

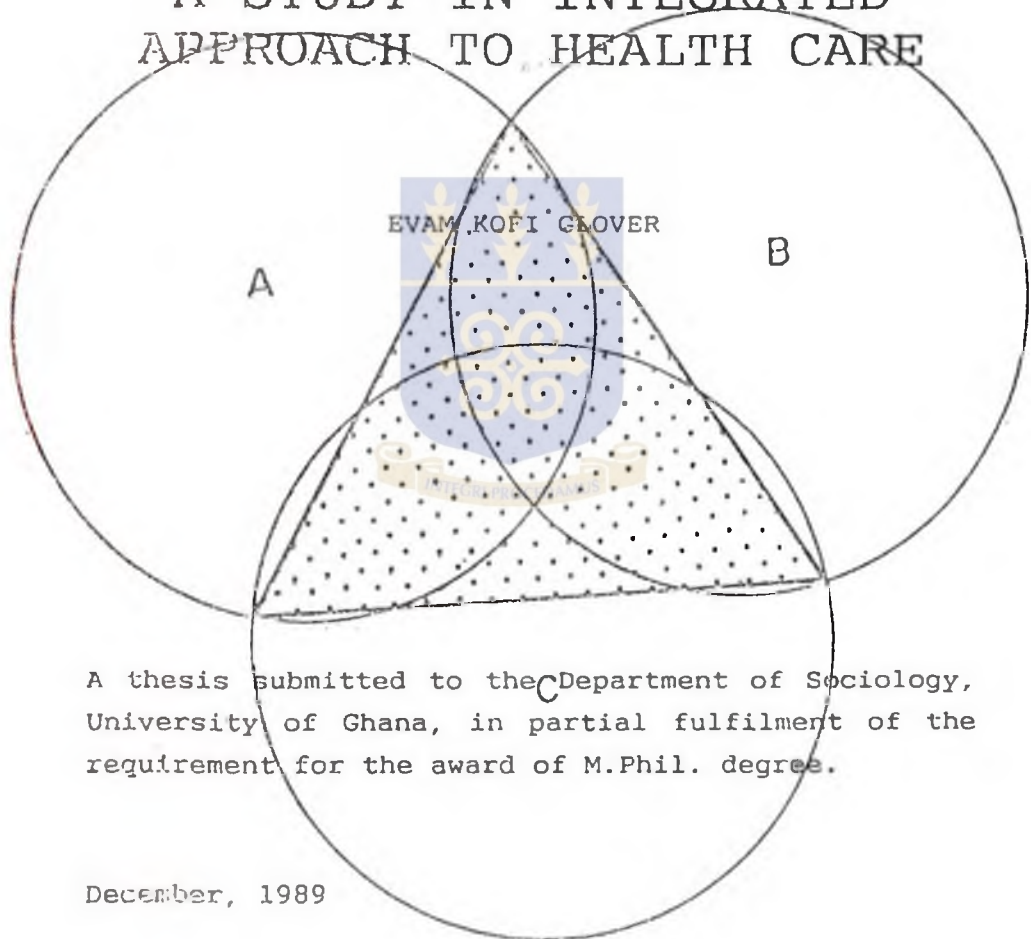


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THE NAZARETH HEALING COMPLEX:

A STUDY IN INTEGRATED APPROACH TO HEALTH CARE



A thesis submitted to the Department of Sociology,
University of Ghana, in partial fulfilment of the
requirement for the award of M.Phil. degree.

December, 1989

DEDICATION

THIS STUDY IS DEDICATED TO THE FEMALES OF MY FAMILY
(AMETORWOSOR, NDA AFAFA, WORLA, AKPENE), AND THE OLD
MAN - SEVATO FOR THEIR MORAL SUPPORT.

... AND OF COURSE TO CHRIS ABOTCHIE, LECTURER,
DEPARTMENT OF SOCIOLOGY, LEGON, FOR INITIATING ME
INTO THIS HIGHER ACADEMIC PURSUIT.



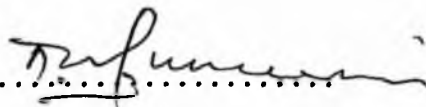
I

D E C L A R A T I O N

I, EVAM KOFI GLOVER, HEREBY DECLARE THAT THIS WORK IS MY ORIGINAL WORK. EXCEPT WHERE ACKNOWLEDGEMENTS ARE MADE, THE MATERIAL PRESENTED IS A RECORD OF MY OWN RESEARCH. NO PART OF THIS WORK HAS BEEN PRESENTED IN ANY FORM FOR ANY DEGREE IN ANOTHER EDUCATIONAL INSTITUTION.


.....

E. K. GLOVER


.....

PROF. P. A. TWUMASI

(SUPERVISOR)

II

ACKNOWLEDGEMENT

Although I must take ultimate responsibility for the material presented in this thesis, I wish to point out that I was not without friends. My sincere thanks go to all friends who contributed in one way or the other to the success of this work.

I am grateful to my supervisor, Prof. P. A. Twumasi for his help and direction.

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III

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E.K.G.

IV

A B S T R A C T

The main thrust of this study is to investigate a novel phenomenon in health care delivery at Vane, in the Volta Region of Ghana called the Nazareth Healing Complex (NHC).

Designed to provide comprehensive health care at one location, the NHC combines faith, herbal and modern medical systems. The central aim of the NHC multispeciality group practice is to allow an interchange of ideas and consultation among all the health practitioners within the same facility. The assumed advantage is the greater continuity of care where referrals between different specialists are effected within the same facility, for the total health care of patients.

This study seeks to discover the role of the NHC in meeting the psychological, social and physical health needs of the people. It attempts to explain the nature of the inter-relationship between the constituent parts and to show the role-relationship between the NHC and the larger community of Vane.

The Theoretical framework for the analysis was the Social Systems perspective which includes features of both rational and a fundamentalist model in the study of social change.

The study adopted three methods for collecting data: participant observation, in-depth interviews and questionnaires.

Analyses of the records show that the utilization of the NHC facilities is rather low. Findings suggest that the people largely by-pass the NHC facilities for other health care systems in the locality. Thus it was concluded that the NHC facilities are relatively unacceptable to the people. The people hardly see it as an added value.

An attempt was made to offer some sociological explanations for this situation. Factors responsible for this situation include external and internal problems facing the NHC. With reference to the external factors, available evidence suggests that the NHC was unable to compete with the already established health institutions at Vane. These health institutions include self-care resources, modern medical systems, and traditional health care resources (including faith healing, general herbalists and diviner healers) in the locality.

The internal factors include; administrative problems and poor co-ordination of constituent parts. This situation led to the eventual collapse of the intersectoral referral system which was the main premise on which the NHC was built.

It has therefore been established that the low acceptability of the NHC facilities on the one hand is a function of poor integration into the socio-cultural milieu of Vane. On the other hand, the failure is a function of poor interplay between the constituents of the organization.

Finally, the results of this study indicated that the diffusion of any innovation in any given community is a function of its relevance to the values, beliefs and expectations of the people. Coupled with this, the internal equilibrium of the innovating organization is also an essential determining factor in the realization of the goals and objectives of the organization. The success of the programme - among others - is positively related to these factors.

The study suggests however, that there is need for further empirical research into sources of self-care services and factors which seem to make this a more convenient source of health care for the rural societies.

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CHAPTER ONE

INTRODUCTION

THE PROBLEM

The study investigates a novel phenomenon in health care delivery at Vane community in the Volta Region of Ghana known as the Nazareth Healing Complex (NHC). This new approach combines faith, herbal and modern medical systems within the same facility. In this wise, the NHC is a multispeciality approach in which three healing systems are grouped together to provide a more comprehensive health care. It is purported to be an answer to the complex ill-health problems which patients usually present at different times to different therapeutic agents.

According to the Christian Medical Commission;

The Nazareth Healing Complex is the only attempt in any part of the world where a serious initiative had been taken and is being sustained to bring three systems (Faith, Herbal and Modern Healing systems) under one "roof" and in a way that offers people a choice. (Contact June 1988:1)

The relevant literature indicate that, Ghanaians in search of therapeutic expertise, usually shop around. (Twumasi 1978, Fosu 1977, Hagan 1986). Seen against this backdrop, the attempt of NHC is to bridge the gap by bringing the different health agencies to the doorsteps of the people in a more comprehensive form.

The central aim of the NHC multispeciality group practice is to allow free association for the communication of ideas and for consultation with other health practitioners within the same facility. The anticipated advantage is the greater continuity of care for the patient through inter-sectoral referrals.

It is the hope of the initiators of NHC that this approach would positively affect members of the society who would seek new and improved methods in their health and illness problems.

This study attempts to analyse the role of NHC in meeting the health needs of the community. Needless to say, any new thing introduced into society would encounter preliminary problems. An attempt to group together three originally independent medical systems into a comprehensive system therefore would naturally involve some problems. Issues relating to the interrelationship between constituent parts of the programme, management of tensions and conflicts, and the relationship between the new system and the social structure of the recipient people, must be taken into consideration. These are some of the pertinent issues which this study attempts to investigate.

Objectives of the Study

What is considered of fundamental importance in the context of the thesis is the examination of the nature of the relationship between the social structure of Vane community and the NHC. It would seem urgent also to determine the nature of the interrelationship between the three constituent parts of the NHC.

The following questions are framed to guide the discussions:

1. How do the NHC constituent parts work in practice?
2. What is the nature of the interrelationship between the parts?
3. To what extent does the NHC cater for the health needs of the people in the community?

Relevance of the Study

For a long time, Developing countries have been trying to find better means of coping with the management of the health problems of their people. The search is for a health care system that would be culturally acceptable, affordable, available and accessible to the people. The NHC programme is one of such attempts adopted by a Ghanaian Community to take care of the sick. By investigating the issues related to this programme therefore, this study breaks new grounds.

As an exploratory and primary study in the direction of the search for integrated approach to health care, this research would be of help to health planners and policy-makers in the field.

Evidently, international organizations such as the World Health Organization (WHO), the Christian Medical Commission (CMC) and the Inter-Church Co-ordinating Committee for Development projects (ICCD) in the Netherlands may also benefit from the results of this study.

It is hoped that, by highlighting the main issues in this new idea, this study would provide broader perspectives and deeper insights into the problems and prospects of this innovation in health care delivery.

This would enable the author to generate some hypothesis for the study of social change.

Theoretical Perspective

This study, as has been stated earlier, examines the interrelationship between the constituent parts of the NHC, and the nature of the relationship that exists between the social structure of Vane community and the NHC. In examining the related issues the study adopts the Social Systems perspective which includes features of both rational and a fundamentalist model in the study of social change.

The concept of social change implies the impact of some influence on the social structure. From the sociological point of view, when a new idea impinges upon the social structure, it affects patterns of social interrelationships in several ways. In the short run, the repercussions may not be far reaching, but in the long run, it would affect all the component parts. From this point of view therefore, the theory which would guide our discussion is that of the systems approach.

The Social Systems Approach, applied to medical systems, implies regarding and respecting the multitude of factors in the social and cultural environment which are considered to have an influence on the causal explanation of health and illness (R. A. Kurtz et al. 1984:5). This focus emphasizes a fundamental interrelationship between medical systems and social structures.

Social and cultural habits, values, attitudes, the world view of a people, and the state of the economy, invariably influence the development and quality of medical systems (G. Myrdal, 1968).

The fact that the NHC is a novel approach to health delivery presupposes that some new element has been introduced into the culture of the given society. It is likely that more than the concept of health and ill-health are affected. To fit in something new where order already exists cannot be done without major changes within the social structure. From the Social Systems perspective, this study explores the interrelationship between the innovation and the extent to which it is integrated with the norms, health needs, values and expectations of the society it serves.

What is considered to be of fundamental importance is the examination of the nature of the relationship between the social structure and the NHC. There must be a co-operative posture between the new idea and the existing social structure within which it is planted. The new idea per se certainly does not determine any social action. Its success therefore is a function of the degree to which there are supporting elements within the social milieu.

Apart from its relationship with the external world, the change Agent's own internal stability is crucial for achieving its aims and objectives. In this regard the institutional theory becomes relevant to our analysis.

Central to the institutional theory is the postulate that human aims are achieved through organization. It focuses on the fashion in which organized groups select specific purposes for accomplishment and fashion specific norms for achieving those aims.

Three elements become fundamental to this focus. There is the concept of purpose, for the achievement of which members co-operate. There is the concept of an institutional group; the group of members co-operating to achieve their purpose. Then there is the concept of the institution per se, the complex cultural expectations which are shared by the members of the given institutional groups.

It is a fact that all institutions include prescription about the ways in which institutional goals shall be attained by the members of the group. This includes the recruitment of personnel, the definition of conduct of personnel, job specifications and the personal interaction of members within the organization. The interrelationship between the component parts of the organization on the one hand, and the relationship between the organization and the social structure of the recipient people - on the other hand, should form a part of the institutional framework. Determination of relationship as argued by Wessen (1951) becomes essential in social change analysis because it means in practice we can get at the variation in attitudes and influence of various personnel and sectors within the NHC. Thus individuals and parts of the NHC, like in all institutional settings, stand in a series of different relationship to each other.

From this perspective, the success of any institution is based on its internal cohesion or the equilibrium of the constituents of the given organization.

Following these trends, this study proposes the hypothesis that, the success of the NHC will depend on the degree to which the organization is integrated into the socio-cultural milieu of the recipient people, and also on the degree to which there is internal cohesion or equilibrium between the constituent parts.

Background Review

The co-existence of the modern and traditional medical systems have been documented in several societies. (Twumasi 1975, Melrose 1982, Standgard 1925).

In Ghana for example, the two medical systems exist simultaneously (Twumasi 1975). This means that alternative and often competing medical services are available to the people.

Throughout history, these two medical systems have confronted each other. Modern medicine has often demonstrated its hostility toward traditional health care which has been termed quackery and "witchcraft". In spite of these misconceptions, many studies have shown that the use of the traditional healer is significant in the every day life of the people of Ghana and other developing countries (Jahoda 1961, Bonsi 1973, Hagan 1986, Djukanovic etc.)

Press (1969) suggests that the phenomenon of resorting to both medical systems is so complex and cannot be understood in simple terms of "pragmatism", "appropriateness" or "acculturation".

One needs to examine the manner in which patients evaluate a whole host of factors, beginning with their beliefs in the efficacy of treatment offered by a variety of healers and their relationship to the healers.

Thus it must be realized that health consumers take many different paths to reach the goal of "relief". This puts the situation in a slightly broader perspective than Parson's view that the sick has an obligation to seek care from the most qualified person - the physician. The shortcomings of the Parsonian concept of the sick role has been noted in relation with the "dual systems" approach to health care in the African perspective (Twumasi 1976, Gallagher 1976).

According to Hagan (1982), the fact of Ghanaians resorting to multiple health systems could be explained in terms of the cosmological perspective they hold as a society. The Ghanaian places life and health in a global frame comprising three interpenetrating sections; the subliminal, the liminal and the superliminal worldly realm. Linked to these are the respective powers of native medicine, allopathic medicine and Faith healing.

Hagan explains that these three therapeutic systems in Ghana rest on three cosmological assumptions about nature and the source of healing power. One is the materialist assumption that nature is all matter, and healing power derives from material things. This premise then asserts the efficacy of materia medica to the total exclusion of spiritual means and rejects symbolic metaphysical rituals from medical kits. (Hagan 1982).

Then there is the second cosmological assumption which asserts that whatever there is, is spirit or is spiritual. On this assumption, sickness could be dealt with entirely or mainly by spiritual and ritual means. Even where the rituals for healing presupposes the use of material objects, these are only seen as symbolic of spiritual agents.

The third approach seeks to integrate the realms of material things and spirit for the resources needed for restoring health. To this school of thought, the universe has two dimension - spirit and matter. This latter approach is dualistic in its perspective. At any point in the progress of a disease and with respect to any disease, material or spiritual resources and techniques would be given greater or less emphasis.

Pathways to health care are thus seen as completely "open". According to Kong-Ming New, (1977) a person seeking health care may take a number of paths, of which the following represent only some;

- a. he may start out by seeking advice from the lay referral system and end with health care in the professional referral system along the lines which Freidson (1961) has suggested.
- b. he may start with advice from lay persons who then may suggest that he takes the "deviant" path to traditional healers, for either advice or care. These persons then may never enter the orbit of the professional physician.
- c. he may enter the "western" medical system but find little or no relief and seek the services of traditional healers.
- d. he may seek the services of orthodox medicine and traditional healers simultaneously (Twumasi 1975, 1988, Hagan 1982, Janzen, Melrose 1982). This endorses the idea of an integration of the two medical systems.

The introduction of the concept and policy of Primary Health Care (PHC) some decades ago, has promoted the idea of the collaboration of modern medicine with traditional medicine in national health care systems. The main focus, however, has been on the Third World countries whose populations are largely rural and poor with little or no modern health care facilities.

The task of providing adequate modern health care facilities for the majority of the people in Developing Countries has been very problematic. In Ghana, for instance, the funds available are grossly inadequate. The modern medical facilities are therefore more or less limited to the urban minority, neglecting a large section of the rural population (Ofosu-Amaa 1975; Ewusi 1978).

Even in the few cases where modern medical facilities are provided for the rural populace, these facilities are understaffed and under-equipped (Twumasi 1975: 81-85, MOH 1988, Twumasi 1988).

Traditional medicine on the other hand is used by a significant number of people every where, and is often the only health system that the majority have recourse to when sick. The acceptance and reinforcement of traditional medical practices are logical consequences of PHC which emphasizes community participation, with people contributing their own resources and sharing responsibility for health development.

Since 1978, the World Health Organization (WHO) has been promoting the PHC idea in an attempt to transform the old model of urban-centred curative health care into a community-based PHC. In this respect, WHO urged Third World governments not to rely exclusively on western-type or western trained physicians in attempting to provide Health Care for all their people. They have been advised therefore to aim at "a synthesis ... between the best of modern with the best of traditional medicine" (WHO 1979).

Following this trend of thought, WHO started promoting international programmes on traditional medical practices which include; the retraining of traditional practitioners i.e. herbalists, bone-setters, and Traditional Birth Attendants (TBAs); the selection of essential traditional medicaments and techniques for use in PHC and the promotion and development of basic and applied research in traditional medicine (WHO, 1978).

In Ghana, quite a few attempts have been made to positively encourage the collaboration of the two medical systems.

Retraining of TBAs in Ghana dates back to 1970 when the Danfa Comprehensive Rural Health and Family Planning project took off. In 1975, the Ministry of Health, with the assistance of WHO, also established the Brong-Ahafo Rural Integrated Development project at Kintampo to train middle-level personnel for the proposed PHC programme.

An attempt was made towards the promotion and development of basic and applied research in traditional medicine. In 1974, the Centre for Scientific Research into plant Medicine was established at Mampong. The aim was to encourage research into and the dissemination of information on herbal medicine. It is ideally meant to be a collaborative effort between the traditional healers and scientists.

Evidence suggests that except three attempts (all in Ghana), no African country has actually attempted retraining general traditional practitioners. (Wondergem and le Grand 1986). The three examples in Ghana include attempts made under the "Primary Health Training for Indigenous Healers' programme" (PRHETIH) 1979, in Techiman to retrain general traditional practitioners. A similar course has been set up in Dormaa Ahenkro (Fink, 1987). Also in the Nandom area, Upper-West region, experiments were carried out with the Co-operation of modern and traditional practitioners (Horst, 1985).

The limitation of these programmes was that, after the retraining, the healers were left alone again to practice on their own. No continuity in the collaboration of the two medical systems was enforced after the retraining programme.

General traditional healers were therefore not integrated into the modern health care system under these projects (Warren et al; 1982). It is evident therefore that, no African country has actually attempted an organized system that would forge the collaboration of both medical systems in an integrated approach towards health care - on any large scale.

There is the interesting work in Aro - Nigeria, where Lambo introduced the use of traditional methods (ethno-psychiatry) to supplement modern psychiatric care. But we must say that by and large, the Region has very little practical experience of the integration of these two medical systems.

In the wider world however, the best results have been achieved in Asia, where collaboration is facilitated by an organized system of indigenous medicine whose infrastructure "parallels" the national health system. (WHO, 1985, Djukanovic and Mach, 1975). The two medical systems may not necessarily be under one roof, but the collaboration is facilitated by this organized system which gives recognition to the role of the traditional healing system alongside the modern system.

Expert opinions on the benefits of combined modern and traditional health care are divided, especially regarding the desirability and effectiveness of incorporating Traditional Medicine into national health systems. Many political, cultural and emotional arguments have been put forward for and against integration.* These discussions mainly concern general aspects of the relation between traditional and western medicine. They deal with the unfamiliarity of modern health personnel with traditional medical cultures and the lack of a sound scientific basis for the traditional practices. These debates however have no direct empirical background of a project which attempted the integrative model of health delivery. They are therefore rather speculative.

*See for example Bichman, 1979, McDonalds, 1981, Phillipsbury, 1982, Velimirovic, vdGeest, 1985, Streefland, 1985, Oku Ampofo and Johnson Renauld, 1978, Twumasi, 1985, Warren and Green, 1988, Green, 1988, Bannerman, 1983.

The controversies emphasize the need for a more systematic study of the phenomenon. This is where the essence of studying the Nazareth Healing Complex (NHC) becomes all the more important.

The NHC in Vane, Ghana, as explained already, has been noted as the only attempt to forge the collaboration of the two medical systems (seen in three strands of faith, herbal and modern healing) under one 'roof'.

However, it must be noted that, given the heritage of mutual suspicion between orthodox and traditional healers and the lack of communication and understanding about each other's diagnostic and therapeutic methods, it is evident that something more than formalized institutional arrangements will be needed if this potential is to be fully harnessed and integrated into the overall national health service.

It is in the light of this that Ojanuga (1981) asserts that the success of an integrated policy would depend on the willingness of orthodox and traditional doctors to work together, that is, how willing would the doctor be to share his position and prestige with traditional healers?

This is certainly a controversial issue. However, the works of a number of social scientists in the field have given clues to some expectations. In his recent work on Professionalization of Traditional Medicine in Zambia, Twumasi (1984) found that 66% of medical personnel expressed positive views on the question of the integration of modern and traditional healing systems.

They argue that the field of modern medicine would benefit from co-operation especially in treating social and psychological illness. Again 84% of modern doctors and nurses emphasized the positive role that traditional healers can play in the Primary Health Care programme as 'Community Workers'.

In an earlier study on the way magic and science work in Western Yunnan, Hsu (1955) described how traditional healers and western trained physicians had to work side by side to eradicate a cholera epidemic rampant at the time. Because the Chinese did not understand the effectiveness of western medicine, more traditional methods also had to be used.

Hsu concludes that any attempt to introduce new knowledge or new techniques in a foreign setting will benefit from the realization that all communities respond to these attempts according to premises implicit in their own cultural traditions.

Another classical example of how traditional healers co-operated with western medical doctors in a refugee camp in Thailand highlights the theme of "the law of inner-necessity" and co-operation. A psychiatrist, Dr. Hiegel (1982) writes that in 1979 many Khmer fled from their villages and sought refuge in Camps in Thailand. The International Committee of the Cross (ICRC) and other humanitarian organizations had to provide for the needs of a sudden influx of people uprooted from homes, exhausted by famines, suffering, fear, sickness and the ravages of war.

A number of people suffering from mental disorders were rejected by the Khmer population whose own lives were so fraught with problems on every side that they did not tolerate the "misfits".

Their admission to hospitals frustrated the medical teams and disturbed the other patients. In the long run a programme co-organised by modern and traditional medicine practitioners was suggested. Refugees with a painful organic complaint attributed their affliction to supernatural causes and believed themselves possessed, behaving in a way that might appear pathological in the orthodox psychiatry nosology. Patients were first examined by an orthodox doctor or nurses and treated by a traditional practitioner.

Traditional treatment and orthodox treatment operated in separate places. The traditional healer however, did not hesitate to ask the opinion of modern doctors when he feels there is a risk involved in a case. Thus there was a referral system between the two health systems. Occasionally a case was discussed and a traditional form of treatment was at times decided on under supervision.

