has helped to erode into the old authority structure.

Table 4.1

Persons Employed in Industries by Sex 1960

(Numbers of Employees are in Thousands)

	Males		Females		Both Sexes	
	No.	%	No.	%	No.	%
Agriculture, forestry, hunting & fishing	1003	64	516	58	1579	62
Mining	46	3	2	0	48	2
Manufactoring	136	9	99	10	235	9
Commerce	96	6	276	28	372	15
Construction	87	5	3	0	90	3
Electricity, water & sanitation	14	1	0	0	14	1
Transport	67	4	1	0	68	3
Services	124	8	31	3	155	6
All industries	1573	100	988	100	2561	100

Source: Population Census, Ghana Government Publication: Accra, Ghana, 1960. p. 114.

IV. The Effect of Change on Formal Education

Educationalists in Ghana as elsewhere, have in the past been unduly influenced by the emphasis which most social scientists place upon the function of education as a transmitter of the cultural heritage.[23] This emphasis is valid in a very simple society which is changing slowly and has no formal educational institutions; in the Ghanaian situation it is totally inadequate for an understanding of education. It is invalid because Ghana is a rapidly changing society which has had a specialized educational system for many years. Far from passing on and strengthening the traditional culture, the introduction of formal

institutions for education has in itself helped to "alienate" youth from the traditional society, thus furthering a process already set in motion by economic factors.

The gradual breakdown of traditional cosmology was encouraged by the establishment of formal education. For example this point is made forcefully by Acquah[24] when she claimed that "no persons interviewed of secondary schooling upwards neglected to have scientific medical treatment".[25] These formal educational establishments are located mainly in the large towns and cities. The educational system, then, has provided a basis for "rebellion" against traditionalism.

Many people in Ghana took advantage of the new education. Table 4.2 indicates there was a remarkable increase in the number of public primary, middle and secondary schools during the period 1950-1964. Relative to this point we see in Table 4.3 that, correspondingly, the number of pupils and students increased in all three levels of education in the country. In this direction a study by Peter Hodge[26] pointed out that as a result of tremendous increase in the number of school leavers at all levels of the educational establishment, many youths are not able to find job opportunities because the economy has remained static in this present era.[27] The problem of unemployment among youth has been a matter of urgency for the present government. The acuteness of the problem has necessitated the government to institute "The Workers Brigade" to absorb the unemployed school-leavers. These school-leavers have no skills but literacy. Their expectations are high when they set out for the urban areas in search of work. Jobs in the

Table 4.2

Number of Public Primary, Middle and Secondary Schools

1950-1964

Year	Primary	Middle	Secondary
1950	1081	511	12
1951	1083	539	13
1952	3069	667	26
1953	3131	704	30
1954	3136	717	31
1955	3210	786	31
1956	3312	862	35
1957	3372	931	38
1958	3402	1030	39
1959	3428	1118	39
1960	3452	1177	39
1961	3552	1252	59
1962	5451	1575	68
1963	6873	1809	75
1964	7490	2224	85

Source: Education Statistics (Accra Government Printer). Ministry of Education reports (Accra, Government Printer), and unprinted data supplied by the Ministry of Education, 1967.

towns, except for seasonal work of an unskilled and menial nature, are unobtainable, but young people prefer to remain in the towns as the restrictions of traditional family life in the villages hold no attractions for them.[28] The response of the Ghana Government to this deteriorating position was quick. A White Paper on a National Workers Brigade was published in September 1970 and referred to the concern of the government at the growing problem of unemployment amongst school-leavers. This document lead to the establishment of a new organization providing a new approach to the unemployment problem in Ghana. Today this establishment, situated in Accra, is training school-leavers in

Table 4.3

Enrolment in Public Primary, Middle and Secondary Schools

1950-1964

Year	Primary	Middle	Secondary
1950	144,300	60,000	2,800
1951	154,400	66,200	2,900
1952	335,100	80,000	5,000
1953	372,400	88,600	5,100
1954	396,900	97,400	6,900
1955	419,400	105,000	7,700
1956	436,900	108,500	8,900
1957	455,700	115,800	9,900
1958	455,100	125,300	10,400
1959	465,300	140,000	11,100
1960	478,100	147,500	*
1961	520,000	157,700	*
1962	701,000	176,000	*
1963	801,100	204,900	22,800
1964	927,500	222,800	28,100

* Figures not available.

Source: Education Statistics (Accra, Government Printer). Education Reports and unpublished data supplied by Ministry of Education, 1967.

the skills of trading, farming and middle management jobs.

We would suggest from this discussion that as more people go through the formal educational system the farther they will be removed from the traditional culture. On the basis of more availability of scientific medical institutions in the towns and cities, coupled with the pressures put on the workers in government and industry to use the services of scientific practice, we can infer that the educated as well as the urban dwellers would be most inclined to use scientific medical service. Acquah's study points to this direction, and from our

analysis of some of the effects of economic measures coupled with formal education it would be reasonable to conclude that these new factors have had the tendency to erode into some of the traditional structures.

V. Rural-Urban Migration

Migration has become a fundamental aspect of Ghana's society resulting from economic and educational factors. Migrants are powerful instruments for carrying changes in the social life to the remotest parts of the country. As in many other countries, the direction of change is inevitably directed towards the adoption by the rural society of more and more of the values of town life. These values themselves are undergoing changes, partly because the towns are the main links with the outside world and hence the towns tend to become more cosmopolitan in values and attitudes, and partly because urban life imposes new pressures upon traditional forms.

We would expect then that as more young men begin to live in the urban areas there would be ideational conflict between the rural dwellers and the urban residents. This speculation is based on the fact that most of the urban residents have been educated in the formal sense where the instruction they received theoretically opposes the traditional cosmology as well as the way of traditional living. If this is so then we would expect that as more young people are educated traditional structures would eventually breakdown.

It is often said that the educational system reflects the way of life of the society in which it is instituted. This is not so in Ghana where the educational system is completely anti traditional.

This point is reflected in Busia's study.[29] He claims that after leaving school in Ghana, the young could hardly understand the traditional society. The educated person becomes, so to speak, a stranger in his old environment. There is also the tendency on the part of the educated minority to look down on others who have not received formal education as the direction of change is clear as the educated reap the rewards in terms of their ability to participate in the benefits of the modern economy.

The effect of migration is evident from the 1960 census, when it was found that about an eighth of the population in Ghana were of foreign origin and another eighth were from a region other than the one in which they were enumerated.[30] The census did not distinguish between seasonal and longer term movement, but it did provide a picture of population movement at a specific point in time.

For the rural-urban migrants the main difference between the towns and the villages is probably that most of the employment which is available to those who live in the towns is non-agricultural. The following table (4.4) shows that in terms of change in the occupational pattern with change in the population of the settlement, there is almost a perfect continuum from the smallest villages to the largest towns. Moving from centers with fewer than 200 inhabitants to those with more than 100,000 the proportion that the agricultural work force makes up of all those in employment drops from 88 per cent to 4 per cent. But it is only in centers with more than 5,000 inhabitants that less than half the work force is employed in agricultural activities.

At yet, the urban centers of the country are mainly commercial,

Table 4.4

Percentage of Work Force Employed in Different Industries, By Size of Locality, 1960

Size of Locality (No. of inhabitants)	Industry						
	Agris	Mining	Manufac.	Const.	Com.	Tr.	Ser.
Under 200	88	1	4	1	4	1	1
200 - 499	81	1	6	2	7	1	2
500 - 999	76	1	7	2	9	2	3
1000 - 1999	69	2	9	3	11	2	4
2000 - 4999	56	3	11	4	17	3	6
5000 - 9999	41	2	13	6	26	4	8
10,000 - 19,999	22	7	15	11	28	5	12
20,000 - 49,999	12	5	15	9	31	11	17
Over 100,000	4	0	16	12	37	7	24
All localities	62	2	9	4	14	3	6

Source: Population Census. Statistical Department; Accra: Government Printing, 1960, p. 101.

administrative and service centers rather than the seats of large scale industrial concerns.[31]

Between 1962 and 1964 a study was conducted by the Population Council of Ghana in an effort to determine the mechanics of rural-urban migration in the country. The main aims were to find out the characteristics of the migrants and the rationale underlying the movement. Information was obtained from 17,000 persons who lived in 2,500 households in sixty-six localities. The survey covered the whole country and concentrated on migration to the major urban centers. The research ignored movements to cocoa-growing and gold mining areas as well as the movement of migrants to other rural areas. In the sample, two-thirds of the people who were interviewed regarded themselves as settled but one-third visited a large town often. Part of the migrant

population, which was settled in the urban centers, was made up of children (45 per cent of the population).

Birmingham and his associates[32] estimate that about one-ninth of the members of rural households are in towns at any given time. A considerably larger fraction of adults belong in this section. They found that education was an extremely important correlate in determining whether a villager is likely to emigrate to the towns. Table 4.5 shows the results of another study in which over three-quarters of those with no education expect to remain permanently in the rural areas, while less than half of those with middle school education expect to do so. The number with secondary and university education are comparatively small. The fact that some are found in their home areas in rural Ghana is explained by their coming back as administrators or teachers to areas where they are familiar with the language and the people.

In Table 4.5 it is clear that individuals with little or no education intend to remain in the rural areas. Persons with middle, secondary and university education tend to migrate to the cities in search of new opportunities.

Another characteristic of rural-urban migration is the high sex ratio. This arises not merely from the fact there are more jobs for males in the towns but is partly a product of social pressures. In a survey by the Population Council of Ghana (1963-1964) it was found that five-sixths of the rural population think it is a "good thing for young men to go to the town for a while in order to earn money, acquire skills and achieve some sophistication".[33] Those who disapproved of females migrating to the towns pointed out there is

Table 4.5

Rural Population of Ghana: Education & Rural-Urban Migration

1963

(All figures shown as percentages)

	Migration Classification	No Schooling	Schooling (highest level reached) Primary	Middle	Secondary	University
(1)	Has not migrated to urban areas and does not intend to do so	76	69	48	34	9
(2)	Has not yet migrated but intends to do so	5	14	14	11	3
(3)	Has migrated to urban areas (whether absent or not)	19	17	38	55	88
		100	100	100	100	100

Source: Rural-Urban Migration Survey, Accra: Population Council Ghana, 1963. (The study covered 17,000 persons living in 2,500 households in 66 localities).

"a danger that the female migrants will become prostitutes".[34] Over half of the rural households surveyed have lost some member to the town.

In a mobile society, like that presently found in Ghana, learning is acquired by these movements. For example, when a villager comes to town he does not cut himself off completely from his natal home. The interplay between village and town is very interesting. The returning migrant has prestige among his people in the village. Both villagers and migrants agree on this point. Some skills and new ideas are brought

back to the village. Many migrants, on their return to their villages use their earnings to build either houses or extra rooms in the family compound house.

Success or failure in the urban centers can reduce or enhance the attractions of rural life. The Population Council study found that most respondents agreed there were people in the urban areas who may delay visiting the rural areas or make such visits very brief because they prefer town life. On the other hand, a considerable number of the migrants will return permanently to the village. Three times as many respondents thought that this was usually due to economic failure in the urban areas than felt that it arose from success of the migrant. Nearly all migrants who return to their natal homes take some goods as gifts for their relatives and families. In town, the migrant can enjoy the bright lights of the city. In essence, the returning migrant is likely to be able to influence his rural kin in some aspect of the urban way of life.

VI. The Effect of Changes in Extended Family System on Medical Practice

As a result of the new economic opportunities (as well as formal education and rural-urban migration), changes have come about in the extended family system, which have ramifications for the utilization of the medical services. For example from the point of view of a differential functional analysis, we would expect that the educated, the young and the urban dwellers will be more inclined to use the facilities of scientific medical services.

This type of inference is based on the postulate that in the traditional social system the viable medical institution was the traditional one. But in recent years scientific medical institutions have been built in large numbers in the urban areas.

We are also aware of the fact that in the traditional social setting (before the advent of contemporary social changes) the traditional individual lived and worked on the ancestral lands. He was committed to the view that the ancestors were the custodians of the morals and the property rights. Life centered around the extended kinship unit. In this respect most of the daily activities were performed within the same unit of relatives and the unit influenced by the dictates of the elders.

In this day and age, the individual who takes advantage of formal education and acquires new skills is able to move to attractive places in search of job opportunities. In the city he establishes a neolocal residence.

Far removed from the immediate dominance of the head of the extended family, there is the likelihood that the individual will have to make decisions, independent from the traditional elder's point of view.

Thus, in answer to the research question (see Chapter 1, page 3) there seems to be a gradual breakdown in traditional structures. This assertion is based on the fact that with formal education and the new economic opportunities, the traditional organizational base has been questioned; and a gradual erosion into the traditional cosmological patterns of behavior has taken place. Furthermore, with changes in

residence, urban dwellers have been exposed to a different environment with its improved housing and sanitation. Now we shall carry our discussion into these three specific areas: urban residence, changes in the family structure, and the individual and the social structure.

A. Residence

The important feature of the urban household is not so much its size as its composition. The rural household is usually composed of a number of persons who are held together by bonds of kinship. The urban household is composed usually of husband, wife and children, with a greater emphasis on the husband - wife relationship. In fact the husband - wife relationship forms the core of the urban household. In certain situations it is found that the spouse may have relatives who stay with them but the relatives have little say in regard to the running of the household.

Thus the trend in the urban areas is for the conjugal family to form the household unit and act as a modified autonomous unit. This means that the influence of the extended family on the lives of the conjugal family is not as great as it is under rural conditions. Tetteh points out that "this influence tends to be in inverse proportion to the distance between the home towns of the marriage partners and their town of residence".[35] Furthermore, Tetteh remarks that where the marriage partners reside in the home town of one of the partners this influence may be great. As an example of this, some non-Ashanti females married to Ashanti men find that when they are living in urban

centers outside Ashanti their relations with their husbands are much stronger than when they live in Ashanti.

B. Changes in the Family

Changes in the family system create changes in the rules of behavior of traditional social system. Previously the authority system was invested in the elder of the lineage and it was based on ascription. There were sanctions regarding rules of behavior for deviants from traditional expectations. But now the individual is able to seek a job in the urban area if he possesses the required skill. With access to income resources, he is able to challenge the traditional authority system whenever he finds it not to be congruent to his new way of thinking.

If ancestor worship is the pervasive world view of the traditional people, then, why do urban dwellers (not long from the traditional society) come to flout these ingrained traditions? To answer this question we shall refer back to our discussion in Chapters 2 and 3. In the rural setting the individual had limited alternatives in employment opportunities. He was anchored in the traditional lineage system where the decision of the lineage elder was all embracing. It was incumbent upon him to "listen" to his elders. Somewhere, along the line of recent development the person in the rural area has been exposed to some formal education, which is anti-traditional. Since independence, education in the formal educational system is free through the elementary school. Even at the secondary level there are

opportunities available to the young to secure governmental grants, if they are capable of gaining entrance. The result is that the young and the educated usually move into the big towns and cities in search for the "bright lights" and job opportunities and are exposed to "urban ways". Busia, in his 1950 studies, pointed out that the "urban ways" are anti-traditionalism.[36] Specifically if the recent rural migrant gains "satisfaction" in his new residence it has long term favorable repercussions. It is necessary for him to act and behave like an urbanite, and as he is then looked upon with respect by his rural relatives he is able to advise them.

In the traditional social system the parental veto in decision making was powerful because the older man was the custodian of the morals and the keeper of ancestral lands. In this case he made all the important decisions relative to who went where to seek medicinal treatment. In this day and age, with the advent of education and changes in the economy, the individual attends school and finds a job in the urban milieu. With access to income, he is in a priviledged position to be listened to on his return to the rural areas. His position makes it possible for him to alter the rules of behavior in the traditional social system because of his access to income resources. He is able to reward his followers and is able to confer benefits upon them. In this direction the elder of the lineage may find it necessary to coopt him to advise in certain areas the elder knows little about because of rapid social changes. The urban dwellers do not severe ties with their rual relatives. They retain contacts; they are accorded prestige, they visit, and they remit money and other goods

to their relatives. They may flout tradition with impunity and can influence rural kin favorable to many new developments, including modern medicine.

We are aware of the fact that a society's pattern of living is a dynamic system of interrelated parts. Therefore, change in one of these parts usually reacts on others and these on additional ones, until they create reverberations throughout in a type of chain reaction sequence. But it is not only changes in the material aspect of a society's culture that set off chain reactions. Ideological changes have similar consequences. Here we have suggested that the introduction of many social changes, including medicine, has affected the traditional system and has started a whole set of chain reactions. For example, scientific theories about the nature of disease are forces capable of changing conceptions of the traditional universe, man's place in it, and his relations to other men.

C. The Individual and the Social Structure

A theoretical framework for the analysis of social change must be concerned largely with what happens to social structure.[37] But to be truly dynamic it must allow for individual action. As a member of a society, each separate individual is striving to attain his ends by interacting with other members in the social process. All of them are largely governed in their behavior by the set of established basic relationships in the social structure. This embodies sets of expectations as to what people will do by virtue of their social roles and

ideals as to what they ought to do. So the conduct of the individual reflects a complex scheme of motivations. His own interests, recognition of interests of other members of the society, and recognition of the structural values by which he has been guided so far in his career, all affect his pattern of behaving. The efforts of satisfaction, if successful, as suggested earlier with the example of a cure, tend to modify that system, and the repercussions of such modification upon other individuals tend to render it irreversible.

As the traditional structure of authority and the position of the head have weakened, individuals who traditionally hold no warrant have achieved positions of influence and control within the lineage. Although they receive no explicit recognition as formal leaders, those who have succeeded economically, who have had formal education, or who have acquired high status through the new political or occupational associations, seem to exert influence and control over the activities of co-members or in policies of the lineage far in excess of that decreed by their traditional rank of seniority. Here are the beginnings of a new authority system, though it is unformalized and often may conflict with the traditional authorities. However, at other times the two are mutually supportive, and the traditional elders knowingly and even voluntarily may refer decision making and the tackling of certain issues in the contemporary setting to the knowledge and authority of the new educated elites. The new authority system gives expression to some of the divergent interests and conflicting claims in extended kinship relationships and may make it possible to contain them. Little[38] claims that in the urban centers new associations

have come into being to assist kinsmen to settle in the towns. By implication these associations are adaptive mechanisms to substitute for the extended kinship systems left behind in the traditional society. In town the migrants are made aware of the importance of these substitute kinship systems more so in crisis situations. And these situations are common place in the urban milieu.

Within the framework of wider social change, the ties of kinship have been weakened as a foundation for the social system. Nevertheless the kinship system and the concept of kinship persist in modified forms. It remains the primary focus of cohesion and a source of stability and control in the traditional society. By accommodating the expression of conflict and by providing a basis to meet changing conditions the kinship system has been able to help channel and contain these conflicts. Thus an additional measure of stability has been given to a changing social system.

However, much of this conflict is centered on the individual who is placed at the intersection of two medical systems, the result is that his interests are frequently contradictory. On the one hand, he is seeking new goals and interests; on the other, he is reacting to the claims of traditional medical theory. He cannot, of course, completely reconcile the insoluble conflict. However through his inconsistencies in behavior and his shifting allegiances and loyalties, he may be able to bear these stresses and strains. (See Chapter 6.)

This is not a wishful interpretation of one's mind or of fiction; the most characteristic theme throughout Ghana today is change and persistency. The change is largely initiated by the

influence of contact with other people. New ideas have sprung up where Ghanaians live and work.

Certainly the introduction of scientific medical institutions has given rise to new sets of interests and values that are often incompatible with and threaten traditional medical theory. Nevertheless the claims of traditional loyalties persist in this transitional period as the individual tries to adjust to the new milieu.

Changes in any culture follow a complicated course and are determined by a large number of complex factors. Therefore one must ask not only which elements change, but which elements persist, and how the old and new ones interact. Similarly conflict and cohesion are complimentary and that conflict does not necessarily lead to a breakdown in a system; in fact we hold the view that stability in a system may derive from the various cleavages within it. The weakening of the authority system of a lineage in secular affairs is evident today but the ritual values attached to the office of the head of the family remains in many spheres.

VII. Summary of Discussion

Throughout this discussion we have tried to point out that in recent years several developmental changes have come into being. It is necessary to relate these recent changes to the effect on old traditional structures; and how they help to "preempt" some of the structures which gave support to traditional medical practice.