Indeed, the relevance of these examples for this study cannot be overemphasized. One salient realization in this union is "the law of necessity" which enhanced the co-operation of the two systems. Thus, this union has emphasized the premise that, the integration of the two systems into a comprehensive system of health care results from forces which pull them together and govern their participation and association without generating inferiority-superiority

complex. Such a union is a function of the confidence the western medical doctors put in the traditional healers and the complementary role of each of these systems towards the realization of the goal.

It must be interesting therefore to find out in the case of the NHC, the response of the community to the new model of health care. The gains are quite enormous.

The literature reviewed show that in the Ghanaian social structure, patients tend to shop around for health care. From the population's point of view it must appear that the new model of NHC has created the situation in which the various health items (herbal, faith and modern health system) for which the people shop around are brought, as it were, under one "roof" to their very door-steps. This is in a bid to forge co-operation between these health approaches so as to cater for the total health needs of the people.

Our interest therefore is to find out the role of the NHC in achieving this goal. Questions like - "what is the nature of the interrelationship between the parts of NHC, on the one hand, and the community on the other? What are some of the problems and issues emerging from these attempts?" - become pertinent issues for our analysis.

Methods

The field work which was carried out from January to November 1988 adopted three methods for collecting data: participant observation, in-depth interviews and questionnaires.

Participant observation technique was the initial method used. During the first phase of the study, the author and his assistants spent some time participating in the society and observing trends in order to design the appropriate approach to the study.

This method made it possible for us to elicit the content of social behaviour, and the general attitude of community members towards health and illness issues.

Apart from participant observation, specific information was collected through semi-structured interviews. Interviews were held with key informants including, healers, health personnel at NHC, health officials at MOH - Ho -, drug sellers, opinion leaders -chiefs, elders, pastors- patients and various people within the community with whom a good personal relationship was established.

Questionnaires were also used to obtain most of the socio-economic data. Field assistants, specially trained for the exercise, administered these questionnaires through conversational interviews in a community survey.*

Illness episode monitoring for the collection of information on the morbidity pattern in Vane was conducted as part of the community survey. Households were the sample unit.

*Copies of the different questionnaires are in Appendix A

Households are defined as all people who are eating from the same pot. Not more than one household per house was included in the study to avoid previous knowledge of the contents of the questionnaire.

Houses were considered as clusters containing several households. The methods used involved serial numbers (using chalk on the walls) of all buildings in Vane (in which people sleep). A systematic sampling procedure was then employed. We depended solely on the random numbers compiled by White et al (1979). A sample size of 664 people from 141 households were involved in this study which is approximately 30% of the population of Vane.

To avoid the built-in limitations of household morbidity surveys, that is, relying on the memories of respondents for data on illnesses, the author tried to ensure that all illnesses which occurred within the selected households were detected each day and recorded. A member of each household was asked to keep a health calendar for all household members for a period of two months. Follow-up interviews were carried out fortnightly with household members based on the information from the calendar.*

*Literate school children were employed in this exercise of recording. Adult sick persons were interviewed but parents were interviewed about diseases in children below the age of 10 years.

Morbidity data and attendance statistics of the health centre of NHC were quite scanty and for only a few number of years. Morbidity data were available only from the period August 1987 to December 1987. Attendance statistics were available only for the years between 1982 and 1987. These were obtained from the figures sent to the regional office of the Ministry of Health - Ho.

In the case of the herbal department of NHC, data from the record books kept by the Assistant Herbalist were used for our analysis. For comparative reasons, we have used the data collected over a period of two years - 1986 and 1987. Visits of clients who came for a second or third time for the treatment of the same diseases were excluded. The recorded data included; name, age, sex, address and ailment of clients. For practical reasons only patients living inside, or within four kilometres of Vane were interviewed.

The Faith Healing Department however lacked adequate records. A research assistant therefore recorded attendance at every prayer/healing session for a period of two months - between July and August 1988. All the people who utilized the facility at the time were recorded. There was a high degree of consistency in the regularity with which the names recorded at the initial stages kept recurring till the end of the two months. This emphasizes that the department was more or less a sect with identifiable membership. People who turned up were recorded only once. The data collected included name, sex, occupation, educational level, year of membership and reasons for coming. A total of 35 interviews were held.

Limitations of the Method

The sampling unit, as explained, was that of households. One housing unit consisted of several households. The concept of household was defined as all permanent residents eating from the same pot. The impression is that a household forms a social and economic unit. However, practical difficulties were encountered in putting this concept into operation.

It was difficult sometimes to tell to which household some people belonged. Their eating places were not very fixed, and they belonged by our definitions to a number of households since they ate from different "pots" e.g. father and son may eat together even though this son may be married, and therefore sometimes eats in his wife's house. This is mainly because accommodation is a difficult problem in Vane, and the household unit is hardly the residential unit.

Secondly, most family heads normally insisted on including all their children in the household, even where some of these are independent of his "pot". To the family head, the family bond was the most important.

Because of this it was quite difficult sometimes to identify people by their households. The solution was for us to cross-check each time so that we do not have double counting problems. This was made easier mainly because the research team lived with the people and became familiar with the individual community members.

Operational Definitions

1. Self-Care:

The term here means the process whereby a lay person functions on his own behalf in decision-making on health, in disease prevention, detection and treatment.* We discern two forms of self-care; use of pharmaceuticals and use of plant medicine (Herbs). These we refer to as self medication. Other forms of self-care, for example personal prayers, and massage are also important aspects of self-care practice.

2. Faith Healing:

As used here means the use of spiritual means within the principles of the Christian religion, as healing power. This approach might use material objects like; the cross, incense, blessed water and florida water. These objects, however are used on account of their symbolic significance along with Christian worship and prayer.

3. Traditional herbal treatment :

By this we mean the use of therapeutic extracts from sources like plants, animals and minerals, with or without magico-religious rituals, as therapeutic device.

4. Professional treatment :

The term in this context means the use of both modern medical treatment (within formal institutions) and herbal treatment by socially recognised traditional practitioners within the community.

*Adopted from Levin 1983.

5. Acceptability:

The term here is interpreted to mean appreciation by consumers - both individuals and the community of the health services at their disposal. Acceptability can be shown in a number of ways; by statements made by community members during community survey and patient surveys as well as the level of utilization of the services of the NHC. Under-utilization may imply rejection of the services while over-utilization may indicate inadequacy of the services provided.

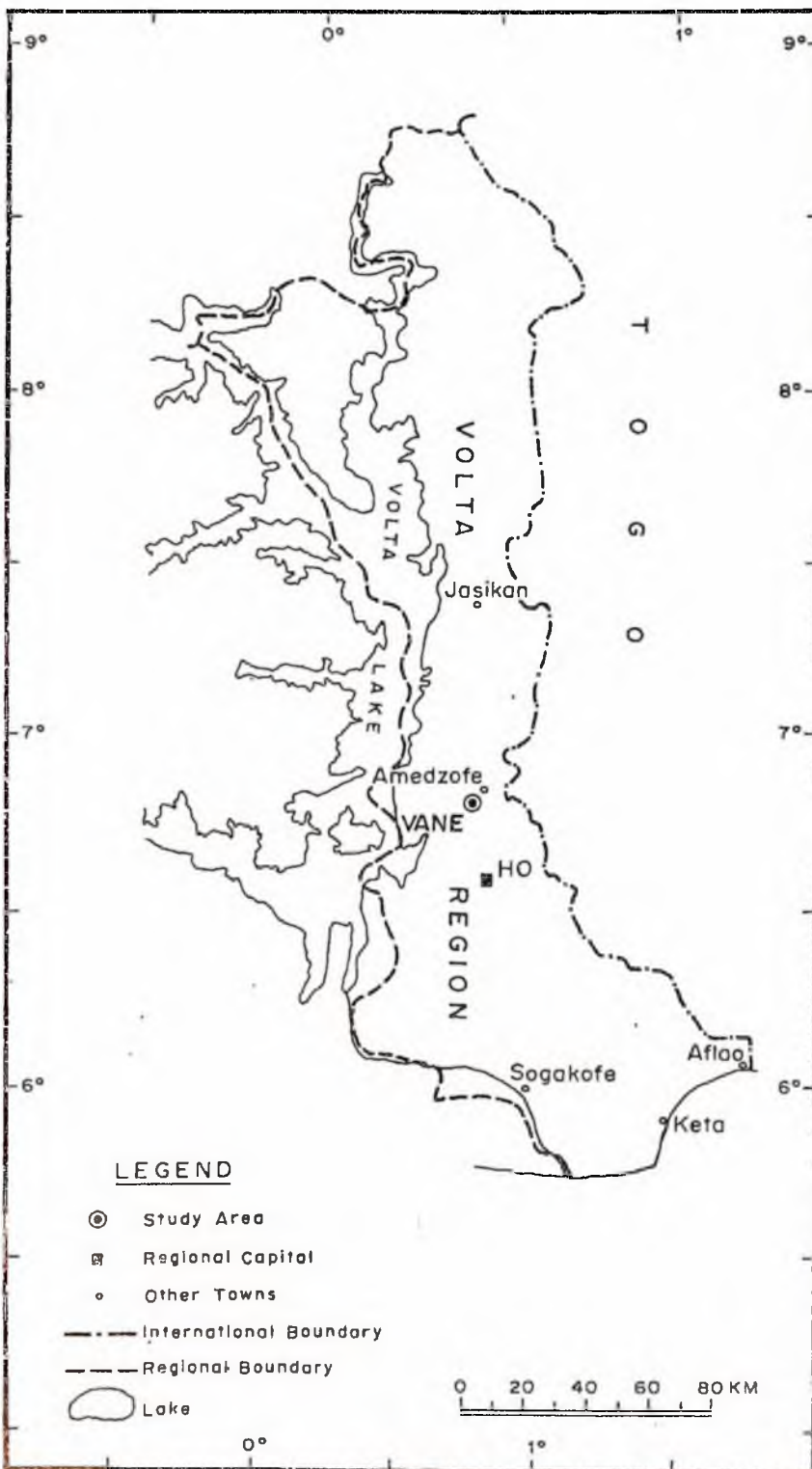
6. Integrated/holistic approach to healing:

The term as used in this thesis means the act of bringing together the modern and the traditional healing systems in a symbiotic relationship towards a holistic medical perspective.

Structure of the Report

This study comprises five chapters. The first chapter sets forth the problem, the background theoretical information, the objectives of the study, the method of study, operational definitions and the structure of the report. Chapter two deals with the social structure of the Vane community. It provides the background from which to analyze the role of the NHC and the attitude of the people towards it. In chapter three, the Nazareth Healing Complex is discussed, its structure, philosophy and history. The chapter also deals with the dynamics of the constituent parts of the NHC - the Modern Sector, the herbal sector and the Faith Healing Departments. In Chapter four, the general problems and issues of the NHC as a project are discussed. The last chapter deals with some of the conclusions, the implications and recommendations of the study.

Fig. 1 LOCATION OF VANE IN THE VOLTA REGION OF GHANA



CHAPTER TWO**THE SOCIAL STRUCTURE OF VANE****Introduction**

An overview of ethnography of Vane Community is necessary for the understanding of the people and their attitude towards health and health-care. The chapter discusses the geography, a brief history, the family structure, economic activities and community participation in development.

Geography

Vane is an Avatime village, 25 miles north of Ho, and about 185 kms. from Accra. It is located on the elevated grounds of the central part of the Akwapem-Togo ranges which rise to about 3,000ft. at Amedzofe and a small area of lowland to the North-West where Dзокpe and Fume villages are located.

It is basically an area of forest-clad mountains intersected by a deep valley along which the villages are scattered. The mountain ranges are formidable barriers and it is not surprising to note that the people of each of the seven villages of Avatime share a sense of unity and feel that as a unit, they are different, compared with people of the other villages of the area. Vane is the traditional capital of the Avatime area. The elevation is sufficient to give much cooler climate.

A dusty road from Ho through Vane and Amedzofe linking the main Accra-Hohoe trunk road is the only motorable road in the area. In the rainy season it becomes extremely difficult to reach Vane when the road becomes inundated and gully erosion makes it impassable.

During such periods, vehicles do not come to Vane. People have to walk over eight miles to the junction at Fume or five miles to Dzolokpuita to join passenger vehicles, even in periods of emergencies when sick people are involved.

The topography of the place however influences the health of the people. As will be discussed later, health problems here include bodily pains, waist problems and injuries. These are positively related to the mountainous nature of the place.

The People: (History)

The people of Vane claim that their forbears migrated from Ahanta in the present day Western Region of Ghana long after the main Ewe influx into the Volta Region. Linguistically, the people of Vane (Avatime) speak a language called Siyasa. According to Ford (1971), this language is characterised by a noun class system, with a degree of concordance and apparently unusual tone system. It is generally placed in the western "kwa" group of languages. However the Ewe language has become the lingua-franca for both native and non-natives.

The arrival of Christian missionaries in the 1890s had a tremendous impact on the life of the people. Education and Christianity are greatly valued by the people and non-Christians and illiterates are usually assigned to the periphery of social life.

Today, the Christian Churches in Vane include the Evangelical Presbyterian Church, the Apostles Revelation Society, and Roman Catholic Church and the Pentecostal Church.

Vane has two primary schools, a middle school, one junior and one senior secondary school which serve the educational needs of some of the surrounding villages as well.

Family System

The key to the understanding of the Vane family system is through the patrilineal descent principle which is based on clan organisation. Clans at Vane are localised. There are eight clans - defined as a group of people who claim descent from one or several agnatic forbears who migrated from Ahanta.

All the clans are also segmented into lineages. In Vane, the lineage is a localised kin group and has practical control over land and succession to various social offices for which a lineage may be designated - priesthood, royal family and land owners.

The smallest group on the scale is the residential unit. A residential unit is spatially isolable in that it consists of a series of buildings. Agnatic descent therefore forms the basis for the relevant groupings in Vane village life. Of these groupings - lineage, clan, village - all have spatial correlates.

Ward's findings in 1950 show that there were a number of female-headed households in Vane. Ward did not say how many female headed dwelling units there were but our observations reveal that the phenomenon is quite common in Vane at the time of this research. Perhaps this may be due to the high rate of migration. Both Ward (1950) and Brydon (1976) have noted that, most Avatime (Vane inclusive) people live and work away from their villages for most of their working lives. Migrants however maintain permanent links with the villages and always return home to settle after retirement.

Economic and Demographic Characteristics

According to the census office, in 1984, Vane had a population of 1,800. Primary subsistence farming is the main economic activity of the people. However, a small proportion of farmers also engage in cash crops. The missionaries introduced cash crops such as cocoa, tea, coffee, and potatoes to the area as early as the 1890s.

Generally, the farmer here balances his activities in a harmoniously diversified manner, the land being his main source of livelihood. The system for farm cultivation is mixed-cropping - cassava, yam, potatoes, maize, rice, beans, plantain, banana, oranges, pears, etc. Indeed, there is both adequate rainfall and suitable climate to provide for crops.

However, farming at Vane has a lot of problems. The land surface is rocky. It is relatively unsuitable for arable farming or mechanical system which would make for big scale economic venture. The people of Vane depend solely on the use of simple implements such as cutlasses and hoes for the cultivation of the land. Bush fallowing, especially the rotation of the fields is still a dominant practice even though the population pressure on the land has greatly limited the practice now. The rocky nature of the land is the limiting factor. Manual work becomes the first string. The people use pickaxes for planting and harvesting root crops. The farms are also far removed from Vane. They are mostly situated in the valleys behind the mountains. It means that the farmers have to wake up early at dawn and trek up and down the hills for some 3 miles to the farms.

There are a number of other income-generating activities in Vane but these are quite few. These include teaching, corn-milling, petty trading, art and crafts.

Political System

The political system of Vane is evolved around kinship and lineage groupings. The people stand together, relatively autonomous and different in the eyes of the Ewe people surrounding them and certainly in their own views.

Vane is territorially divided into two compact areas of habitation - known respectively as Tsadome and Osorpome in respect of the two major clans. Each is further divided into four sub-clans, thus making up the eight known clans of Vane-Avatime.

The two major clans have their chiefs respectively. The Osie is the Chief of the Osorpome, but he is the Paramount Chief of Avatime Traditional area as well. The Chief of Tsadome is therefore responsible to the Osie.

A well developed form of democratic procedure has been evolved for settling disputes and distributing duties in the society. Vane has evolved an almost ideal, fanatical sense of difference, of social cohesion and of intense group loyalty. These sentiments are exploited to effect social development projects eg. schools, toilet facilities, clean drinking water and the maintenance of roads - keen community participation.

The spirit of self-reliance therefore has great implications for health and related issues especially in relation to environmental sanitation and other contributions towards health development.

Existing Medical Systems

Health Conditions

The Vane community is served with pipe borne water from a spring up the mountains. There are two public latrines, and two dunghills. Relatively, because of the elevation, the Vane (Avatime) community enjoys a cooler climate and low population of snakes, scorpions and mosquitos.

As part of the community survey, data were collected on morbidity patterns at Vane through a household survey. This is intended to serve as a backdrop against which the utilization of Health Care services could be assessed.

The health problems mentioned included the following: malaria, pains and bodily weakness, stomach troubles and diarrhoea, cough and throat pains, ear and eye troubles, fractures and dislocations, menstrual problems, hypertension and heart problems, boils hernia, piles, asthma and mental disorders.

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Table 1: MORBIDITY PATTERNS AS PORTRAYED BY ILLNESS EPISODE

DISEASE	ILLNESS EPISODE	
	NO.	%
Malaria	40	32.78
Pains	46	37.70
Pyrexia of unknown origin other than malaria	10	8.20
Diarrhoea	4	3.28
Cough and Colds	4	3.28
Boils	4	3.28
Asthma	3	2.46
Skin diseases	-	-
Ear and Eye troubles	2	1.64
Fractures/Dislocations	2	1.64
Other accidents	-	-
Barrenness/Menstrual problems	2	1.64
Hypertension/Heart problems	2	1.64
Complications in Pregnancy	1	0.82
Anaemia	-	-
Mental disorder	1	0.82
Hernia	1	0.82
Pneumonia	-	-
Malnutrition	-	-
TOTAL	122	100

SOURCE: Illness episode: (see Chapter 1 under methods).

Table 1. shows that generally, bodily pains/weakness and malaria/fever predominate while the incidence of diarrhoea and stomach trouble was low.

The morbidity pattern shows that the major health hazards were very much related to the environmental problems including geographical hazards and working conditions; waist, leg, head pains, general bodily pains and weakness should be related to the topography.

Malaria has been of a high endemic nature. A significant proportion of cases in the sickness episode (32.8%) were of malaria.

Ideas on Health and Disease

As in all societies, the people of Vane have causal explanations for diseases. According to literature (Twumasi 1984, Fosu 1977, Senah 1981) cultural explanations and definitions of diseases are determining factors for the choice of therapy.

In Vane, diseases are defined in terms of modern and traditional concepts. By and large however, interviews with opinion leaders irrespective of their socio-economic dispositions show that the people classify diseases into two major types: - diseases caused by natural agents and those caused by supernatural agents - but there is a third which is not very clear - the natural/supernatural element.

The contemporary world view of the people of Vane is therefore an admixture of modernized, traditional and Christian elements. By their cosmological assumptions, it is believed that illness may result from three main sources:

- (a) Natural elements including food, the sun, cold, dirt, blood problems etc. etc.;
- (b) Supernatural elements like witchcraft, ancestral spirits, personal soul, punishment from God etc; and
- (c) A combination of both natural and supernatural elements, especially depending on how long the natural sickness persists even after the usual remedies were applied.

The reliance on any of these however depends on the individual's social background, education, sex, religion and this in turn influences the choice of therapy.

In the case of the natural elements, the belief is that the effective functioning of the human body depends, among other things, on the quality of one's blood, and stomach conditions.

The "dirt theory of disease causation" becomes paramount here. "Dirty blood" is deemed to account for many common kinds of malady. Bad blood may manifest itself in various forms of boils, infertility, menstrual disorders and piles. The blood may run short or may be in excess and these have their physiological manifestations.

Excessive blood is termed hypertension and it is believed that Herbal medicine is the main solution to this problem. When blood is short, it may manifest itself in dizziness and fatigue, or bodily weakness. Herbal blood tonics are very common in Vane. In addition to these, the head and the stomach are seen as capable of accumulating dirt which causes ill-health when the body does not expel it. Retention of faecal matter is believed to be responsible for many physiological problems - headache, fever and general weakness. Herbal enema and purgatives are very common in Vane for these ailments.

The head may also retain dirt in the form of mucus and phlegm. Local snuff, and herbal nasal drops are prepared as solutions.

The Supernatural element relates to the belief in witchcraft and sorcery in the Vane system. Assimeng (1974) has observed that "the central focus of religious activity in traditional Ghanaian society seems to be the warding off of "honhom fi" from the affairs of men. No doubt therefore "the greater part of the set of beliefs in magic, sorcery and witchcraft which are the daily baggage in traditional Ghanaian religion are directed towards this". (Assimeng 1974: 21).

In Vane, this belief system has been grafted on and transfused into the Christian teachings about the Devil and its powers of evil. Indeed the majority of healing "testimonies" during prayer sessions at most syncretic groups are usually deliverance from such forces and most prayer sessions are devoted to "binding the devil".

However, "spiritual dirt" through breach of taboos and norms may incur the displeasure of the ancestors and other spiritual agencies and create physical malaise and death. Various rites and ablutions exist for cleansing individuals and corporate groups of their "spiritual dirt".

These perceptions on the aetiology of illness are shared by a large number of the people - Christians as well. In times of health problems therefore, efforts are focused on whatever element is perceived to have precipitated the condition. Patients and healers share the same perceptions. Thus in the act of diagnosis, the healer's authority is also shared by the client.

Perhaps the views of the oldest practising traditional practitioner of Vane may give us clues to the general cosmological assumption and causal explanations for diseases and illness;

We have different diseases but they can all be grouped under two main sources. There is the first group which we believe are naturally caused. These are day-to-day health problems; They are related to the workings of one's stomach, or the blood system, or just straight forward injuries on the farm, or too much of work, food, drink, sex, etc. or effects of the change of the weather; cold or hot, or eating fresh fruit and fresh "foods" early in their seasons eg. mangoes and yam.

The average family elder, and most youths know some home treatments for such ailments. Indeed one may choose self medication by buying some pills at the wayside stores, use herbs at home, or go to the nurse for some injection.

There is the other group of diseases that are caused by supernatural agents like sorcery, witchcraft and evil eyes. Diseases like gonorrhoea may be natural or supernatural depending on the causal agent. Gonorrhoea may be contracted through magic by a rival. In such a case the problem is a supernatural force and must be treated by traditional specialists. Another shade of this is sickness brought about as a result of "spiritual dirt". This is punishment from ancestral spirits where the people or a person breaches the taboos of the clan. He must be given a ritual-bath, and the ancestors must be appeased. These problems cannot be solved by the modern doctor...

The above classification system has been observed in many societies by various Anthropological studies. Twumasi (1975, 1984) Warren (1974) Nukunya, Twumasi and Addo (1976).

Fosu (1977) for example observed in his ethnographic study of the Berekuso of Ghana that there are diseases whose causes are found in nature on the one hand, and those which are caused by supernatural agents on the other. However, unlike other studies, Fosu has established the third category of the natural/supernatural causation. This however was not fully accepted by some practitioners.

When further explanation was sought in this specific direction, the old traditional healer had this to say:

In reality only these two extremes exist. What you call the natural/supernatural category is usually a limitation on the part of most healers. The healer's inability to discern appropriately at the first go, the primary source of the problem at hand, may be responsible for this assertion. Thus in his diagnosis he may fail to detect the exact source of the problem. He may therefore assume that it is a natural problem at the preliminary stages. It is only when the problem defies the treatment he gives that he may wake up to the reality.

Nevertheless a natural case could be hijacked by spiritual agents and made worse; perhaps that is what you termed natural/supernatural. But an expert diviner sees it clearly at the very first go as a supernatural case..... that has become the driving force behind it.

However, in the view of the lay public, Fosu's assertion of the third category of natural/supernatural elements have been commonly acknowledged. The cultural definition of natural ailments however may not necessarily be identical with the definition of modern medicine. A cultural theory explains the prevalence of malaria for example, and this explanation is the single factor that determines how this problem is cured traditionally.

In the opinion of a 70-year-old traditional healer of Vane,

The whiteman's medicine says mosquitoes are the cause of malaria, but in Vane mosquitoes are rare and yet still malaria is endemic. Our malaria is therefore not caused by mosquitoes. Our malaria is caused by too much manual work in the fields. Excessive work under the sun, without any adequate resting may result in the blood system generating heat. Since the blood flows in the body, the heat is carried to all parts. The stomach becomes inactive when the heat is too much. The bowels are closed and constipation engender the settling of dirt in the stomach. The dirt enters the blood stream and it is the cause of the restlessness, bodily weakness, general bodily pains, fever, dizziness, and nausea which are associated with fever and malaria.

No doubt, the local treatment for malaria includes purging and draining. The sick may be given enema. As will be seen later, orthodox treatment using injections is highly valued for partial treatment of malaria since it is believed to give faster relief to the fever.

However the complete cure of malaria, according to the beliefs of the people, "is through the combined use of herbs and injections".

The complementary use of herbs and injections in treating malaria becomes plausible if we consider the background cultural assumptions about the effects of both treatments on the body and the disease. There is the idea that, the hypodermic needle reaches the blood stream directly with the medicine which brings down the temperature at a relatively faster rate than swallowing medicine.

No doubt, in most cases, the efficiency of a medical treatment is often judged by the willingness of the medical personnel to give injections. This, among others, is a principal reason for the near failure of the Village Health Volunteers under the Primary Health programme in the surrounding communities since they are not to give injections. Quack doctors therefore dominate the market because they satisfy the demands of the average person in these communities.

In the people's perception however, the ultimate cure for malaria must involve the removal of the dirt in the blood and the stomach, this is the role of herbal medicine in malaria treatment.

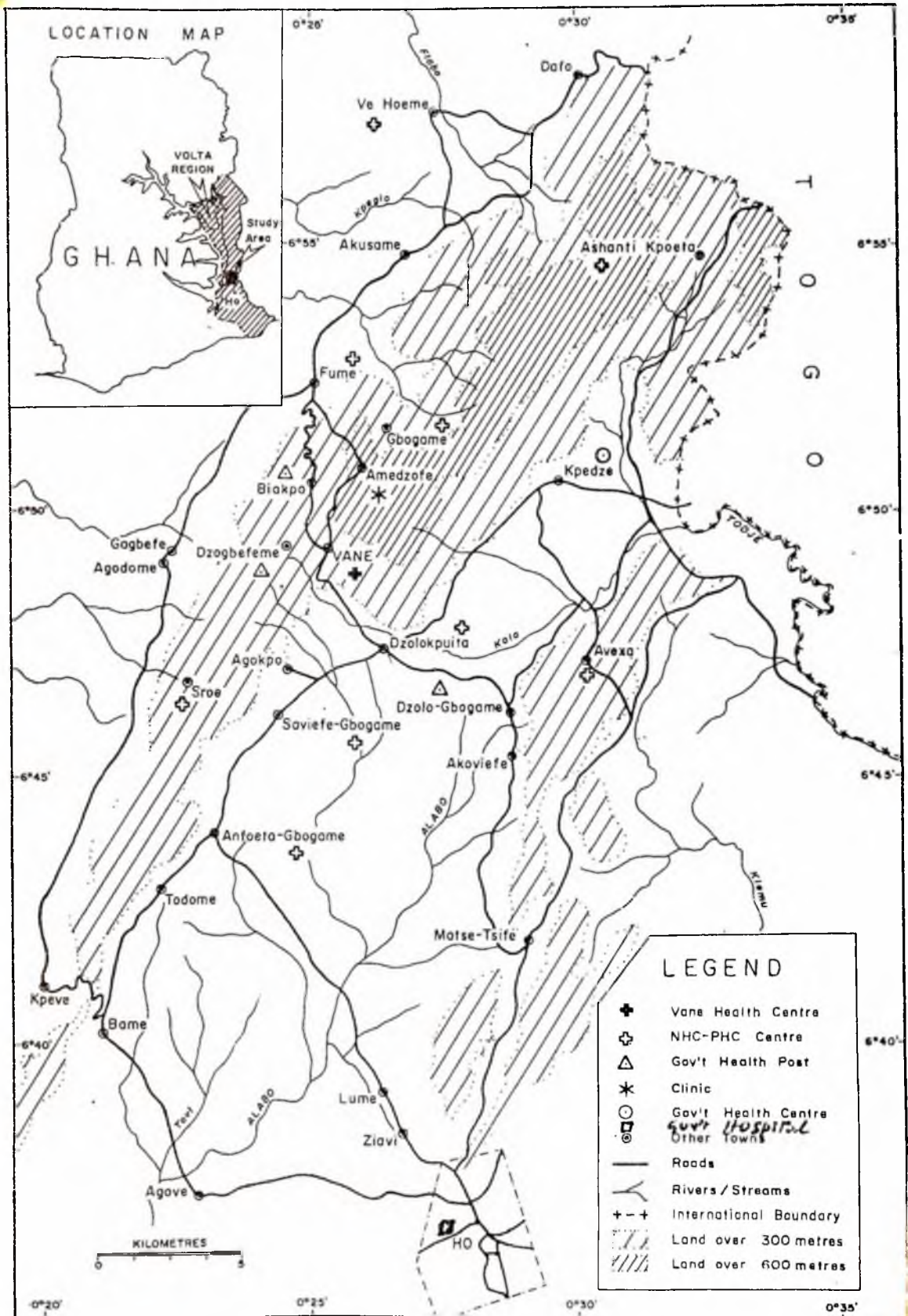
Health Resources

Introduction

Our discussion here gives an overview of the health resources including the Basic Health Services and the Community - Based health care systems in the locality of Vane to which the people have recourse when sick. This is to serve as background to the understanding of the nature of the relationship between the original health systems of Vane and the NHC innovation which impinges on these.

Basic Health Services

At the time of this research, the area enjoyed a number of public basic health facilities. Most of these facilities - especially the Hospitals - were not precisely in the traditional area of our concern but if we map out where individuals are wont to go for health services, a comprehensive "Health Community" evolves.



The orthodox facilities included the following:-

The NHC Health Centre within Vane itself, and the kpedze Health Centre (about 5miles from Vane) were the only Health Centres in the immediate environment. The health posts included; Liate Catholic Mission Clinic, Dzolo Clinic, Hlefi, Amedzofe and Nyagbo-sroe clinics (an average of about 6 miles from Vane). There is also one Dressing station at Dzolokpuita (5miles from Vane) and four hospitals in the area - including Anfoega and Hohoe government hospitals, and two hospitals in Ho (an average of about 20 miles from Vane).

In addition to these, there are a number of private clinics in towns surrounding Vane and about 8 primary health care centres in the immediate communities.

Community-Based Health Care

Introduction

Under this, we shall discuss the common health care services within Vane which are outside the public health system of NHC. These include unofficial dealers in pharmaceuticals, store keepers, itinerant drug sellers and traditional healers.

Unofficial Sources of Pharmaceuticals

The sources of pharmaceuticals in Vane are many and often involve complex relationship of familism and patronage. To a large extent, this complex situation is a function of the peculiar health needs of the people, poverty, as well as the structure of the official health care facility at their disposal.

The Ministry of Health (MOH) is responsible for the supply of drugs for the Health Centre of NHC. Apart from this, as a Mission Centre, the NHC clinic also benefits from The Christian Health Association of Ghana (CHAG) supplies of drugs to complement the efforts of MOH.

However, the absence of any effective drug monitoring system and the high demand for pharmaceuticals have enabled private drug sellers to make some inroads. A haphazard, uncontrolled system of drug distribution has evolved: Various small shops and a number of lay members of the society sell pharmaceutical products.

As we shall see later, this has dwarfed the significance of the role of the "NHC modern sector" through self medication. In most cases, to avoid the payment of consultation fees, patients auto-diagnose and auto-prescribe. Where the latter involved injectables, these are bought from the small shops, or individual dealers, or nurses. Injections are administered by quack doctors and unofficially by nurses of the Health Centre at home for a lower fee. Injections are also administered by retired nurses and other retired personnel who illegally practice at home.

Such treatments are not only cheaper than the fee paid at the clinic, but they are also more convenient to the patient since he could go to his farm at dawn and work the whole day, then consult the "Physician" at home in the night.

Given this complex nexus of demand and supply, dealing in pharmaceuticals in Vane has become a lucrative business.

Traditional Healers

Introduction

There are four main types of traditional healers in Vane. They are classified as Traditional Birth Attendants (TBAs), General herbalists, Diviners and Faith Healers

We shall discuss these in turns.

The Traditional Birth Attendants

The Traditional Birth Attendants are the traditional midwives. They focus attention on obstetrics, assisting delivery of children and seeing to the health of mothers.

Before the introduction of the maternity clinic of NHC, TBAs were the sole midwives for the people. It was a part-time family occupation, and usually considered as service to the community not necessarily for pecuniary purposes. In almost every clan or lineage, there are old experienced TBAs who deliver their own kins to replenish their stock. Thus TBAs tend to have intimate knowledge of their clients. Indeed they share a common belief system. In time of complications during delivery, this belief system becomes the means by which solutions are sought. In some cases the TBA may call for the services of a Diviner to diagnose the given problem. In other instances, she may rely solely on her knowledge of herbs and other medicaments. Various herbal preparations are used by TBAs for massage, insertions for expectant mothers and for spiritual protection of the mother and the baby.

TBAs are very important individuals in the rural community of Vane. They are usually elderly women who played very important roles in the nubility rites. They are the resource personnel during these rites. They treat topics relating to sexual reality, that is relationships between man and woman, sexual roles, social norms for sexual behaviour, sexually transmitted diseases, motherhood etc. They are the marriage counsellors of the community. As mothers of the community, TBAs are the authorities on traditional family planning techniques.

In the words of one elderly TBA of Vane;

Contrary to what the nurses think, we had ways of birth control, using our own methods of planning and use of herbs, long before they (nurses) were born. Why do they think that we are as prolific as rabbits? Traditionally, a man married several wives and spent nights with the different wives as he may wish, but it was taboo for him to "sleep" with a wife who is breastfeeding...his semen could poison the breast milk and the suckling child could die...Weaning took between two to three years and most times the pregnant wife leaves the husband's home for her own family (of orientation) to deliver and time enough for weaning...Stigma was attached to a family with "weak" children...yes, the simple code was; have a lot of children, but donot have them too close. Gossip and "malicious pity" safe-guarded the codeand we knew the periods of every month when a woman could "sleep" with a man without any fear of getting pregnant...or don't you know that a man can "withdraw himself" before he ejects the "life-giving-fluid?"....These are taught when girls are nubile....that is one purpose for the nubility rites.

However, the old TBA accepted the fact that the society itself encourages the possession of large families.

Only two TBAs still exist in Vane. Social change has greatly eroded their role in the community. Though they were retrained under the Ministry of Health, the womenfolk no longer patronise their services after the NHC with a maternity wing was introduced. Nevertheless, these TBAs still play some minor roles in the society especially in the preparation and sale of blood tonics and treatment of some health problems peculiar to the female gender. Though now very much different because of the effect of christianity, nubility rites still exist in Vane and so the role of TBAs in this field.

General Practitioners (Herbalists)

They are the most common of the traditional practitioners in Vane. Their approach to healing is related to the use and application of therapeutic extracts from plants, animals and minerals. They are often called herbalists since herbs are invariably the most common component of their medicaments. In Vane, herbalists include specialists in bone setting and general medicine.

Most of these practitioners had undergone a long period of training under mentors (Twumasi 1975: 25). This training was done within the context and practice of magico-religious rituals. Their long socialization, code of ethics and reference were the traditional beliefs and values.

With the advent of Christianity, education and orthodox medical practice however, the position of these practitioners within the Vane community was threatened. Almost all these healers in Vane were influenced by social change. Most of them accepted Christianity and were baptised into the Church.

Despite the effect of social change on their practices, the underlying beliefs and practices including the spiritual, intrinsic powers of herbs, ancestors, ghosts and relics, beliefs in sorcery and witchcraft; are still important aspects of their causal explanations of health and disease. They also use "the dirt theory of disease".

On the other hand in Vane, there is the emerging group of healers Bonsi (1973), Jahoda (1961), and Twumasi (1984) have termed "new-healers". These are practitioners whose underlying tenets of practice are relatively related to modern medical practice. They see herbs as therapeutic substances per se and not necessarily as having any intrinsic spiritual powers which effect healing. These neo-herbalists therefore do not use any magico-religious rituals in their practices.

The Diviners

The third category of traditional practitioners in Vane are the Fetish priests and Diviners. In Vane itself, only one person was known as a diviner. But one other diviner was stationed at Dzogbefeme, a quarter of a mile from Vane, and two others were stationed at Dzolokpuita - some 5 kilometres from vane. There was however evidence that people from Vane patronise the services of these other diviners - perhaps because they were situated in other villages, and thus consultation could still remain relatively confidential, the anonymity of the client ensures the secrecy.

The author and his team had the opportunity of accompanying the diviner of Vane on some of his rounds and healing sessions, and we were privileged to be participant observers in two consultative sessions of the two diviners at Dzolokpuita.

Diviners use methods of possession, casting of bones and other ritual means to diagnose and to effect healing. They claim they are only vessels through whom the deities and spiritual agencies speak to clients. The "casting of bones" by the Diviner is a whole panorama of symbols - bits of plants, organs of animals, - bones, skulls, claws, etc. stones, cowries, palm kernel etc. are used. The Diviner fills in the hiatus by verbal interpretations of proverbs which are quite pliable.

When he is satisfied with the diagnosis of the problem, the Diviner may resort to an interviewing technique to get more information. The basic theoretical tenet here is that social relationships have a telling effect on the health of a person. Enemies may cast spells to limit a person's progress, wealth and peace. Thus such tenets take into consideration social and psychological dispositions in understanding health problems.

Diviners charge fees for their services, however for purposes of rituals, clients were usually asked to bring food items like palm oil, goats, sheep fowls and eggs etc. for sacrifice.

Social change has affected these practices considerably. In a predominantly Christian society like Vane, stigma is attached particularly to the practices of diviners. On their part however, some of the diviners regard themselves as christians since they have been baptised into the church.

The Chief Priest and Diviner of the cult in Vane for example alleged he was baptised into the church in 1941..."before being called by the gods to serve at the shrine".

Until his death (during this research project), he held that he was a Christian. He explained that the lord's supper was the only Church sacrament that he avoided - his reason was clear:

"....because I have two wives and it is taboo to the Christian God for one to join in "the sharing of bread" on the holy table when one has more than a wife."

The clients of diviners include all social categories - Christians, highly educated people, poor, rich, government appointees etc. Most of these consult the oracle under the cover of night especially in the case of Christians, to avoid social sanctions like excommunication from the church.

The Chief Priest and Diviner of Vane was one of the seven traditional practitioners attached to the NHC herbal department as consultants during the second phase of the programme.*

Faith Healing

Before the advent of the NHC, the notion of Faith healing as a profession - full-time or part-time - was unknown in Vane. It used to be known or spoken of in urban circles, when migrants returned home with interesting awe-inspiring experiences and stories about the sectarian churches, Christian Fellowships and Open air Crusades in the city. They have brought home news about the Bonnke crusade, the Oral Roberts; Tommy O'del. Derek Prince etc; with supporting posters to portray their illustrations about the thousands of people who flock there from all walks of life, for worship and healing sessions.

The established denominations in Vane took some time to co-opt this new dimension of religiosity into their churches.

*The phases are discussed in chapter 3.

Youth wings emerged and were accommodated in the various orthodox Denominations. The Catholic Charismatic Movement, and the Presbyterian Prayer/Bible Study groups respectively were of this calibre.

Apart from these denominations, Vane has a number of syncretic groups. These churches included the Apostolic Church of Ghana, the New Covenant Church and the Apostolic Revelation Society. An example of the attitude of members of most of these new movements towards health care institutions could be illustrated using the Christian Fellowship of Vane.

The Christian Fellowship of Vane has been the most recent Christian group to emerge. It is interdenominational - thus its membership cuts across all the denominations and sectarian churches. They are a minority however, and membership is very youthful - pupils and secondary school students of the local school and training college. The Christian Fellowship is not a church. Members still belong and play salient roles within their churches of orientation.

What is most important to members of the fellowship has been the central role of prayers for the sick in preference to the use of other health care facilities. They believe that the devil is real and seeks to destroy man. Sickness and general ill-health, accidents, failures in life, infertility and mishaps are tribulations imposed on man by the Devil.

In some other cases, God may punish a sinner through disease and death. Though Fellowship members may seek professional medical care when sick, prayer or faith healing is the first string. Even then, it is the modern medical system that is acceptable. Traditional professionals are not trusted because "their practices tend to lean on deities other than the Spirit of God"

SUMMARY OF DISCUSSIONS

Vane community may be described, in relative terms, as a homogeneous society. Kinship and descent groupings in Vane are the basis of social, economic, religious and political organizations. In many respects, Vane is an agricultural community where the people live very close to the soil.

The early contact with the missionaries in the early 1890s however, has effected social change in Vane. The introduction of modern institutions like schools and churches in the area have gone a long way to influence the world view of the people. The contemporary world view of the people of Vane is therefore an admixture of modernized, traditional and christianized elements. These perspectives are utilized in defining illness and health issues.

The morbidity pattern showed that the major health hazards are related to environmental features including geographical hazards and working conditions.

The health resources in the area include; public health facilities, unofficial sources of modern drugs, and traditional sources of health care. It is within this social setting with apparent christian flavour but appreciably strong traditional beliefs and practices that the NHC as an innovation in health care delivery finds itself.

It is important to note however, that the acceptability of any innovation by a people is a function of the extent to which it is integrated into the values, beliefs and expectations of the given social structure. Against this background therefore, attempts shall be made in the next chapter to analyse the role of the NHC in satisfying the health needs of the people of Vane.

CHAPTER 3

THE NHC

INTRODUCTION

In the preceding chapter the main elements in the Vane social structure - including the various social institutions, health conditions and health facilities existing before the advent of the NHC - were discussed.

This chapter attempts an analytic description of the organizational strategy of the NHC, and the examination of the historical background, the aims, objectives, structures and utilization of the various constituent parts of the NHC programme. It is hoped that this exercise will enable an appreciation of the dynamics of the NHC - as an innovation in health care delivery.

The History and Organization of NHC

The primary preoccupation of the NHC is to satisfy the psychological, social and physical health needs of the people of Vane and surrounding communities. A central feature of the NHC social system is the high degree of division of labour and task specialization. It is a multi-speciality approach where three healing systems, herbal, modern and faith healing are grouped together in the same facility.

The aim of the NHC multi-speciality group practice is to allow association for the communication of ideas and for consultation with other health practitioners within the same facility.

The Origin of the NHC Idea

The idea for the NHC project grew out of the personal experiences of the founder and director of the project - Mr. Emmanuel Baku - a retired engineer and a faith healer. Interviews with the founder and some opinion leaders revealed that the original idea of a tripartite healing system that would merge the diverse health systems in the community stems from the founder's social background. As a child, it was alleged that he was strongly attached to things pertaining to the mystic world. The use of spiritual forces for healing the sick fascinated him.

An important aspect of life which influenced the ultimate development of his ideas and perspective has been the unique experiences he gained from belonging to a family of conflicting religious orientations. His father was among the first converts of the christian faith in Vane. As a result, the family rejected all magico-religious practices substituting christian principles for them. On the other hand, the maternal family (of the founder) adhered strictly to the practices of the traditional religion. The maternal grandfather for example, was a famous diviner/healer.

The Christian religious outlook of his father as the pater familia greatly influenced the child, but this did not rule out the influence of his mother who devoted herself to the success and spiritual protection of her son, through traditional magico-ritual practices.

This conflicting value orientation enabled the child to understand the beliefs and values of each of these two religious persuasions and their implications for health related issues.

Participating in the activities of both religious orientations, the founder became aware of the hypocritical attitude of some professed christians when seeking health care. It was common place that some christians condemned magico-religious practices in the open, but during acute and bizarre ailments they sought refuge with the founder's maternal grandfather. According to the founder "the white man's medicine could not penetrate such health problems... especially where no germs are involved..." To avoid excommunication from the church, most christians consulted the fetish in the night.

What gave the founder impetus towards concretising his ideas may be traced to his experiences in India and Britain. The opportunity to study engineering in India, under what was then termed the Ghana Government Independence scholarship, gave the founder the opportunity to learn from a social structure that had diverse religious orientations and strong inclinations towards metaphysical healing practices.

The thoughts and teachings of Gandhi about the use of religion for social development greatly inspired the founder. Coupled with this, the very fact that he studied in both Hindu and Moslem universities in India widened his mental horizon about the attitude of other religions towards health issues. As a student, he also participated actively in the India Evangelical Students' Association and later in the Cambridge Brotherhood of Britain. These were christian organizations that practised faith healing.

Mr. Baku also became aware of the diverse efforts in India at the time to improve upon the traditional medical system. He was determined therefore to follow this line which recognised some inherent capabilities in the traditional medical system. According to the founder:

...the experience that back at home people were standing in ambivalence between the two cultures and religious forces in terms of health issues... so that certain christians went secretly in the night to the Diviner/healers, while in the day condemned these ritual and herbal drugs made me resolve to do something to save the situation...

He was aware that, back in Ghana, at the time, there were very few modern medical facilities, and in the remote areas of the country especially, the people depended solely on traditional healing systems. Though this worked for the people, the traditional medical system had its own limitations especially in handling certain physical ailments like tetanus, cholera and some general infectious diseases.

Likewise he was aware that even though in the cities the modern medical facilities were available, to the average person with a traditional background, these facilities seemed to lack something important.

Some cases of bone setting and infectious diseases defy treatment with modern medicine. Co-operation with other traditional methods of healing greatly enhances the overall success of treatment. And while the knowledge of traditional healing can be fully integrated into modern practice, the hygiene and quality of these other treatments can also be improved with attention to up-to-date medical methods" (Mr. Baku: Contact: 1988:4).

In other cases where people were confronted with bizarre and anxiety-provoking situations, the average person resorted to the traditional resources for healing.

The founder was aware that, the Christian Missionaries rejected the magico-religious practices of the traditional healing system, yet they were not able to make any adequate restorative substitution using the symbolic system of christianity to invoke in their converts the same supportive traditional universe necessary for faith healing. Commenting on this, the founder said;

Christianity itself has stronger spiritual powers the Holy Spirit power which could be used to effect healing. But the orthodox churches were rigid and European in their outlook and therefore did not want to open up and reach out to the suffering with faith healing and the manifestation of the gifts of the Holy Spirit.thus I came to the realization that, given the strengths and weaknesses of each of these health systems, it would be in place to evolve a new system that combines all these health systems for the benefit of the society.

Shrewdly analysing the various health institutions within his native society, and aided by his wider perspective and experience in other cultures, the founder reasoned that an ideal system in which these health systems were made to collaborate would cater fully for the total health needs of the community.

It is clear that a wholesome, open-minded approach on the part of all healers can only help a suffering person more completely. In the right spirit, inherent differences among the systems are truly complementary (Mr. Baku: Contact 1988:4)

After graduation, the founder returned to Ghana to work in the Ministry of Works and Housing as an Engineer. His first posting took him to Nsawam as the district Engineer. In the late 1960s, Mr. Baku became one of the founding fathers of the Nsawam Association of Healers, made up of medical doctors, herbalists and faith healers. He acted as a faith healer and the organizer of the Association. He founded similar Associations in all the subsequent stations he was transferred to. The principal objective of these Associations were to effect informal referrals between the different specialists, on the basis of trust, mutual respect and understanding.

After the founder retired from active service in the Ministry of works and Housing, he returned to his native home - Vane - to settle. The sanctuary which he built in his house formed the nucleus of the three-in-one complex he had been thinking of. Thus at this stage he was operating only as a faith healer, and referring patients to traditional healers depending on the case at hand.

As the number of his patients grew larger with time he thought of building a hospital complex of modern, herbal and faith healing sections.

The building of this edifice started in 1974. The herbal and spiritual Healing Sections of this complex were officially opened in December 1976, whilst the modern medical section was opened in June 1977.