In the past the parental veto was very important in the lives of the young. But today many facilities independent of family

influence have come about resulting from the recent and rapid developments. For example the young person goes to a formal school. He learns from people who are not related to him by blood. His teachers and peers provide him with new dimension from which to view his existence. The teachers are his models; and as suggested by Busia the young learn less about their own society. Thus it is not surprising that the young and the educated become strangers to their traditional environment. This is not the end of the story. The educational system views the world through the scientific process of enquiry. This in itself challenges the traditional religious dogma of ancestor worship. The educational system makes it possible for the young to question the system and to ask for meaningful answers in the here and now. As the elders have not been through the same process of formal education the young do not see the relevance of approaching the old for advice. All these factors mitigate the traditional system.

The residential pattern has also changed in recent times. Many of the young go to the cities and the towns in search of jobs. Life in the cities and towns is of different nature at least in the sense that blood relatives do not reside together. Relationships are based more on impersonality than was the case in traditional social settings. With changes in residence, education and access to income resources, the young are able to assert a degree of independence that has repercussions in terms of decision making.

In conclusion we would point out that the confrontation of the traditional social structure with the modern economic system has

consequences which may be perceived at very different levels of generality and complexity. The most common observation one may deduce concerns the rapid decline of the subsistence economy which has in turn affected the traditional pattern of behavior and belief.

Furthermore the recent confrontation of the traditional way of life with that of a modern economy has had other consequences for the people. Traditional structures have been questioned and new institutions have been imported into the Ghanaian social scene. All these have helped to broaden the cultural experience of the Ghanaians, but have also brought conflicts to the people, as for example, in their pursuit of medical attention.

In the next chapter therefore, we shall take our discussion into the area of scientific medical institutions, after which we shall discuss the similarities and differences between the scientific and traditional medical systems.

FOOTNOTES

[1]New Ghana, Ghana Government Publication Report: Ministry of Information, Accra. IX, No. 6 (1965). Also see Ghana Cultural Review, 1 (1965).

[2]Ibid, p. 4.

[3]S. McPhee, Economic Revolution in British West Africa (London: Macmillan Company, 1926), pp. 289-290. Also the Annual Report of the Accra Town Council, 1899-1903.

[4]Dennis Austin, Politics in Ghana (London: Oxford University Press, 1964).

[5]Ibid.

[6]For a summary report, consult the Royal Institute of International Affairs: "Ghana, a brief political and economic survey", London, 1957. Crown Agents, pp. 41-88. Also see the Gold Coast Annual Report, 1957.

[7]See discussion on the tribal social structure in Chapter 2. During the colonial rule the chiefs had a greater share in managing the affairs of their own people which meant that the various tribes were ruled by their tribal heads and chiefs.

[8]David Apter, Ghana in Transition (New York: Macmillan Company, 1968).

[9]Max Weber, The Theory of Social and Economic Organization (New York: Oxford University Press, 1947), pp. 358-392. Also see Reinhard Bendix, Max Weber: An Intellectual Portrait (New York: Doubleday, 1960), Chapter X.

[10]David Apter, op. cit.

[11]John Gunther, Inside Africa (New York: Harper and Row, 1955), p. 804.

[12]Sir W. Arthur Lewis, Report on Industrialization and the Gold Coast (Accra: Government Printing Services, 1953).

[13]K.A. Busia, Social Survey of Sekondi Takoradi (London: Crown Agents for the Colonies, 1950), pp. 100-120.

[14]Ione Acquah, Accra Survey (London: University of London Press Ltd., 1958),p. 62.

[15]Ibid, p. 63.

[16]J.C. Mitchell, "The Causes of Labour Migration", Bulletin of International African Labour Institute, 6, No. 1 (January 1959). Also see Dorothy Swaine Thomas, one of the proponents of the migration theory, in her article in Social and Economic Aspects of Swedish Population Movement, 1750-1933 (New York: Macmillan Company, 1941).

[17]New Ghana, op. cit., 1965.

[18]General Plan for the Development of the Gold Coast. A Sessional Paper No. 2 of 1944. Ghana Government Publication.

[19]Ibid.

[20]The Royal Insitute of International Affairs, op. cit., p. 59.

[21]Sir W. Arthur Lewis, op. cit.

[22]Sir W. Arthur Lewis, op. cit., p. 31

[23]P.C. Lloyd, Africa in Social Change: West African Societies in Transition (New York: Frederick A. Praeger, 1968).

[24]I. Acquah, op. cit.

[25]I. Acquah, op. cit, p. 122.

[26]Peter Hodge, "The Ghana Workers Brigade: A Project for Unemployed YOuth", British Journal of Sociology (1969), pp. 44-50.

[27]Ibid.

[28]Ibid.

[29]K.A. Busia, Purposeful Education (New York: Praeger, 1964).

[30]W. Birmingham, J. Neustadt and E.M. Omaboe, A Study of Contemporary Ghana (Vol. 2, London: George Allen, 1967), pp. 125-144.

[31]Ibid, p. 125.

[32]Ibid.

[33]Ghana Population Council Study (Accra: Chief Statistician's Office, 1963), p. 144.

[34]Ibid, p. 144.

[35]W. Tetteh, "Marriage and Residential Pattern" in W. Birmingham et. al., op. cit., pp. 215-216.

[36]K.A. Busia, op. cit.

[37]Raymond Firth, Elements of Social Organization (Boston: Beacon Press, 1961). See especially Chapter 3 on "Social Change in Peasant Communities", p. 80.

[38]Kenneth Little, West African Urbanization (London: Oxford University Press, 1964.)

CHAPTER 5

SCIENTIFIC MEDICINE

I. Introduction

In this chapter we shall describe and analyze the nature and the impact of scientific medical institutions on the Ghanaian milieu.

Scientific medical practice takes place within an institutional context, that is there are certain regular and identifiable modes of action and behavior which persist regardless of the particular personnel. Furthermore scientific medicine is a cultural import arriving into Ghana from Europe. Since its arrival the sick person is offered at least two alternative forms of medical aid and must make his choice, taking into consideration which medical practice will suit his realm of acceptable possibilities.

We shall also discuss briefly in this chapter the initial difficulties which were met by both the colonial administrators and the missionaries in their attempt to establish scientific medical practice. Our discussion deals with these specific areas: a brief history of scientific medicine in Ghana, government action towards scientific medicine, medical education, the training of doctors, the training of auxiliary personnel, the impact of scientific medicine, and scientific medical institutions.

It is necessary to examine some of the aspects of Western culture in which scientific medicine is culturally embedded. These aspects have direct implication for the actors who are involved with

scientific medicine.

II. Brief History of Scientific Medicine in Ghana

The history of the Ghana Scientific Medical Service dates back to the colonization of the country by Britain in 1844 when British Medical officers were posted to the Gold Coast to take care of the colonial administrators. The medical officers were given the responsibility to care of the health needs of the senior administrative officers working in the civil service of the colonial government.

As time went on, the various missions in the country also brought in medical officers to take care of their personnel. They established dispensaries that were sporadically spread throughout their area of influence. By 1878[1] the missions and colonial medical officers had enlisted the help of male orderlies to bathe and to feed the sick, to dress wounds, and to administer drugs to the local population under their medical supervision. It is recorded, however, that formal medical work started in Accra after 1878[2] and spread slowly thereafter to other parts of the country, mainly the large towns.

In 1899, the first British Colonial nursing sister arrived in Accra and provided a certain amount of in-service education to the male orderlies who had little or no formal education.[3] Traditionally it was improper at that time for females to enter into the medical service. Males were looked upon as breadwinners, to provide support for their family, and so initially began working in the new institutions. Females stayed in the homes to nurse the sick. To recruit females to enter the

medical profession to look after non-relatives would have been considered quite unsuitable for young girls.

Scientific medical practice did not have a smooth beginning. As with any new idea, initial opposition was felt from the indigenous population. There were obvious difficulties. The traditional social system had not as yet been prepared to give support to the new institution. In terms of recruitment there were not many job seekers who came forward to be trained as medical personnel. The recruits needed basic formal education in order to be able to communicate with the colonial administrators and other personnel who were associated with the medical institution. The traditional cosmology was opposed to the scientific explanation of disease, supporting the view of super-natural causation of illness, where causal factors between events is not one of the natural world but of the supernatural. Experimentation was therefore unnecessary, because supernatural laws were immutable and were known. As we have shown (in Chapter 2) the society was permeated at this time by a vast body of beliefs held by both the medicine men as well as by the general population. For example, the view of lineage elders and old women of families was that the malefic action of another person or intervention by a spirit may cause illness. This view was backed by the experience of the older generation, who could cite empirical evidence from specific cases. The structural conditions of the society at this time were effective in supporting traditional beliefs. The whole structure of the extended kinship system in which the authority was vested in the elder of the lineage gave some support to traditional medical practice. These then would help to explain some

of the initial difficulties which confronted both the early colonial administrators and the missionaries in their endeavor to establish the basis of scientific medical practice. To establish the new medical practice it followed that certain changes, at least in the belief system, needed to be made before it could become a viable medical practice.

The health problems at this period were mainly environmental, in sanitation and malnutrition, which helped to give rise to various tropical infections such as malaria, worm infestation, yellow fever, sleeping sickness and yaws, to name only a few. Scientific medicine at this time had developed a technology to deal with most of these diseases. Once scientific medicine began to gain acceptance (see Chapters 4 and 6), reinforced through the process of formal education, changes in residence, access to income resources, a whole set of structures were modified or constructed anew.

III. Government Action Towards Scientific Medicine

The relevance of the government's attitude towards scientific medicine is seen in its rapid acceleration of scientific medical projects and health education. This is not to argue that hitherto there was no development of significance. For example, under the late British Governor, Sir Gordon Guggisberg,[4] the first scientific health plan was enacted which gave the country its first scientific medical institution as far back as 1924. This is the Korle Bu Hospital in Accra. The attempts however were too few and belated to meet the overall health

needs of the country in this period.

Let us now examine the recent specific developmental projects by the government which have had profound repercussions on the health needs of the people. In 1957 the government built the first health centers. They were distributed throughout Ghana with the exception of two regions, the Western and the Central. The reason offered in ignoring these two regions was that the Central Hospital, (Korle Bu Hospital built in 1924) drew many of its patients from the Central and Western regions. The hinterland was neglected in terms of scientific medical facilities, so the priority was given to the other regions and health centers were built as quickly as possible. As shown in Table 5.1 twelve health centers were in operation by 1958. This developmental trend continued, culminating in 1963 with forty-one health centers operating in all regions of the country.

Coupled with these health centers, the government came forth with the idea of medical field units (see Table 5.2). The essence of this aspect of scientific medical care was to control many of the environmental diseases which were rampant at the time. As pointed out by the Director of Medical Services,[5] the mortality rate among mothers and children in the past was very high. Some authorities put infant mortality as high as 250 deaths out of every 1,000 babies born.[6] This high rate was attributed to inadequate and poor services for the pregnant women, and lack of doctors, trained midwives, public health nurses and other health workers. The pre-school child suffered from such diseases as malaria, bronchopneumonia, measles, diarrhoea, malnutrition, tuberculosis, and worm infestations.[7] Poor sanitation, poor water

Table 5.1

Health Centers in Operation in Ghana

Region	1957	1958	1959	1960	1961	1962	1963
Total	10	12	16	22	27	33	41
Western	-	-	1	2	4	4	6
Central	-	1	1	2	2	2	2
Eastern	1	1	3	4	6	8	12
Volta	1	2	3	3	3	3	3
Ashanti	1	1	1	2	3	3	5
Brong-Ahafo	2	2	2	4	4	7	7
Northern	3	3	3	3	3	4	4
Upper	2	2	2	2	2	2	2

Table 5.2

Medical Field Units in Operation in Ghana

Region	1957	1958	1959	1960	1961	1962	1963
Total	8	8	8	9	6	7	8
Western	-	-	-	-	-	1	-
Central	-	-	-	-	-	-	1
Eastern	-	1	1	1	1	1	1
Volta	1	1	1	1	1	1	1
Ashanti	1	1	1	1	1	1	1
Brong-Ahafo	2	1	2	2	1	1	1
Northern	2	1	1	2	1	1	1
Upper	2	3	2	2	1	1	2

Source: Republic of Ghana Annual Report of the Medical Services of Ghana; Accra: Government Printing Accra, 1967, p. 11.

supply and housing greatly contributed to the high morbidity as well as factors such as health education, superstition, poverty and ignorance.[8]

It was within this state of affairs that the government instituted the medical field units. Their purpose was to carry out field research and to educate the rural population in scientific health matters. These medical field units were to act as a "travelling scientific medical service" which could move on wheels, so to speak, to the remote areas of the country. For example Kintampo, Ashanti, was the headquarters of the medical field unit which acted as a medical educating center to survey and to determine the nature and types of health hazards in the adjoining areas. When the survey work was completed by the field unit scientific medical personnel were notified and posted to needy areas to tackle local problems. At present the headquarters of the medical field unit has been moved to Accra, in order to centralize the health services at the headquarters.

Since 1957 there has been a corresponding increase in the number of scientific medical personnel employed in the government's civil service and non-government services. For example Table 5.3 shows that between 1957 and 1963, the number of doctors in Ghana increased from a total of 330 in 1957 to 904 in 1963. During this period there was a similar rate of increase among all types of health personnel.

The effects of these increases in health centers, medical field units and health personnel, were crucial in helping to lower the death rate (see Table 5.4). Furthermore the decline in the death rate can be attributed to the improvement in the sanitary conditions, in the dietary habits and the overall effects of health education. We base

Table 5.3

Medical and Public Health Personnel in Government and Non-Government Services

	1957	1958	1959	1960	1961	1962	1963
Doctors	330	342	346	586	726	879	904
Government Service	120	123	126	227	292	363	379
Specialists	18	20	22	23	43	120	130
General Duty	102	103	104	204	249	243	249
Private Practice[1]	90	96	94	132	142	153	146
Dentists	18	14	17	17	22	29	36
Government Service	12	10	14	14	14	17	28
Private Practice	6	4	3	3	8	12	8
Midwives	616	691	789	900	1008	1104	1235
Government Service	345	376	412	481	530	611	954
Private Practice	271	315	377	419	478	493	281
Trained Nurses	800	986	1627	1848	2023	2191	2366
Government Service	768	958	1001	1130	1241	1344	1453
Private Practice	-	-	601	692	732	769	804
Health Visitors	32	28	25	26	50	78	109
Para-Medical Field Staff	310	439	469	497	588	621	724
Leprosy Service	26	28	33	32	47	150	155
Medical Field Units	105	200	197	217	311	206	233
Malaria Service	-	18	45	50	26	27	55
Health Educational Officers	1	6	6	8	8	17	10
Health Inspectors	178	187	188	190	196	221	271
Qualified Pharmacists	312	311	326	298	329	342	355
Attached to Government Hospitals	96	82	92	91	127	75	91
Attached to non-Government Hospitals	13	12	14	9	9	11	15
Non-attached to Hospitals	203	217	220	198	193	256	249

[1] Including doctors at mining and missionary establishments.

Source: Statistical Year Book, Accra: Central Bureau of Statistics Accra, Ghana, 1963, p. 33.

Table 5.4

Death Rate per 1,000 of the Population

Year	Estimate
1948	48
1957	32
1960	27
1967	21

Source: The Health Services in Ghana, Accra: Ghana Government Publication, Ministry of Health, 1967, p. 12.

this assertion on the postulate that before the advent of the government's accelerated health plan, the existing situation was one of environmental neglect and poor dietary conditions.[9] These two interrelated conditions help to explain why the death rate was relatively high in Ghana, as in most developing countries.

As has been noted, before the accelerated development plan the infant death rate was as high as 250 deaths per 1,000 babies born. This rate primarily affected the lack of scientific medical facilities which made it difficult for the expectant mothers to receive proper prenatal and post-natal care. But during the period 1950-1970 these facilities were made available in many areas of the country, and by 1967 the infant mortality rate had dropped to 79.1.[10]

Let us now look at some of the other factors which have assisted the spread of scientific medical practice and have helped to challenge the metaphysics of traditional medical theory.

A. Scientific Medical Institutions

This section deals with the description of types of scientific medical institutions available in Ghana. The purpose is to throw some light on the various types of agencies which come under the scientific medicine.

As an institution, scientific medicine is established for the purpose of achieving some implicit social functions. These functions are expected to be carried through its social structure - a network of role relationships in which the diverse activities of the institutions are allocated and coordinated into a system. In the process of performing these functions, scientific medicine develops its own set of behavioral patterns, its own system of shared values, beliefs and orientations. This common pattern establishes standards of conduct for behavior and has its own unique effects on the action not only of the staff, but also for its patients. Therefore, in order to understand social processes within the scientific medical institutions, it is necessary to have at least a rudimentary understanding of the various agencies of scientific medical practice.

As with all aspects of human behavior, the social scientist studying medicine must keep in the foreground the question of whether the specific behavior patterns are universal, reflecting the exigencies of human situation, or whether they are the special product of the configuration of a specific culture. We assume, however, that many of the problems faced by the sick and the needs arising from their problems are everywhere at least similar despite differences in

underlying explanatory theories and techniques used for coping with them. Thus studying these agencies in Ghana provides the opportunity to gain some insight into human behavior in a non-Western cultural setting. Furthermore the development of a conceptual scheme depends in part on the availability of the descriptions of different systems of medical care, and their techniques. The aim of this section then, is to provide some insights into the application of scientific medicine in a non-Western society.

B. The Ministry of Health

The Ministry of Health in Ghana is responsible for providing all the integrated health services in the country. The constraints under which health care is provided have two major consequences for the design of scientific health services. In the first place, health programs must reach the communities if they are to solve the dual problems of overcoming distance and effecting changes in human behavior and the physical environment. Secondly, the constraints of availability of doctors and physical distance make it impossible to place doctors in all the scientific medical services throughout the length and breadth of the country.

Rather, non-professional or auxiliary personnel must provide primary care for both individuals and communities. If the principle of delegating responsibility to paramedical and auxiliary personnel is not accepted - if there remains an insistence that auxiliaries cannot handle the problems of scientific medical care - then it is clear that

scientific medical practice will not be able to reach more than a small part of the people in the rural areas. On the other hand, accepting the principle of delegating responsibility to paramedical and auxiliary personnel allows the flexibility that is essential for designing the system of scientific medical practice in a developing nation such as Ghana.

C. Medical Education and Its Implications for Health Care

Before we go into some of the details of medical education, some comments are necessary about the nature and training of the doctors who practice in Ghana today.

In Ghana prior to the establishment of the medical school (in 1964), the practitioners of scientific medicine received their medical training in countries such as Britain and Germany, and more recently from Russia, East European countries, Canada and the United States.

On their return from these countries the doctors either practiced scientific medicine as private practitioners or entered the government medical service. Many of the Ghanaian doctors who returned from overseas training, tended to retain the medical orientation they received. This has meant that frequently the Western medical model, with its own cultural characteristics is not sufficiently adjusted to the Ghanaian cultural milieu.

As indicated in Chapter 1, the essential factor of scientific medicine is its utilization of the scientific method which is universal and cumulative. However, we must not lose sight of the fact that

certain basic adjustments need to be made when a developing nation, such as Ghana, borrows from the West. Perhaps an example will illuminate this point.

The social and economic development of the Western countries is of a different nature in terms of its standard of living, economic resources and its special bureaucratic institutions. This difference is very noticeable in the effect of applying Western standards of economic incentive to the current state of scientific medicine. Many of the Ghanaian doctors who have returned from the West bring with them the idea of seeking the best in terms of financial reward, sometimes at the expense of providing adequate medical coverage. The Ghanaian government reinforces this Western influence by rewarding primarily the hospital-based specialists with more pay. Hence, as the salaries and fringe benefits for the hospital-based specialists remain higher than for the community-based practitioners,[11] many Ghanaian doctors prefer to train and work as specialists within the well equipped hospitals which are mainly in the urban centers. The ramifications of this situation will be considered below.

Besides the effect of economic incentives, there is an additional Western influence which can be seen as having a negative effect upon health care in the country. In most of the Western countries there has been and still is a strong influence toward curative medicine.[12] As expected, this has also become a major Ghanaian medical orientation despite the fact that the two major problems still effecting the health of the people are malnutrition and insanitation. This is not to suggest that the curative emphasis has not had a significant effect upon lowering

the overall death rate and lengthening life expectancy. Treating directly the infectious diseases and other organic disorders is of high priority in any underdeveloped country, the tendency to emphasize the curative at the expense of the preventive can be considered serious. Serious in the sense that Ghana still needs more drains, better water supplies, more approved public lavatories, and market places devoid of swarms of flies and other carriers of infectious diseases. Based upon the evidence presented in Tables 5.1 and 5.2 we suggest that at present, emphasis be placed on the preventive aspects of scientific medicine rather than the curative.

As pointed out by Blishen,[13] among many others, it is clear that the freedom to determine the location of practice is related to the maldistribution of doctors. This freedom, based upon the professional autonomy so cherished within Western medicine, can be seen as a handicap in meeting the health-care needs of the people. It is true that the urban population has been growing at a rapid pace and therefore not illogical to find that hospitals and other major medical services tend to concentrate in the urban centers. It is also not unreasonable to find that doctors are attracted to these medical centers because of the availability of services and facilities and the potential economic reward. An indication of this urban attraction of physicians is supported by the fact that while only 23% of the Ghanaian population lives in the urban centers,[14] 42% (267) of the 638 doctors working for the Ghana government health services practice in the cities.[15] Consequently, as found in many countries, such as the United States and Canada, while medical services are better distributed in relation to the

population there is still a need for physicians in rural areas. As long as the freedom of the doctor prevails and as long as the government does not provide direct incentives to get physicians into the rural areas this maldistribution is likely to persist.

These factors also explain why preventive medicine sometimes remains in the background of priorities. As a medical speciality, preventive medicine is still not considered the most prestigious for the reason that it does not focus upon the dramatic curative aspects of medicine. Therefore, the professional rewards are limited and the economic incentives enjoyed by hospital-based specialists are absent. The cultural and social amenities of the city are also a strong attraction when compared with working and living in the bush or other outlying areas where most of the outstanding preventive measures are urgently needed.

Again, the argument is not being made that the curative orientation should be de-emphasized. On the contrary, even those generalists or specialists who are now practicing in rural areas are kept so busy with the curative aspects that preventive medicine of necessity has to be de-emphasized. The point is that the problems associated with preventive medicine should be confronted directly and separately by trained public health officers and not left as an activity to be handled in the physician's spare time.

Therefore, there is a need to redefine the role of the specialist in preventive medicine to enhance both its immediacy and its position in the organization of professional medical services. We suggest five main proposals that could lead to this end:

(1) increase the remuneration of the preventive medical specialist. This would provide a major encouragement that now actually pulls doctors away from such an area of practice.

(2) train all doctors in the Ghana medical school in comprehensive health care. This is not now being done systematically although plans are being made to consider such an orientation.

(3) permit all doctors to serve in the rural areas as interns and provide professional and training rewards to lead to this. The result would hopefully be a more natural orientation toward the meaning of comprehensive health care and particularly the role of preventive medicine. This may not keep the trainees in the rural areas but might make them more aware of the problems of rural patients who migrate to the cities. This proposal may be realized soon because the doctors are now receiving pressure from the government to relieve the current maldistribution of physicians.[16] To preserve their own professional freedom and autonomy, Ghana's medical profession may establish their own scheme to direct more doctors toward practicing in the rural areas.

(4) promote an institutional environment which will foster a more coordinated approach among the other specialists. We would like to suggest that a large number of urban specialists are ignorant of the role of a preventive medical specialist rather than actually being unconcerned about this realm of health care.

(5) Increase the number of public health and community nurses. Also, other health personnel are needed, for example, public health engineers, sanitary inspectors and nutritionists. In this regard, more emphasis might be placed on ambulatory treatment centers, rather than

hospitals.

Finally, the health aspect of town planning should be stressed as there is a great need for a team approach to community health problems. A combination of these five proposals will require changes in the educational preparation of the scientific medical practitioner. For instance, in some medical schools in Canada, Blishen[17] points out that students are exposed to the problems of general practice in various contexts such as the patient's home, public health clinics and out-patient clinics. In Ghana this orientation could be incorporated more fully.

There is another factor that is also pertinent. It is difficult to estimate how much understanding exists between the scientific medical personnel and the population, since many of the patients come from rural backgrounds. Medical sociologists[18] have found that different cultural orientations tend to color the essence of the therapeutic relationship existing between medical personnel and patients. It was within this framework that Hollingshead[19] argued that practitioners of medicine find it most helpful when a patient reveals enough of his beliefs and attitudes to enable the practitioner to formulate properly a professional or rational explanation of disease. On the other hand, practitioners of medicine find it frustrating when a patient cannot understand or accept medical explanations and instructions because they are inconsistent with the patient's beliefs and attitudes. Koos[20] also claims that a practitioner's effectiveness in treatment varies with his understanding of how the patient perceives the situation. When we relate this discussion to the practice of traditional medicine we are

aware of the cultural homogeneity surrounding the actors involved in the practice. Differences in cultural orientation have implications for the actors who seek medical aid. For example, Zborowski,[21] also has shown how cultural factors can affect the relationship of pain to the sick role. In a study of three cultural groups, Jewish, Italian, and "old American", Zborowski found that members of the three groups reacted differently to pain. The differences found were measured by how stoically each group accepted pain and which subsequently affected their interpretations of levels of illness and recovery. We would argue strongly that in Ghana among the different ethnic groups there is also a similar tendency for them to react differently to the concept of ill health. Among the Ewe,[22] for example, is the notion that a person goes to a hospital only when he is critically ill; whereas among the Fantis,[23] the first sign of illness will often send the person to hospital. Thus Zborowski's insights have broad cross-cultural applications beyond his original study. (This aspect of taking the needs of each cultural group into consideration, in the therapeutic relationship shall be considered in the following section on the training of scientific medical practitioners.)

But before we move into the specific aspect of the training of doctors a few concluding remarks related to the problems faced by patients are in order. Barnes[24] has noted that coming into hospital is an anxiety ridden episode (it is so in Ghana, as elsewhere), so the patient needs a practitioner who is able to put him at ease and to relieve him of his fears and anxieties.

What can be done to bring improvement in this therapeutic

relationship? The organization and content of medical education today are under critical scrutiny in most countries to determine whether the educational process can produce health personnel competent to meet the continuing problems facing practitioners in changing conditions as more demand is made on scientific medicine.[25] Although they must still provide practitioners qualified to treat human ills, medical educators are questioning whether or not the various types of physicians they train in fact, have acquired the knowledge and skills required to meet the needs of the patients. Cope[26] makes a comment about medical schools which is clearly applicable to Ghana. They "must provide, somehow, generalists with a wide range of knowledge and skills; specialists with a profundity of insight and the capacity to manage increasingly intricate facilities, research men who can move medicine steadily forward toward new goals; and medical men akin in function and in spirit to the social systems".[27]

In line with Cope's argument there is a need to understand the patient as he operates in the social system. Therefore we would say that the cultural needs of the society have to be taken into consideration in the formulation and the implementation of medical curriculum. The contemporary and critical scrutiny of medical education is not new. The Abraham Flexner Report[28] was indeed the culmination of a period of criticism of medical training in both the United States and Canada. As a result of the Flexner report medical education in these countries resulted in its transformation from an apprenticeship system, under which the student gained his professional knowledge while working with a medical practitioner, to a discipline within a university.

The emphasis of a liberal education became central in medical education in order to assist the practitioners of scientific medicine to increase cultural awareness. Put differently this emphasis on liberal education is intended to increase the physician's capacity to accept the patient as a total individual, bringing social psychological and physical aspects to the theoapeutic relationship.

At present the medical school in Ghana is an integral part of the university. Countries such as Ghana with low standards of living and levels of socio-economic development need to discriminate in applying the techniques of highly industrialized countries. The essence of the discrimination is to be selective in picking ideas to fit the particular cultural needs. Ghana can also learn from the strengths and weaknesses of the more industrialized countries by being innovative and adaptive. This will be examined in the following section.

D. The Training of Scientific Medical Practitioners

As of 1969 there were 669 doctors on the Ghanaian medical register.[29] At the same time the Ghanaian population, according to estimates from the recent census was 8.5 million.[30] Roughly, this presents one doctor per 10,700[31] population, supported by a cadre of nurses, pharmacist, and other personnel. (Table 5.5 shows the changes in medical manpower since 1963).

These limited data clearly indicate the need for more doctors.[32] The urgency of this need is further indicated by the fact that the rate of population increase per annum is now 2.5%[33] which in raw numbers is an increase of about 212,500 every year.[34]

Table 5.5

Distribution of Professional and Para-Professional Man Power in the Ministry of Health, Ghana.

1963-1967*

Types	1963	1964	1965	1966	1967
Doctors	379	465	548	597	633
Dentists	28	36	37	39	41
Midwives	954	1189	1201	1394	1481
Nurses	1453	2090	2381	2660	3078
Pharmacists	355	355	355	362	367

Source: Republic of Ghana, Annual Report of the Medical Services of Ghana. Accra: Government Printing Services 1967, p. 58.

* According to the 1969 Register there were 669 doctors practising in the government medical service.

To provide a solution to the shortage of doctors, the government decided in October, 1964, to open the Ghana Medical School.[35] A student qualifies for admission to the school when he passes the general Certificate of Education Examinations or the West African School Certificate in at least five subjects; three of which must be at an advanced level owing to the scientific nature of the profession, preference is given to students who have passed in the science subjects. However the trainee does not enter the medical school immediately. He enters the University of Ghana to complete a one year pre-medical course before he qualifies to begin his clinical training in the medical school.

There are two types of Ghanaian doctors practicing medicine today. Those who received their training from abroad and, those who entered

the Ghana Medical School in 1964 or after. Of the first category it has been noted that on their return to Ghana, such practitioners are less likely to understand and meet the cultural needs of the people. It was to correct this deficiency that the Ghana Medical School has placed emphasis on the training of doctors who will understand the societal and cultural needs. In otherwords, there is an awareness of the fact that medicine and society are not isolated but integrated into a complex network of beliefs and values.

In modern industrialized nations, disease and illness are most often seen as natural phenomena and hence subject to investigation and study by scientific methods. Consequently, beliefs about causes of various diseases require scientific proof for substantiation. Thus, answers to questions of etiology are sought in the laboratory and in the field under controlled conditions. In the traditional Ghanaian setting, many if not most diseases are seen as manifestations of supernatural powers; thus causal explanations in these settings take on a magico- religious tenor. (The doctor needs to understand this predicament of the traditional people). Although this generalization will hold in most instances, it should be noted that the integration of medical beliefs with other aspects of the culture is not perfect in either modern or traditional settings. For example, the rate at which an innovation or practice diffuses will vary markedly both between modern and traditional settings and within them. This means, among other things, that the degree to which different segments of the population are even aware of the innovation, much less accept it, will vary. One consequence of this variation is that even in urban areas

where sophisticated scientific medicine predominates, one can find situations in which unverified beliefs are the basis upon which people act.

The point of this discussion is to throw light on the fact that for practitioners of medicine to be effective in their therapeutic relationship the medical curriculum should articulate with the needs of the society. Thus the present effort in Ghana to find ways and means to prepare doctors to understand better their environment in which they will work.

At the outset the Medical School curriculum was based on the Western Model with its emphasis on the training of hospital-based practitioners. This aspect of the training encouraged the students to specialize on some aspect of curative medicine. However, we have indicated before that Ghana needs specialists and/or generalists who are able to operate within a societal milieu that lacks sufficient well-equipped hospitals to meet the demand for care. Although the medical school must still provide practitioners qualified to treat human ills, medical educators need to ask whether or not the various types of physicians they train have, in fact, acquired the knowledge and the skills required to meet the health problems of the country keeping in mind the economic problem of a large treatment service.

At present in the Ghanaian medical curriculum more emphasis is placed on the science subjects. It is strongly suspected that to meet the needs of the country there should be a shift of emphasis from the sciences to the humanities and/or the social sciences.

Such a move towards the social science orientation in medical

education would assist to prepare health practitioners who are responsive to the local needs. For this reason it is desirable that the medical students spend part of their training period with the rural population in order to familiarize themselves with the traditional cultural setting. In furthering the medical student's orientation to the cultural setting, he needs to have specific goals. Since most of the endemic diseases could be prevented, he needs to discover how to motivate the population to take the necessary steps to improve their environment.

E. The Training of Auxiliary Personnel

The nursing personnel include the following categories: general, mental, public health and community health nurses. In addition there are midwives who may or may not be qualified nurses, and tutors who are nurses with special training. According to the 1967 figures, there are a total of 3078 nurses working in the Ghanaian civil service (see Table 5.5). Among the professional and para-professional personnel, the nurses are in the majority, and are posted to nearly all hospitals and health centres throughout the country.

The growth of medical technology increased the demand for hospital care, and public health services which resulted in a gorwing demand for nursing skills to keep abreast with the times. Dr. Rae Chittick[36] established a period in Ghana which there has been a shift from teaching specific facts to that of experiential teaching; teaching as a process of enquiry.

As a result nurses have begun to delegate menial tasks to auxiliaries is a response to the need to make the best use of trained

personnel. This is also evident in some of the Western Societies.[37] The objectives in nursing education are to make nurses more responsible and to help them to be more effective team members. This of course, involves a deeper understanding of patients.[38]

The nursing field, like other sub-fields of modern medicine, is engaged in a struggle for status and prestige which becomes important in the emerging professions.[39] Carr-Saunders[40] claims that professions by nature tend to ask for substantial prestige in the eyes of the public.

Before the arrival of Chittick[41] in Ghana, all nursing training had been undertaken by hospitals.

In Canada there is the tendency to train some of the nurses in the university. This tendency came to play a significant part in the improvement of nursing techniques.[42] The writer does not think that this tendency is practicable or that Ghana has the educational institutions to prepare all nurses. What is urgently demanded is a modified hospital apprenticeship system with greater emphasis on education, where graduate nurses would acquire some knowledge and skills in community nursing.

Ghanaian nursing is now caught up in many of the rapid technical and organizational changes found in many western countries. As with physicians, it is often hard to distinguish how the unique character of Ghanaian values and beliefs has significantly altered the models of nursing education brought to the country. Even in the future nursing may continue to develop along lines which are established outside of the country. Yet there are certain distinctions within nursing that can be directly attributed to Ghana itself and these have both an

historical, contemporary and future influence; as the following discussion will try to indicate.

At present, the great majority of nurses are females; but this has not always been the case. It was difficult for the early colonial administrators and missionaries to recruit females into nursing, so in its inception nursing was primarily a male occupation. However, as western medical influence began to predominate, and women were graduatlly able to leave their villages, nursing established its feminine orientation based on its expressive, nurturant role. As this orientation became more prevalent, the proportion of male nurses declined and some chose occupations of a more obvious masculine nature. (There are no available statistics at present on the actual sex ratio among nurses). However, many males did remain in nursing and became important because they could be posted to outlying areas without interferring with family life, also, because male nurses were frequently placed in charge of wards and health centres. This fact has important implications for the potential use of nurses in other than traditional areas of expertise, and it is this factor which will now be discussed.

Considering the relative abundance of nurses (and other types of auxiliary personnel) there is no reason they cannot be used in different capacities to fill some of the gaps of health care caused by the acute shortage of doctors. There are many indications that registered nurse could be elevated into a new auxiliary category - the medical assistant. This is a type of "physician-associate" position now being developed in the United States and Canada, which involves delegating to the medical assistant many responsibilities now considered

the prerogative of doctors. The physician-associate works in hospitals, doctors' offices, clinics and health centres as well as in homes and in industry. The physician associate makes primary visits to sick people, screens patients for the doctors and may diagnosis and prescribe treatment under the supervision of a doctor, particularly in such areas as infant care, chronic illness and geriatrics.

In the United States medical assistants are now primarily ex-military medical corpsmen who are given two years of advanced training in a medical centre and then assigned to work with a physician who has a very high patient load, usually in a rural area. In Canada the Canadian nurses association has asked that nurses assume the role of physician-assistants. Nurses are currently negotiating with medical associations on the exact nature of the responsibilities, and there are early indications that nurses who have completed a university programme will be used in this extended role.

Among physicians there are mixed feelings about the medical-assistant. More favorable responses are coming, as expected, from the rural physicians who are often overburdened with patients and without support from colleagues or properly trained auxiliary people. Traditionally there are reasons to expect an ambivalence among physicians. As Becker and Carper[43] have suggested, physician's have always been sensitive about their responsibilities and tasks ..." in order to protect their technical titles and to distinguish the degree of competence (based upon) restricted membership."[44] In the past there were many resons to protect the public from dishonourable practitioners,[45] but now doctors are aware of manpower shortages and may be more willing to accept the medical assistants particularly if they are in control

of the assistant's activities and have some voice in the training program.

Taking the exigencies of the current Ghanian situation into consideration, there is not only a need for such medical assistants but also a need to reduce known instances of unqualified people in-competently playing the actual role of doctor. In many of the outlying rural health districts (see the following section on health centres and posts) there have been known instances of auxiliary people, primarily male nurses, assuming the practice of medicine illegally and causing harm to the sick population who come to them. This does not happen by chance.

It is not unusual to travel to rural areas and see nurses, male and female, on the open veranda's of health posts administering minor treatment. However, because physician's are often not permanently attached to many of these posts, more than minor treatment may be given either by necessity or choice. Moreover, in lieu of a permanently residing physician, the government health service appoints "health superintendents" to assume responsibility for decision making functions. Most frequently it is the male nurse who receives such an appointment. Returning to the earlier point about male nurses staying in the profession and moving to leadership positions because of their continuity of service, not only is the male nurse frequently in a position of power and independence on a legitimate organizational base; but he is sometimes likely to go that one step further in order to emulate the masculine role, authority and prestige of the physician.

This practice often goes unquestioned because the rural population generally lacks the sophistication to differentiate between the functions of doctors and nurses.

Should a medical assistant program be introduced, certainly female as well as male nurses would be utilized. But by understanding the current position of the male nurse, such a program could be used to train him for a legitimate role he currently takes regardless of his expertise.

The question of how much training and by whom is obviously important for many of the above reasons. Not only the additional skills but the structural meaning of such training has significance in itself. It is, after all, the acquisition of the body of knowledge that gives his basic authority.[46] This is one reason why the physician is often reluctant to give up what many define as "routine tasks". Many physicians are threatened when any of the basic professional trappings are removed; because, in essence, this reduces some of the symbolic base of their authority.

It may be coincidence that the medical-assistant program in the United States is more than two years ahead of Canada. The program, as such, did originate in the United States but the need in Canada has been just as great. But consider the fact that in the United States the training of medical-assistants is in the medical schools under the control of physicians. Thus, in line with the view of early medical educators[47] the physicians have primary responsibility and authority over the training sequence and the development of the role itself. We are suggesting the possibility that the delay in Canada may be due to

problems of two professional groups trying to reach a common goal (i.e., better health care for the public), but at the same time wrestling with problems of separate identities and status structures. In fact one concern among Canadian nurses is that a medical assistant role will be used to mute their own identities as registered nurses. (Of course, one circumstance to be considered in the Canadian situation is that foreign policy has not led to the establishment of a large pool of highly trained military para-medics who have a very limited civilian job market for these skills.) The situation in both countries has implications for the need of a similar position in Ghana and raises questions about control over training and responsibilities.

The question of training such a potential auxiliary person in Ghana will of course depend upon whether or not nurses or lesser skilled people would fill the role of medical assistant. It is possible that the Canadian situation would be more likely if nurses are used. This would be more practical since Ghana does not have the pool of trained or educated people who could be drawn into such a program. There is plenty of competition from other developing vocations for people with high school education or some college background and so volunteers are limited.[48] Even with inducements of pay and prestige recruitment would not be very easy. What may happen is a major elevation of the currently trained professional and semi-professional auxiliary groups who could rather quickly learn to assume skills and responsibilities above present levels. This might then leave a space at the bottom for bringing in school leavers among whom there is now a high rate of unemployment. There is no need to belabour the point that ward orderlies or aides can

be taught on-the-job skills that require very little if any education. Such people, judiciously used in the more rural areas, may in fact help to provide the rapport among indigent patients who often find much of scientific medicine impersonal and alienating. The medical assistant and such lower level medical aides might together provide the type of rapport which is more commonly found among the traditional medicine man and his untrained assistants.

Let us now look at another aspect of how the nurses and other paramedical personnel act in the work situation. The relevance of this discussion is that in the work arena people are expected to perform according to the rules and regulations of the institution. In Ghana it was indicated (in Chapters 2 and 4) that the majority of the workers have moved recently from the traditional cultural setting into the urban centers in search for jobs. The point to be remembered in this regard is that while the individual was anchored in the kinship network he was not expected to make decisions. He depended literally on the "commands" of his traditional ruler. Thus the individual who enters the contemporary work situation (with its universalistic outlook) is faced with problems of adjusting to the industrial or the technological world. This in itself has implications for the performance of the individual and a direct effect on how auxiliary personnel operate.