Information on the source of funds for the complex is not very clear. However opinion leaders are of the view that the complex was put up through the founder's own private funds and loans from the banks. Members of the Vane community however offered some communal labour by fetching water and stones at the initial stages of the project. The government of Ghana and some Non-governmental organizations including The Christian Medical Commission of the World Council of Churches (CMC), the Christian Health Association of Ghana (GHAG), and the Inter-Church Co-ordinating Committee for Development projects (ICCO) in the Netherlands have contributed towards the provision of equipment for the project.*

Today the NHC is a Christian Mission Health Institution under the auspices of the Evangelical Presbyterian Mission. According to the traditions of the Mission, Management Boards exist for all mission institutions including Health Institutions.

*See Appendix C for other related projects of NHC funded by external donors.

The Management Board of NHC comprises representatives from: the Mission Head Office, Medical Officers from the Mission Hospital, the office of the Regional Medical Director - MOH - the Regional Secretary of State, the Regional Association of Psychic and Traditional Healers, local healers, as well as significant others from the Vane community - the Chiefs and the Church. The Board is supposed to deliberate upon issues concerning policy, and the dynamics of the project. It is supposed to meet at least once a year.

The Management Committee of NHC is the locally constituted Committee. Members include lieutenants of the founder/director, some opinion leaders of the society, representatives of the Vane development committee, representatives of the local traditional healing system, and some individuals who show interest in the project.

The management board of NHC, represented by the Management Committee at the local level, is therefore the single point of command or policy making body over all the various sectors of the NHC. The Chairman of this committee and the one directly in control of the project is the founder/director of NHC. He serves as the Co-ordinator of the project, presiding over all meetings as well as controller of the finances and personnel of all sectors.

Having discussed the history of the NHC, the focus will now turn to the appreciation of the basic philosophy of the NHC model.

The Basic Philosophy of NHC

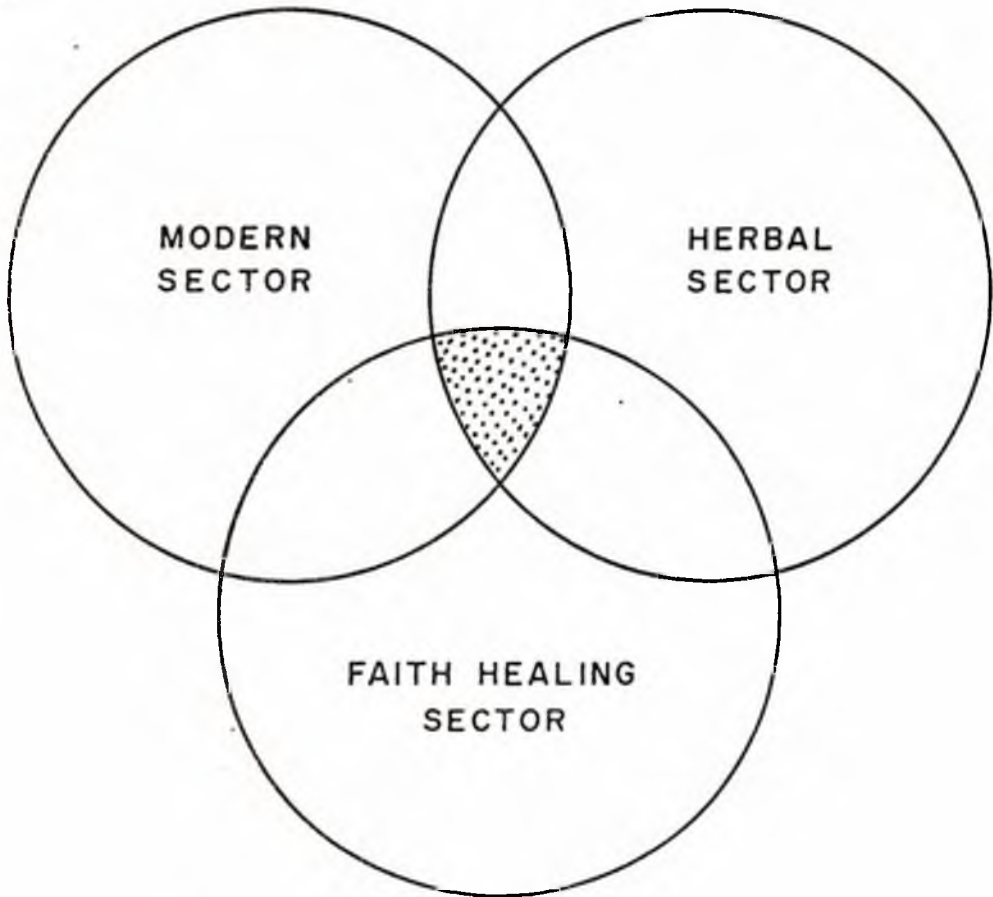
Three structures in the same yard, house the three departments - a Modern Health Centre, a Faith Healing Centre and a Herbal Clinic. As depicted in the diagram (fig. 1.1) the basic philosophy of the NHC model stressed joint effort, and respect between the three constituent parts. The thrust of this model therefore is the interplay of the various parts within NHC towards an integrated approach to healing.


The patient may enter the orbit of NHC through any of the three sectors depending on the appraisal of his own health needs. Once in the system, the responsibility for the ultimate healing of the patient is shared between all sectors - depending on the problem at hand. This is effected through an inter-sectoral referral system.

In this wise, it may be said that a patient-care team, depending on the problem at hand, forms around the entering patient. The team plans and implements the care needed and dissolves when that patient leaves. A new team, with different members depending on the new case at hand, immediately comes into being to manage the next entering patient.

This approach becomes crucial if we take into consideration the people's cultural interpretation of health and illness issues.

Fig. 1.1 THE PHILOSOPHY OF NHC



 Interplay between sectors.

A hypothetical approach to the treatment of a case of lorry accident may illustrate the multi-speciality approach in NHC. In the perspective of the modern medical system, a lorry accident is regarded purely as a physical health problem. The wounds must be treated against tetanus, the blood flow must be stopped, and the wound bandaged, pain killers are prescribed and rest recommended.

Many people who sustain injuries during accidents would readily accept the first aid treatment against tetanus, and the dressing of the open wound, however in the treatment of fractures, many reject the modern medical system's use of the plaster of paris and prefer the treatment given by the traditional bone setter who uses herbs and massage. The role of the herbal sector is then called into play.

Apart from this, the emotional state of the patient has to be considered. The cosmological assumptions reviewed in Chapter 2 give the impression that, the average patient would attribute the accident not to the carelessness of the driver or mechanical faults per se, but to the machinations of his enemies who intended to kill him. The anxiety, fear and belief in the activities of invisible forces would invariably affect the treatment process. The patient would be afraid that evil forces are still after him, and would eventually destroy him, even at the hospital in his sleep. As a result of this presentiment, he would become restless, and anxious.

He knows the doctor would not understand him when he tries to explain. This fear and presage may precipitate other dimensions to the health situation. In such cases therefore, the faith healing sector of NHC is called upon to offer prayers towards delivering the patient from the hands of these haunting spirits. Thus a seemingly physical health issue like a lorry accident may have certain dimensions which call for the multi-speciality approach.

Having examined the ideals of the founder and the history of the organization and how it is supposed to operate, it is important now to examine how the NHC functions in practice. The remainder of this chapter shall therefore be devoted to the description of each of the sectors. This is necessary for the subsequent analysis of the organizational problems in the next chapter.

The Constituent Parts of NHC

The modern medical sector

The modern sector of the NHC was opened in June, 1977 and was officially handed over to the Ministry of Health whose personnel still manage this sector. This sector consists of a number of rooms designated for various departments just like in a normal hospital. However not all the departments were operating at the time of this investigation. The modern medical sector included an Outpatient Department, Dispensary, an X-ray department, a Recovery Ward, two Rest Rooms for the staff and toilet facilities.

At the time of this research, the number of health personnel in the modern medical sector totalled 19. This includes; six non-medical personnel and thirteen medical personnel.* The personnel of this sector are responsible to the Ministry of Health (MOH) in Ho, the regional capital.

At the local level however, the personnel are responsible to the health superintendent. The MOH is responsible for the supply of drugs, equipment, and staffing. As a public health centre, the NHC modern sector performs first aid services at the advanced level. The sector is supposed to act as the central referral point for the Primary Health Care Units, Dressing Stations and Health Posts in the area.

Treatment Procedures

How does a patient utilize the services of the modern sector? The relationship between the patient and the modern medical services of the NHC may be described through some case studies recorded during the field study.

Afi, a twenty-five year old housewife has been feeling unwell for a week now. She has tried some local remedies, and then some pharmaceuticals bought from the wayside stalls for self-care. The illness persisted. She was experiencing nightmares and restlessness over the night. This morning she is feeling terrible - nausea, loss of appetite, dizziness and general bodily pains and weakness. She has decided therefore to report for a check-up at the clinic.

*A table showing the duties and functions of the various personnel at the Modern Sector is in Appendix G.

Afi reports at the clinic at 9:00 a.m. The personnel are yet to come, but the cleaners are still cleaning the offices and arranging the benches. Afi sits on a bench, in the open hall which serves as the waiting room and maternity clinic. By 9:30 a.m. work starts. Three other patients - Besi, Kofi and Joe have also come to report for treatment.

Today is quite a busy day - four patients by 9:30 a.m. Besi's case is certainly a more serious one. She could not sit up right. She lies on a cloth spread on the cement floor, shivering. When the nurse in-charge of records arrives, Afi is called to register. Since this is her first visit to the clinic, she is asked to pay fifty cedis (¢50) for registration. The other patients submit their identity cards without paying this fee. The nurse records the name, age and address of Afi. After a while the nurse appears through the door and calls the names of patients from the cards. The patients are made to sit according to the arrangement of the cards.

A bell rings, and Afi, the first in the row, enters the consulting room. A health centre superintendent and an assisting nurse, work in this room. One half of the room is screened off for injections; a small bed for emergencies is also spread here. Close to this enclosure stands a kerosine ridge, and a hand washing basin on a stand.

In the centre of the room is a big table at which sits the superintendent, in a white overall with a stethoscope loosely hanging on his neck. The table itself displays cards of patients, some drugs and some jars of syrups. Two thermometers stand in a clear bottle half filled with a colourless liquid.

The nurse waves Afi to a chair. The superintendent then asks questions in Ewe. "What is wrong with you", "when did it start," "why did you not come to the clinic when it started," "can you describe how you feel?" The Superintendent is apparently annoyed that Afi kept so long at home before turning up for treatment. He examines the eyes of the patient. The nurse takes the thermometer and after vigorously shaking and rechecking it, she places it between the lips of the patient - the tip reaching under the tongue. The patient dutifully closes the lips over it.

After some minutes, the thermometer is removed. The nurse enters the thermometer readings on the card. The superintendent takes the card and notes down his diagnosis. The consultation took about six minutes. Afi is then asked to go to the laboratory for her blood film. The bell rings and Besi enters.

The laboratory is a single room with a cupboard, a bench for patients, and a big table on which stands a microscope, slides, some small empty bottles - for taking samples of the urine and stool of patients for testing. A male Laboratory Assistant manages the place.

He collects Afi's card and offers her a seat. Afi on request shows her left thumb. The laboratory Assistant cleans the tip of the thumb with cotton wool and alcohol, then uses a lancet to prick the thumb once. The blood sample is pressed on to a small glass slide. Afi is asked to wait outside on a bench.

The blood is spread on the slide for drying. 15 minutes pass. The Laboratory Assistant then takes the slide, stains the sample with geimsa and puts it near the window for another 15 minutes to dry. He then washes the stain off, dries it for another 10 minutes before examining it under the microscope for about 20 minutes. Then the report is ready.

Afi is requested to pay laboratory fee of ₵200.00 to the laboratory assistant. No receipts are given. The explanation is simple. According to the laboratory assistant there is shortage of giemsa stain at the medical stores of the Ministry of Health (MOH) at the time. This is the reagent for testing malaria. What he has used for Afi's test has been through his own private arrangements. The money collected does not go into the coffers of MOH. Afi grumbles over the cost involved. She pays the fee, collects the card and traces her steps back to the consulting room.

The Superintendent reads through the card and scribbles something on it. The nurse collects the card, opens a cupboard and brings out one new hypodermic needle and syringe. The nurse asks Afi whether she has eaten this morning. Afi could not eat any solid food. She has however managed to drink some tea.

She is taken behind the screen for the injection. Afi has however brought her own chloroquine injection. She bought it from the nearby small shop.* This is to avoid the comparatively high cost of this drug in the clinic.

Because Afi itches with chloroquine, phenegan injection is added. After this, Afi is given some drugs. These include, chloroquine tablets, paracetamol, vitamin B complex, multivite tablets and some valium. She pays five hundred cedis (¢500.00) for these drugs. She is instructed as to when and how to take each. The use of the needle and syringe attract a hundred cedis (¢100.00) fee. Receipts are given to cover these. In all, Afi's bill for the malaria case amounts to eight hundred and fifty cedis (¢850.00) excluding the Chloroquine injection she brought herself.

Interviews with Afi shows that she is disappointed with the services, not only because the treatment is expensive compared with self-care using the same drugs, but also because of the time spent.

*See Appendix F for some of the pharmaceuticals sold in the shops of Vane and their prices.

Getting the laboratory report alone took over one hour. Next time there is a case like this, Afi has decided, it would be better to go to a hospital where a doctor would make a thorough examination before the prescriptions. In such minor problems like malaria, Afi is of the opinion that it is better to see the nurse at home. In such a case, one would not have to spend that much time and spend money on consultation fee, laboratory fee and registration fee. There would also be no need to pay for the syringe and needle because the same is used several times for different patients after sterilization (by the boiling method).

When questioned about her impressions about the three-in-one complex of NHC, Afi is of the opinion that unless a medical doctor is attached to the health centre, the goal of the NHC cannot be achieved. She thinks that the attendance of a clinic is positively related to the quality of personnel at the centre not the availability of drugs per se.

On the issue of her views about traditional healing, Afi explains that she has never consulted any traditional practitioner before. She however often buys a neo-herbal concoction called "Alafia Bitters" sold at a pharmacy shop in Ho for the treatment of rheumatism. She also accepts that for minor ailments like cough, bodily pains, constipation and ordinary boils, she uses herbs and roots for self-medication.

Afi alleges she has never been to the faith healing sector of NHC. However, she is aware that the faith healer uses certain items like holy water, incense, florida water, and candles during healing sessions.

Afi is of the opinion that a true Christian must approach God through Jesus personally. According to her, the traditions of the faith healing department of NHC does not tally with the standards of her Church. She thinks that such items as used by the faith healing department are normally associated with magicians who invoke spirits other than the Holy Spirit of God.

The case of Kofi, a twenty-year old is quite different. He has been experiencing severe pains in the chest for about ten days now. He has a bad cough and feels restless. He has tried some home remedies - chewing ginger and some sugar. This could not solve the problem, so he decided to consult the health superintendent.

After examining Kofi, the superintendent gives him some tablets of paracetamol, and valium. According to the superintendent, there is shortage of cough mixture at the time. Kofi is asked to go to the Regional Hospital, Ho, or drug stores in Ho (20 miles away) to buy this drug.

An alternative, according to one nurse, is to pay three hundred cedis (¢300.00) to the mid-wife who has - by her own private arrangements, procured the drug for retailing in small bottles. For all these services, Kofi pays seven hundred cedis (¢700.00).

Mr. Doe, on the other hand goes through only the registration and consultation. The superintendent diagnoses his complaint to be hydrocele. He is given some paracetamol tablets for temporal pain relief. His case would involve a surgical operation.

Explanations are given by the nurse and a referral letter is written for Mr. Doe to the Regional Hospital at Ho for treatment. Mr. Doe pays two hundred cedis (¢200.00) for the services.

An interview with Mr. Doe after the treatment shows his disappointment especially because of the cost involved even for the few paracetamol tablets given, and the long waiting time. He complains that in the first place, he could have gone straight to the hospital with the problem instead of reporting first at the clinic and paying two hundred cedis (¢200.00) for a drug which after all could be got at sixty cedis (¢60.00) at the roadside shop. It would have taken him only a hundred cedis (¢100.00) by bus to Ho. Now he is going to incur extra cost after the first aid treatment.

Mr. Doe is of the opinion that the NHC does not adequately meet the health needs of the people. The initial promise by the management was that the NHC was going to be a complex hospital with resident medical and supporting staff, equipment and drugs. The herbal department was expected to be manned by highly trained research personnel, like in the case of the Centre for Scientific Research Into plant Medicine - Mampong. The Faith Healing Sector was expected to be an interdenominational fellowship, managed by a charismatic leader.

According to Mr. Doe, the community members are disappointed because none of these expectations has been fulfilled. The community members therefore have little confidence in the personnel of the NHC and prefer to seek health care at other places that have facilities that meet the people's expectation.

One other problem of NHC, according to Mr. Doe, relates to the role of the founder/director of NHC. To Mr. Doe, there is relatively high community apathy toward the project because the director/founder is so emotionally attached to the project that he ignores the views of community members completely. Thus community participation is very low, and many see the project as a private venture that goes to benefit an individual and his family.

Although limited to only three cases, these profiles depict the general pattern of patients' utilization of the services of the modern sector of NHC. These cases give some insight and the procedures adopted at the modern sector.

What is apparent from these cases is the shortage of some basic drugs. There is also problem of the high cost of the services provided at the NHC. Many complain about the high cost treatment. This is perhaps because they compare the cost of the drugs obtained at the NHC with those available in illegal drug-shops in the village.

What is most apparent is the fact that the superintendent did not in any case refer patients to other parts of the complex. Despite the fact that there is a herbal specialist for hydrocele in the complex, the superintendent preferred to refer the case to Ho hospital. And in the cases of malaria, there were no referrals to the herbal side for a complementary treatment at a relatively lower cost although this is possible. The principal issues and implications of these findings will be analytically discussed in chapter 4.

In the next section, the records of the modern sector of NHC are analysed. This analysis will help us to appraise the utilization of the services of this sector, and the social characteristics of those who patronize this facility.

TABLE 2: MORBIDITY PATTERNS AS PORTRAYED BY ILLNESS EPISODE AND DATA FROM THE NHC HEALTH CENTRE RECORDS

DISEASES	ILLNESS EPISODE			NHC HEALTH CENTRE		
	NO	%	:	NO	%	:
Malaria	40	32.75	:	232	59.18	:
Pains	46	37.70	:	-	-	:
Pyrexia of unknown origin other than malaria	10	8.20	:	14	3.57	:
Diarrhoea	4	3.28	:	30	7.65	:
Cough and Colds:	4	3.28	:	-	-	:
Skin diseases	-	-	:	5	1.28	:
Ear & eye troubles	2	1.64	:	5	1.28	:
Fracture/dislocation	2	1.64	:	-	-	:
Other accidents	-	-	:	28	7.14	:
Barrenness/Menstrual problems	2	1.64	:	-	-	:
complications in pregnancy	1	0.82	:	1	0.26	:
Hypertension/Heart problems	2	1.64	:	16	4.08	:
Anaemia	-	-	:	7	1.79	:
Mental disorder	1	0.82	:	-	-	:
Boils	4	3.28	:	-	-	:
Hernia	1	0.82	:	-	-	:
Asthma	3	2.46	:	-	-	:
Pneumonia	-	-	:	8	2.04	:
Malnutrition	-	-	:	6	1.53	:
14 other diseases unnamed	-	-	:	40	10.20	:
TOTAL	122	100	:	392	100	:

Source: Illness episode: (See chapter 1 under methods).
(b) NHC records obtained from the Regional

The Dynamics of the Modern Sector

In Table 2, the morbidity pattern at the health centre is compared with the morbidity pattern gathered during the illness episode monitoring. What is very clear from the table is the endemic nature of malaria. A significant proportion of cases in the sickness episode (32.78%) were of malaria. It is also the single highest proportion of cases sent to the modern sector, (59.18%).

From the Table, it can be said that the modern sector facilities are basically used for malaria/fever, diarrhoea, and general accidents. The utilization of the modern sector for the treatment of malaria could be explained perhaps by the underlying faith in a complementary approach to the treatment of this disease. As discussed in chapter 3, modern treatment (especially injections) are believed to offer fast relief in terms of decrease in the fever that usually accompanies malaria. The ultimate cure of malaria however, (it is believed), must be sought through the use of herbs.

In the case of general accidents and injuries, explanations might be due to the fear of tetanus infection which is best handled through modern preventive treatment.

The case of diarrhoea may be explained in terms of its association with the cholera epidemic which spread through Ghana in the late 1960s and early 1970s. The role of modern medical treatment in eradicating the problem in this area is well known and perhaps such experiences maybe responsible for the use of the modern sector for a health problem with quite similar symptoms.

In Table 2, the predominance of pains in the illness episode (37.7%) and the very fact that this is not reflected by the Health Centre (Modern Sector) records may have a number of explanations. We may say that the illness episode records are the layman's idea about the symptoms of his disease; the fact that it is not reflected in the records of the modern sector may be explained in terms of wrong diagnosis of the lay public. Pains may be symptoms of other health problems. In this wise, the difference in the incidence of this health problem may be due to differences between lay definition and professional definition of health problems.

Another interpretation might be because individuals have other health systems to which they have recourse for such a problem. Perhaps the people do not trust the competence of the modern sector in the treatment of this health problem. Other health facilities including self medication, traditional healers, and other official and private health facilities in the area may be consulted.

Attendance levels

The levels of utilization of the modern sector, measured in terms of the number of visits per individual (all age groups) per year, has been declining steadily over the years.

TABLE 3: ATTENDANCE OF THE MODERN SECTOR BETWEEN 1982 - 1988

YEARS	NO. OF PATIENTS	% OF BASE YEAR	% DECLINE USING 1982 AS BASE YEAR
1982	5519	-	-
1983	5101	92.43	7.57
1984	2522	45.70	54.30
1985	1397	25.31	74.69
1986	772	14.00	86.01
1987	837	15.17	84.83
1988	556	10.07	89.93
TOTAL	17104		

Source: Ministry of Health, Ho.

Using 1982 attendance as a base, the utilization of the modern sector in subsequent years (1983-1988) declined steadily and steeply. The attendance for 1987 improved over that of 1986, though the decline was not stemmed by this as the attendance showed a further decline of almost 90% of the 1982 figure in 1988. In 1988 for example, the total number of patients recorded was 556 which is less than 3 patients per working day. For a staff of 19 personnel, this is certainly not cost effective. The question that emerges is why this steady and steep decline over the years? A number of factors may be responsible for this trend. These factors shall be discussed in chapter 4.

AGE DISTRIBUTION OF PATIENTS OF THE MODERN SECTOR

In Table 4 the age of patients who patronize the NHC Modern Sector is given. From the Table, it can be seen that there is an inverse relationship between the age of patients and their patronage of the health centre.

TABLE 4: AGE/SEX DISTRIBUTION OF PATIENTS

YEAR :	UNDER 15		15 - 44		45 - 60		61+ :		TOTAL	
:	NO	%	NO	%	NO	%	NO	%	NO	%
1982 :	2402	40.6	2211	37.4	694	11.7	612	10.3	5919	100
1983 :	2215	43.4	1954	38.3	513	10.1	419	8.2	5102	100
1984 :	1177	46.7	749	29.7	424	16.8	172	6.8	2522	100
1985 :	708	43.6	477	29.6	399	20.9	101	6.2	1625	100
1986 :	345	45.7	260	34.4	103	13.7	47	6.2	755	100
1987 :	364	44.1	269	32.6	121	14.7	71	8.6	825	100
TOTAL:	7211	43.1	5920	35.4	2194	13.1	1422	8.5	16716	---

*Figures (distribution by age) for 1988 were not available at the time.

Source: MOH, HO.

According to Table 4, 43 per cent of those who visited the Health Centre between 1982 and 1987 were under 15 years of age. Those of the 15 - 44 years group contributed 35 per cent while the 45 - 60 year group constituted 13 per cent and the least being those over 61 years (9%). The distribution by age is skewed towards those under 15 years of age and declined steadily with age. It means therefore that there exists an inverse relationship between the age of a patient and the utilization of modern sector facilities.

The pattern resembles those found in other places (Asare 1975). In his study, Fosu (1977:92) for instance, found that infants have a substantial representation in the hospital population.

This conclusion has been confirmed by the IDS research Reports on some rural communities in Ghana. According to this Report, When Guameng mothers were asked about the choice of therapy for fever in young children, a typical response has been "the baby would be taken straight to the health centre, but from one year of age self-treatment is all right..." (IDS Health Group 1978:50).

Another interpretation may be given in terms of differential response to modern facilities by age groups. The young generation are more likely to be attracted by the modernizing influence of the western world. Indeed Busia (1964) has indicated that the youth are generally alienated from the traditional society because of education. They may therefore become strangers to traditional healing systems and naturally prefer the modern medical system.

The older generation on the other hand, with their relatively greater exposure to traditional healing systems, and perhaps with the higher incidence of incapacitating and chronic health problems are much more prone towards the use of traditional methods after trying the modern system to no avail.

(Wondergem, Senah and Glover 1987: 69).

When sex is considered in relation to the utilization of the Health Centre, it was found that though more males [8485 (50.8%)] patronise the facilities than females (17.2%), the difference between the sexes is too negligible for any further analysis.

After discussing the records of the modern sector of the NHC, let us now take a look at the Herbal department. First the history of the department is discussed, then descriptive profiles of practitioners are given and finally the records of the herbal department are analysed.

The Herbal Department

The herbal department consists of one long room which serves as an office, a store room, a shop for herbal drugs and a consulting and treatment room. It is located next to the chapel of the NHC faith healing department.

The herbal department is opened at about 9:30 a.m. each working day and closed before noon to enable the practitioners to do their own farming in the afternoon.

This department has been operating since December 1976. The department has had two phases in its development history. During the first phase (between 1977 and 1980) there were only two personnel at the department. These were the herbalist-in-charge, Mr. Togbe and the Assistant herbalist, Mr. Yao.

Between 1983 and the time of this research, 1988, the second phase was introduced. A group of seven traditional healers based in the Vane community were attached to the herbal department as consultants.

The herbalist-in-charge and his assistant together with the seven consultants make up what is termed the NHC traditional healers' Association. The purpose of this association is to broaden the scope of traditional health care available for patients.

The consultants however practised at their various homes. Mr. Yao, the Assistant herbalist of NHC is the liaison officer between the members of the Association. It is his duty to go round regularly to record the cases treated by each member of the Association.

To community members however, there is a sharp difference between the two categories of healers. The herbalist-in-charge and his assistant are designated as the "NHC healers". They are perceived as literate, christian oriented, neo-herbalist and are more directly associated with the NHC herbal department - perhaps because they are directly responsible for the long room which serves as the herbal department.

The other category of practitioners are nominally attached to the herbal department as consultants. They have no direct control over the premises of the herbal department. They are often seen by community members as practitioners who have a stake in the magico-religious belief system. For the purposes of this study, the former category shall be called the "NHC Healers" and the latter "the consultants".

The records of NHC herbal department between 1977 and 1987 show the following attendance statistics:

TABLE 5: NUMBER OF PATIENTS PER YEAR OF THE HERBAL DEPARTMENT (1977-1987)

YEAR	TOTAL
1977	148
1978	80
1979	73
1980	65
1983	11
1984	59
1985	103
1986	469
1987	480
TOTAL	488

As can be seen from Table 5, the initial attendance rate was relatively high, then it started dropping until 1980. Between 1980 and 1983, attendance was so discouraging that, the practitioners alleged they stopped recording completely. In mid 1983, recording was resumed. It started picking up in 1984 apparently after the team of consultants had been attached to the herbal department.

Since the utilization of the services of the herbal department is ultimately linked with the personalities of the different traditional specialists, a descriptive profile of some of these healers becomes necessary for our analysis. We will begin with the NHC healers.

THE NHC HERBALISTS

Mr. Togbe is the herbalist-in-charge of the NHC herbal department. He is about 70 years old and looks quite weak and he is also hard of hearing.

Mr. Togbe had been the clerk and organizer of the district branch of the Ghana psychic and traditional Healers Association in Dzolokpuita. He had been living away from his native home, Vane for over fifteen years. He is therefore relatively unknown as a traditional healer in Vane.

Mr. Togbe was the obvious candidate for the new post of the healer-in-charge of the NHC herbal department mainly because he is the only literate among the native practitioners who come from Vane.

Mr. Togbe's office is obviously a multipurpose place. The office serves as the consulting room and dispensary of the herbal department of NHC. Encircling this room are tall wooden shelves which display an assortment of different herbal drugs. Most of these drugs, as one could see from the labels, are products from different country-wide herbal clinics and individual experts.

The labels on them boldly display the name of the drug, the diseases they cure, the dosage, instructions, the names and sometimes pictures of the producers and their addresses. These drugs include; Hermeron A & B mixture, Hermeron pile mixture, Aparico original black medicine, Aparico rheumatism powder, Aparico inhaler ABCD, Blood purification mixture, eye-lotion, worm-expeller, convulsion powder, Xomdagbe mixtures, Tseco blood tonic, Hernia powder, gonorrhoea powder, liver and jaundice mixture, spiritual ointment, healer herb, snake bite remedy, hallucination mixture and barrenness/infertility drug; to mention but a few.

However it was apparent that these drugs had been on these shelves for a number of years. In almost all the cases where dates of expiry were written on them, findings showed that none of them was viable for treatment any longer. It seemed that they only played the essential role of being part of the decor of the place, and also as samples - not medicaments in active use.

Mr. Togbe seemed to be mainly using his own herbal preparation of roots, barks and leaves. The author tried to find out some of the herbs Mr. Togbe uses for specific diseases. It was initially difficult since Mr. Togbe explained that he does not reveal the formula of his herbal drugs to anyone. However, after offering some palm wine to the host, the discussions became warmer.

Mr. Togbe has some roots barks and some leaves in a sack behind the door from which he showed the author samples. For the treatment of whitlow, the fresh leaves of "ashanti nugbe" (*altuenanthera pungens*) ground with "akanu" (salt petre) is smeared on the affected finger. One may also encase the infected finger into a lemon fruit for two days.

For the treatment of waist pains, the fresh leaves of "ashanti nugbe" are ground with *agumetakui* (ginger) for enema - using the tube method.

The leaves of *amadze* (*amaranths viridis*), *Kafia* and *kumini* are roasted together on fire and ground into powder. This is then mixed with water for drinking as often as necessary.

This is the treatment for gonorrhoea. Jaundice is treated with babatidze which is boiled in water and lemon juice for drinking frequently.

Other treatments include headache - the dried roots of adetutugbe, ground with drops of water and used as nasal drop, twice daily. For regaining semen and sperm, the dried roots of the same herb is ground and mixed with coconut water for drinking, one tea cup, three times daily.

For general health problems that have no specific diagnosis, Mr. Togbe has a herbal powder he calls the Aparico-All-Purpose-Medicine which takes care of that.

At 10.30 a.m. Dovi, a 35 year old farmer turns up at the herbal department for consultation. Indeed for the past two days, Mr. Dovi has been trying to contact Mr. Togbe in vain. The office hours are usually irregular, and it is generally difficult to meet him at home.

It is the season for sowing the local rice, the farms are far afield, and therefore, like all others, Mr. Togbe wakes up at 5 a.m. each day, except on Wednesdays* to go down to his farm. Today being Wednesday, Mr. Dovi was sure to meet him at the herbal department.

*It is a taboo in Vane to work on the farm on Wednesdays.

After the customary greetings Mr. Dovi is asked about his mission. Mr. Dovi's symptoms include a splitting headache, most severe in the frontal region of the head and the back of the eyes. No appetite; there is nausea, vomiting, a rising temperature and chill - which comes intermittently. The fever normally lasts for two or three hours, then the patient begins to sweat profusely after which the fever subsides only to come another time. This has been the case for about three weeks.

Mr. Dovi has tried the Ho hospital for treatment but did not feel relieved. He has therefore decided to try herbal treatment alongside the modern drugs. Mr. Togbe thinks the problem is kuwe ("go-slow" or relapsing fever/malaria). The consultation lasts for 15 minutes and no physical examination takes place. The patient is given a dark powder* to be used as beverage, one tea-cup after supper before going to bed. This is to serve as a first aid. The patient's name, address, age, sex and the health problems, are recorded.

A new appointment is made for the following day - Mr. Dovi is requested to send two empty bottles to the house of the Assistant Herbalist of NHC for the collection of some herbal concoctions.

*In the course of the author's discussion afterwards, it was revealed that the black powder is made out of the seeds of ahomotoyife (cassia prodocarpe) which are roasted and ground.

Mr. Togbe explained that the herbal department has no facilities at all for the preparation of herbal drugs on the spot. When concoctions must be prepared, the Assistant Herbalist, Mr. Yao does this at home. Patients who consult at the herbal department may therefore be given some time interval for the collection of drugs. This arrangement leaves room for Mr. Yao (the Assistant Herbalist of NHIC) to gather appropriate materials from the bush, and the market for preparing the drugs under the direction of Mr. Togbe.

Mr. Dovi is requested to make an advance payment of sixty cedis (¢60.00) against the purchase of some ingredients from the market. After the patient has left, Mr. Togbe gives directions to his assistant as to what to do. He is to gather the roots of a tree locally called "lataflala", add the dried leaves of papaw, guava, kpotidze, oti and pineapple fruit. These are to be boiled together for about an hour and then mixed with lemon juice. The concoction is allowed to cool off, sieved and then bottled. A hand written label put on the bottle reads - "Dosage; one tea cup to be taken frequently."

For the second bottle, Mr. Yao is detailed to boil the dried roots of "nyimo" (*nauclea latifolia*), and the barks of mahogany and mango trees. This is sieved and bottled as blood tonic. Mr. Togbe explains that malaria normally siphons the blood of the patient and therefore makes the sick person weak, anaemic and dizzy. The dosage reads; one tea cup, three times daily. The patient is also to boil the leaves of kumini and liyiranyofunyofu for sponging frequently to reduce the fever.

Despite the laborious task and time consuming treatment, Mr. Dovi pays only hundred cedis (¢100.00) for the services. Mr. Togbe explains that, under the instructions of the director/founder of NHC, only token fees should be charged.

Interviews with Mr. Togbe show that he is a specialist in the treatment of general physical ailments like piles, jaundice, malaria, hypertension, general bodily pains, headache, diabetes, and irregular menstruation.

As a Christian herbalist, Mr. Togbe claims he does not treat cases which are supposed to have spiritual causation - like mental problems, charms and epilepsy. Asked whether he refers such cases, Mr. Togbe explained that it is quite difficult to recommend practitioners for such ailments. The impression was that referrals to other practitioners is a matter of prestige. In Mr. Togbe's opinion, the choice of therapy in regards these bizarre ailments are best left to the patient and his relatives. As a Christian, he naturally faces some ambivalence about referring such cases to practitioners whose practices involve magico-religious rituals. The other alternative would be to refer such cases to the faith healing sector of NHC. According to Mr. Togbe, experience has shown that the people generally do not regard this sector as an adequate alternative for the diviner-healer. They certainly prefer shopping around.

However, Mr. Togbe is aware that the records show that his assistant (Mr. Yao) sometimes prescribes drugs for the treatment of charms. Mr. Togbe explains that, such treatments are for minor problems which are in the marginal region between natural and supernatural ailments.

In cases of convulsion in a child for example, he is aware that his assistant (Mr. Yao) applies what he calls spiritual ointment before the treatment. This is mainly because the people believe such a problem has some spiritual connotation. The ointment is purported to give protection against the infiltration of evilforces. On his part however, Mr. Togbe prefers to offer a short prayer before treating the patient with herbs.

On the question of cooperation between members of the association of traditional healers, Mr. Togbe complained about the lack of trust, and loyalty of members. He explained that each member is autonomous. There is virtually no legitimate leader, no financial benefits to members and therefore no moral obligations for co-operation.

On the question of problems he faces as the Herbalist-in-Charge of NHC, Mr. Togbe felt his most pressing problem has been the lack of any reliable form of remuneration for his services. He is paid only a commission on the sale of drugs on the shelves. However, as explained already, these drugs seem to be hardly patronised. No doubt, Mr. Togbe puts more emphasis on the sale of his own preparations to make some money.

Unfortunately for him his expertise is hardly known or recognised in Vane since he lived and worked outside Vane for so many years. He is aggrieved because he is not on the pay roll of the NHC unlike the personnel in the modern and the Faith healing Sectors.

Coupled with this, there is lack of any adequate financial support for buying ingredients for the preparation of drugs. He also complained about the lack of processing room and equipment at the herbal department for grinding, cooking, and drying of herbs.

Mr. Togbe was bitter about the negative attitude of the personnel of the modern sector of NHC towards intersectoral referrals. On his part, Mr. Togbe alleged that he is open to any kind of collaboration with the modern sector. At the initial stages, according to him, he was referring patients to the modern sector for the blood film and blood pressure, before treating cases like malaria and hypertension. Eventually however, with the introduction of the hospital fees of late, such treatment now attract some fees which the health superintendent has refused to waive. This attitude has actually broken the cooperation between the two sectors.

He complains that although he continues to refer cases like hernia, labour and general problems of child birth to the modern sector, the reciprocity of this gesture is not forthcoming. The modern sector refers cases only to the hospital, ignoring the horizontal referrals.

Mr. Togbe is however optimistic regarding the future of NHC. He argued that the future of the complex depends largely on whether the MOH would upgrade the modern sector to a hospital status with a resident Physician. He thinks that with an "understanding" Physician given authority to refer cases to any sector of NHC without problems from MOH, the prestige of NHC would be enhanced. Success in the modern medical sector of NHC would lead to the influx of patients to NHC and this is likely to spill over to other departments and bring a new set of relationships enhancing intersectoral collaboration. He strongly believes that eventually the government would take over the administration/funding of the entire NHC project. In that case, he would be absorbed and paid his due.

As mentioned earlier, the Herbal department of NHC is ran jointly by a group of practitioners attached as consultants. Thus for a full picture of the Herbal Department to emerge, it is necessary to take a look at some of these consultants and their modus operandi.

The Diviner Consultant of NHC

Mr. Fozo, the diviner consultant of NHC is obviously a poor man. He lives in his paternal compound (family) house: a low swish building, with rusty iron roofs of four rooms accommodating twelve people. The house is enclosed, with a very small compound crowded with farm tools, big mortars for threshing local rice palm-nuts etc. Four Big earthen pots and two wooden structures serving as barns for rice and maize respectively, also stand in this small compound. In addition, the compound has a pen for fowls.

As it were, everything in this compound is crammed together: There is hardly room enough for both the fowls and the people to move around.

At one end of this Compound towards the bush is a small grove, and a one-room swish building isolated from the others. This is the shrine of the god of which Mr. Fozo is the chief priest. It is the only shrine in Vane and the priest is a highly respected elder of the chief's court. Mr. Fozo is reputed for his miracles during healing seances; it is alleged, for example, that he once resurrected a man in a nearby village who was certified to be dead.

During the study, the research team was invited to witness a healing seance at the shrine one morning. The team met Mr. Fozo lying quietly on a local rocking-chair smoking a pipe. He is about 65 years old, quite energetic and healthy looking.*

The patient is a 25 year old female. She is a graduate of one of the Universities in the country and at the time, national service at the Logba Junior Secondary School, some fifteen miles from Vane. About two months back, the patient had woken up in the middle of the night with excruciating baffling pain in her right hand.

*Fozo died suddenly towards the end of this research period. Before his death he was on admission at the clinic. He was alleged to have foreseen his own death and called a family meeting for discussing relevant issues. According to the medical reports, Mr. Fozo died of jaundice. The oracles however showed otherwise. He died because of the breach of certain taboos of the god he worshipped.

Since the pain was severe, she applied lion-ointment, took some tablets of paracetamol and valium and then returned to bed. The next day, the whole arm got swollen with a burning sensation through the nerves; a sharp persistent pain moving to and fro from the tip of the fingers up through the arm to the armpit; a feeling similar to scorpion sting.

She took the case to the hospital twice and each consultation lasted a few minutes, attempts to diagnose the problem have all been to no avail. She was given some injections and antibiotics, but they had no effect on the symptoms.

Being a christian, she tried faith healing sessions at her local church at Logba. She also visited some herbal practitioners. But none of these treatments improved her condition. Her relatives decided to consult Mr. Fozo whose fame in handling bizarre ailments that defy modern treatment was established in the area.

The therapy managing group (and the author) were invited to enter the semi-dark room of the shrine. Hanging on the walls are such things like talismans, horns, skulls and dried anatomical parts of animals. By their look, they might have been hanging here for ages.

A number of empty gin and schnapps bottles are parked in one corner; and in another corner there is what looks like a box (chop box) painted black. A small mat is spread in front of this. From a pot in the other corner, Mr. Fozo fetches water with a calabash for each of us in turns to drink (from the same calabash). He sits on the mat facing us - in the Hindu-fashion - listens to the case history, presented by the patient's therapy managing group and then requests for a consultation fee of ₵600.00 and a bottle of schnapps. A relative of the patient places the money and the drink on the mat before the box.

Mr. Fozo then addresses this box in a solemn voice, in a language which is certainly peculiar for communicating with the gods. He opens the box very carefully, and brings out a small bell, and three cowries. He rings the bell, and bursts out in incantations. He raises the three cowries in both hands and suddenly allows them to fall on the mat by themselves. The three cowries turned face upwards. This exercise is repeated three times. All these times, the cowries behaved the same way.

According to Mr. Fozo, this exercise was to find out the cause of the problem and also to find out the will of the deities concerning the cure. In this case, the patient was said to be charmed by an offended suitor who allegedly felt cheated. The oracle specified that the patient had been steady friends with this suitor for a long time until the transfer of a new member to join the staff.

A relationship developed between this new member of staff and the lady to the virtual neglect of the old suitor. The old suitor then became a laughing-stock among his colleagues. He therefore decided to engage the services of a juju man to torment her.

According to the oracle, the charmer had planted certain foreign items, by mystical means, into the blood stream of his victim. He alleges that these items were poisonous to the blood. These were responsible for the pain and the swelling. Mr. Fozo explains that these items could only be removed by mystical means and cannot be treated by the modern medical system. On the other hand, it is not all traditional practitioners who are capable of this kind of "mystical surgery". The patient confessed the alleged unfaithfulness on her part and that the old suitor on one occasion threatened her.

For the healing rituals, Mr. Fozo requests the relatives to provide a bottle of akpeteshie (the local gin) and one white fowl. Mr. Fozo puts some herbs into a small basket and places the live fowl in to the basket. The basket is placed in the middle of the room. We looked on as the healer invokes the powers of his deities focusing his eyes on the basket. After a short moment the fowl dies by itself.

The crop of the dead fowl is removed. A coal-pot is brought, and the crop is roasted into black powder. A new blade is used to make some incisions on the hand of the patient and some of the black powder is rubbed into them.

The rest is dissolved into warm water for the patient and her therapy managing group to drink.

The next stage of the healing seance is the removal of the foreign items from the body of the patient. The procedures are simple: One relative of the patient is asked to pour some water and the lather of a black local soap called adzaleyibor into a rubber bucket. Some herbs are squeezed into this mixture.

A relative helps the patient to wash the affected arm in the mixture. After this exercise, the herbs are removed and the water is drained. At the base of the empty bucket remains such items like broken pieces of bottles and glass, cowries, fishing hooks and some tiny shells of sea snails. These are alleged to be the foreign items spiritually planted into the arm of the patient. The patient felt relieved, and the pain subsided.

The treatment has taken the whole of the morning already. The relatives of the patient have been actively involved in every stage of the treatment - some preparing the black powder for the incision, others fetching water and also helping execute the orders of the healer, and others cooking the chicken which was served to all the participants at midday after which the session closed.

Apart from the consultation fees of ₵600.00, the fowl, and the drinks, no official charges are made. It is however open for the relatives to show their appreciation after the patient is declared healed through the final ablution after a week.

A follow-up interview of the patient revealed that five days after the ritual healing the swelling subsided fully and the arm returned to its normal state. The patient however admits that in desperation for fast relief she was still using some antibiotics after the rituals.

A week after the healing rituals, the patient returned with her relatives for the final rituals signifying the end of the treatment. Early morning, about 6 a.m. a group of elders, and the relatives of the patient gathered in the small compound of Mr. Fozo for the ceremony. We all sat on benches arranged in a circular form. A big calabash into which was placed five different types of herbs, seven grains of corn and some water was placed before the patient. She sat on a low stool before the door of the shrine. Both the patient and her relatives were satisfied with the treatment.

Libation was then poured by Mr. Fozo, thanking the deities for their help and deliverance. Five small stones were put into fire. When they were red hot, Mr. Fozo placed them into the calabash in the centre.

The herbs were then squeezed into the hot water of the calabash. Mr. Fozo sipped a mouth of schnapps, and spat the drink into the air, mumbling a formula. He repeated this three times. He then sprinkled a half glass of the drink around the small gathering and around the patient. Some dried tobacco leaves were put on hot coals. It smoked profusely, filling the place with a strong "incense".

The patient was then given a drink, with some herbal powder sprinkled into it. According to Mr. Fozo, this powder would make the patient gain immunity from any such attacks.

After this, a pot of palmwine was provided by the patient's relatives. We all joined in the celebration of the recovery of the patient. In gratitude for the services rendered, the relatives of the patient gave a sum of ₵800.00 and a bottle of schnapps to Mr. Fozo.

Interviews with Mr. Fozo show that, on the average, four such cases a week were brought to him from other villages and towns. Mr. Fozo performed both spiritual healing and protection rituals. According to him, he had cures for all diseases - including epilepsy, chronic sores, oedema, madness, barrenness, leprosy, snake bite, and the extraction of bullets from the muscles - using herbs. Mr. Fozo however explained that, he was only a vessel of the deities whose directions must strictly be adhered to.

Asked about how he came by his healing powers, Mr. Fozo alleged that he was kidnapped when he was about eight years old by a group of dwarfs. He was taken to their abode in the forest for seven days. Within this period, Mr. Fozo alleged he was taught the rules and conditions of association with these beings.

He was also taught the secret of communicating with plants; a secret which became his greatest asset and possession. He alleges that every plant has a "secret name" (a spiritual name) and plants respond when you call them by these spiritual names.

To make friends with plants, there are a number of conditions one must satisfy. One must communicate with them, know their spiritual names, what they could be used for, the appropriate sacrifices for them, other herbs they could be combined with for a particular effect, as well as the taboos relating to them.

To Mr. Fozo, the gifted traditional practitioner is one who has been given this rare gift of knowing the secrets of nature, and the laws that govern it. By this secret therefore, God has made adequate provision for man to treat all diseases that afflict him. Man's only limitation is his inability to acquire the art of communicating with plants.

However, Mr. Fozo admitted that though he could treat all diseases, his main limitation was the fact that he was completely in the hands of some deities. They decided what diseases he should cure, and which ones he should not meddle with. He consulted them each morning for directions. He explained that the rules governing his status were rigid, and disobedience leads to death.

Mr. Fozo has clients from diverse religious backgrounds who might have tried hospitals, other traditional practitioners and faith healers for treatment but who had not been cured or had felt disappointed with the treatment. Mr. Fozo however complained that, most of his patients came from outside Yane. According to him, this was because of the fear of gossip, and possible excommunication from the church if the christian was seen consulting his fetish.

He explained however that, some of the Christians and Church leaders nevertheless consult him when they failed to find succour elsewhere for themselves or their family members. Such consultations were done in the night or indirectly through other people.

Mr. Fozo was quite open to the idea of any kind of collaboration with the modern sector of NHC. Indeed interviews with the health superintendent confirmed that Mr. Fozo quite often referred patients directly to the modern sector if the latter felt that their diseases could be subjected to modern treatment. Mr. Fozo explained that although herbal drugs could cure all diseases, in the case of some physical ailments herbs are relatively slower than modern medical drugs. For example, in the case of malaria, the swallowed herbal drugs take some time to effect the fever; but injections reach the blood stream directly and therefore lower the fever within a shorter time.

However, the modern medical treatment, according to Mr. Fozo, does not completely eradicate the problem. Plant medicine destroys the roots of the malaria completely. Thus complementary treatment of malaria was highly recommended by Mr. Fozo.