The point pertinent to the discussion is that many of the workers find it difficult to cultivate the "industrial work incentive"[49] because in the kinship situations the elder of the lineage possessed the collective conscience. Consequently, since Ghana is passing through this transitional phase many of the Ghanaian hospital personnel are not

yet adapted to the work schedule.[50]

In conclusion we may point out that the real meaning of the concept of culture is nowhere more forcibly brought out than in the study of the introduction of scientific medicine to lesser developed parts of the world. We have argued that health techniques are not isolated parts of the life of the people. In fact they are related to the whole aspect of the cultural configuration.

We shall now discuss the main types of scientific medical institutions available in Ghana today. In this connection the discussion will focus on these specific areas: hospitals, health centers and health post. The relevance of this section is to point out that in Ghana the ministry of Health has provided these scientific medical services throughout the length and breadth of the country. However, due to the maldistribution and lack of response to manpower needs many areas in Ghana do not receive the full "benefits" of scientific medicine. Lastly we shall discuss some of the implications of scientific medicine on the larger society.

IV. Scientific Medical Institutions

Ghana has two main types of hospitals - the district and the regional. The district hospitals are small and scattered, and both staff and facilities are limited. A district medical officer is in charge of the hospital as well as all other supportive health services in the district. The regional hospitals are the modern, fully equipped institutions with a full complement of specialists and general duty

medical officers.

A. District Hospitals

In providing leadership for the district's health care, the medical officer is heavily dependent on other para-medical personnel such as the nurses, health inspectors and ward orderlies. The district hospital staff is based at the hospital, while the team seeks to balance the needs within the hospital with those of the surrounding areas. The untrained staff (ward orderlies) are employed to take care of the domestic and basic routine work. As in Western countries the importance of using these orderlies is to allow them to handle the many relatively simple problems, freeing the nurses and the doctors to concentrate on those things that only they can do. The major clinical focus at the district hospital is on the serious and complex medical problems referred by paramedical and auxiliaries from the health centers, and health posts.

There are nine district hospitals, located in each of the nine regions of Ghana. Specialized services are rendered to patients at these hospitals. By specialized services we mean that the staff comprise of surgeons, physicians, obstetricians and paediatricians who are supported by general duty doctors and other paramedical personnel.

B. Regional Hospitals

The district hospital depends upon the regional hospital. Most patients requiring hospitalization can be given care at the district

hospital, but usually it will have neither the professional staff nor the modern facilities for taking care of complex problems. There must be, therefore, referral channels to specialized services at regional hospitals. The regional hospital has the capacity for dealing with complex laboratory examinations such as hematological, parasitic, biochemical, and bacteriological problems. At the regional center barium studies and intravenous punctures might be routine: whereas the district hospitals may have only a simple X-ray for chest and extremities. The level of administration is closely associated with the central offices of the Ministry of Health, in keeping with ministerial policy and, on the other hand, carrying problems from the field to the ministry.

The location of regional and district hospitals in cities and large towns leads to their use for massive numbers of simple medical problems from the surrounding towns. This use somewhat defeats the objective of attempting to match each illness with the facility appropriate for that illness.

In addition to these hospitals, there are two main psychiatric hospitals in the country: one is situated in Accra and the other is at Ankarful near Cape Coast. They have a total bed capacity of 687.

The Psychiatric specialist claims that the two mental hospitals are already overcrowded and inadequate to meet the needs of the country. According to Forster:

> "Owing to the typically asylum character of the hospitals, the traditional medical practitioners flourish and are often consulted and give some form of treatment before any patients are removed to scientific medical institutions, irrespective of the

> illness. Except in the case of the destitute insane, no patient went direct to mental hospital for treatment. The traditional medical practitioners are regarded as able physicians who possess skills unequalled by those of the scientific medical practitioners, particularly where the treatment of psychosomatic disorder is concerned".[51]

Forster goes on to say:

> "That the prevailing belief at this time is still that mental disorder is due to the influence of a religious deity, and some as due to the influence of ancestral spirits which had not been revered by customary rites laid down by tradition".[52]

Basing our analysis on Forster's insight we would argue strongly that as scientific medicine has both curative and preventive aspects, there need to be the creation of medical aides (as suggested earlier) to operate in rural clinics and health posts in order to serve the rural population (see Chapter 6 for a discussion on mental illness and its relation to traditional and scientific medicine).

C. The Health Center

The first health center in the country was built in 1957. Its aim was to provide ordinary out-patient services, so that they could relieve the regional and district hospitals from all but their most specialized functions. Ideally therefore, the out-patient departments of the hospitals in Ghana see patients referred to them by the health centers; but in practice the ideal seldom happens, and most out-patient departments of general hospitals have to see anyone who comes to them.

Its main functions are to promote healthy living conditions; to emphasize prevention through immunization, teaching better child feeding

practices and early diagnoses of diseases; and to be curative by treating minor ailments which would otherwise have to be referred to hospitals.

As of 1969, and as shown in Table 5.6, there were seven urban and thirty-eight rural health centers. None of the health centers is permanently staffed by physicians so professional services are provided on a visiting basis, particularly in the rural areas. The health centers are mainly staffed by paramedical and/or auxiliaries of which there are usually four kinds: an auxiliary midwife who looks after the problems of maternity and the illnesses of childhood; an auxiliary sanitarian who is responsible for environmental control and whose functions extend widely through the fields of public health and health education; an auxiliary nurse trained broadly as a community nurse with the capabilities for working in both the health center and the community; and a health center superintendent who acts as a medical assistant trained for diagnosis and management of simple medical problems. The capabilities of these people could be varied or other personnel could be added according to local problems and the needs of the community. It must be remembered in this regard that these services are insufficient in terms of meeting the health needs of the communities, and a growing population.

We would suggest that the health centers, to be effective, should not exist in isolation. Their staff need to cooperate with other workers, especially agricultural extension officers, community development workers and school masters. Cooperation in this sense must be mutual to promote community health.

Table 5.6

Health Centers and Health Posts in Operation in Ghana

During 1969

Name of Region	Urban Health Centers	Rural Health Centers	Rural Health Posts
Accra	4	-	-
Eastern	-	8	-
Volta	-	4	9
Central	-	2	-
Western	1	4	-
Ashanti	2	6	-
Brong-Ahafo	-	7	-
Northern	-	4	-
Upper	-	3	-
Total	7	38	9

Source: The Health Services in Ghana, Accra: Ministry of Health. Government Printing Services, 1970.

D. The Health Post

The smallest unit of health care is the health post. The staff include the following personnel: a health post superintendent, a community health nurse and a medical auxiliary. Minor cases are dealt with at this level, but serious ones are referred to an adjacent health center and/or the nearest district hospital. A medical practitioner may make only periodic visits to the health posts which generally serve as little more than first-aid stations and health observation posts.

Yet it is obvious, from Table 5.6, that the number of health posts could be increased. With the large majority of the population living in rural areas such posts could serve a very useful function as preliminary

screening units and where the role and image of scientific medicine could be brought closer to the people. These are also very likely locations for personnel such as medical assistants.

V. The Impact of Scientific Medicine

In the field of scientific medicine there is extensive occupational differentiation in terms of personnel and the types of services provided. The differentiation of occupational roles is a relatively new cultural innovation. Hitherto it was unknown in the traditional system of medicine. The sick person who sought aid from the traditional medical practitioner met the practitioner directly in his practice or shrine. The sick person did not have to go through various intermediary clinics or sub-hospitals before he was finally referred to the specialist. In the traditional system the patient's contact with the specialist was direct. Likewise the practitioner than traditional medicine performed the various diagnoses by himself without resorting to laboratory investigations. We would suspect then that the rural population would find it more time consuming to "see" the scientific medical practitioner that to "see" the traditional medical practitioner. The latter is easily accessible to the public. It would then seem reasonable also to infer that the sick person would find it easier to establish a rapport with the traditional practitioner than with the scientific medical practitioner. However we must not lose sight of these two points: (1) that some of the techniques used by the practitioners of traditional medicine could be viewed as harmful to

the patient and can lead to the further spreading of infection; and (2) that we need to emphasize the preventive measures of scientific medicine.

When one compares scientific medicine with traditional medicine, the former has brought obvious "benefits" to the country. It has helped to lower the death rate and has increased the life expectancy of the people. However, in terms of scientific medicine's impersonal nature, operating on universalistic principles, certain alternative suggestions have been indicated (see the previous discussion on medical education).

At present there is no dialogue between the practitioners of traditional and scientific medicine. There is a need for such a dialogue in order to determine whether the traditional practitioners have the "potentiality" they claim to possess. Such dialogue, we would strongly suggest, would be beneficial for the sick population in general and the rural population in particular.

We base this assertion on the postulate that at present the specialized services are located in towns and cities. The rural sick person is unable to get the aid of a scientific medical specialist at a relatively low cost. So as a result of specialization of functions and staff, scientific medicine, in a relatively developing economy, has become a rare commodity difficult for the poor person to purchase, particularly in time and transporation. The cost factor is a problem as a result of specialized services and the differentiation of occupational roles. In his study of the problems of development Gunnar Myrdal[54] discusses the place of cost factor in the development of health

programs. His arguments are relevant for the developing world as a whole. One of Myrdal's central points is that health should not be considered in isolation from other elements in the developmental process of the economy. Health affects socio-economic factors and is itself affected by socio-economic factors, notably income and level of living. A person's ability to take full advantage of the health care program is related to his socio-economic status. Recognizing the interrelationships, Myrdal cautions against over simplifying the understanding of health by isolating it from other socio-economic and institutional factors of the developmental process. In this process the certainty that social conditions are independent will lead the health planners to attack the problem of health care on its broadest possible front taking into consideration the standard of living of the people who are directly involved with the type of service designated. This implies that rationally the health problem becomes integrated in the general problem of planning for development.

The point we need to stress is that limitations of resources strongly influence health services. Now it must be said that before these limitations become appropriate determinants of health planning and design, it must be decided who should receive health care. This may seem a naive question with a painfully obvious answer - everyone should receive health care. This point of view, however, is seldom implemented. But those who decide where and how efforts and money are to be spent have choices. The areas of greatest need in Ghana, are the rural areas. They are the most difficult to reach with supplies, transport and personnel. The pressures favor the cities. There is also the pressing

demand to meet the high cost of maintaining and improving central hospitals and urban centers because these demands often have professional strength behind them. The professionals would like to remain in the cities. So there is no local sense of urgency; the rural people have been without much scientific medical care throughout history of scientific medicine in Ghana. Today is only another day added to yesterday.

VI. Summary

In this chapter we have indicated that as a cultural import scientific medicine in both its curative and preventive aspects has brought "benefits" to the Ghanaian people. However like all aspects of cultural importation there is still a need to adopt appropriate scientific medical practices that suit the cultural needs of the society.

We have argued that in Ghana the two basic problems of ill health are insanitary conditions and malnutrition. As many of the infectious diseases which come into the hospitals are derived from the environment, we have suggested that the government through the medical educators need to lay emphasis on the training of generalist and specialist in the field of preventive medicine. Furthermore, we have pointed out that since the Ghanaian society is largely agricultural, with a large rural population, there is an urgency for the practitioners of scientific medicine to understand the cultural needs of these people. We have also emphasized the broadening of the medical curriculum to

incorporate the social and the humanistic discipline.

One major fact of the Ghanaian situation is the acute shortage of doctors. This situation has been worsened by the maldistribution of doctors. In this direction we have suggested the creation of a new category - the medical assistants - to fill in the vacuum. These people would have a positive effect by performing basic and routine medical duties so the doctors can perform their more specialized technical skills.

Lastly we have pointed out that in the field of psychiatry the facilities are grossly inadequate. Consequently, we suspect the traditional healing agencies are performing important social functions. However, we have cautioned that with certain illnesses the traditional healing may be harmful, in the sense of spreading infection.

A dialogue is necessary between the two medical orientations to find out what really could be the contribution of traditional medical practitioners.

In this direction we suggest interdisciplinary research into the area of traditional medicine, to find out some of the therapeutic claims made by its practitioners.

We would ask at this juncture: where it is found necessary to send a patient to scientific medical institutions, is it also necessary to subject him to the sort of regime which may apply in the industrialized or Western world generally? Is there not a case for employing the principles related to the Ghanaian cultural setting in treating ills? Some answers to these questions will be attempted in the following chapters.

FOOTNOTES

[1]Dorcia A.N. Kisseih, "Developments in Nursing in Ghana", International Journal of Nursing Studies, V (December, 1968), p. 205.

[2]Ibid, p. 206.

[3]Ibid, p. 210.

[4]Ghana Government's Publication, "General Plan for the Development of the Gold Coast" Sessional Paper No. 2 of 1944. It was during the governorship of Sir Allan Burns that the survey was undertaken.

[5]Ghana Government Publication, "The Health Services in Ghana" (1967), pp. 3-47.

[6]Ibid, p. 11.

[7]Ibid, p. 12.

[8]See a foreword to the Ministry of Health Report by the Director of Medical Services, The Health Services in Ghana (Accra: Ministry of Health, 1967).

[9]The two contributing factors of ill-health were: malnutrition and insanitation.

[10]Ghana Government Publication, op. cit., p. 47.

[11]The writer has no data on this. But based on his experience on the pay structure of the Ghanaian medical scale, this is the case. Blishen sees this tendency to be universal. See Bernard R. Blishen, Doctors and Doctrines (Toronto: University of Toronto Press, 1969).

[12]Ibid.

[13]Ibid.

[14]Joseph P. Otchere-Darko, "The Ghana Medical Service" Daily Graphic, (Monday, August 17, 1970), p. 8.

[15]Ibid.

[16]Ibid.

[17]Bernard R. Blishen, op. cit.

[18]A.B. Hollingshead and F.C. Redlich, Social Class and Mental Illness (New York: Wiley and Sons, 1958).

[19]Ibid.

[20]E.L. Koos, The Health of Regionville (New York: Columbia University Press, 1954).

[21]Mark Zborowski, "Cultural Components in Response to Pain", Journal of Social Issues, No. 8, (1952), pp. 16-30.

[22]Ewe is a tribal group found around the Volta region of Ghana.

[23]Fantis is a tribal group found in the central province of Ghana.

[24]Elizabeth Barnes, People in Hospital (New York: MacMillan Company, 1958).

[25]Royal Commission on Health Services, Final Report, Volume 1, (Ottawa: Queen's Printer, 1964), p. 112.

[26]Oliver Cope and Jerrold Zacharia, Medical Education Reconsidered (Philadelphia: J.B. Lippincott Company, 1966).

[27]Ibid, p. 27.

[28]Abraham Flexner, Medical Education in the United States and Canada (A report to the Carnegie Foundation for the advancement of teaching: Bulletin No. 4, New York, 1910), p. 325.

[29]The Health Services in Ghana, Ghana Government, Ministry of Health Publication (1969), p. 7.

[30]Ibid, p. 7.

[31]Ibid, p. 8.

[32]Ibid.

[33]Ibid.

[34]Joseph P. Otchere-Darko, op. cit., p. 8.

[35]The Health Services in Ghana, op. cit.

[36]Rae Chittick, "Post-Basic Nursing in the University of Ghana", International Journal of Nursing Studies, Vol. X, (February, 1965), pp. 39-41.

[37]Helen K. Mussallem, Nursing Education in Canada (Ottawa: Queen's Printer, 1965).

[38]Literally the doctors hand maid.

[39]To become members of the medical therapeutic team.

[40]A.M. Carr-Saunders and P.A. Wilson, The Professions (London: Frank Cass, 1964).

[41]Rae Chittick, op. cit.

[42]Helen K. Mussallem, op. cit.

[43]H.S. Becker and J. Carper, "The Elements of Identification with an Occupation", American Sociological Review, Volume 21, No. 3, (June, 1956), pp. 341-347.

[44]Ibid, p. 347

[45]Ibid.

[46]A.M. Carr-Saunders and P.A. Wilson, op. cit.

[47]Abraham Flexner, op. cit.

[48]Maurice King, Medical Care (London: Oxford University Press, 1966).

[49]C. Kerr, Industrialism and Industrial Man (New York: McGraw Hill, 1968).

[50]From the authors personal experience with the system; further research is needed to study this process of adjusting to the industrial and technological system.

[51]E.F.B. Forster, "Short Psychiatric Review from Ghana" (1970). Unpublished manuscript, p. 7. Dr. Forster is now a Psychiatrist in Accra, Ghana for the Ministry of Health.

[52]Ibid.

[53]Ibid.

[54]Gunnar Myrdal, Asian Drama: An Inquiry into the Poverty of Nations (New York: Pantheon, 1968), pp. 1531-1619.

CHAPTER 6

THE EFFECTS OF SCIENTIFIC MEDICINE ON THE SOCIAL SYSTEM

I. Introduction

In the preceding chapter we have indicated that in a developing nation such as Ghana, the necessity is for health planners to emphasize the preventive aspect of scientific medicine. The basis of our assertion was derived from the fact that insanitary conditions and malnutrition loom large throughout the length and breadth of the country, especially in the rural areas.

In this chapter we are concerned with the effects of scientific medicine on the social system. We are concerned with how the people in Ghana have been affected by scientific medicine (both in the preventive and the curative aspects).

Specifically we shall discuss these topics: the Government of Ghana policy towards preventive medicine, methods used in health education, the penetration model, the usage of scientific medical facilities, and the dilemma posed by the co-existence of the two medical systems (traditional and scientific).

II. The Government Health Policy

This section is a contribution for our understanding to how health programs are implemented in Ghana by the various agencies of the Government.[1] The government's health policy has placed high priority

on public health education. It has machinery for ensuring that health services are developed through the cooperation of the central government and such agencies as the municipal and the local authorities at the community level.

Interest in community studies as a social phenomenon is in some respects as old as humanity. How men organize themselves for living together through time was a main concern to Plato in his exploration of leadership and stratification in The Republic, and to Aristotle in his Politics. The classical tradition of political thought shows a steady absorption in the problem of order and the discovery of consensus for collective action. Early sociological theorists, like Durkheim, probed the forms of interdependence in organized society and the nature of collective images binding men together. Freud in his seminal contributions to our knowledge of behavior was captivated not only by the labyrinth of interior mental life, but by the way individual desire is accommodated to the necessities of a group existence.

Sociologists have taken a keen interest in the way particular communities are governed, in the way people distributed themselves territorially and interacted with one another to create an ongoing collective pattern.

What patterns of community organization promote an effective health program and stimulate action addressed to those needs? Although it is unrealistic to expect that any single factor or any single chain of events will constitute a magic key to the implementation of health programs, given the broad variety in community size, region, structure,

and health profile.

Our analysis will consider two major sets of interacting factors that must be understood in terms of the health education programs. The first of these has focused on the context of the community: what sort of community framework existed at the study's inception? What is the character of community leadership and past experience in solving problems? What are the apparent crucial health needs? The second range of factors embraces activities that are part of the health study itself: who initiated the study? How was it organized and led? What was the nature of community involvement?

As a social technique, community health studies rest on the premise that local action will be more effective if substantial number of persons - especially leaders in other community affairs, can be involved in assessing health conditions and setting strategies for attack upon critical problems. There is good reason to believe that wide spread voluntary efforts are essential to improve levels of public health programs. This belief is based on the fact that the prominent health problems in Ghana - insanitary conditions and social organization of medical care - do not lend themselves to easy solution. Further, evidence from social psychological research[2] indicates quite persuasively that people are more likely to sympathize with actions they have had some part in devising than with actions imposed arbitrarily from without. Thus the Ghanaian Ministry of Health, the coordinating body of health education programs has stimulated communities to get involved in initiating their own health programs. Coordinators of

health education are provided by the government. But the chance that the coordinator of health education will be effective in his role, and hence that the study will have maximum yield, appears to depend on several things: his personal qualities; his professional experience; his position in the community structure; his degree of meaningful engagement with the aims of the project. Above all, committee members must be made to feel an integral part of an ongoing enterprise, an enterprise that by informal discussion, employment of mass media, and other means comes to seem a matter of widespread community interest.

One of the principal issues in the organization of a health education program concerns the way in which various elements of local leadership may be recruited to the program. What representation of the various types and levels of leadership structure is most desirable? What is the appropriate stage in the study process for their participation? In which sectors of the total format of the program can lay leadership be most effectively encouraged? Answers to such questions must be modified by the nature of the study itself, the characteristics of differing local leadership groups, and the specific properties of a given community. It should be plain that there is no single formula for leadership involvement in community health action. We can, nevertheless, gain significant information (in a future fieldwork study), about which local leaders actually did participate in health programs, how they participated, and the extent to which the leadership cadre of a given study reflects the reported leadership structure of the community as a whole. Let us now examine some of the specifics of the governmental

health program.