In the case of piles, Mr. Fozo was of the opinion that modern medical treatment seeks to remove the projected growth in the anus. Herbal drugs on the other hand attack the roots of the problem from the blood stream and uproots the problem completely.

He also thought that hernia and all problems associated with the scrotum are curable by herbal drugs although many disagree. To Mr. Fozo, the cases of boils should be left to herbal treatment since it is dangerous when treated with modern drugs and fatal with injections.

Mr. Fozo is a member of the Association of NHC healers. However, he complained about the negative attitude of the personnel of the modern sector towards referrals to the traditional healers of the Association. He was of the opinion that instead of referring certain patients to the hospital for operation (which he felt in most cases is uncalled for), cooperation with herbal healers may help very much. He believed that the problem is the lack of a medical doctor at NHC whose authority would confer approval and legitimacy on the horizontal referrals in the complex.

Mr. Fozo however did not refer cases to either the herbal practitioners at the NHC (NHC healers) or the faith healing sector of NHC. He did not also refer cases to other healers in the association. From discussions with the Healer, it became obvious that there exists a superiority complex in his relation to other healers in the Association which invariably makes it difficult for him to refer cases.

The Herbalist

Mr. Tete is a reputable herbalist in the Vane community. He is a Christian by baptism and a nominal church member of the Evangelical Presbyterian Church.*

He is married to three wives with twelve children. He is very interested in the education of his children. Two of his children are University graduates, and one is a practicing medical doctor. Mr. Tete is illiterate; a farmer and a herbalist by profession, a founding father of the National Association of the Psychic and Traditional Healers. He has traveled widely through the West African coast learning traditional treatments and treating cases. After many years of service as a herbalist, Mr. Tete has decided at the age of 68 years to settle at home. Mr. Tete is of the middle class status by the standards of Vane. He lives in his own house, he has farms and a cornmill at the market place.

I was a participant observer at one of Mr. Tete's healing sessions. The patient, Simon, a 22 year old man, is a student of a teacher training college. He was seated on a low stool. His head was swollen, his eyes had sunken in. He complained of intense pain, and difficulty in swallowing anything including water. The neck was stiff, lying down was a problem, and he was writhing with pain.

*He alleges he attends Church Service twice every year; Christmas festivities when Christ comes into the world anew, and Easter when he takes away the sins of the world.

According to the patient the problem started about a week earlier. It started with a small swelling like a pimple at the back of the right ear which was quite irritating. The tip got scratched. Within two days however, the whole head got swollen and the body temperature was rising.

The relatives alleged that during the previous year, the elder sister of Simon suffered the same health problem with similar signs and symptoms. She was rushed to and admitted at the Regional Hospital for treatment but died a week later. The death was explained in terms of the local belief that modern medical treatment, especially injections are fatal to cases of boils.

Mr. Tete explained that a boil is accumulated poison that seeks a vent to come out of the blood stream. A boil must therefore never be forced open nor disturbed. It must rather be encouraged to grow on its own. Mr. Tete alleged that, injections rather go to dissolve this poisonous clot, and disperse it into the blood, poisoning the blood further.

Applied plant medicine on the other hand has the effect of speeding up the further siphoning of the poison from the blood stream into the "clot" making the boil mature, until it comes to a "head". There emerges a white pustule at the top, which may break eventually by itself or could be pricked to drain the accumulated "poison" (the pus).

For the treatment, Mr. Tete first shaved off all the hair of the patient. Then he used a soft cold charcoal to mark off some spot after feeling around the affected spot. He explained that the poison accumulates in the form of an egg-like (oval) shape. The herbalist must find out where the small tip of this shape is turned because that is the spot where the herbal drugs must be applied and the pus eventually would accumulate.

Mr. Tete made small incisions around the marked spot using a new blade and rubbed a black powder into the incisions. He then smeared a herbal ointment on the whole head. Another herb was squeezed into the nostrils of the patient.

Mr. Tete promised to return the following morning to administer another drug. He felt that three treatment sessions were necessary. He gave instructions to the relatives of the patient on diet control for the patient. Until the end of the treatment, it is a taboo for the patient to eat shrimps and crabs.

After this, Mr. Tete announced to the relatives that an amount of ₵4,000.00 was his fee for the treatment of the whole case. This fee may be paid by installment within the three days. However, after a hard bargaining a fee of ₵2,000.00 was accepted. ₵500.00 was paid for this first day, as part of the arrangements for paying by installment.

On the subsequent treatment days the author accompanied Mr. Tete each morning for the treatment. On the fourth day, the white pustule appeared at the top of the boil, and was punctured with a needle.

After the pus had been drained, the ritual cleansing ceremony was performed. Mr. Tete picked the leaves of a plant locally called Kporti from a nearby bush; he squeezed this into a bowl of water and the patient used this for bathing. Some of the mixture was sprinkled in the compound and on participants and relatives. This signified that the healing was complete and the patient was now free to resume his normal eating habits.

However, with the pus out, there remained quite a deep sore. Mr. Tete recommended that the patient could then report at the MHC health centre that morning for the treatment of the sore. He was paid the rest of his fees, and we left.

Interviews with Mr. Tete show that, he does not think that he is capable of treating all kinds of diseases and would immediately refer patients with symptoms of health problems like; hernia, and tuberculosis to a hospital or clinic.

Mr. Tete thinks that in the case of hernia traditional healers have completely no cure. Plant medicine may help reduce the pain but the complete cure must be done through operations in the hospital. Mr. Tete suffered from this problem himself and had to be operated upon at the Hospital. He explains that hernia means the intestines have broken their bounds through the walls in which they are encased. They must therefore be pushed back physically into place*.

Mr. Tete also explained that his attempts to cure goitre in women** has failed. He is of the opinion that it is better treated by the modern medical system through operations. He alleges however that he cures impotency, barrenness, madness, hunch-back, jaundice and malaria - using herbs.

Mr. Tete is a member of the Association of Healers of NHC. He complains about the attitude of the modern sector of NHC towards referrals to the traditional healers. He thinks that there is the need for a medical doctor at the NHC if cooperation is to be effected. He thinks that the absence of a doctor makes the NHC cycle incomplete since the Superintendent is not authorized to take major decisions like referrals to other sectors (non orthodox sectors) of NHC.

*Perhaps this definition is what he gathered from his admission at the hospital or from the son who is a medical doctor.

**The eldest wife of Mr. Tete has goitre problem.

On the participation with other traditional healers in the NHC association of Healers, Mr. Tete is of the opinion that the main problem has been the lack of any effective leadership. Apart from this, there is the lack of any common arena for members to discuss health issues together and no incentives are provided in order to motivate members. Thus in the absence of any incentives, members of the Association do not feel obliged to contribute fully towards the goal of the association.

However, Mr. Tete agreed that he personally never referred any case to the faith healer, or other members of the association of healers. He thinks that these other healers have limited experience and expertise. In his opinion, these practitioners ought to depend on him so as to learn, but not vice versa.

Mr. Tete is obviously secretive about his own treatments. When asked about the formula for the drugs for "Agorku treatment", he refused to divulge the information. He explained that as long as nobody knows the formula, he stands to enjoy some level of monopoly in the treatment of the disease in the local area. It is certainly because of this partial monopoly that Mr. Tete's charges for treatment are relatively high.

The Bone Setter

Dome, a 72 year old black-smith, and farmer, is a member of the Association of NHC healers (consultant). He is the bone-setter specializing in both types of fractures Compound and simple fractures. Dome has been practicing for many years; It is a family art. He learnt the profession from his paternal grandfather a popular bone setter many years ago.

The patient Kwame a 21 year old pupil teacher from Dangbafeme (a quarter of a mile from Vane) had a fracture of the right tibia during a football match.

The family of Kwame decided against hospital treatment alleging that they know from experience that the plaster of Paris may help heal the tibia, but the affected limb may carry some deformity after the treatment. The family therefore decided to consult the local bone-setter at Vane for treatment.

During the first consultation, the bone setter requested for one fowl and half a bottle of local gin (Akpeteshie). Prayers are said, using the local gin, committing the case into the hands of the gods supplicating for wisdom and blessings on the tools to be used, and the efficacy of the herbs.

The time of the treatment itself is then fixed for 5.00am (the next day). All subsequent treatment sessions on this case were done at this hour. The healer sits on a low stool, with his herbal bag beside him. Kwame lies down on a mat spread before the healer.

The healer touches the affected part of the leg with a herb three times; he takes shea-butter, rubs it into both hands, and carefully feels around the affected area. The eyes are closed as if in deep meditation; he turns his neck slightly to allow the right ear to be tuned to his hands as if to hear the movement of the bones as he diligently messages the affected leg using his fingers expertly on the veins. He sets the bone. We look on, (the therapy managing group of Kwame, and the author), in the quietude of the early morning, with only the noise of the patient, writhing with pain.

The healer then requested the fowl to be brought. He tried to effect a similar fracture on the leg of the fowl as Kwame's.

Interviews with the healer afterwards reveal that Kwame had a multiple fracture. The art of bone setting especially in cases involving complex fractures like Kwame's demand some experimentation and caution. The fowl represents what the guinea pig or the rat may represent for most laboratory tests in most scientific research projects.

In all subsequent healing sessions, Kwame and the fowl are given the same treatment concurrently. It is assumed that the response of the fowl to treatment is just a reflection of Kwame's condition. The fowl is closely studied, and in cases of complications, according to the healer, the fowl could be used as case study for trying other herbs. It is certainly more convenient to risk the life of the fowl for the possible effects of such treatments rather than the patient.

A number of roots ground together are applied to the affected area. For the purposes of keeping the joint in place, the healer has a bandaging device. Small stripes of palm-frond are woven in the fashion of the local mat - short enough to go round only the affected part of the leg. This is fastened tightly in place by four strings attached to the mat. In this way, the joint is kept stiff.

Treatment was changed every three days using different herbs, depending on the improvement in the condition of the patient. After two weeks of treatment, the fowl could hop around conveniently pecking on food. Kwame was then encouraged to exercise himself - though with caution leaning on a walking stick. After about two months, Kwame could now walk steadily without pain.

The healer was paid ₵500.00 and a pot of palm wine for the treatment. Dome, alleges that cases declared hopeless at the hospital especially accident cases which are supposed to be amputated are brought to him for treatment. In each case, the patient returns home without amputation.

Dome has never referred any case to the hospital, or the NHC modern sector. In his opinion, co-operation with the NHC is very minimal because he derives virtually no benefit from such co operation. He explains that, if the NHC is upgraded to a hospital status, with an X'ray facility, it may contribute much to his role in the society.

So far, the discussions have been about some profiles of members of the NHC Association of healers. These profiles give some insight into the activities of some of the members and their views about the NHC model. A number of issues have emerged from the discussions and there is need to highlight some of these.

On the question of co-operation between members of the NHC association Healers, it is apparent that there is mutual distrust. Members are suspicious of the intentions of others. There is also the development of a superiority - inferiority complex between these practitioners.

On the question of co-operation between the modern sector and the association of traditional practitioners of NHC, it is apparent that the referral system is one-way. The traditional practitioners allege that they refer some cases to the modern sector and are willing to co operate with the modern medical personnel. They complain however that the modern medical sector does not reciprocate this gesture of mutual respect and trust. The modern sector refers cases only to the hospitals.

It is the view of the traditional practitioners that the modern sector of NHC (which is a health centre) should be upgraded to the hospital status with a resident medical officer who is willing to work with traditional healers. In their opinion, such an authority would confer approval and legitimacy on the horizontal referrals in the NHC.

The members of the Association of NHC also complained about the lack of any incentives from NHC in order to motivate members of the Association. The principal issues and implications of these findings will be analytically discussed in Chapter 4.

In the next section, the records of the herbal sector of NHC are discussed. This discussion will give an insight into the role of the diverse specialists, and the utilization pattern of their services by community members.

Specialization of Healers

Table 6 shows data on the most recent years (January 1987 to March 1988) of the records of the herbal department. For the sake of clarity and confidentiality, we have used numbers instead of the names of the healers. The distinction here is that, the practitioner 1 is the herbalist-in-charge of NHC Herbal Department; and healer 2 is the liaison officer. The numbers 3 - 8 are for the outside healers of NHC.

In this table, an attempt is made to find out whether a set pattern in the consultation by clients of the services of the various healers within the group can be discerned.*

For the purposes of analysis, the response of those toward whom a healer directs his efforts is the critical element in assessing his specialities. A relatively good response indicates the recognition of the expertise of the healer in treating the specific disease; but a poor response means the community does not recognize his abilities in the treatment of the specific disease.

*The activities of one of the herbalists were not covered by the records of NHC Herbal Sector. The liaison officer explained that it is a problem of co operation on the part of the healer.

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TABLE 5. contd.

	NEC HEALERS			OUTSIDE HEALERS								TOTAL
	SUB			SUB								
	1	2	TOTAL	3	4	5	6	7	8	TOTAL		
<u>Digestive Tract</u>												
Abdominal Pains	12	9	21	3	8	-	-	-	-	-	11	32
Worms	-	4	4	-	-	-	-	5	-	-	6	10
			25								17	
<u>IMMUNE TRACT</u>												
Cough	-	-	-	-	-	-	5	-	-	-	5	5
Astma	2	4	6	8	8	1	-	9	1	1	27	33
Throat pain & sore throat	-	-	-	-	-	-	-	-	-	10	10	10
			6								42	
<u>OTHER INFECTIONS:</u>												
Malaria/Fever	12	129	141	1	5	10	5	9	3	33	174	
Jaundice	-	-	-	-	-	-	-	-	-	-		
	-	-		1	2	61	-	-	-	-	64	64
<u>DILY PAINS</u>												
<u>skin diseases and boils</u>												
Rheumatism	-		-	-	-	-	-	-	-	-		4
General bodily pains and Weakness	7	1	1	-	-	-	1	1	-	12	73	
Stiff muscles	-	59	66	7	3	-	-	1	1	14	15	
	-	1	1	7	7	-	-	-	-			
			63								26	
<u>UPER NATURAL</u>												
Charm	-	14	14	45	2	-	-	-	-	47	61	
Bad spirit	-	3	3	14	-	-	-	-	-	14	17	
Good Luck	-	4	4	27	-	-	-	-	-	27	31	
Breach of taboo	-	-	-	1	-	-	-	-	-	1	1	
<u>ISCELLANEOUS</u>												
Headache	2	8	10	3	6	-	-	-	-	9	19	
Snake bite	-	-	-	7	5	1	4	-	-	17	17	

Table 7. SPECIALIZATION OF HEALERS ACCORDING TO
COMMUNITY RESPONSE TO THEIR SERVICES:

<u>DISEASES /CATEGORY</u>	<u>HEALERS</u> <u>(identity</u> <u>number)</u>	<u>NUMBER</u> <u>TREATED</u>	<u>TOTAL CASES</u>
<u>Reproductive System</u>			
Hernia *	7	20	33
Breast inflammation	3	6	8
Obstructed labour	3	16	23
Barrenness	3	6	7
<u>Fractures</u>	5	61	64
<u>Skin diseases & boils</u>			
Boil	4	30	69
Piles	6	23	69
Piles	2	29	40
<u>Blood circulation tract</u>			
Hypertension	2	5	10
Anaemia	2	5	10
<u>Digestive tract</u>			
Abdominal pains	1	12	32
	2	9	"
	4	8	"
<u>Other infections</u>			
Malaria/Fever	2	129	174
	1	12	"
<u>Bodily pains</u>			
General bodily pains and weakness	2	59	78
Supernatural problems	3	87	87

* These are traditional definitions of health problems: they may not correspond fully with the modern medical definitions.

This certainly gives us a picturesque portrayal of the differential responses of the community in terms of perceived specialization of the Healers.

We however suspect an under-reporting of the activities of the outside Healers for a number of reasons. During our interviews, almost all these outside healers of NHC complained about the fact that the records do not reflect the true patronage of their clients. They blamed this upon the irregular visits of the Liaison Officer of the project. The officer, on his part explained that the outside Healers tend to forget patients who come with less complicated matters. It is rather plausible that the outside practitioners deliberately concealed information on a number of cases from the records. Such cases include those often regarded as "confidential problems". In a homogeneous rural community pervaded with fear and distrust in inter-personal relations, gossip is rife and facts about people could be maliciously distorted. Secrecy becomes very important. Thus it is probable that consultations for such intimate problems like impotency, barrenness, quest for promotion at work place, quest for protection, abortions, gonorrhoea or other venereal diseases etc. may not be related on paper for perusal by others. The Practitioner knows that he must protect the confidentiality of clients.

From Table 6 it can be seen that comparatively, NHC Healers are consulted for Seven specific diseases. These include, piles, hypertension, Anaemia, Abdominal pain, Malaria/Fever/Jaundice, Bodily pains/Bodily weakness and Headache. These diseases are relatively physical ailments.

According to the records, it would appear as if among the NHC Healers, Healer 2 (Assistant Healer) was treating more cases than the Healer-in-charge Healer 1. In a sense, the records reflect the irregularity of attendance and attention paid to the work by the Healer-in-charge. He gave ill-health as a factor, but the main problem as explained by him was the lack of adequate remuneration for his role in NHC. The role of the Healer-in-charge could best be described as a voluntary service. He is not on the pay roll of NHC. He is only given some commission on the sale of pre-packed herbal drugs. The Assistant Herbalist on the other hand is paid by MOH through some form of informal arrangement as a labourer attached to the modern sector.

Another interesting point we realize from Table 6 is the fact that NHC Healer 2 treated supernatural or spiritual cases and healer 1 virtually treated none of these. This is very interesting since by the objectives of the NHC, supernatural problems were supposed to be referred to the Spiritual Healing Department of the complex.

The fact that supernatural problems were treated in the Herbal Department also presupposes the use of some magico religious practices. This must have implications for the utilization of the facility by some community members who frown upon these practices. It also emphasizes the overlap between the herbal sector and the faith healing sector. The finding indicates an appreciably weak division of labour (interdependence) between these two sectors. This shall be discussed later in Chapter 4.

By the general trend in Table 7 we conclude that there is a fixed image of each Healer as a specialist and not a generalist. This fixed image is a fact by which the society members are guided for the choice of therapy.

Seen against these findings therefore, the idea of a herbal department staffed by only one or two practitioners within a healing complex of modern and spiritual healing would certainly not go with the traditional division of labour and specialisation.

Age of Patients

Analysis of the records of practitioners shows the age group of 0-19 to be very under-represented (see graph 3.1), but the least represented is the age group below 4 years. Most of the patients are of the age group between 4 and 39 years. It is quite conclusive that, children are hardly treated by the Association of Healers in NHC.

Many informants said that in time of illness, children are usually first given home treatment using enema. In severe cases however, they prefer to take the child for a thorough check up at the hospital or clinic. This has been confirmed by the finding that the distribution by age of the utilization of the modern Health Centre of NHC is skewed towards the age group of 0-15 years [(43.1%) (see Table 4)].

The behaviour of the group between 40-59 and 60+ is difficult to interpret. One interpretation could be the differential use of herbal drugs in self-medication between age groups. Findings from the community survey on illness episode monitoring establish a positive relationship between age and the use of herbs in self-medication, (Graph 3.2). More people above 30 years in Vane use herbs in self-medication than people below 30 years. This may be due to the differential exposure to modern ideas. The older generation certainly is a product of an era when there were no modern medical facilities in the area and the mainstay was plant medicine, they naturally grew up to have ample knowledge and trust in the use of this compared with the younger generation who have modern medical facilities at their disposal. This relative familiarity may be a factor.

FIG 3-1

AGE DISTRIBUTION OF PATIENTS

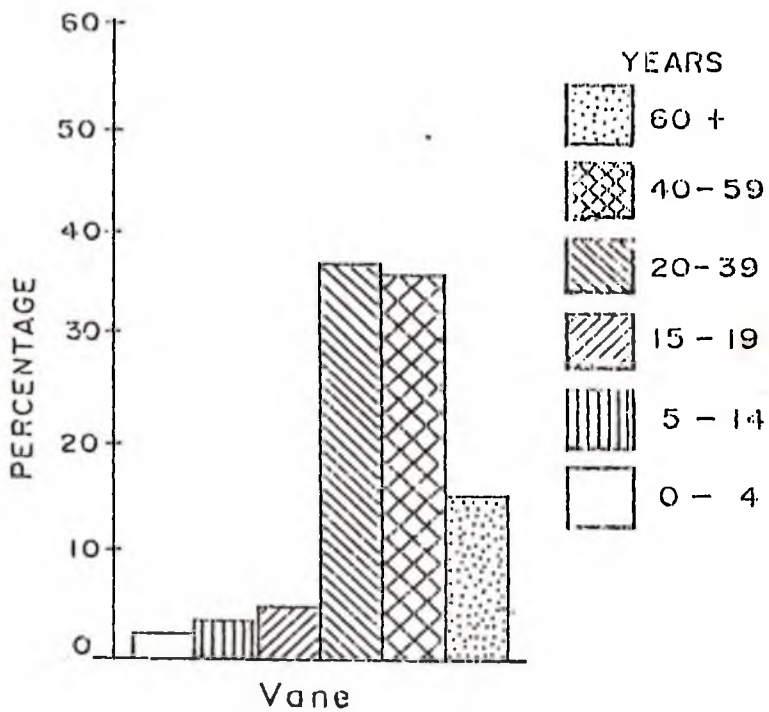
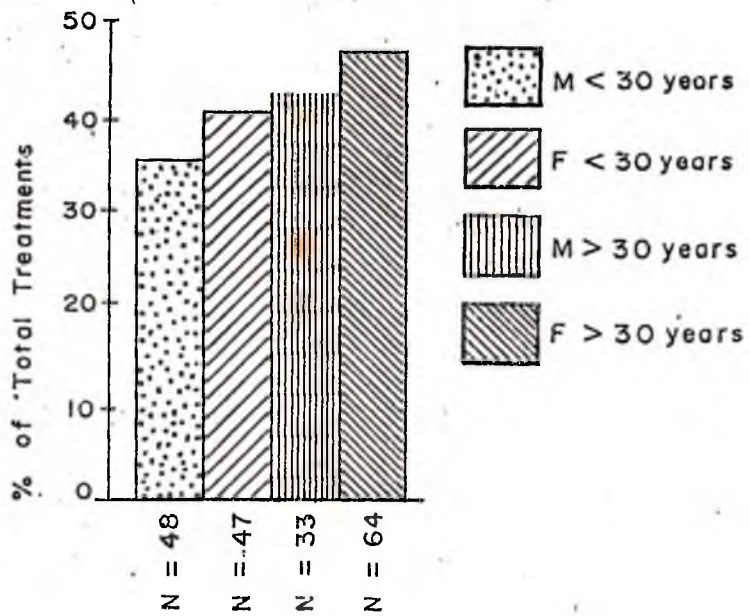


FIG : 3.2

PROPORTION OF HERBAL TREATMENTS IN SELF MEDICATION PER AGE/SEX GROUPS



Patients of the NHC Healers: Reasons for the Choice of Therapy

Table 8 presents data collected through interviewing patients of the NHC healers. The purpose was to find out the reasons for which patients choose the NHC healers*. Patients were asked to state the perceived advantage that influenced their choice between traditional healers in general and the NHC healers.

TABLE 8: ADVANTAGES OF NHC HEALERS OVER (OTHER) TRADITIONAL HEALERS THAT INFLUENCED PATIENTS IN THEIR CHOICE

PERCEIVED ADVANTAGE OF NHC HEALERS OVER OTHERS	Vane	
	N = 246 Freq.	%
No Difference	125	50.1
Cheaper	36	14.6
No Ritual/Christian	26	10.6
Know cause better	15	6.1
Easier to reach	10	4.1
Neater	10	4.1
Treat Spiritual Problems	9	3.7
Assisted by Other NHC departments	8	3.2
Better Drugs	7	2.8
No Faith in Traditional Healers	--	-
T O T A L	246	100

* Note that by NHC healers (as defined already) we mean only the two practitioners that manage the Herbal Sector of the NHC (not the consultants).

One fact which emerges clearly from Table 8 is the comparative cheapness, and Christian orientation of the NHC healers.

Comparing our results with findings in Table 9 (as to be discussed later), it is obvious that despite the higher fees demanded by outside healers of NHC and other healers in the community, respondents prefer these other services to NHC healers. This means that economic accessibility per se, does not effect patronage. Perhaps, there is even a positive relationship between the two variables.

Barker suggests that:

It is as true in Zululand as elsewhere that prestige is gained by paying heavily for medical advice (Baker 1989: 50)

The argument is that a free gift, to many people, must be suspect. Value on goods suggest that they are not low quality goods and in precarious situations like illness, people are pragmatic and "want to get well" (Parsons 1951). People would therefore want to consult competent professionals whose expertise are normally expected to be expensive because they are good.

On the other hand, the Christian flavour of NHC herbal sector may be an added value in a predominantly christian society like Vane. However, it is more probable that the individual's quest for therapy may be fixed much more upon effects than the flavour in which it is given per



It is interesting to note also that the majority of the patients of NHC healers interviewed (68%) say they see no difference between the practice of other Traditional healers and the NHC healers. This finding invariably has implications for the achievement of the objectives of NHC. Indeed the initial closed systems approach in the organisation of the Herbal Department has as its objective the elimination by substitution of the indigenous practitioners. The NHC herbal sector thus was designed to exhibit basic differences between these categories of healers. The NHC herbal sector was supposed to be Christian oriented and with some level of co-operation from the modern sector to enhance its dignity and therefore be more attractive and of better quality than the indigenous practice.

However if findings portray that majority of the clientele see no difference between the local Healers and the NHC Healers, it means that the very basic objectives of setting up this department are not met, and that its existence does not seem to bring any added value to the consumers.

The Utilization of Professionals Traditional Treatment in Vane Community.

In the wider context of the community, we sought to find out the attitude of the people to the utilization of professional traditional treatment.

The crucial question we shall attempt to answer here is whether community members who seek traditional healing see the NHC healers and/or the Association of NHC healers as adequate alternative for the other healers in the environment. The objectives of the NHC herbal department and its association of healers is to satisfy the total health needs of community members who demand traditional therapy. How far then does this sector cater for the "traditional" health needs of the people?

From the lay man's point of view, three alternative traditional medical approaches to the treatment of ill health have now become available. These include the NHC healers (with a relatively christian approach), then there are the group of diverse specialists (including a diviner healer) who are consultants to the NHC, and finally, there are the numerous other healers in and around the community. The assumption is that, in keeping with man's pragmatic pursuit, the individual seeking health care might choose the one which has more to offer. The hypothesis is that the NHC Association of healers (including NHC healers) will be more attractive because of the diverse specializations and interdependence. This assumption leads us to expect that the majority of members of the community who are sick would patronise the services of NHC Association of healers more than other healers in the society.

Table 9 shows the response of community members to the choice of therapy in terms of traditional healers visited.

TABLE 9: COMMUNITY SURVEY - TRADITIONAL HEALERS VISITED

Type of Healers	FREQ.	%
(Not at all)	74	45.1
Herbalists of NHC	10	6.1
Consultants of NHC	28	17.0
Other Herbalists in Vane	6	3.7
Herbalists within 10km.	20	12.2
Herbalists further than 10km.	26	15.9
Total valid Answers	164	100

It can be seen from Table 9 that 74 (45.1%) of respondents claim they have never consulted any traditional practitioner before; 10 (6.1%) consulted NHC healers; and 28 (17%) consulted the consultants attached to NHC herbal department. Thus a total of 38 (23.1%) of respondents claim they have patronized the services of the Association of NHC traditional healers; and a total of 52 (31.9%) of respondents claim they have consulted healers other than those of the NHC Association of healers.

The fact that nearly a half of respondents within the larger community claim they never consulted professional traditional healers, may be interpreted in terms of the effects of social change in Vane. Perhaps the basic change in cognitive orientation due to acculturation (Education and Christianity) has effected a new orientation for the society.

On the question of comparative patronage, the table shows that only 6% of respondents in the community survey claim they ever consulted NHC healers. The NHC healers were therefore largely by-passed. With the NHC Association of healers, the services of the consultants of NHC were much more patronised than those of NHC healers*.

On the whole however, the assumption that the services of the Association of healers would attract more clients has been proved wrong.

* This comparison is important mainly because it portrays the failure of Phase I of the herbal sector. The NHC healers were supposed to serve as generalists with all the traditional (herbal) medicaments from all over the country in stock for treatments. Findings show that the community response does not see this as an added value.

The NHC Association of Healers (including the NHC healers), cover only a fraction of the health needs of the people. Some Community members still shop around for traditional treatment outside this Association. The factors responsible for this shall be discussed in Chapter 4.

After discussing the modern and herbal sectors of NHC, the remainder of this chapter shall now be devoted to the discussion of the dynamics of the faith healing sector of the NHC.

The Faith Healing Sector

The history of the faith healing department of NHC is closely linked with the fact that the founder/director of NHC, until recently, was a practitioner of faith healing. This Department was therefore the first of the three sectors to be established in Vane. Initially, one room in the residence of the Director was used as a sanctuary where healing sessions were held for the sick. After the building of the NHC structures, the practices were transferred to the NHC site. Though the sanctuary is still used for emergencies that come late in the night, the routine prayer sessions are now held at the NHC Faith Healing Department.

This Department comprises a chapel, a consulting room, a library (not in use at the time), and an office (not in use at the time). The Chapel, a towering structure with a big cross in its courtyard is equipped - among others - with a piano, an organ, pews, a big stage and an altar.

The walls of this Chapel show some scriptural quotations on posters and framed pictures of some important occasions during Jesus' life - the Lord's supper, the Resurrection, the Ascension and the Transfiguration.

A sanctuary is attached to this Chapel. At the main door of the sanctuary, visitors are supposed to take off their footwear before entering. Any casual observer who entered would naturally be struck by the emphasis on the colour white - white walls and white floor (tiles). The hall has a set of sofas, a globe, spiritual journals and books, and many framed pictures of Jesus and his disciples. The inner room, arranged in the fashion of a bedroom has a medium-size bed (for the sick) dressed in white beddings. A candle burns on the mid-arm of a three-armed-candle holder. Beside this stands a cross, with Christ transfixed on it, and a rosary spiralled around it. There is also an oversize Bible, a bell, a bottle of communion wine, a Catholic prayer book, etc. Burning incense fills this room with a sanctimonious scent. The atmosphere evokes in a stranger an ethereal experience - perhaps a psychological disposition necessary to prepare the sick towards healing. With its quiet setting, this place is an awe-inspiring site, and no wonder it is designed to evoke faith in the sick, a basic requirement for spiritual healing.

A professional faith healer heads this department. Though the NHC is under the auspices of the Evangelical Presbyterian Church, the original plan was that, for this department to be acceptable to the larger society, the cooperation of all the denominations in Vane was necessary. In this regard, all the various denominations in Vane especially their prayer groups, were invited initially to form the core healing team under the NHC. It was supposed to be seen as a melting pot of all the Christian Churches, a fellowship for healing purposes, with individuals still belonging, and participating fully in their various Churches of orientation.

In practice however, this did not work. The factors responsible, and the effects on the utilization of the faith healing sector of NHC shall be discussed in more detail in Chapter 4. For the moment, suffice it to say that instead of an interdenominational fellowship, a sect has steadily developed around the professional faith-healer of NHC with an obvious identity of membership.

At the time of the research there were 35 regular members according to the survey. Registered members pay a token fee of thirty cedis annually as dues. Apart from this, every prayer session includes a period of thanksgiving and contributions where free donations are made by members as thanks to God for protection and sustenance. Visitors who seek the services of the group pay fees not exceeding one hundred cedis (C100.00); however, this depends largely on the capabilities of the visitor and his personal willingness to express his heartfelt gratitude to God.

Unlike in the case of the personnel of the herbal sector, the professional faith healer enjoys a relatively steady source of allowance through the contributions of the Christian Health Association of Ghana (CHAG).

It means that monies realised from these services do not decide the healer's financial status at all. Such monies go into renovations of the Chapel and maintenance of equipment and the purchase of basic daily items needed for worship and for use during healing sessions, including candles, incense and florida water. Such contributions are also used for defraying costs and funeral expenses of deceased members.

Mode of Worship and Healing

Faith healing, according to the professional healer-in-charge, is based on the biblical example of Christ and the disciples; "And they cast out many demons, and anointed with oil many that were sick and healed them". (The Bible: Mark 6:13). There is also the injunction that, "Is any among you sick? Let him call for the elders of the Church, and let them pray over him, anointing him with oil in the name of the Lord". (The Bible: James 5:14).

Prayer sessions of the Faith healing sector are held every evening. Tuesday and Friday evenings are the major healing sessions between 8 p.m. and 10 p.m.

Healing sessions normally start with a short sermon by the faith healer. The importance of this period is to encourage members to confess their individual sins and to "purify" themselves before God.

Then there is a short period of thanks-giving, and worship. This is the period for the invocation of the "Spirit" to descend before the healing is started. It is a spectacular display of hand clapping, drumming, local choruses, dancing, clamour and leaping for joy. This leads to the period of healing. The sick are asked to come forward onto the stage and kneel before the cross - and the chandelier of burning candles.

The faith healer in a white gown, rings a bell and some significant others within the group - prophetesses, healers and some elders come out of the congregation to stand behind the patients in a suppliant mood. The bell continues ringing, singing and drumming starts afresh as one elder encircles the people on the stage with smoking incense.

The faith healer raises his voice above the noise announcing the purpose of the session, encouraging the congregation to pray fervently in supplication for the sick. This is the period of intercession.

The drums continue playing, the rattle and tambourine clangour at the background become more prominent as the singing gradually dies down and the congregation launches into a period of vigorous prayers, clamour, cries, weeping, spirit possession, speaking in tongues, rolling on the floor, stamping of feet, clapping of hands and various motor reactions related to intense energy and emotional involvement.

It is a period of general physical and emotional struggle against the devil and invisible forces including sickness, misfortunes and sorcery. It is a period of pandemonium, of physical exhaustion, of profuse tears and sweat.

Many of the sick completely collapse, lost in this intense atmosphere of ethereal experience and of heat and noise. The bell rings and the noise subsides to sobs, especially from the sick. The strong-emotionally-charged voice of a prophetess breaks the relative silence. She is heard rattling "tongues" interspersed with encouragements to the sick not to fear because God's healing Spirit has descended into the hall to effect healing.

The faith healer stands before each patient in turn, laying his right hand on the head, looking up to the heavens and shouting a prayer, stamping his leg - a physical and spiritual assault on the devil, "the tormentor", "the accuser of the brethren", "demons of sickness", to leave the body of the victim. The congregation, the therapy managing group of the clients, and all of us therein assembled shout the chorus - Amen! Hallelujah! with great enthusiasm at every command that the leader pronounces. In this wise we were not only participating but we were involved completely - body, spirit and mind.

After the healing session, those who have experienced a cure or a change for the better express their joy in the form of testimonies. A vivid picture is often given about the history of the sickness, and the various health institutions visited prior to coming for faith healing, and their condition during the prayers and after the prayers. The response of the congregation is always enthusiastic with loud "Hallelujahs", "praise the Lord" and "Amen".

After the testimonies come the period of tithes and offerings. This is accompanied by drumming and local choruses. The women file out from the pew dancing to the stage to a small table near the alter where a bowl stands for the collections. The men follow in the same way. The collection is then blessed, and closing prayer of thanksgiving is done.

At any healing session, members are required to bring bottles filled with water. These are blessed by the priest and taken back home for use by members in ritual baths as "Holy Water" for spiritual protection.

The faith healer explained that, sacred objects including candles, holy water, florida water, incense and sometimes herbs and fruits revealed to him through dreams and visions are used as healing aids. According to him, for spiritual healing to be effected, the client play a very crucial role. He must believe, have the "conviction of things hoped for, be certain of things he cannot see (but perceive). But "Faith" is not palpable - the intangible aspect of the culture of spiritual healing.

The use of physical (sacred) objects help to raise the faith level of the client. These are spiritual tools for expressing and evoking faith, for evoking the spiritual atmosphere which is the mental and emotional state necessary for the religious experience.

PATRONAGE OF THE FAITH HEALING SECTOR:

Distribution by Sex and Age

Table 10 gives the distribution of the sex and age of people who utilized the NHC faith healing sector at the time of this research.

TABLE 10: DISTRIBUTION OF MEMBERS BY SEX AND AGE

Sex	MEMBERS		Under 20 Yrs.		20-29 Yrs.		30-39 Yrs.		40-49 Yrs.	
	No.	%	No.	%	No.	%	No.	%	No.	%
Male	6	17.1	4	11.4	-	-	2	5.7	-	-
Female	29	82.9	2	5.7	3	8.6	6	17.1	18	51.4
Total	35	100	6	17.1	3	8.6	6	22.8	18	51.4

As can be seen from Table 10, patronage of the facilities of the Faith Healing Department is low. Thirty-five people were registered within the 2 months survey. They were largely women (82.9%). The greater number of members were of the age group between 40 and 49 years (51.4%) and they were females. The male registered members were relatively few; 6 (17.1%) and younger; 4 (11.4%) being under 20 years and the rest, 2 (5.7%) were between 30 and 39 years of age.

Asked why females seem to participate relatively more than males, the Healer explained that it is plausible that females are generally more sympathetic and emotional, carrying the burdens of the family more than their male counterparts. The woman in traditional societies plays roles which put her in a more generally disadvantaged and persistently tense situation than the males within the rural social structure. Factors like low education, lack of viable employment, and polygyny with its concomitant irresponsibility of most males towards their wives and children make life more difficult for the woman. She is therefore more prone towards seeking solace from "God's sanctuary".

Perhaps one related problem has to do with the mode of inheritance in the Vane community. As discussed in Chapter 2, the patrilineal system which favours males in the distribution of family property especially land which is the single most fundamental economic asset in this locality must be seen as one source of such frustration in women. The land is small; the demand is invariably higher than the supply. This has led to the fragmentation of the land. The small size does not lend support to any viable economic venture.

The people are generally poor, but the womenfolk are, relatively, the poorest of the poor save the few who have had higher education and have migrated into the cities to work. Those who do not migrate have no alternative than to compete with the menfolk over strips of land for farming - trading not being common in Vane.

Coupled with this, the farming procedures in Vane are very difficult. The rocky land demands manual labour since tractors can hardly work the land. Pickaxes, axes and cutlasses are used instead of hoes even for planting and clearing the forest. The females are at a greater disadvantage not only because such work require more manual energy but also because due to the migration of the youth, most mothers have to foster their grandchildren along side. Brydon (1976) and Ward (1950) have discussed at length the high incidence of female household heads at Vane and Amedzofe.

On a more general note, however, the sociological interpretation of the over-representation of women at the faith healing sector must take cognizance of the people's belief system.

The people of Vane, as described in Chapter 2, have a belief system which is an admixture of traditional and modern perspectives. In this wise, to the average person, every happening has spiritual links. Where there are misfortunes, it may be interpreted as disobedience to the deities, or the punishment for sins, or temptations from the devil. Where there is progress, or wealth, or promotions, it may be seen as blessings from God.

From this point of view it may be argued that the spiritual explanatory variable becomes a fundamental factor. In Vane where polygyny is very common, a woman who is almost always having problems with the husband may attribute the situation to spiritual warfare with other rivals. In a case like this, the help of the priest is called into play to offer prayers to neutralise the powers of her rivals.

Apart from these, the fact of more females patronizing the faith healing sector, may be seen in another light. A whole series of beliefs about the inherent evil of femininity - an evil which is endowed with occult powers that can harm others is wide spread in literature about Africa. (Ravindra Jain; 1979 Ampong Darkwa 1984). Ampong Darkwa for instance found in his study that women are more accused of witchcraft than men in Ghana.

Perhaps the reason why more women patronize the faith healing sector is to seek protection from the harassment of fetish priests. It is certainly more convenient for suspected witches to seek refuge with the "Christian God" who is relatively sympathetic, and easily forgiving irrespective of one's sins, after confessions are made*.

*"Come let us reason together: If your sins are as red as scarlet, they shall become as white as snow".
Bible; Isaiah 1:18.

The forgiven person then becomes "a new creation...behold the old is gone, the new has come". (The Holy Bible: 2 Corinthians 5:17). Thus she becomes a member of a new family, a class of righteous souls tailored for heaven. What is most essential is the fact that even where the large society rejects the person for her alleged destruction, she finds forgiveness, a clean record and a family of christians who do not regard her previous life as crucial in the new era. At the shrine on the other hand, the suspect goes through a long ritual process of disgrace, torment, insults, degradation and trial by ordeal. In some communities the body of people suspected to be witches or wizards are burnt when they died - a disgrace to the family. Joining the church is obviously a very peaceful route of transformation and acceptability by society through the sanctifying "blood of the Lamb".

EDUCATIONAL STANDING OF RESPONDENTS

In line with the socio-economic background of the people of Vane, it is expected that the utilization of the services of the Faith Healing Department would be influenced by socio-economic factors like education and occupation of members.

When level of education is considered, findings show that the utilization of Faith Healing at NHC is inversely related to the level of education of members. Data show that 54% of members were illiterate, 40% had elementary education and only 6% had secondary school education. (Appendix D).

This finding is in line with findings in a number of studies on sects in Africa. Hans Debrunner (1961) has remarked that the new African healing groups found their following among people of very little schooling or illiterates. A similar conclusion was drawn by Baeta (1962) in his study of some selected syncretic churches in Ghana.

OCCUPATION OF RESPONDENTS

Most of the members were farmers 19 (54.3%) and petty traders/farmers 8 (22.9%). Two members worked as community nurses, and 6 (17.1%) were pupils or students (Appendix E).

Reasons for Attendance

It is important to look at the various reasons given by members for associating with the faith healing department. Table 11 provides the distribution of members according to the reasons given for membership.

TABLE 11: REASONS FOR ASSOCIATING WITH THE NHC PRAYER GROUP

Reasons	ABS.	%
Sickness	25	71.43
Spiritual Protection	18	51.43
Economic Reasons	5	14.29
Marriage Problems	3	8.57

* Multiple Response Possible

It can be seen from the table that majority (71%) of the respondents said they associated with the group in order to obtain healing from various types of sickness. These included chronic stomach problems, heart troubles (including palpitation), severe headache, stroke and other problems related to "Spiritual ailments". A number of case studies may illustrate the trend of diseases, treatments and the remarks of members*.

The Case Studies

Case I:

Name: Name (Female)

Sickness: Bodily pains, restlessness and growing lean. She alleges that She tried a number of hospitals and clinics to no avail.

Prescribed treatment at NHC:

- (i) A bucket full of water was blessed for her to use for her bath daily at 12.00 mid-night.
- (ii) Consecrated water was given to her to drink daily.
- (iii) Some potion was blessed for her to smear over her body daily.
- (iv) Regular prayers were said for her daily until cure was effected after 3 weeks.

Result: She reported fully cured.

* Most of the cases were taken from the few recorded cases of the faith healer of NHC. Follow-up was done for only two of these cases since only these, among the lot, still lived in Vane.

Case II:

Name: James

Sickness: Blood in urine for five years. Health institutions visited before coming to NHC Faith Healing Sector included Hospital treatment and traditional healing.

Prescribed Treatment at the Faith Healing Sector:

- (i) Sea water, florida water, rain water, and lathered lux soap in a mixture for syringing was done daily for 3 days.
- (ii) The patient was made to drink rain water and pineapple juice which were blessed.
- (iii) Regular prayers were said morning and evening for absent healings* (since he came from outside Vane).
- (iv) He was advised to combine the faith healing practices with the prescriptions of modern drugs from the hospital. He recovered after two months.

-----*

Prayers said on behalf of a patient who is not present during the session.

Case III:

Name: Grace

Sickness: Serious headache for 3 years. Tried hospitals, Professional Herbalists, and Malams without success. Treatment at NHC Faith Healing

Department include:

- (i) Prayers
- (ii) The patient was given blessed water for washing her head daily – evening and morning.
- (iii) The patient was given consecrated water to drink regularly.

The patient reported cured after about a week.

Case IV:

Name: Kofi

Sickness: Gonorrhoea for many years. Tried treatment at many places including Professional Herbalists and Medical Doctors without success.

- (i) Prayers every morning and evening.
- (ii) The patient drank the juice of one pineapple daily for a number of days.
- (iii) A combination with orthodox drugs was recommended: Cure was effected after a month.

Case V:

Name: Julie

Sickness: Waist pains, headache and very irregular menses for three years. Tried hospitals for treatment and herbalists in and outside Vane without success. Treatment at the NHC Faith Healing Department included:

- (i) Little drops of blessed Florida water added to "bathing water" daily for 9 days.
- (ii) Blessed Olive oil was inserted in the vagina regularly for a period of 2 weeks.
- (iii) Regular prayers were said for the patient.

Result: She claims her health has improved greatly.

Another group of visitors consists of those who were traditionally tied to spiritual treatment - (57%). Such visitors are those who always felt that something unusual would happen to them if they were not spiritually protected. This may be associated with psychosomatic problems including fear, due perhaps to moral lapses, worries, and anxieties.

Other complaints included passing of examinations, promotion at work place, protection for one's family (especially migrant children), marriage problems, and economic problems in general.

Eight out of the twenty-five people who said they became members of the group for purposes of healing claim they have not yet received healing. However, they were very optimistic. They claim they were new members of the group, and that "God, in his own time, would touch with His healing power".

What is interesting in the case studies is the use of some "medicaments" in faith healing: oils, potions, herbs, fruits, etc. This must have some implications for the inter-sectoral referrals between the herbal sector and the faith healing sector since apparently, their services are overlapping.

The case studies also show the different attitudes of people according to the progress they make when sick. It is apparent that most people start by resorting to physical cures - especially using the modern medical system. When the sickness persists, they change their approach to traditional health systems including shrines, malams and general herbalists. The impression given is that Faith healing at the NHC is often used as a last resort. In this respect, reliance on faith healing seems to be typical of the sick in the condition of despair. Prayers become the main basis of hope. In some instances however, faith healing was combined with herbal and/or modern medical prescriptions. Prayers become the main driving force that may positively influence the efficacy of medicaments.

This also shows the dual dimensional approach to the human health situation. There is the physical aspect for which the drugs are important. There is also the spiritual aspect which arises out of the emotional and cosmological world view of the patient, his beliefs, and/or the quality of his social relationships and conduct. Findings therefore confirm the idea that Ghanaians resort to multiple health systems especially in cases that are chronic and bizarre.

According to Table II a little more than a half of the people (51%) felt the need for protection and explanation for the aetiology of their illness and misfortune. This demand for etiological explanation within the cosmological premises of the people is what modern medicine is mostly unable to meet at the level sought by clients. In contrast, the spiritual healer is believed to know this through visions, dreams and prophecies. The quest for spiritual protection is similar to the practice where people seek refuge in traditional shrines or cults. As Hagan (1986) has pin-pointed, the belief in supernatural forces as influencing the life processes of human beings for evil or good is a deep-seated attribute of the Ghanaian.

Whatever the symptoms, the faith healing approach is believed to give lasting preventive and recovery results when applied to psychosomatic and spiritual problems; mental stress, anxiety, hatred, selfishness, laziness, inordinate ambition, spiritual and "soul sicknesses".

These are supposed to affect the inner-mind or spirit-self of the person and in most cases precipitate physical ailments.

A case in point which illustrates this situation was given by the Priest. He was approached by the elders of a family whose child (Kofi) was suspended from a boarding school in a nearby town for an offence of rape which he vehemently denied at first but eventually confessed.

However, after staying home for two days, Kofi started developing the signs and symptoms of hysteria; a neurotic manifestation presenting itself in the form of - refusal of food, ignoring personal hygiene, easily irritable, and general restlessness.

A further probe into the circumstances surrounding the case revealed that Kofi was the "ring leader" of a gang of eleven mates who raped a junior school girl in the bush.

The father of the girl was very offended and pronounced a curse on Kofi. Kofi's parents were so annoyed with their ward that they virtually ignored him.

After 2 weeks, Kofi's case worsened. He started exhibiting gross behavioural changes in the form of total lack of personal hygiene, verbally very insulting and aggressive.

Three principal elements in the aetiology of Kofi's health situation became very crucial in the healing process, and the choice of the faith healing system.