The National Institute of Health and Medical Research has been created by the Government to undertake research into health needs of the people under specific environmental conditions.[3] The Research Institute serves as the scientific arm of the health services, to make scientific medical help accessible to the entire population. In order to achieve this objective it studies the specific health problems of all rural and urban areas to be able to deal with them in the community and its families. These agencies participate in the community development by giving expert knowledge to the people; such knowledge covers the areas from food habits to personal hygiene and the prevention of preventible diseases.

The success of the government health plan obviously needs the cooperation of the community so at every level of its implementation the health officials make it their explicit duty to get the people who "matter" in the society to be involved at their level of understanding. Also attempts are made by the health officials to get the cooperation of other departments such as Social Welfare and Community Development, Food and Nutrition Board, the Ministry of Education, Ministry of Labour, Ministry of Housing, the Health Inspectorate staff and the Health Education Service in an effort to make it effective.

At other periods National Health Week Campaigns are called into being, during which time the health workers as well as the related departments make an attempt to illustrate to the communities the effectiveness of scientific medical practices in eradicating preventible

diseases. Health films, cooking lessons and plays are presented in many areas of the country to make the villagers see in a concrete way the benefits which may come about in adopting new practices.

Without the cooperation and consent of the community leaders (local chiefs, traditional elders, church leaders, school teachers, to name only a few) the governmental health education policy implementation is doomed to failure. Thus cooperative efforts on the part of the health educators and the local community is deemed both expedient and necessary.

The newly formed family planning association has recognized this fact. It has installed local leaders as heads of family planning agencies within the municipalities and the local communities. Through the participation of local leadership, family planning agencies have been established in many parts of the country. It is however, too early to assess the effectiveness of these agencies. The point to be remembered in this regard is that once local leaders are made to understand and to be involved in a new program it is more likely that the new program will be accepted with a minimum of opposition.

It is worth remarking that, although the effect of this work will gradually show on the population, it is only when a rigorous registration system is developed and specific statistics are available that the full effect of the policy implemented by the Government can be adequately assessed.

III. Methods of Health Education: Implications for Scientific Medicine

Health education employs the scientific method in which the

general public are made aware of the processes involved through which disease-causing organism may attack man. In this regard it is incumbent upon the planners of public health education to employ public health nurses and community nurses to educate the public about the necessity of keeping both their homes and the total environment in a clean condition. It is to be remembered in this regard that the average Ghanaian, by custom, takes pride in attending to his personal hygiene but does not see the necessity to keep his environment in a clean condition. This stems from the fact that the ancestral spirits and the family gods are expected to take care of their health; so they do not relate the causation of illness to the insanitary environment. The type of education necessary to break down this belief system of the traditional people is through face to face contact with health personnel. Each confrontation is expected to be a learning experience in itself.

In this respect, inter-departmental approaches are also desirable in which members of various government agencies will pool their resources and ideas.

For the information to reach the people, it goes without saying that the local living conditions need to be taken into consideration. Such factors include food habits, local customs, their taboos and language difficulties. If these factors are ignored the health education policy may not be effectively implemented. For example, it is only through the utilization of the language they understand that rapport may be established between the health authorities and the local population, in order to uproot old habits. As with all aspects of

introducing a new idea or technology into a different culture there must be an awareness of the question whether a specific idea or behavior would fit into the local situation or whether it is the special product of the configuration of a specific culture.

One aspect of local involvement is the use of various audio-visual aids, evidence comes from Samarasinghe.[4] His observation of the health projects in various communities suggests that local leaders are appointed to serve on the local health committees and that in these rural communities the people take the advice of their lineage elders. This being the case, if the local leaders are convinced of the effectiveness of the scientific medical education they can convince and/or supervise their respective lineage members in the ways of scientific medicine. As pointed out by Samarasinghe[5] the local health leaders appreciate the use of the audio-visual aids because at the concrete level they see the "benefits" to be derived from living, sleeping, eating and drinking in a clean sanitary environment.

The success of any local health program is intimately related to the prevailing socio-economic conditions of the time. Furthermore, health education is best able to influence people who themselves have a scientific background, since it is based fundamentally on scientific knowledge. The advantage of literacy to the work of health education can hardly be exaggerated.

The point we again want to emphasize is that as a first step in the penetration model of scientific medical programs, a thorough understanding of the community in which the project is to be carried out

is necessary. We regard a disgnosis of the existing situation as a prerequisite of planning, and this entails a complete study of the community with respect to its social structure, its social and economic background, and particularly its cultural configuration and the existing patterns of community organizations. The latter may serve as important guides in exploring channels for the implementation of the health program.

One should not pretend to have a monopoly on expert knowledge. In this context, rural life should be respected and should not attempt to impose any "imported" superstructure so to speak, on the existing one. To be really effective therefore, health programs should evolve within the framework of each society's own culture.

Borrowing is always selective. If scientific medicine is to find acceptance in another culture it must have utility, compatibility, and meaning in the adopting culture. What is more important is it must lie within the area of culture where change is acceptable.

In this regard the urban centers are more receptive to broader areas of change. These centers accommodate a heterogeneous group of individuals who have migrated from the rural areas in search of a new way of life. In the urban centers the characteristics of the migrants are somewhat different from the rural population. The difference lies in the level of education, age and sex ratio.[6] Many of the migrants have gone through some form of formal education.

An aspect of formal education process is the inculcation of new ideas, such that those who have been through the process are more receptive to new ideas.[7] The school leavers have been taught to

develop the scientific approach, to question and to enquire. They have been brought up to question the existing traditional system. They have been brought up to the level in which they are ready to experiment with new ways of living. This is a crucial point because in traditional societies with the advent of formal education, many of the school leavers we have indicated have become "strangers" within their old environment.[8] What one learns is the school system does not prepare the individual to accept the traditional way of life, rather it alienates the individual from the traditional setting. The foundations of the traditional social life are shaken by the formal educational system, so to speak; because the school system does not take into consideration the needs of the traditional society. Rather there is an imposition of new cultural artifacts on the existing social system. In accepting the need of public health education in the cities and the main towns of Ghana, it will be expected that the surrounding villages will also be touched by the benefits to be derived from living in clean sanitary environments. As the urban areas are the ideological brokers, so to speak, the demonstration effects of scientific medicine will penetrate to the villages and/or the surrounding communities.

We shall carry our discussion to the curative aspect of scientific medicine to show that scientific medicine has gained acceptance into many parts of the country.

IV. Usage of Scientific Medical Facilities

This section will show the extent to which the various levels of

the Ghanaian social structure have taken advantage of the presence of scientific medical facilities. In this context, therefore, we shall draw our material from the following sources: (1) utilization of maternity facilities; (2) the educational background of users of the medical systems; and (3) the distribution of patients who were treated in an Accra hospital during the period 1954 and 1967.

In Table 6.1 there is an indication that pregnant women from both rural and urban settings are making use of the facilities of scientific medicine, for consultation and delivery purposes. Women in the rural areas are also taking advantage of the scientific medical facilities though not in significant numbers. But here other factors could play a significant role although the necessary data were unobtainable.

Why go to an impersonal scientific medical institution to have a child when this process of delivery has been done for years in the rural areas? The rural women would be expected to use the facilities of scientific medicine because they have been convinced by its adequacy. Relative to the section under rural-urban migration (see Chapter 4) we did point out that many of the rural people in Ghana have been touched by the demonstration effect of urban living. Furthermore many of the rural families have skilled men who work in the urban areas. If these urban dwellers are convinced about the services, then it will not be surprising to expect them to influence rural kin. All this would seem to suggest that rural women who go to the urban areas to seek medical attention in this context are convinced of the advantages of the service

Table 6.1

Distribution of 2674 Female Maternity In-Patients by

Residence - Five Regional Hospitals

January to December 1966

Residence of Patient		Korle Bu	Cape Coast	S.di	D'dua	Ksi.	Total
Same Region as that of the hospital	(same urban areas as hospital	851 (93.20%)	198 (61.30%)	390 (90.91%)	187 (77.59%)	500 (65.88%)	2126 (79.51%)
	(Different urban areas as hospital	5 (0.54%)	39 (12.07%)	9 (2.10%)	3 (1.24%)	17 (2.24%)	73 (2.73%)
	(Rural area	1 (0.11%)	78 (24.15%)	20 (4.66%)	50 (20.75%)	223 (29.38%)	372 (13.91%)
Region other than that of the hospital	(Urban area	33 (3.25%)	5 (1.55%)	9 (2.10%)	1 (0.44%)	7 (0.92%)	55 (2.06%)
	(Rural area	32 (3.10%)	3 (0.93%	1 (0.23%)	-	12 (1.58%)	48 (1.80%)
Total		922 (100.00%)	323 (100.00%)	429 (100.00%)	241 (100.00%)	759 (100.00%)	2674 (100.00%)

Source: Ministry of Health. Medical Statistical Report No. 1, Ghana Government Publication, 1967, p. 9.

they will receive.

There is yet another way to interprete the data: since there are alternative possibilities for these rural women, it would seem to indicate that rural women use the services which given them immediate satisfaction. It is also possible that a rural relative who is not satisfied with the traditional practice in the village can refer the situation to the urban clinic. The point to be remembered in this connection is that rural women are using facilities of scientific medicine because it sustains their levels of implied possibilities.

This is not to suggest that this indicates a breakdown of traditional practice of midwifery. We are only pointing out that with alternative possibilities the rural women seeks whichever service she finds advantageous after "economizing" the risks and uncertainties each entails. We have also indicated two possible explanations: (1) that urban relatives could exert pressure on rural kin to use the services of scientific medicine; (2) that rural women resort to the services of scientific medicine when immediate curative satisfaction has not been met within the traditional situation, but has been in the scientific medical situation. However the influence of various norms will also enter into the determination of an individual's choice of alternatives. The patient is involved constantly in the problems of economizing in the sense that she wants what costs or pleasures are to be derived from each action she takes. It may be assumed also that some rural women who come to use the services in the urban areas do so because they have been told to do so at the collective level, that is through community education. Another insight which is related to the usage of scientific

medical facilities comes from Acquah.[9] Her Accra survey was undertaken in 1956 sponsored by the West African Institute of Social and Economic Research. Acquah was the English wife of a Ghanaian civil servant, the Director of Social Welfare in Accra, and had a first-hand knowledge of the Ghanaian way of life. The methodology utilized by Acquah was the field interviewing technique (in which she employed Ghanaian field assistants) and questionnaires. The only other urban social survey which has been undertaken in Ghana up to the time of Acquah's studies was done by Busia in 1948. Busia's was the pioneer study of the urban area of Sekondi-Takoradi.[10]

Using a sample of 325 males and 176 females Acquah related the educational background of her subjects to treatment they sought when ill. As shown in Table 6.2, out of the total sample of 501, 93 percent, sought only scientific treatment when ill; 4 percent sought treatment solely from traditional healers. We infer from Acquah's sample, though small for an adequate generalization, that the usage of scientific medical facilities is not restricted only to educated persons. Patients with no formal schooling take advantage of the services of scientific medicine. For example out of a total of 118 persons with no formal education, 94 of them use only the services of scientific medicine when ill. This is a surprisingly high proportion of the illiterate members of Acquah's sample.

While we have argued that the young and the educated, because of their prior exposure to scientific rationale are expected to use the new institution, data cited in the last few pages show that the effects of scientific medical institutions are spreading, to include such

elements of the Ghanaian population as the rural, the women and the illiterate.

Table 6.2

Educational Background of 325 Males and 176 Females in Relation to Treatment Sought by Them When Ill

1956

Scientific Medicine Only			Traditional Medicine Only		Both Scientific & Traditional Medicine		
Background	Male	Female	Male	Female	Male	Female	Total
No Schooling	32	62	9	6	3	6	118
Primary School	14	11	-	-	4	-	29
Middle School	193	71	1	1	6	-	272
Technical & Commercial	5	-	-	-	-	-	5
Secondary & Teacher Training	50	18	-	-	1	-	69
University or equivalent	7	1	-	-	-	-	8
Total	301	163	10	7	14	6	501

Source: Ione Acquah, Accra Survey (London: University Press, 1956), p. 122.

It is difficult at this juncture to estimate how many sick persons would frequent the services of the traditional medicine man. But a future field study could provide some significant data. The significance of this exercise would help to throw some light on the competitive nature

of the coexistence of the two medical systems in their endeavour to treat specific ills. The point to be remembered in this regard is that the average Ghanaian who perhaps frequents the traditional medicine man may distort his answers because he "knows" that going to traditional practitioners is not the "right" thing to do. The writer has observed instances of it during observational studies, while interviewing patients as a civil servant in the Ministry of Health Ghana. The Christian teachings as well as formal education condemn the traditional healing practices.[11] Consequently, adherents, both educated and uneducated, do not usually admit that they use traditional healing agencies. Acquah makes this point more forcefully:

> "the attitude of the more educated class is that, outwardly at least, one should show a preference for the scientific methods of treatment, and persons in the employ of Government, the local authority and some of the large private firms must, but nature of their employment, attend the hospital when they are ill".[12]

Acquah goes on to claim that:

> ".....where the individual wishes to be successful in trade or in other field work, in examinations, in a law-suit or for barrenness, impotency, or some other desired purpose.....also if the patient is not quickly cured at the scientific medical center.....he goes to traditional practice".[13]

The old belief that people do not become afflicted with illness and/or death except as a result of the evil influences of others of of their own eveil deeds or thoughts, is still strongly held. Consequently in addition to seeking scientific medicine, many would be expected to resort also to traditional medicine for some protection to help them

ward off illness or evil influence. Jahoda[14] also suggests that the limited utility of scientific medicine leaves open a relatively permanent area of chronic nonincapacitating ills as well as "areas of stress of modern living" within which traditional healers thrive and would continue in a complementary structural position. This point substantiates that made earlier by Forster (see Chapter 5) that there are not enough facilities for the care of psychological ills. Implicit in this assertion is the notion that the technology in this area is vague.

Another example of the usage of scientific medicine comes from Acquah.[15] In Table 6.3 are comparative figures from Korle Bu Hospital for patients treated in the years 1954 and 1967. There is a clear indication that hospital attendance has increased. The majority of people in Accra appear to avail themselves of modern forms of scientific medicine either exclusively or in conjunction with traditional treatment. Such modern treatment is available in Government hospitals, the clinics of private qualified doctors, in infant welfare clinics and in the homes of qualified midwives.

Our analysis is indicative of three points: (1) there is a steady increase in the number of scientific medical institutions which have been built in the country in recent years; (2) there is an increase in both the in-patient and the out-patient consultation at the hospitals; and (3) the government health policy carries legislative sanctions against those who willingly refuse to cooperate with the health plan. In this respect there is emphasis on scientific enquiry, which in turn puts pressure on adherence to traditional beliefs.

Table 6.3

Accra, Korle Bu Hospital: Patients Treated

1954 and 1967

Year	In-Patients			Out-Patients		
	Male	Female	Total	Male	Female	Total
1954	6,510	3,300	9,810	58,883	36,330	95,213
1967	7,743	3,916	11,293	258,293	100,004	358,297

Source: Ione Acquah. Accra Survey, 1956. The 1967 figures from Health Statistics, Ministry of Health, Ghana, 1967

Scientific medical practices are steadily infiltrating into the traditional social system. However the limited facilities of scientific medicine, particularly in terms of mental health and the ineffectiveness of scientific medicine in treating some diseases, leaves open a relatively permanent area of chronic nonincapacitating ills within which a traditional system of medical care can thrive and continue in a complementary structural role. Thus the general tenor in the country would be likely to disvalue traditional medical practices in areas where the disease or illness has specific cause detectable by modern technological applicances except in insulated reference groups. In the field of mental illness such evidence is not forthcoming.

No matter how isolated their lives are from the mainstream of the Ghanaian society, it probably would be difficult for rural inhabitants to escape the feeling that traditional medical attitudes are not quite up to the times. Such a situation of disequilibrium would put these people under pressure to seek some reconciliation of these

values. Mechanisms for coping with this sort of value conflict are for the individual to avoid contact with the wider social system by isolating himself within his traditional group or to insulate the two value systems from each other in his every day life, utilizing each in a specific, non-overlapping situation.[16]

V. The Dilemma

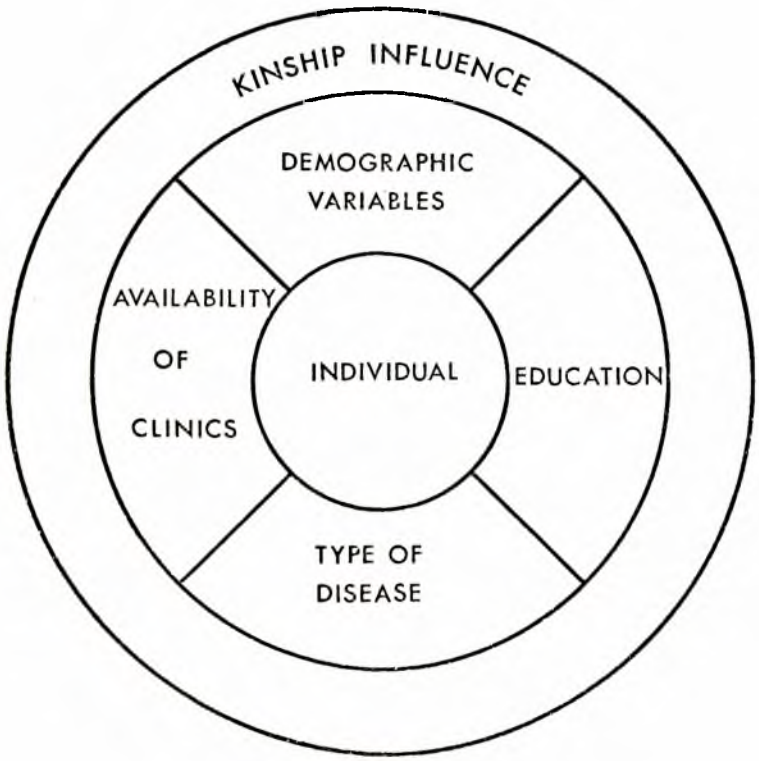
From the population's standpoint, two alternative medical approaches to the treatment of ill-health have now become available. In keeping with man's pragmatic pursuit, which is characteristic of so many facets of life, the individual might show a willingness to take what each has to offer. He might accept each to the degree that its use appears to yield favorable results, but he has little insight into the empirical basis of either system. Put differently, the individual's evaluations of the two medical approaches are fixed upon effects, as he is unclear about causes, beyond those which his world view enables him to deduce.

There are other relevant factors necessary to the understanding of the interplay between traditional and scientific medical systems. Although it would seem that there is a tendency for the two therapeutic approaches to divide between them the task of treating chronic/psychosomatic and critical ills, other social and economic variables do influence the paths through which scientific medical theory enters the traditional social system. The individual, it would seem, is influenced by some of the following factors which may need testing at a future date

in a fieldwork study in Ghana: rural-urban living, extent of formal education, the availability of a clinic or relevant medical technology, type or nature of the disease, such demographic variables as age and sex, and lastly, but by no means the least the extent and degree of extended kinship influence. Put diagramatically, we would suggest that these variables are some of the modifiers.

Diagram 6.1

Concentric Model



The idea of this concentric model is to provide an awareness of some of the social-psychological variables which influence the individual in his attempt to seek medical attention in this contemporary setting. It will be a worthwhile experience to subject some of these variables to rigorous examination in a future fieldwork study in order to explicate the nature of some of the specific relationships as well as to investigate the determinants of the pattern.

At present there is a clear indication of a trend: more people will tend to use the facilities and the therapeutic approaches of scientific medicine. However, the traditional medicine man if he keeps abreast with the times, may have a part to play. His effectiveness is obviously in his ability to understand the patient, emphasizing the tremendous psychotherapeutic potential of the medicine man. Ackerknecht[17], Kempf[18], Lambo[19], and Gustav Jahoda[20] indicate in their various studies that there is a kind of psychological safety valve in the medical approaches of the traditional medicine man, which are effective where the patient is under very strong psychic pressures and anxieties.

The expanding literature on transcultural psychiatry tend to place emphasis on the role of the traditional medicine men in their capability to relieve the patients of their fears and anxieties.[21] In the field of mental illness we have suggested that scientific medicine has not fully developed specific techniques as yet to cope with the situation. It may be relevant to the discussion to look at the field of psychiatry for evidence of vaguely define technology. It seems that in this area scientific medical theory per se virtually collapses and as a result the area plays into the hands of the traditional

medical practitioners.

In its present form the field of psychiatry is a relatively young and imprecise science and has not found as yet a workable definition of itself. To begin with, it is not really a special field but a broad area, utilizing concepts from philosophy, sociology, physics, chemistry, religion, and art, to name only a few.

The point is, the uncertain field of psychiatry has had a contradictory beginning. It developed a wide variety of equally contradictory ways of treating its patients. Treatment, for an example, is given by a wide variety of medical personnel prominent among them are psychiatrists, psychiatric nurses, psychoanalysts, psychologists, social workers, trained counsellors and all the combinations thereof. Patients are being treated singly and/or in groups, as family units or in groups of families; and they are being given psychoanalysis, drugs, electric shocks, hypnosis or simply advice and reassurance.

The variety of psychiatric experience today, therefore, is enormous. Given the wide range of activities in this area, it is useless to try to find a workable definition to cover the whole broad spectrum. It is more profitable to describe how the field generally handles those it treats.

The background of almost any patient population is one of heterogeneity. They come from all ranks and stations, from rural, urban areas, of both literate and illiterate categories. Some have obvious immediate problems and some do not have, some act in a bizarre way, but many do not, some are functioning successfully in the world and some are not. Whatever their troubles, almost all these people come to seek

medical aid with the patient's natural expectation that the doctor is able to repair the damage, but the treatment is seldom specific.

Psychiatrists do not generally locate and remove mental gallstones or even diagnose and cure specific emotional infections. The only psychiatric treatments that produce definite, predetermined results are drugs and other physical treatment and even here, there are strong differences of opinion concerning how and when they should be used. In analysis however, sudden insight on the part of the therapists may bring improvement but statistically in terms of the admission and the discharge rates this is insignificant. Furthermore psychiatric recovery is generally a slow and invisible process. Studies[22] conducted in this area indicate that treatment even with its selected clientele succeeds only some of the time, a rate not distinguishable from spontaneous recovery rates after no treatment at all. Psychoanalysis, for example has come under attack from those who want to treat patients on a large scale basis or within a relatively short time. Psychoanalysis is not a straight-line process, with the patient tossing out whatever comes into his head and the analyst explaining what it means but a constant shuttline back and forth by both doctor and patient between expression and interpretation. The ground rules for this exploration were evolved by Freud from his own observation that certain basic formations are common to all men's minds.

But a limitation of psychoanalysis is that a confrontation with the unconscious mind is not always feasible or even desirable. It is uncertain science. The difference between psychiatric medicine and

traditional medical practice is not one of kind but of degree. Although technology is vague it would seem that traditional medicine is functionally effective. The traditional medicine man at least shares the same world view with his patient.

In this context therefore it may be pointed out that scientific medical theory which finds specific causes before treatment is given, cannot always be applied here. The ways in which the practitioners of scientific medicine operate in this field, we would suggest, leaves doubt in the minds of the sick who seek aid in this area.

If this is so then it would be fair to suggest that so long as the technology is ineffective and perhaps bizarre, traditional medicine or something functionally equivalent to it will not be circumscribed.

Let us remind ourselves at this point that practitioners of scientific medicine, though long blinded to such things by the success of the germ theory of disease, more and more realize that disturbances in the individuals social relations can in fact contribute to a whole series of illnesses, ranging from those commonly assumed to be of psychotic nature to primary organic diseases.

In making this rediscovery however, the scientific medical practitioners, especially in psychiatry, have tended to relate it with the so-called "pressures of modern living", imagining traditional societies to be psychological paradises in which psychiatric diseases were thought to be minimal. This viewpoint has never been put to adequate testing.

However medical theory in the field of traditional medicine views disease in the light of social causation. In this context therefore

when one is afflicted with an illness and the traditonal medical practitioner is brought to the picture he performs what Turner has termed "social analysis".[23] These are the social-causal explanations of all those ailments which get into the hands of traditional medicine men. Though we have no statistics on such cases, judging from recent symposium on traditional medicine, many social scientists and some practitioners of scientific medicine are now generally convinced of the place of traditional medical insights in the field of psychiatric ills.[24] Accounts of cases which the traditional medicine men deal with suggest that most fall into the psychiatric or psychosomatic category (mind body diseases, definitely marked by bodily changes but "touched off" or exacerbated by mental stress).

This category includes gastric and duodenal ulcers, migraine, dermatitis, limb pains and certain kinds of paralysis, hypertension, as well as many doubtful or obscure causes of agonizing and several potentially lethal complaints. Turner points out that many scientific medical men nowadays tend to agree that effective treatment of this kind of illness will eventually have to include some sort of diagnosis of and attempt to combat stress-producing disturbances in the patient's social life.

When tension arises between individuals engaged in a particular activity, it tends to color a large sector of the extended kinship life. As suggested earlier (see Chapter 2) almost all their activities in the traditional area involve many relatives. In societies of this type, a person performs a whole series of activities with the same set of partners. Being caught up in hostilities or a breach of social norm we

have suggested is particularly crushing since it is often extremely hard for people to move out of the field in which the trouble arose.

The point we make here is if life in a traditional setting contains sources of mental stress sufficient to cause or exacerbate a wide range of sicknesses, so too does life in an urban environment. Hence the need to approach traditional medical theories of the social causation of sickness with respect. Such respect and readiness to learn is, we suggest, particularly appropriate with regard to what is commonly known as psychosomatic medicine.

From the ongoing discussion it should at least be clear that one commonly accepted way of contrasting traditional medical thought with scientific thought is misleading. We are thinking here of the contrast between traditional thinking about medicine as nonempirical and scientific thought as empirical. The contrast is misleading in the first place because traditional medical theory is no more nor less interested in the natural causes of things than is the theoretical paradigm of the sciences. Indeed the intellectual function of its supernatural beings is the extension of people's vision of natural causes. The contrast is misleading in the second place because traditional medical theory does more than postulate causal connections that bear no relation to experience. If some of the connections it postulates are almost certainly real ones, then it grasps reality as it is defined in the traditional social setting. It is not claimed here that traditional thought is a variety of scientific thought; but in certain crucial respects, the two kinds of thought are related to experience in quite different ways.

We may raise two questions here: on what kinds of occasion do people ignore the spirit world, and on what kind of occasion do they attend to it? Radcliffe Brown[25] and others after him have claimed that people think in terms of the spirit world when they are confronted with the bizarre, the unusual of the uncanny. They think this way in the face of anxiety provoking situations, or whenever they are faced with any emotionally charged situations, and particularly when major crises threaten the very fabric of their society. So it is hard to make a clear cut distinction when men begin to think in "objective" and/or "subjective" ways. Hsu[26] claims that even in science oriented settings men do not always think "objectively". The Weberian thought on this point is that the non-rational elements are essential in motivating people to action. Weber[27] was not merely interested with the phenomenological description of these elements; rather he placed the non-rational elements, at least incipiently, within the context of a general theory of action.

VI. Summary

In Ghana it would be safe to suggest that the traditional practitioners will fade away (perhaps in the urban areas) in their original form. They will be able to persist in the contemporary setting only if they begin to adopt and to accommodate the new trend of thoughts by modifying their practices to suit the present population. As more hospitals and health centers are located in the urban centers of Ghana it would be expected that the urban population would be more exposed to

the world view of scientific medical theory.

In recapitulation, the traditional social setting was such that it allowed members of a given social unit to perform almost all forms of activities together in a face to face interactive situation.

Presently all members of the extended family do not reside in the same abode or for that matter participate in the same round of events and activities. Family life is at present segmented. Some of the members have moved to urban centers and towns, in search of the "bright lights".

Some of the old structures which gave credence to traditional medical theory are breaking down in the face of the new changes which have come about. These changes indicate the new direction of events; this is the age in which old institutional structures are being questioned, the age in which the educated, the urban dwellers and the young do not accept the traditional medical theory in its entirety. They subject ideas both of the old and the new to shifting analysis in order to examine them in terms of the resulting satisfaction.

However, in the face of the Government's drive against diseases as well as the necessity for keeping the environment clean people are being made increasingly aware of scientific medicine's value as a means of combatting diseases. The overall trend would appear on the basis of data presented to be moving toward adoption of scientific therapy in combating acute illness.

But when people are faced with uncertainties there are both rural and urban dwellers who fall back on traditional medicine. Acquah's, Jahoda's and Busia's studies tend to emphasize this point.

Maladies manifesting clearly and predominantly psychiatric characteristics prove less amenable to conscientious efforts at producing changes using the therapeutic orientation of scientific medicine. It can also be inferred from data that the more formal education a person has, the greater his awareness of the existence and the utility of scientific medicine, if only because formal schooling tends to inculcate ideas on behalf of scientific medicine.

FOOTNOTES

[1]The Health Services in Ghana, Ministry of Health Publication, Accra: Ghana Government Printing Department (1967), p. 8.

[2]Stanley H. King, "Social Psychological Factors in Illness" in Howard E. Freeman et al., (eds.), Handbook of Medical Sociology (New Jersey: Prentice Hall, 1963), p. 112.

[3]Annual Report of the Medical Services of Ghana, Accra: Ghana Government Printing Department (1967), pp. 1-9.

[4]C.E.P. Samarasinghe, "Health Education in Ghana", The Ghanaian Nurse, VI, No. 1 (February, 1969), pp. 13-18.

[5]Ibid, p. 13.

[6]The Health Services in Ghana, op. cit., p. 1.

[7]W. Birmingham et al., A Study of Contemporary Ghana (London: Oxford University Press, 1967). See especially the chapter on rural-urban migrants.

[8]Ibid.

[9]Ione Acquah, Accra Survey (London: University of London Press, 1958).

[10]K.A. Busia, Social Survey of Sekondi-Takoradi (London: African Institute, 1956), pp. 74-85.

[11]Ione Acquah, op. cit.

[12]Ibid, p. 75.

[13]Ibid, p. 112.

[14]Gustav Jahoda, "Traditional Healers and Other Institutions Concerned with Mental Illness in Ghana", International Journal of Social Psychiatry, VII (1961), pp. 245-268.

[15]Ione Acquah, op. cit., p. 112.

[16]Judith T. Shuval, Social Functions of Medical Practice (San Francisco: Jossey Bass, 1970). See especially chapter 17.

[17]Erwin H. Ackerknecht, "Problems of Primitive Medicine", Bulletin of the History of Medicine, XI (January, 1942), p. 513.

[18]K. Kempt, "Psychology of Primitive Medicine", Bulletin of the History of Medicine, XII (December, 1943), p. 516.

[19]T.A. Lambo, "Neurophychiatric Observations in Western Region of Nigeria", British Medical Journal, No. 1388 (1966), p. 15.

[20]Gustav Jahoda, op. cit.

[21]Ibid.

[22]E. Cummings, Ego and Milieu (New York: MacMillan Co., 1968).

[23]Victor Turner, The Ritual Process (Chicago: Aldine Publishing Company, 1969).

[24]Ibid.

[25]A.R. Radcliffe-Brown, The Andaman Islanders (Glencoe, Illinois: The Free Press, 1948).

[26]F.L.K. Hsu, Religion Science and Human Crisis (London: Routledge and Kegan Paul, 1952).

[27]Max Weber, The Theory of Social and Economic Organization (New York: Free Press, 1952), pp. 18-27.

CHAPTER 7

THE COMPETING SYSTEMS

I. Introduction

In this chapter we are concerned with the interplay between traditional and scientific medicine including some of the unintended social consequences of scientific medicine, the current practice of traditional medicine and cross cultural experience relating to the co-existence of two medical systems, traditional and scientific.

II. Interplay Between Traditional and Scientific Medical Systems

The analysis to this point assumes that the dominant Ghanaian value orientation at present would tend to emphasize scientific medicine, its attitude towards rationality and empiricism and would therefore put a certain pressure on people adhering to traditional medical beliefs and practices.[1] Except within isolated reference groups, the general opinion, we suspect, is likely to devalue such traditional practices. This would lead us to expect a certain conflict among people with a positive orientation towards traditional medical practice.

It is also worth noting that people can maintain a parallel set of orientations and in fact may be positively oriented both to traditional and scientific medical practices.[2] In fact utilizing a sample from Accra, Acquah[3] found this to be the case. These medical

systems are by no means mutually exclusive. The functional scope of each system is largely determined by its ability to get results in cases of il-ness and/or uncertainty. It would be expected then that in keeping with the pragmatic spirit characteristic of so many aspects of life, the sick person would show a willingness to take what each medical practice has to offer, accepting each practice to the degree that its usage appears to yield favorable results.

Maladies manifesting predominantly psychosomatic characteristics no doubt prove less susceptible to therapeutic efforts at the present level of knowledge in scientific medicine. We suggest that were it not for the extensive preliminary screening, mental hospitals in Ghana would be overwhelmed by a flood of cases with whom the staff as well as the present facilities could not possibly deal.[4] The facts of the situation in Ghana point in this direction. On the basis of this we would argue that any campaign of enlightenment ought to be cautious in condemning traditional medical practice, because traditional practitioner's perform an extremely important social function in this area.

However it would appear that the spread of scientific medicine is achieved at the expense of an all-pervasive traditional medicine, the role of which is increasingly circumscribed.

Let us now take a look at some of the unintended social consequences of scientific medicine, then we shall carry our discussion into the area of the current practice of traditional medicine, in order to explicate the present functional role of traditional medicine in the larger society.

III. Unintended Social Consequences of Scientific Medicine

The concept of unintended consequences extends our perspective beyond the question of whether or not the new idea attains its purpose.[5]

On the basis of the health statistics we would claim that scientific medicine has among other factors of social change, brought "benefits" to the Ghanaian society in terms of the remarkable improvement in the health of the people. For example the death rate has declined, the infant mortality rate has been lowered and the expectation of life among the general population has increased. Both the preventive and the curative aspects of scientific medicine have contributed to this effect.[6]

There is improvement of the health of the population and as a result but the balance between the death rate and the birth rate has shifted tremendously since the introduction of scientific medical practices. The death rate has declined but the birth rate has not, thus there has been an increase in the population. This point is worth stressing because of its obvious implications for the society and the provision of social services. As the economy has remained fairly static it is difficult to see how a developing country such as Ghana can meet the needs of its population when for example so many young Ghanaians are annually leaving school from all levels of the formal educational system. With free educational system the economy is burdened with school leavers who cannot find employment.[7] To check this increase in population growth family planning is being strongly advocated (see Chapter 6).

Moreover in the field of infant and maternal mortality, there has been remarkable improvement in the health of the mother and child (see Chapter 5). Accordingly 44.5 per cent of the Ghanaian population are under the age of 15, whereas only 3.2 per cent of the population are over the age of 65, (see Table 7.1). Thus the dependency ratio, in a developing economy such as Ghana, is relatively high, a small working population must support a large proportion of the population, who are unable to work. This is meaningful not only for the national economy but for the individual. A worker is expected to look after many of his relatives. Frequently a worker may find it difficult to make ends meet due to the constant financial pressures exerted on him by his rural relatives.[8] As he derives some measure of comfort from his relatives he is committed, so to speak, to support them.

In his analysis of the Ghanaian unemployment situation, Hodge[9] had claimed that the problem of unemployment among youth in the developing countries has been a matter of urgency for many of the governments in Africa, Asia and Latin America. This situation we attributed to the fact that a high proportion of the population, in the developing countries, is under the age of 15. Cross cultural comparison with the developed countries throws some light on the fact that the population pyramid in the developing countries is "bottom heavy" meaning that the dependent ratio is high. This in itself is an unhealthy sign for the developing countries. How can meagre resources cope with the demands made upon it? It might be added that scientific medicine is a highly cultivated cultural import needing great financial resources to maintain it. How can a developing economy maintain this without a

Table 7.1

Dependency Ratio 1969: Ghana and Selected Other Countries

(Percentages)

Country	Population under 15	Population 15-64	Population over 65	Demographic efficiency* (Sweden = 100)
Ghana	44.5	52.3	3.2	79
Malaya	45.1	52.2	2.7	79
Thailand	42.3	55.3	2.4	83
Ceylon	40.7	57.4	1.9	87
India	39.6	56.8	3.6	86
Venezuela	42.1	55.2	2.7	83
Brazil	41.9	55.7	2.4	84
Argentina	30.9	63.9	5.2	96
U.S.S.R.	34.3	55.2	10.5	83
Japan	30.0	64.2	5.8	97
Australia	30.1	61.5	8.4	93
Canada	33.8	58.6	7.6	88
U.S.A.	31.2	59.5	9.3	90
United Kingdom	22.2	65.9	11.9	99
France	25.6	62.4	12.0	94
Sweden	21.8	66.2	12.0	100

* a ratio of total population to population 15-64 years of age, in Sweden, divided by the same measure for the country concerned.

Source: United Nations Demographic Year Book (1969).

highly efficient labor force?

It is estimated that about 41 per cent of the people in Africa are under 15; 40 per cent are estimated to be under 15 years of age in Latin America as well as in Asia. The most important contributory factor, it is suggested, is the improvement in the areas of environmental sanitation and nutrition which is helping to raise the health standards of these people.

Since a small portion of the people is supporting a large

dependent group, the living standard of the Ghanaian workers will be expected to decline in the face of a more-or-less static economic situation. Unless ways and means are found to keep up with the increase in the birth rate it will further deteriorate. For example, the estimated rate of growth of the population in Ghana is 2.5 per annum;[10] whereas the rate of growth of the economy is about 1.5 per annum.[11]

If we carry this analysis further we would expect that with increased dependency ratio there will be a lowering in standard of living. We would also suspect that with deterioration in the living standard of the workers there will be increased frustration, stress and a possible conflict with relatives, giving rise to more psychosomatic ills. If this is the case, then we would expect that there will be more need for the services of traditional medicine men.

It may be well to remind ourselves that systems of medical care reflect the cultural characteristics of each society. Historical studies in such countries as the United States, England and Germany have illuminated the extent to which the medical systems operating in these countries have been shaped by the dominant social and economic institutions and values in the cultural settings. Social scientists have similarly examined and compared the characteristics of medical care systems in non-industrialized societies. The argument in these orientations is that the rise of scientific, technologically equipped medicine in a relatively short period in developing economies, has produced great problems of stress and conflict in the action taken to apply scientific medicine on a mass basis, and to absorb new knowledge

and techniques into different culturally determined systems of medical care.[12] The sociologist is also interested in the effects of scientific medicine on roles, functions, relationships, and beliefs of those involved. Central, then, to our enquiry of unintended aspects of scientific medicine is the concept of choice in systems of medical care, which has been greatly accentuated by the impact of scientific medicine. First, specialization of scientific medicine is accompanied by an increasing structural division in medical care labor. This has helped to widen the area of choice for the sick person. This sick person, with limited financial resources, would find it difficult to seek a specialist. In the developed nations this point may be overlooked or taken for granted. There is more to choose from in the open market, more options open. More preferences are expected to be expressed in consumer behavior, and there are more alternative routes to diagnosis and treatment. Drugs are, of course, but one example. In Ghana scientific medicine, with emphasis on occupational differentiation and specialized clinics and hospitals, has played a primary part in expanding the areas of choice in medical practice.

In the developed nations, rising standards of living and of mass literacy have led to patterns of consumer behavior in which people are expected to exercise choice, to express preferences, to be more articulate about "rights" and more critical and discriminating in respect to medical standards, quality of care and physician's behavior. The private market, the economist would argue, will not function effectively without a discriminating public. Choice would seem to stimulate dis-

crimination which in turn enlarges choice. These specializations and differentiations would seem to have led to a great increase in the cost of running the practice of scientific medicine.[13] To have a viable medical practice the people in the developing nations will have to pay high taxes to maintain this alternative institution. Could they afford it indefinitely without support from other developed countries? They haven't been able to in the past and possibilities for the future are uncertain. We have suggested (in Chapters 5 and 6) that if emphases are placed on the preventive aspect of scientific health care, it will help to reduce the cost of maintenance.

Ghana today can be viewed as a society in transition. Its population are faced with the problems of adjusting to new institutions. In this vein Ward[14] discusses the significance of an alledged increase in the number of traditional healing agencies specializing in witch-finding. She takes the view that the increase, in the number of the witch-finding cults can be taken as evidence of a widespread rise in the general level of anxiety resulting from rapid social changes. But in a subsequent rejoinder Professor Goody[15] has challenged not only the view that such traditional agencies have in fact been numerous, but also challenged the underlying assumption that rapid social change produces an emotional malaise in the people caught up in it.

We need not enter into the details of the controversy here; only a few comments may be in order to have an idea of the implications of the effects of change. What Goody was pointing out in his paper was a methodological problem. He was arguing that we have no means of evaluating comparative stress, so that statements abut an overall

increase in malaise are necessarily always speculative. One can perhaps sympathize with Goody's attack on Ward's idea that rapid social change leads to anomie (in the Durkheimian sense)[16] although it is doubtful whether many sociologists would really believe this; the problem here is perhaps of a semantic nature. Even if we reject the notion of a drift towards anomie, it does not affect the likelihood that conflicting norms, as suggested by Busia,[17] will exist side by side during the transition phase, so that individuals would lack a firm base for their conduct in various situations. Put differently we suggest here on the basis of the argument that as a result of contemporary changes people will tend to adopt new goals. If these goals are very difficult to achieve it would seem to generate increased anxiety and discontent. Busia would agree with this point.

It is in this sense that in earlier chapters on role of religion was stressed. The essence of the historical review of the place of religion consists in an emphasis on religion as an institutional means of social control. In the last century Durkheim[18] wrote that religious ritual was of primary significance as a mechanism for expressing and reinforcing the sentiments most essential to the institutional integration of the society. This is clearly linked to Malinowski's views[19] of religious ceremonies as a mechanism for reasserting the solidarity of the group or situations which involve severe emotional strain. If we accept the point that one function of religion is fostering social integration, then in time the traditional social system would break down. The new changes in the contemporary setting in Ghana reinforce this orientation.

What in effect we are pointing out is the more successful the practice of scientific medicine becomes, the more demand it would seem to create for certain kinds of traditional practice. The rural-urban migrants are faced with problems of adjustment thus generating some of the stress of urban living. It creates all sorts of psychological problems so vividly described by Ward[20] and Forster.[21] Since there is a lack of facilities to cope with these problems it would be fair to conclude that traditional medicine in its modified form will continue to draw clients from this area of psychological illness.

Let us examine the area of current traditional medical practice, to explore what continuing functions traditional medicine performs in the contemporary setting.

IV. Current Traditional Medical Practice

The central question to be considered is: why is traditional medical practice persisting in Ghana in the face of contemporary social changes? Is it simply a consequence of inadequate facilities? Do structural conditions exist in the present time to give support to current practice of traditional medicine? Before an attempt is made to discuss what has taken place it will be helpful to review some of the factors which have challenged traditional structures.

A. Traditional Cosmology

The world view of the traditional system has been shaken. With the advent of formal education, there is a form of conflict between

the old and the new. The educated and the young tend to look down upon traditional explanatory models of illness. In terms of future projection we would claim that as more and more people are educated through the formal education system, there will be an eclipse of the traditional cosmology. Furthermore as a result of some of the recent social changes the "parental veto"[22] is no longer very powerful: with access to income resources more and more young men are able to move away from parental dominance. Lastly we may subscribe to the view presented by Middleton[23] that traditional cosmology will disappear, not only as a result of the growth of Christian religion or education per se but because of the development of a society in which a large proportion of the day to day activities and relationships are based on impersonality and segmentation.

If these are some of the factors then why is it that traditional medicine is still persisting in the present social situation of Ghana? We shall make an attempt to discuss this issue, describing first the reasons for continue persistence of traditional medical practice, and second, the ways in which it is adapting to the changed conditions of contemporary society.

B. Persistence of Traditional Medical Practice

Traditional medicine has persisted in the area of chronic or psychosomatic ills where scientific medicine has either failed to produce equally good results or has simply ignored the need for systematic attention and research. The functional scope of each medical system has been largely determined by its ability to get results in specific cases of illness.

This is not to argue that scientific medicine is unable to deal with psychosomatic or psychiatric ills. It is to argue that functionally scientific medical aid, in this area, is not specific to the types of disorders. Scientific medical practice is sometimes able to cope with many of the symptoms of mental illness by drug therapy and other medical techniques. The point is however that faced with such chronic ills, complicated with social psychological factors, the sick person may find it more satisfying (in terms of relieving some of the underlying social psychological factors such as fears and anxieties) to approach traditional medicine. As these ills are not specifically treated, in many cases, we would suspect that traditional medicine would draw many such clients. At least it offers social-psychological support, an essential component in sustaining health.[24]

This analysis also suggest that in remote village areas traditional medicine would persist in its original forms. So far as these areas as yet have not been touched by the government's scientific medical program, traditional medicine would continue to serve the local population.

C. Adaptation of Traditional Medical Practice

In looking at adaptation of traditional medical practice we shall be concerned with non-structural, and structural.

In the field of nonstructural adaptation, there are some new-style healers in the contemporary setting who have telephones, visiting cards, waiting rooms, and white overall coats. They have adapted these

modern artifacts of scientific medicine to attract some of the urban patients. These aspects of adapting to the situation give the practitioners or traditional medicine "a modern look". This look we suggest has advertising implications for the users of medicine. In visiting the medicinal shrine of three traditional medical practitioners the author had the opportunity to observe some of these modern aspects of traditional medicine. Jahoda[25] has also pointed out that in many areas, especially near the urban environment, traditional practitioners have exhibited sign boards and plates to indicate to the public what they can offer. The point is that traditional medicine has kept in touch with what is going on in the society and is willing to meet some expectations to become more attractive to clients. Lystad[26] had also claimed that in certain areas, traditional medical practitioners suggest to some of their patients to go to a scientific medical institute to get an injection such as an antibiotic. However, the crucial test of the efficacy of the injection, its potentiality and efficiency lies in the traditional medical theory of magico-religious assumptions from which the practitioner's thinking proceeds.

Acculturation has brought changes in the types of requests the traditional medical practitioner receives from his clients. Clients' expectations have changed and some of these are accommodated by the traditional practice. In terms of the requests made nowadays, Christensen[27] indicates that the usual broad pleas for good health, protection and fecundity are still made. However there has been increasing emphasis on "aids and nostrums" to meet with the needs of the modern society.[28] On the basis of Jahoda's, Lystad's and

Christensen's studies it is clear that the popularity of some of the traditional medical practitioners are based on the reassurance they give to clients, who are possessed by fear and anxieties reflecting an attempt to ameliorate the insecurities prevalent in a society in transition. In a subtle way traditional practitioners provide a certain amount of stability to a people in transition.

Jahoda[29] has studied some of the traditional healers who practice in the Accra-region, and an interesting point about his sample is that among the five participating traditional healing agencies two of the heads were completely illiterate (they could not read or write their own language or the English language), two had attended school for a few years, and one finished an elementary school (an equivalent of grade 7). All were experienced healers, middle-aged, who had been practising for many years. It cannot be claimed that these five were representative of the numerous healers in the region but on the other hand there is no reason to believe that they were particularly unusualy except that some of them have had some form of formal education. Of a total number of 386 patient cases covered by Jahoda, 84 were children below 15. The children were excluded, partly because most of them suffered from a clear-cut physical complaint, and partly because the information available about them was usually "too patchy" to be of much value. The remainder of the sample was composed of 97 women, 65 per cent of whom were illiterates, and 205 men with only 18 per cent illiterates.

Some two-thirds of the literate men were in some form of white-collar employment. Clerical work predominated, but there were also

teachers and salesmen. The rest were mainly skilled artisans, traders and shopkeepers. About two-thirds of the illiterate were fishermen and farmers, with the addition of laborers, house servants and drivers. About half the literate women were also clerks and teachers, the remainder consisting of seamstresses, petty traders and housewives. The bulk of the illiterate women, nearly nine out of every ten were petty traders. Apart from this there was a scattering of farming and crafts; and it is noteworthy that four traditional medical practitioners were to be found among the clients.

In view of the paucity of demographic background material one has to be cautious in drawing conclusions, but a few points stand out. Both the male and female literacy rates correspond broadly to those obtained in a study by Birmingham et al[30] using a random sample of voters. Hence the sex-differential cannot be interpreted as indicating mainly a reluctance on the part of literate women to consult traditional healers; it largely reflects the fact that in the past men had a much better chance of acquiring an education. Responses to the question about reasons for visiting the traditional healer were divided into five broad categories as follows:

(1) Gynaecological and veneral diseases (barrenness repeated miscarriages, disturbed pregnancies or other complaints described more vaguely as "womb trouble"). Both kinds were shown by the frequency with which specific details of magical causation were offered by both healers and clients. (10 per cent of the patients were in this category).

(2) Other physical. This is self-explanatory, but it should perhaps be added that borderline symptoms one might suspect of being

psychosomatic in origin were also included. (5 per cent of the patients were in this category).

(3) Mental. Many of the cases were categorized under this general heading - from acute behavior - disturbances of a type which may be attributed to organic or functional psychoses. Others were more suggestive of psychoneurosis, so argues Jahoda, indicating that any such categorization must necessarily remain speculative. (45 per cent of the patients were in this category).

(4) Job, Love and Marriage. This covered all the specific problems relating to these crucial aspects of life. (20 per cent of the patients were in this category).

(5) Protection and Ritual. The former refers to a wish for safeguards against any enemies who might be scheming some supernatural way of doing harm, so that the client would continue to prosper. The latter concerns various types of customary ritual, including the "cleansing" of clients believed to be witches. (20 per cent of the patients were in this category).

What we would infer on the basis of Jahoda's study is that among his sample a large majority was classified as suffering from the area of psychological/psychosomatic ills. As this is a recent study we will infer that patients continue to "see" the traditional medical practitioners with these ills. It could also be inferred that some of these patients unable to receive adequate cures from scientific medical service "drift down or up" to "see" the traditional medical practitioners. Forster's[31] study confirms this assertion. In future fieldwork studies it may be possible to substantiate claims that some patients have gone to see the

traditional medical practitioners because they have been unable to get cures from the scientific medical institutions, or that patients have in fact gone to consult the traditional practitioners because scientific medical facilities are not available to them.

On the level of structural adaptation, viewed within the historical context the traditional medical practitioners had the opportunity of meeting with all the patients who came to "see" them. In recent times due to an increase in population, there is a structural occupational differentiation. Patients with minor ills such as abrasions, snake bites, fevers are seen by the assistants of the traditional men.[32] Furthermore dispensers and general factotums are employed to serve the immediate nursing needs of the patients. Hitherto when the sick person went to see the practitioner his relative was usually asked to stay with him. Nowadays the relatives are asked if they would wish to stay at the medical shrine. If they are unwilling, the services will be provided by new occupational groups. This in itself is an aspect of division of labor which points to adoptive rigor among traditional practitioners.

D. Current Traditional Practice: Its Similarity with Folk Medicine

As the Ghanaian society is passing through a transitional period due to the rapid social development in this contemporary period, traditional medical practice has adopted some of its practice to suit the contemporary situation. The point which is worth stressing however is the similarity of current traditional medical practice with that of

folk medicine as found in the Western World.[33]

For example in folk medicine tradition plays a key role.[34] There is a vast body of beliefs held by non-medical people concerning the cause of illness and the ways of treating it. Backed by the weight of experience of the older generation, citing empirical evidence from specific cases and from nature, folk medicine has more of an emotional flavor than a scientific inclination.[35] Beliefs are held and remedies accepted not on the basis of experimental evidence but on the authority of respected members of the community who have had the experience. Whenever the patient does not get the appropriate cure from scientific medical institutions, he may drift "downwards" to see a folk medical practitioner.[36] In the Ghanaian situation today, there is this similarity. The sick person may start with the traditional medical practitioner or end up with him if he is not satisfactorily cured by the services of scientific medicine.

The exigencies of the Ghanaian situation where there is an acute shortage of psychiatric facilities and scientific medical personnel would seem to demand the use of both medical services, traditional and scientific. Faced with a similar predicament how have other countries coped with the problem of utilizing the services of both medical systems?

V. Cross Cultural Experience

In a country, such as Ghana, where scientific medical services are sometimes inadequate, it would be helpful to look cross culturally to countries such as China and Nigeria to examine how they have dealt

with the problem when faced with the co-existence of two medical systems.

China, as well as Nigeria was credited with the capacity to fuse two ideas, indigenous and foreign medical systems to suit their cultural needs. In China[37] as late as the beginning of the twentieth century, the population patronized traditional medicine though some of the urban dwellers began to move away from the traditional system. But not for long: during the Second World War China experienced shortages which also affected the supply of medicine.[38] These equipments were hitherto imported from the West. As a result of the shortage of drugs the Chinese began to reinstate an interest in traditional medicine. Ghana, at this point in time, would "benefit" from finding the ways and means to fuse the two medical systems (especially in the area of treating psychiatric ills) by drawing upon the potentiality of each. Let us now make a comment on Chinese medicine to show the importance of studying indigenous medicine in Ghana.

A. A Brief Comment on Chinese Medicine

All the sciences of ancient times and the middle-ages had their very distinct ethnic characteristics whether European, Arabic, Indian or Chinese, and it is only modern science which has synthesized these ethnic entities into a universal culture.[39] But while all the physical and some of the simpler biological sciences in China and Europe have long ago fused into one, this has not yet happened with the medical systems of the two civilizations. There is much in Chinese medicine which cannot yet be explained in modern terms. It is not

valueless, nor that it lacks profound interest.[40] The whole history of the social position of doctors in China might be summarized as the passage from the wu, a sort of technological servitor, to the shih, a particular kind of scholar, clad in "the full dignity of the Confuscian intellectual".[41]

The transmutation from magico-religious to metaphysical pathology was an achievement, but it was not scientific, either in its method of observation or in its reasoning, in that it entirely failed to make use of the method of induction. It remained a pre-Renaissance science.

B. Effects of Chinese Medicine

There has been a recognition by the Chinese Government as a whole that while there must be modernization it need not be westernization,[42] and it need not involve going through all the stages of capitalism in the Western World.

There has necessarily followed a tremendous demand for the improvement of the health of the people and for increased medical facilities. Since there were so few Western trained physicians in comparison with the size of the population, there has been, since the revolution, a great "revival" of traditional Chinese medicine.

There are now many medical schools which teach it and general encouragement is given to its practice. Refresher courses have been introduced for men trained only in the traditional medicine so that they may play their part in modern health measures, while at the same time the modern physicians have been persuaded to take traditional

Chinese medicine seriously. Today[43] the traditional medical men are working side by side with the others in full cooperation. This has been brought about in China by the natural renaissance which has taken place during the past fifteen years. The two types of physicians and surgeons have joint observations, joint clinical examinations, and there is the possibility for patients to choose whether they will have their treatment in the traditional or the modern way; in other cases the physicians themselves decide which is best and proceed to apply it. And if one reads the Chinese Medical Journal,[44] for example, one will find certain fields, as for instance the treatment of fractures, where prolonged consideration has decided that in fact there were many valuable features in the traditional methods, and what is in use now is a combination of the two, the Chinese and the Western. According to Lu Gwei-Djen such fusion is going to happen more and more, giving rise to a medical science which is truly modern and eccumenical.

All this is being done under the conviction that an integration of the Chinese and the Western systems of medicine must emerge. Actually what is at issue is the comprehension in modern terms of the quasi-empirical practices which grew up in China through the centuries. Since the theories of traditional Chinese medicine always remained relatively "pre-Renaissance" in type, there cannot be much future for them except in so far as they may be re-interpreted in modern terms.

There is danger here for the historian of medicine, who must be careful not to read too much into the ancient theoretical formulations, but at the same time must be careful to avoid making them seem quaint, archaic or senseless.[45]

In China today, there are four colleges, six schools and twenty-three refresher courses centers for teaching Chinese medicine alone; there are 5,000 highly trained modern doctors (300 of them full-time) studying traditional medicine. The Government of China employs 20,000 traditional doctors to man 144 hospitals and 453 clinics exclusively for traditional medicine. All colleges of modern medicine and pharmacy in China are obliged to pay special attention to research in traditional Chinese medicine and pharmacy.[46]

Faced with shortages China has embarked on a large-scale program of fully utilizing the services of practitioners of traditional Chinese medicine. The Chinese population of over 600 million is served by half a million traditional practitioners with over 40,000 apprentices, supplemented by 70,000 practitioners of modern medicine.[47]

One might feel that if any type case was needed to demonstrate the moulding of medicine by the culture in which it grew up, Chinese medicine would be such a case.[48] But, on second thought, is there any reason for regarding it as more "culture bound" than Western medicine? To think of the latter as self-evidently universal in application may be an illusion commonly entertained because most of us happen to have been born with it.

Western medicine is only modern because it is based upon the assured results of modern scientific physiology and pathology, in a way which the traditional medicines of the Asian civilizations are not. In the last resort, all medical systems have been culture-bound, and modern medicine is only rising above this in so far as it can partake of the universality of modern mathematized natural science.

Scientific medicine[49] today has reached a truly astonishing degree of perfection, but, though commanding admiration, there is something vital lacking in its practice in other cultures outside the West (especially when one thinks about the field of psychiatry). For this reason it may be a worthwhile experience if Ghana heeds the need to formally train traditional medicine men to be utilized in assisting in such things as the treatment of psychiatric patients. In Nigeria, Lambo[50] utilized the services of traditional medicine men in treating psychiatric patients as intermediaries in allaying the fears and anxieties of his psychiatric patients. The idea was simply this: the rural population (from which many of these patients come) live in large extended family's houses. Traditional medicine is predominantly an art derived from cultural experience. Thus it was realized the medicine men understood the fears of these patients. In fact, Lambo found that cooperation developed between the psychiatrists and the medicine men. The medicine men looked after the social psychological aspects of the psychiatric patients whereas the physical symptoms were treated by the modern psychiatrists. Ghana would seem likely to benefit from this experiment because there are similarities between the cultural heritages of these two countries.

C. A Need for Integration

There is a need in Ghana to develop a perspective which will utilize the essential features of traditional medicine together with the essential features of psychiatric practices in treating mental

illness.

The traditional healing agencies have been attributed with a psychotherapeutic potential.[51,52] In Ecaudor, Erasmus[53] found that among the essentially traditional people illness of a psychiatric nature was treated by the traditional medical practitioners whereas acute ills such as fevers, surgery, infected wounds, were treated by the practitioners of scientific medicine.

In Ghana it will be many years before enough facilities in the realm of psychiatry are provided. In the face of some of these problems we may suggest the utilization of traditional medical practitioners in the area of psychiatric practice. By Western standards we know that we would be accused of introducing the irrelevant into psychiatric practice. The argument is however, to consider what is operational and effective in the Ghanaian cultural scene. Even though by Western standards this approach is indefensible and though some of these traditional procedures may be caricatured as primitive and antediluvian, they nevertheless, can be emotionally reinforced; and as a historical and traditional legacy, the psychiatrist working in this setting must be sensitive to its implications and reckon with them.

If we do not tackle this problem of explicitly recognizing the functional utility of traditional medical practitioners in the area of mental illness, much harm could be done to patients who go to the medicine men, privately, with physical ills. In otherwords all that we are trying to indicate is that in the present Ghanaian setting, these traditional healers operate independently. Operating in secrecy

they could cause more harm so why not bring them into the open to access what they can do?

For example, patients who frequent the traditional shrines with ailments other than mental illness may receive more harm than cure. As we are not totally convinced about their therapeutic potential in the realm of acute ills, it would be a wise step for research to establish what they can accomplish. By bringing the service of traditional medicine into the open, the Government will be able to access its capabilities and its defects and to control it.

In conclusion, we may point out that the training procedures to become a traditional medical practitioner have remained relatively unaltered. The trainees are still drawn primarily from the illiterate segments of the Ghanaian population. It could be interesting to find out if literates could be recruited into the services of traditional medicine if it became an open legitimate activity.

VI. Summary

Throughout the discussion, one thing was made clear: in Ghana, the sick are expected to seek medical attention from the scientific medical institutions. However in the realm of mental illness the sick person may well consult a traditional medical practitioner or end up with him, after exploring the possibilities of effective cure from the scientific medical institutes. We have argued that the rural population generally utilizes both services.

Since there is scarcity of psychiatric resources there is

available evidence to suggest the integration of the two medical practices, each drawing out the others potentiality. In this case we have indicated the significant psychotherapeutic skills of the traditional medical practitioners, and noted that further interdisciplinary research is necessary to determine its specific potentiality. Certainly any endeavor to use the services of traditional healers should be preceded by research and evaluation of the contribution of healers both in relation to patients and to the work of other practitioners and services.

In conclusion then, we would offer these three suggestions as indicated by our analysis: (1) a shift from traditional medicine to scientific medicine will occur whenever the latter succeeds in destroying the traditional sanctions of the former; (2) return from scientific medicine to traditional medicine is possible whenever the former fails to sustain the level of implied possibilities; and (3) a return to traditional medicine does not necessarily imply a full return to the values characteristic of this usage but rather to some kind of intermediate or marginal ones.

FOOTNOTES

[1]Ione Acquah, Accra Survey (London: University Press, 1958), p. 122.

[2]Ibid.

[3]Ibid.

[4]Dr. Forster's papers point to this conclusion also. Letter from Dr. E. Forster, Specialist Psychiatry, Ministry of Health, Ghana (June 21, 1970).

[5]R.K. Merton, Social Structure and Social Theory (New York: Macmillan Company, 1968).

[6]Please see tables in Chapters 4, 5 and 6.

[7]Ghana Population Census, Chief Statistician's Office. Accra: Government Printing Press (1970).

[8]See the discussion in Chapter 4.

[9]Peter Hodge, "The Ghana Workers Brigade: A Project for Unemployed Youth", British Journal of Sociology (1964), pp. 113-127.

[10]Ghana Population Census, op. cit.

[11]Ghana Population Census, op. cit.

[12]R. Horton, Traditional Background of Medical Practice in Nigeria (Ibadan: Institute of African Studies, 1966).

[13]See Chapter 6 for a discussion on health education.

[14]B. Ward, "Some Observations on Religious Cults in Ashanti", Africa, XXV (1956), pp. 47-60.

[15]J. Goody, "Anomie in Ashanti?", Africa, XXVII (1957), pp. 356-363.

[16]Emile Durkheim, The Elementary Forms of the Religious Life (New York: Free Press, 1946).

[17]K.A. Busia, A Social Survey of Sekondi-Takoradi (Accra: Government Printing Department, 1950).

[18]E. Durkheim, op. cit.

[19]B. Malinowski, Magic, Science and Religion (Glencoe, Illinois: Free Press, 1948).

[20]B. Ward, op. cit.

[21]E. Forster, "A Short History of Psychiatric Review in Ghana". Unpublished paper delivered in the Ghana Medical School, Accra (1969).

[22]Peter Omari, "Changing Attitudes of Students", British Journal of Sociology, XI (September, 1960), p. 180.

[23]John Middleton, Magic, Witchcraft and Curing (London: Oxford Press, 1958).

[24]Gustav Jahoda's analysis also points to this direction. Please see his article "Traditional Healers And Other Institutions Concerned With Mental Illness In Ghana", International Journal of Social Psychiatry, VII (1969), pp. 245-268.

[25]Ibid.

[26]R.A. Lystad, The Ashanti: A Proud People (New Jersey: Rutgers, 1968).

[27]J.B. Christensen, "The Adoptive Functions of Fanti Priesthood" in William R. Bascom and Melville J. Herskovits, Continuity and Change in African Cultures (Chicago: University of Chicago Press, 1962), pp. 257-278.

[28]Ibid, p. 258.

[29]G. Jahoda, op. cit.

[30]W. Birmingham et al., A Study of Contemporary Ghana (London: Oxford University Press, 1967).

[31]E. Forster, op. cit.

[32]G. Jahoda, op. cit.

[33]M. King, Perception of Health and Illness (New York: Macmillan Company, 1964).

[34]Ibid.

[35]Ibid.

[36]Ibid.

[37]Joseph Needham and Lu Gwei-Djen, "Chinese Medicine" in F.N.L. P ynter, Medicine and Culture (London: Wellcome Institute of the History of Medicine, 1969).

[38]Ibid.

[39]Ibid.

[40]Ibid, p. 256.

[41]Ibid, p. 257.

[42]Joseph Needham and Lu Gwei-Djen, Ibid.

[43]Ibid.

[44]Chinese Medical Journal (1968), translated by Lu Gwei-Djen.

[45]Ibid.

[46]N.H. Keswani, "Modern Medicine in Traditional Setting: A New Brew in an Old Vat", in Medicine and Culture, ed. by F.N.L. Poynter, op. cit., pp. 189-198. Also see Lancet, XX (September, 1968), pp. 633-635.

[47]F.N.L. Poynter, Medicine and Culture (London: Wellcome Institute of the History of Medicine, 1969).

[48]F.N.L. Poynter, op. cit.

[49]A. Schopenhauer, The World as Will and Idea (London: Macmillan Company, 1907), p. 240.

[50]T.A. Lambo, "African Traditional Beliefs, Concepts of Health and Medical Practice". A paper delivered at Ibandan (1963).

[51]A. Lewis, "Between Guesswork and Certainty in Psychiatry", Lancet, I (1958), p. 171.

[52]M.K. Opler, Culture, Psychiatry and Human Values (New York: Macmillan Company, 1956).

[53]Charles John Erasmus, "Changing Folk Beliefs and the Relativity of Empirical Knowledge", Southwestern Journal of Anthropology, VIII, No. 4 (1952), pp. 411-428.

CHAPTER 8

SUMMARY AND CONCLUSIONS

I. Introduction

This chapter presents the summary and conclusions of the thesis. We shall consider the following: (1) a summary of the salient features of the thesis; (2) the present status of the two medical institutions: scientific and traditional; (3) the lessons to be drawn from the study and (4) lastly we shall present both the practical as well as the theoretical implications of the study.

II. Summary

In the Ashanti traditional society, due to the nature of the social organization, (see Chapter 2) the belief system gave credence to traditional medical theory.

We noted that in Ashanti traditional setting, family life, economic, rules of moral behavior or any other aspect of social organization evolved out of a sociological theory of clan continuity which found its most concrete expression in the magico-religious dogma of ancestor worship. The key to the influence of this particular pattern of belief was not to be found in the definition of the attributes of the gods and the ancestors but it was to be found in the meaning of a two-fold relationship: firstly it played a part in shaping and controlling human behavior, individual and social; secondly it

provided the sanction for social organization and cooperative enterprise.

The culture of the people, we noted, consisted of a number of integrally related aspects which arose in the first place from their efforts to control and manipulate their environment for the satisfaction of their primary needs, and as a result of the necessity for any society to organize the activities and relations of its members.

Traditional medicine was part of the design which evolved as an integral part of the system. As the only viable medical system, (before the advent of scientific medicine and the recent social changes) traditional medicine was largely patronized. The answers the sick person received from this agency usually involved a god or other spiritual agency, and the remedy prescribed involved the propitiation or the calling off of the spiritual agency or being. It gave some acceptable account of what, for example, moved the spiritual agency to intervene in the temporal world. As an intermediary between the spirit world and the living, the practitioner of traditional medicine was expected to give some account of what moved the spiritual agency; so his account usually involved reference to some event in the world of visible, tangible happenings. It was usual for him to add something about the human hatreds, jealousies and misdeeds that had brought such spiritual agencies into play. It was also usual for him to point to the breach of kinship morality which had called down the wrath.

The point is that the traditional medical practitioner who was faced with illness did not just refer to traditional beliefs but he

used ideas about the belief systems to link disease to causes in the world of visible events. He used his theory of supernatural causation to transcend the limited vision of natural causes provided by common sense. However the question posed at this juncture was: in the face of contemporary social changes would the new structural base support the practice of traditional medicine?

This led us into a discussion of some of the recent social changes which have relevance to the practice of medicine. Change, we noted may be produced by internal forces, as when an invention or a new idea revolutionizes material culture and ultimately affects aspects of the economy, residential pattern and the moral life of the people. We also noted that change may be produced directly or indirectly, through contact with an external culture. In any case change never affects any one aspect of culture per se. It is never possible, that is, to limit a reform of one aspect of culture to that aspect alone.

We discussed the following aspects of changes which have had profound repercussions on the lives of people in their pursuit of medical aid: formal education, economic changes and the government medical aid program; regarding the first two aspects of change, we have argued that as a result of formal education and the result of the new economic changes, the individual who availed himself of the necessary skills was able to seek job opportunities in an urban area - away from his natal home. With independent means of support, we have suggested that the young, the educated and the urban dwellers have been presented with new ways of acting and thinking - a challenge to traditional way

of life. We also pointed out that as rural-urban migration is a necessary concommitant of the present opportunities coupled with the fact that the individual worker does not sever his relations with his rural relatives, the urban worker is himself an agent of change.

With the introduction of scientific medicine the sick person who is satisfactorily cured would be expected to attain positive feelings towards the institution of scientific medicine; and would be expected to carry this attitude beyond the immediate boundaries of his influence. Thus traditional social structues have been invaded.

We carried our discussion into the area of the present status of both medical systems. For it goes without saying that a new idea after effecting changes does not follow its original form. Its character, impact and dynamism would depend on the place it takes in the society, its frame of reference to, and its compatibility with other cultural institutions. Therefore as component part of the Ghanaian cultural experience we looked also at the present positions of the medical systems.

III. Present Status of Traditional Medicine

Observers of traditional medicine have related it to the anxieties arising from rapid social change and the social-psychological problems of the new situation. The evidence however suggests that it would be fallacious to seek any single explanation, even one as broad as social change, for the continued vitality of traditional medical practice.

Although there are many new types of request made of traditional practitioners (see Chapter 7) the old forms of request continue at least in the rural setting. However as a result of contemporary social changes, it is remarkable that traditional forms and beliefs continue, exhibiting a great adaptability. The evidence would seem to indicate that traditional medical practice will continue to play an important part in the social organization of the Ghanaian people. The gods and the ancestors will continue to be honored. It should be emphasized however, that in the Ghanaian urban milieu, there is little ritual in social life, hardly any in domestic or economic relations. This is perhaps a factor which may seem reasonable to support the continuance of ritual practices in the institutional context of traditional medicine.

In the sphere of traditional medicine perhaps the most recent development of note is the formation of a Ghana Psychic and Traditional Healing Association which purports to research into mysticism as employed by the traditional practitioners. The pharmaceutical values of known herbs are being investigated as well as some of the therapeutic claims of the practitioners.

In any social formation in Ghana, where "traditional mentality" predominates, it would be reasonable to expect that traditional medicine would be a vital medium. For that matter the practitioner knows the community well and he is expected to use that knowledge. Besides its psychotherapeutic characteristics, and its social interrelations, traditional medicine seems to have another characteristic: as far as the remote areas and rural people are concerned it is more satisfying than the brusque impersonality characteristic of scientific medicine.

A social psychological aspect of illness is a basic craving for social support by the sick person, perhaps a metaphysical need, and in Ghana scientific medical practice is little able to meet this need under present conditions.

IV. Present Status of Scientific Medicine

An attempt to graft a foreign culture inevitably brings about a reaction from the indigenous culture. The attempted graft is always modified or adapted as compared with its original pattern. We have indicated that the institution of scientific medicine is embedded in the cultural trappings of the Western World. The cost of maintenance and the recruitment of professionally trained personnel has become a problem for such a developing nation as Ghana. Unable to find enough resources to maintain the system, certain syncretic formulations have come into being. In this regard we mentioned the different types of clinics which are operating in contemporary social setting. The important thing about some of these clinics is they are neither adequately equipped nor staffed by the necessary skilled personnel. In this direction we have pointed out that emphasis should be placed on preventive medicine and further training of assisting personnel such as physician-associates and extension of both treatment and preventive services beyond the hospital. By placing emphases on the preventive side, travel costs incurred by the rural population will be minimized. Furthermore, as Ghana is embarked upon the development of full scale institution of scientific medical practice, it is bound to face limited

financial and educational resources. These are so severe that it is reasonable to expect at best that Ghana can produce only a trickle of fully qualified scientific medical personnel over the next few decades. Reliance, we have suggested, should be placed on the training and the use of auxiliaries and other varieties of professional and sub-professional personnel. These trained people can handle ably many of the activities now considered the responsibility of the doctor.

In recapitulation we have pointed out that scientific medicine as a theoretical construct has two aspects: curative and preventive. Of late, Ghana has placed too much emphasis on the curative aspect of scientific medicine. As a result, she has faced problems involving costs, lack of hospital beds and acute shortage of doctors.

The need is to emphasize the preventive measures of scientific medicine. This is so because many of the health hazards which loom large are based on insanitation and malnutrition.

We have also pointed out that in the training of doctors the ultimate aim is to produce more generalists, than specialists, who would be thoroughly trained to deal with comprehensive medical care, (emphasizing preventive medicine). As it now stands these general practitioners receive "poor" renumeration, when compared to specialists, therefore we have argued that their work incentives should be made attractive.

Medical assistants should be trained to assist general practitioners in the length and breadth of the country. Perhaps medical assistants are here to stay and are not necessarily a stop-gap.

At present there is no interplay between the scientific medical

practitioners and the traditional medical practitioners. In one particular area of need, we have argued for the necessity of ongoing consultation between the psychiatrists and traditional practitioners. This could eventually lead to the recognition of each others potential. The present Chinese and Nigerian situations are cases in point. These provide us with empirical evidences of how the two medical systems could work together in a complimentary relation.

V. Lessons to be Drawn from the Study

(1) Traditional medicine, or its functional equivalent, may never wholly disappear from the Ghanaian traditional society, regardless of how urbanized life becomes. There is a continued prevalence of pseudoscientific medical beliefs and therapeutic measures (placebo) existing in the practice of all forms of healing including scientific medicine. Even in industrialized societies like the United States and Western Europe, pseudoscientific belief and practices have not wholly disappeared.

(2) The limited utility of scientific medicine in the area of mental illness leaves open a relatively permanent area of chronic nonincapacitating ills within which traditional medicine may survive and may continue in a complementary structural position, at least in the rural setting. This point is predicated upon the idea that so far as scientific medical technology is functionally not specific in treating ills in the field of psychiatry, traditional medicine or its functional equivalent will continue to operate in this area.

(3) The Ghanaian Government needs to emphasize strongly the preventive aspect of scientific medicine.

(4) The urban areas are more receptive to new ideas. More scientific medical institutions are located in the urban areas that are now attracting a characteristically new crop of inhabitants. The young, the educated and those who are ready to experiment with new ideas are most frequently found in the cities. Hence, these groups are the most frequent users of the scientific medical facilities. As the young and the educated are accorded prestige in the traditional system, because the traditional authorities derive some measure of advantage from them, their new ideas will be carried across to the rural areas acting as potential carriers of scientific medicine. Furthermore the government gives support to the practice of scientific medicine. As the government decision making process carries weight because of its sanctions, it would be safe to conclude that, as times goes on scientific medicine will largely be patronized at the expense of traditional medicine. Viewed historically it is clear that the structural accommodation of scientific medicine will be achieved at the expense of the previously all-pervasive traditional medical system.

VI. Practical Implications

On the basis of various studies we have discovered that traditional medicine possessed psychotherapeutic potentiality. As the facilities for the treatment of mental illness are inadequate, and so long as the country is embarked upon the process or urbanization and

industrialization it was inferred from data that "the stress of urban living" will cause urban dwellers to seek aid in these areas of psychological ills. Thus there is a need for traditional medicine to play a complementary role.

We would suggest that traditional medicine has a part to play in the contemporary setting. Specifically the point is simply this: the scientific medical practitioner tends to rely on technical information and skills derived from scientific knowledge in diagnosing and presenting treatment. On the other hand the traditional medical practitioner assumes a more holistic approach using skills derived from his knowledge of the patient and his environment.

Given the problem of scarce psychiatric resources we suggest the value of integration of the two services, at least in a complementary role. We are aware that critics will raise many objections as to the feasibility of such an attempt. It may be necessary then to take these criticisms into consideration in order to build an appropriate model.

We would suggest a further period of training for the practitioners of traditional medicine in the principles of hygiene. We would also enquire if the Government is able to subsidize the practitioners of traditional medicine to make it possible for them to operate in hygienic environments and to use aseptic techniques. This might be tried as a pilot project. We would suggest that some of them could be utilized in the rural health posts and health clinics under medical supervision to assist patients to cope with some of their anxieties.

Coming into hospital, we are aware, is an anxiety producing experience. It is more so for the mentally sick in their pursuit of treatment. If the experiment proves useful the scope of traditional medical practice could be broadened to other health institutions, particularly those concerned with mental illness. Simultaneously research could be embarked upon to learn more about their therapeutic potentials in this area as well as other related areas.

The Ghana Medical School could assist in this respect. Medical students could be taught to accept traditional practitioners as playing a complementary role in the art of healing particularly in mental illness. This would involve a study of traditional medical practices and giving such a study a place in the curriculum.

Scientific medical practitioners are frequently accused of being more interested in the disease than in the person. The doctor must rely on many other skilled personnel, such as laboratory technicians and specialists, in making a diagnosis and treating his patient and sometimes the patient as a person is overlooked. On the other hand the traditional medicine men as we have pointed out, understand "the fears and the anxieties" of the patients and so treat the person as a whole - utilizing the unity view which underlies traditional medical theory. The two types of practitioners might work together to the advantage of the patient.

VII. Theoretical and Research Implications

Scientific medicine is built upon questioning and change; traditional medicine is built upon tradition and certainty. There is little doubt that in the social-psychological sphere the reassuring effect of the latter attitude is the greater one. Employing the scientific methodology, scientific medicine proceeds in an analytic way, in splitting phenomena into smaller units with the aid of scientific categories. Traditional medicine on the other hand, ties together as many phenomena as possible; it aims at, and obtains to a certain degree, a maximum of mental integration. It has, so to speak, a holistic character when compared to scientific medicine. To the traditional medical practitioner there is no conceptual separation between physical and mental disease, there is only disease. There is no separation between diagnostics and therapeutics.

As disease is fundamentally a disintegration on all levels - mental, physical and social - it is understandable that this approach should have some value. We need then to broaden the scope of scientific medical theory in its contemporary form to incorporate the social and the psychological as well as the physical aspects of illness.

Medical systems, like other aspects of cultural institutions, grow up to meet the specific needs of a given society. In Ghana the health services need much more of a team approach with greater cooperation between the hospitals and public health services, as well as joint planning with the agriculture and nutrition services, town planning and local government authorities. It is on this team that the traditional

healers might find a place.

In future field studies, there is a need to conduct inter-disciplinary research which will look into the therapeutic claims of the traditional medical men. There is also a need to study the types and the calibre of patients who frequent the services of traditional medicine. This will assist us to understand some of the referral patterns. Furthermore we need to look into the number of patients who actually receive "cures" from traditional healers. This type of research is necessary as well as expedient in order to estimate the actual potentiality of these healers. At the moment many of their techniques are clouded in secrecy, and difficult to disentable the truth from the opinion. This is an aspect of the magico-religious symbolism inherent in the practice of traditional medicine.

In this regard scientific medicine has had a significant impact on the traditional society. But the future should hold more than a simple imposition of imported medical service without regard to indigeneous culture.

The form of medical practice which exists in conditions of high standards of living in highly industrialized areas of the world can be made available to Ghana, and indeed to most developing countries, through a system of aid and cooperation which however can only be temporary, and indeed diminishing in extent. It is therefore a mistake to reject out of hand a traditional form of medical practice, the psychology and medicines of which may possess certain valid features, even if nothing more than employing principles related to

the Ghanaian cultural setting in treating ills.

> "We must learn again from scratch, without contempt and with patience, how to talk to our fellow men and listen carefully to what they say: This is our only claim to integrity". (R. Oppenheimer)

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APPENDIX A

ASSESSMENT OF THE ADEQUACY OF DATA

The author of this thesis is a Ghanaian Civil Servant who has had an experiential basis for examining the adequacy of the data presented in this study. Over a period of two years, he had the opportunity to come into contact with scientific and traditional medical institutions. In his capacity as a supervisory officer in the Ministry of Health, Ghana, he visited both types of medical institutions and gained some insights into the raison d'être of both medical practices.

Through these interactions the author had observed what went on, noticed some of the medical procedures, and gained some knowledge into the types of patients who were admitted. From these contact, the author arrived at some understanding of the problems which were faced by both staff and patients in their day to day activities.

With this background he examined data from the following sources:

(1) theoretical writings in Sociology which have relevance to the thesis area;

(2) various studies conducted in Ghana;

(3) primary sources of data from Ghana Government documents;

(4) periodicals and documents received from the Ghana High Commission in Ottawa;

(5) statistical documents received from the Government Statistician, medical statistics and the Medical Research Institute;

(6) personal observations conducted at the medical shrines of traditional medical practice;

(7) the Director of the African Studies, University of Ghana. Through his offices the author was able to keep in touch with current traditional practice;

(8) the recent publication from the Secretary of Traditional Healing Association which helped to provide useful insights in writing the section on current traditional practices.

All these processes of eliciting information afforded the author the opportunity to compare data and to establish some measure of reliability and validity in the findings.

The compiled data were divided into two main sections. First, we looked at the Ashanti traditional society, which provided us with the background to view the present changes. In this section, we utilized anthropological data as well as other social science data, documented in Ghana. The material was found to be adequate for our purposes. The data on the traditional medical system were found to be inadequate in the sense that so little documentation has been compiled in the area. Furthermore it is a recognized fact that there is difficulty in getting the full cooperation of the traditional medical practitioners because of the tendency for some of them to be secretive in many aspects of their healing practices (see Chapter 3). However, with the author's insight into traditional practice, some of the

inadequacies which might have been left unfilled were filled. Furthermore, in visiting some of the traditional medical shrines, the author gained some insights into the medical area. This helped him to check some of the claims made by the earlier social scientists who have studied this field.

Second, data in the contemporary section was primarily from statistical compilations gathered from various agencies of the Ghana Government.