In the first place, rape/sex in the bush is an abomination against the land - the fact of rape means Kofi has offended the personal soul of the girl involved - having forced her and therefore defiled her. Secondly, a curse by an offended elder on a child is a very strong power which is believed to have instant drastic effects. Thirdly, the near rejection of Kofi by his own kins (the parents), brought about social isolation - friends and other members of the society labelled him as evil and avoided his company.

In-depth interviews with the Priest gave a strong impression about the "social causation theory" as a fundamental explanation not only for the cause but also as a pointer to the procedures for effecting healing. The curse must be "lifted" from Kofi, he needs to be sanctified and forgiven for his sin. He must confess to God and the "family of God's people" -the church- and in return, they must accept him as a member of the family. Fasting and prayers for two days on behalf of Kofi by the entire church was effected. By the third day when the final ceremony of blessings by the church was held for him the signs and symptoms had disappeared.

Analysis of this case study reveals that, just like in the proto-typical traditional belief system, it is assumed that there is a link between the physical health of individuals and corporate groups, on the one hand, and the normative system of society on the other.

The relationship and conduct of the individual towards others in the society can and does exert an important influence on his health.

Thus whether christian or not, the individual's basic cosmological assumptions - the basic ideas regarding the character of the universe, of its forces, possibilities and modes of operation remain unchanged; as it were, the symbols of tradition, and the cause and effect equation is only given a cosmetic dressing - within the christian social order.

What is important is that the prayer groups and healing sessions within the community (including the NHC Faith Healing Sector) represent a turning away from the proto-typical traditional resources of supernatural succour in order that help may be sought for the same purpose from God proclaimed in the Christian evangel.

Baeta explains that:

It may be stated generally that people do not attend spiritual churches unless they find themselves wanting something or the other that the (groups) enable people to obtain..... usually people go for healing after having unsuccessfully tried scientific medicine or African herbal treatment, fetish priest or all three. (Baeta 1962).

In this respect therefore, the attempt to restore health, even in the case of the Christian Evangel, implies the need for some form of norm-oriented action. The corporate group (or representatives) must extend a hand of forgiveness and re-acceptance in cases of guilt for breach of social norms which may precipitate some health problems.

The sick needs some reassurance of the protective powers of God and the forgiveness of his sins, a relief from the guilt derived from moral lapses. He needs faith in the ultimate good; he needs counselling; he needs to be told repeatedly that he is "not alone in the battle", that "all is not lost"; that the "blood of Christ is able to dissolve all problems and principalities". This is where the role of the faith healer in the NHC configuration becomes very important.

Baeta's (1962) observation that syncretic groups meet the spiritual and emotional needs of the members while providing them with a recourse in their mental and physical illnesses has thus been confirmed. Indeed, the bond of loyalty, the face to face interaction, the concern for each other, and the emotional attachment and identity are forces which provide a gratifying scheme within which members of the NHC Faith healing group could live their whole life.

Members assist one another in a number of social activities - weddings and funerals. Besides, a condition of hope, security and greater expectation of material and spiritual prosperity is indeed what keeps most of these members within the group long after healing is effected.

On the other hand, whilst it is true that the faith healing sector seeks the unity of members and harmony within the larger society, findings show that it has some inherent disruptive tendencies.

There is the strong belief in a world view that credits entities and other people in the society with malign influences: a world filled with the evil intentions of people against other people, of sorcery, and witchcraft. The patient tends to believe that his illness persists because it is caused by others in the society who envy him and intend to destroy him. This tends to aggravate and perpetuate anxiety in life, hatred, and the break up of family relationships. Such a situation also breeds suspicions between friends and relatives and where the patient has no strong will and level-headedness; it could put him in a very awkward position with negative implication for health of individuals and the society.

According to the faith-healer however, these tendencies are very much known by him and in his daily role, he tries to safeguard the harmony between the group and the society.

SUMMARY:

The organizational structure, characteristics and the dynamics of the NHC have been the subject of discussion in this chapter.

An appraisal of the historical background shows that, the NHC is an attempt by a private initiative to fuse three therapeutic systems (modern, faith and herbal healing systems) into a comprehensive health care model. The idea for this grew out of the experience of the founder and director of the project Mr. Emmanuel Baku, a retired Engineer, who hails from Vane.

His childhood experiences of belonging to a family of conflicting religious orientations - Christian and traditional - contributed very much to his awareness of the limitations and strengths of each of these in terms of illness and health issues.

His further experiences, as a student in India, gave him the idea that it is possible to enhance the dignity of the traditional healing system, and to improve upon its practices for the benefit of the community.

Observing that despite widespread dependence on the modern medical system the traditional healing systems still persist and are often used for certain specific ailments, the founder reasoned that an ideal system in which the traditional and modern health systems are made to collaborate would cater for the total health needs of the community.

The NHC project was set up through the private funding of the founder with members of the community offering some communal labour for the construction. The Government of Ghana as well as some non-Governmental organizations, local and foreign, also made contributions in terms of provision of equipment. The three sectors are housed in separate structures within the same yard.

The basic philosophy of the NHC model stresses joint effort, interdependence and equality between these three constituent parts. The aim of the NHC is to satisfy the social, psychological and physical health needs of the people. In this wise, a patient-care team made up of personnel from the various sectors, enforced through intersectoral referrals, becomes the prime objective of the NHC. The thrust of this model therefore is the interplay of the various parts towards an integrated approach to healing, and the satisfaction of the total health needs of the people.

The utilization behaviour survey showed that the rate of acceptability in terms of the utilization of the NHC facilities is appreciably low. Using 1982 attendance as a base, the utilization of the health centre in subsequent years (1983-1988) declined steadily and steeply. In 1988 for example, the total number of patients recorded was 556 which is less than 3 patients per working day. For a staff of 19 personnel, this is certainly not cost effective. Factors responsible for the low patronage shall be discussed in details in Chapter 4.

The records of the health centre indicate that, the facility is largely used for malaria/fever, diarrhoea and general accidents.

It was noted that the utilization of the NHC health centre was inversely related to age. The younger the patient the more likely he is to be sent to the health centre when sick.

Explanations may be given in relation to the use of self-care methods by the adult group of Vane and the preference for other public health care systems in the locality. Coupled with this, the younger generation, have been found to be more positively oriented towards western and scientific influences than adults (Busia 1964). Analysis by sex showed that slightly more males (50.8%) than females (47.2%) utilize the Vane health centre. But the difference is too negligible for any further analysis.

The dynamics of the herbal sector was discussed. At the initial stages (between 1977 and 1980) the herbal department was managed by two practitioners. The records show that the utilization rate of the department at the time declined steadily and steeply until 1980 when the department almost collapsed. These findings show the failure of the initial approach - the closed-systems approach - in the management of the herbal sector.

Between 1983 and 1987, a reparation saw the attachment of seven consultants to the herbal department. An association of healers - including the two NHC healers - was formed. The aim was to give a comprehensive service to clients by including all specialists in this department.

Findings however showed that the Association of healers did not completely meet the health needs of people who were disposed towards the use of traditional therapy.

We may conclude therefore that comparatively, the innovation of an Association of healers in NHC was not perceived by the people as an added value. The people still shop around for traditional health care and they prefer this to the Association of healers. Factors responsible for this shall be discussed in Chapter 4.

Analysis of the faith healing sector show that patronage of the facility is appreciably low. The people who utilize the services are largely females of the age group between 40 and 49 years. Most of the members are illiterate. Reasons for coming to the faith healing sector include health problems, lack of employment, and security against real or imagined evil forces.

The case studies cited show that many of the patients are those who have tried other health institutions - including hospitals, modern clinics, herbalists and diviners but did not obtain any cure. There were also those who want spiritual protection from evil forces including witchcraft and sorcery.

The faith healer, apart from prayers, used other means of therapy. These included ritual baths, prescription of herbs and certain fruits as well as the use of incense, candles, potions and lavender.

It is interesting to note that the bias of treatment here is not prayer per se; but the use of "medicaments" - herbs, fruits and potions. Such a finding should have adverse effects on the ultimate goal of the NHC and the interplay between the various departments.

In conclusion findings have shown that the rate of acceptance of the NHC facilities by the people is appreciably low. The people largely by-pass the NHC facilities for other health institutions outside.

This leads us to the next Chapter in which an attempt shall be made to put a sociological focus on the issues and problems relating to this unfortunate situation.

CHAPTER 4**THE PROBLEMS OF THE NAZARETH HEALING COMPLEX'S APPROACH
TO HEALTH CARE DELIVERY****INTRODUCTION**

In the preceding chapter, data on the utilization of the various constituent parts of the NHC programme were analysed. Findings have shown that the acceptance of the NHC facilities by the community members is low. This chapter is intended to appraise the issues related to the failure of NHC to meet the total health needs of the people.

The central theoretical focus of this thesis is that of the social systems approach in the study of social change. As it were, this focus implies and emphasises the fundamental interrelationship between NHC as a medical system - on the one hand, and the social structure of Vane - on the other.

The theoretical focus also lends a critical analysis of the fundamental interrelationship between the various parts (internal equilibrium) of the NHC as a medical system - a crucial factor in the realisation of the goals of NHC in the Vane community.

This theoretical orientation upholds the view that the failure of the NHC to meet the total health needs of the people could be explained in terms of a confluence of both internal and external factors.

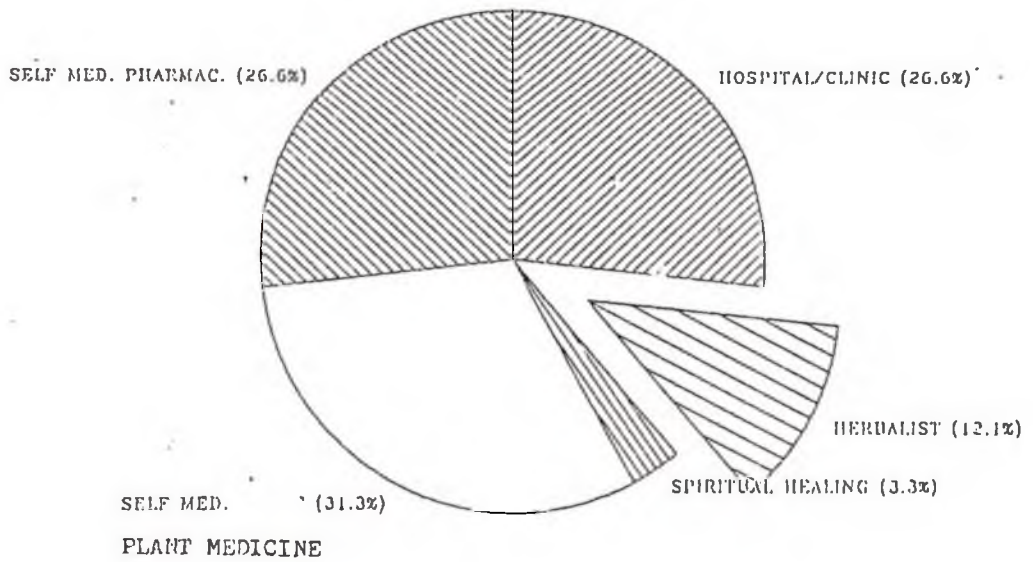
External Factors:

In discussing the external factors responsible for the inability of NHC to meet its stated objectives, a review of the health-seeking behaviour of the people of Vane becomes very essential. Pertinent issues including self-medication and accessibility of professional health care become very crucial.

The result of our morbidity survey reveals that the most popular mode of treatment for ill health in Vane is self-medication. Findings show that nearly 58 percent of respondents who reported sick during household interviews said they resorted to self-medication relying either on pharmaceuticals bought from wayside stalls (26.6%) or the use of plant medicine (31.3%).

The reliance on self-medication - 58% - is quite high for a community which enjoys the services of a modern health centre and its other professional health facilities - Faith and Herbal sectors.

FIG. 4.1
SOURCES OF TREATMENT



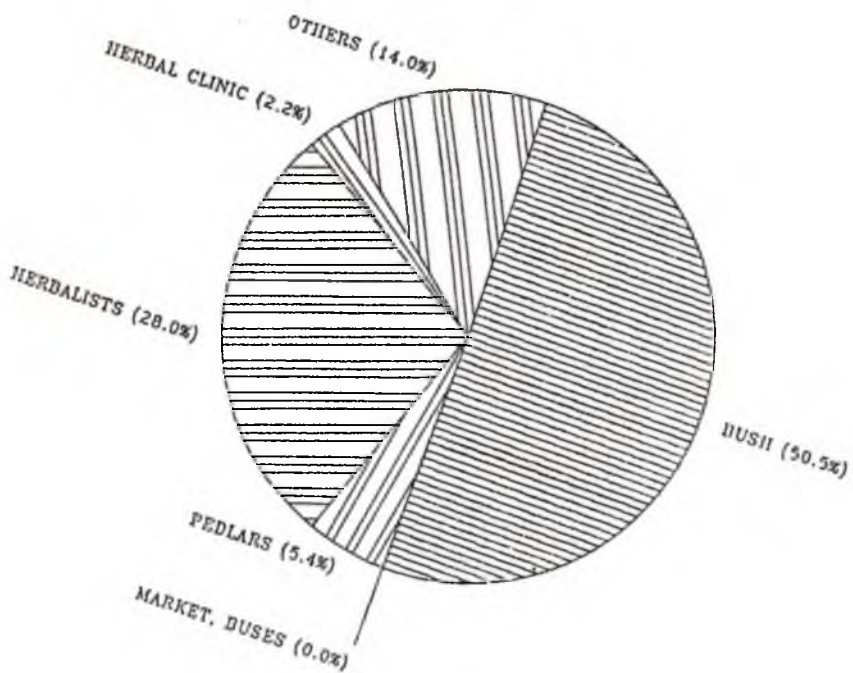
Herbs and Self-Medication

According to Figure 4.1, self medication using herbs is a very common phenomenon in Vane (31.3%). This is to be expected mainly because, as explained already, herbal medicaments for common ailments are well-known by nearly all members of the family.

Apart from the general knowledge in herbs (plant medicine), the relatively high use of herbal drugs may be attributed to its physical and economic accessibility in the area. During the illness episode monitoring, respondents were asked to state the sources of their herbs. Figure 4.2 gives a portrait of these sources: 50.5% of respondents claim to have got their supply from the bush. Indeed, this is related to factors including, physical, cultural, and economic accessibility. Markets are not a popular source of herbs in Vane, and only 2.2% of our respondents mentioned the NHC herbal centre as their source of supply: comparatively however, apart from the bush, community members resort more to healers other than NHC healers for their herbal medicaments (38%).

Another source is the drug stores especially in Ho which sell pre-packed popular concoctions. 14% of respondents said they obtained herbs from shops (outside Vane) and left-overs from other people in the locality. These are grouped under "others" (Figure 4.2). Some consumers however depend on drug pedlars (5.4%).

FIG. 4.2
SOURCES OF HERBAL DRUGS



This situation is least expected because apart from offering professional treatment to clients, the NHC herbal department was also making some open market sales to the public at the market place especially for prophylaxis of malaria.

According to our findings therefore, the attempt by NHC to make the pre-packed herbal drugs popular did not displace the other more popular sources.

Pharmaceuticals and Self-Medication (fig. 4.1)

Self medication in Vane also took the form of the use of pharmaceuticals - (26.6%) - It is interesting to note that, within the Vane Community, there are several sources of unofficial drug distribution. There is indeed a number of informal injection and modern drug providers who are consulted outside the professional circle.

Community members see this as a relatively cheaper and a more available, acceptable and accessible source of health care. In Chapter 3, the issue of the informal nexus of pharmaceutical distribution in Vane has been discussed. These include store-keepers, the "injection practitioners" and personnel of the health sector who practice unofficially at home.

Professional Medical Treatment

As can be seen in Figure 4.1, professional medical treatment comprising hospital/clinic treatment, herbalists, and faith healing, is comparatively low (42%). Of this percentage, modern medical treatment caters for the most (26.6%).* Herbal Professional treatment is 12.1% and Faith Professional Healing was the least (3.3%).

It may be concluded therefore that while modern health care system is by no means the only source of care to which sick people of Vane community have recourse, it is clearly the preferred option as far as professional treatment is concerned.

* It must be noted, that modern medical treatment, herbal treatment and spiritual treatment as used in this case, do not refer specifically to NHC. It includes any "Professional" treatment that the community members have recourse to when sick - both outside and inside NHC.

This finding is similar to the observations of the IDS Research Report (1978). In their discussion of the characteristics of the patient that influence his choice of therapy, the IDS Report noted:

there is a strong tendency to concentrate upon modern medicine, even at village level, indicating the lower esteem in which the other modes of treatment are apparently held within what might be called the educated universe of discourse. (IDS Research Reports: 1978:52).

So far, the findings on the health seeking behaviour of the people of Vane show that the activities of the relatively strong and rival health institutions in the locality have a telling effect on the patronage of the NHC facilities.

A new picture emerges if we analyse these diverse close substitutes and how they impinge on the various sectors of the NHC. This discussion begins with how these factors impinge upon the patronage of the modern sector of NHC.

Though the people of Vane prefer Modern Medical Services, findings however show that preference is not for the utilization of the services provided at the NHC modern sector. The following are the major factors responsible.

Lack of Supervision and its Effects

One basic problem of the modern sector (NHC Health Centre) has been the lack of adequate supervision by the Ministry of Health (MOH). Supervisory visits to the NHC health centre are irregular, and unsatisfactory.

The NHC personnel could not remember exactly when the last visit occurred. Interviews with the Medical Officers at the head office of MOH, Ho, show that on their part, the major problem has been the lack of transport facilities and logistical support for supervision. This problem however, has been identified in other rural public health systems in the country (IDS Report: 1978: 198).

Lack of adequate supervision may be responsible for the lack of discipline in the modern sector of NHC. As a consequence, there has developed some informal network within the bureaucratic system with adverse effects on the effectiveness of the health centre.

The informal lucrative business of drug distribution and the private medical practices by the staff of the NHC modern sector have already been discussed. Thus some of the drugs meant for the public at the modern sector were often used unofficially outside at lower prices. One respondent who did not see the essence of utilizing the NHC health centre services when sick gives an explicit explanation:

"Why should I go to the clinic which is expensive when I could equally get a cure from the same people in their various homes after work at a far cheaper price using same instruments and medicaments?"

Another elderly respondent explained that:

It is far better to wait until the staff closed from official duties especially in the night, and consult them at home. The patient and the "doctor"* could sit in a relaxed, cordial manner and talk in-depth about the health problem. The treatment is better here, and even the injections are given in a more sympathetic manner because of the social relations with the "doctor." Since he needs more private clients, the home treatments are better and cheaper.

It is certainly not only the personnel involved in this unofficial practice who benefit. As expressed by our respondents, the client benefits much more than just the low price. Sociologically, we may argue that medical care is an intimate activity and its patronage may be a function of the degree to which it meets the purely personal needs of the client. The patient wants full attention from the professional. He wants absolute privacy. He would not like a system which keeps him waiting uncomfortably for a long time before he receives some attention. He appreciates it most when there is no officially fixed consultation time so that he could consult at his own convenience. But the bureaucratic system does not permit such indulgence.

* By "doctor" the respondent means any member of the staff of the health Centre (especially nurses) who practice informally at home.

There are fixed periods for consultation (save emergencies), and in their relationship with clients, professionals are supposed to show "neutral affectivity" (Parsons 1951).

The unofficial practice thrives much perhaps because it meets the convenience of both personnel and clients alike. Its functional role cannot therefore be over emphasized. Nevertheless, its adverse implications for the utilization of the official services are certainly great.

The Modern Sector and other Public Health Facilities

Apart from the unofficial sources for self-care, the NHC health centre has to rival with a number of public health delivery systems in the locality.

Findings show that the people prefer to take their sick to public health facilities other than the NHC modern sector because of the faith they have in the quality of care in those other health institutions.

Many respondents observed that, the same pharmaceutical drugs prescribed at a higher cost in the NHC modern sector are obtainable at a cheaper rate from the local dealers.* Even then, some drugs are not available at the modern sector and are prescribed to be bought from the informal sector for treatment within the NHC.

* See appendix F for some pharmaceuticals sold at the local shops at Vane and their various prices

The people argue that comparatively, the NHC modern sector lacks adequate drugs and efficient personnel and equipment for the thorough medical examinations of blood, urine, stool etc. before prescriptions.

It is common place in Vane for the seriously ill to trek down the hills to Dzolokpuita "Dressing Station" 5 kilometres away to consult "a Dresser" without reporting first at the NHC Health Centre; or to walk over 8 kilometres down to Fume for transport to Liate Catholic mission clinic, or to Hohoe and Anfoega hospitals. No doubt the most common felt need, according to the people of Vane, is the need for a resident "doctor" at the modern sector.

Perhaps a case study may illustrate the severity of the lack of trust in the NHC modern sector. On one occasion, the research team was astounded when we met a group of people at dawn (on the road apparently returning from Dzolokpuita) wailing over a dead child. As it were, the dying child was rushed on foot from Amedzofe down the mountain through Vane - the anticipated target, surprisingly, was the Dressing Station, 8 miles from Amedzofe. The child died after some 2 miles from Vane.

Such occurrences may appear unreasonable if we consider the fact that in an emergency like this, the therapy managing group of this child virtually ignored the higher status health facilities in the immediate locale - the Amedzofe public clinic (situated in the same town as the case); and the Vane NHC modern sector (public health centre) with 13 trained medical and para-medical personnel - just about two miles away from Amedzofe. What is quite interesting is that the road they took passed right through Vane and almost through the shadow of the towering buildings of NHC clinic. They were heading for the Dressing Station supposedly the lowest on the scale of public health facilities, with only one person - a Dresser - working here, located 8 miles away, on foot.

Diverse interpretations could be given to this attitude. No matter the other possible reasons, findings show that when serious health problems occur, proximity and economic accessibility are not crucial factors per se in determining the choice of therapy. What is paramount to the people is the perceived quality of care and the confidence the people have in the health institution and personnel.

These findings confirm Suchman's (1964-65) observation that "symptoms perceived as serious were most likely to elicit contact with a physician". The prototypical definition of a "Physician" by most rural people include any orthodox medical practitioner (be it a Dresser, a nurse, etc.) in whom the people have confidence and trust.

Twumasi gave the example of male nurses and health superintendents in rural localities assuming the "... authority and prestige of the physician. This practice often goes unquestioned because the rural population generally lacks the sophistication with which to differentiate between the functions of doctors and nurses". Twumasi (1975:81).

Another factor often mentioned by respondents is the fact that the NHC has established about 30 PHC centres within a radius of 45 km from Vane. All the villages surrounding Vane therefore do not depend on the NHC modern sector for first aid services any longer. Coupled with this, almost all these PHC Centres are closer to the trunk roads of Ho and Hohoe than they are to Vane. No doubt they naturally prefer making direct referrals to the hospitals.

Findings therefore show that the major general problems in the acceptance (patronage) of the NHC modern sector by the people include (1) the perceived inefficiency of the personnel (2) the fact that there are relatively more "convenient" sources of pharmaceutical drugs in the community for self-care and (3) the preference for other public health facilities in the area because of the relative confidence the people have in these.

This leads us on to the discussion of the effects of external factors on the herbal department.

Problems of the Herbal Department

The two phases of the developmental sequence of the herbal department of NHC have been discussed in Chapter 3. In this section, the problems of those phases in relation to the needs of the community shall be discussed.

As mentioned in Chapter 3, the choice of the herbalist-in-charge of the NHC herbal sector was based on the capability of the candidate to read and write. He must also be a practising Christian.

The attitude of the management must be seen against the background of the NHC as a configuration of different parts. The Herbal Department is a part of this configuration. The NHC aims at operating on the principle of mutual respect and interdependence of sectors. Personnel in such an ideal configuration must see each other as equals and must be able to relate and depend on one another. This presupposed the basic premise of mutual understanding. To facilitate this, language was seen as an important element. Unfortunately the illiterates would not be able to communicate in the lingua-franca - the English language. This was important because NHC is made up of personnel (especially those of the modern sector) who were non-natives of Vane.

Apart from language difficulties, there was the need to work alongside the modern medical department which operated on bureaucratic procedures. There were other duties like record keeping, hosting symposia and conferences as well as giving explanations to worldwide visitors to the project site; - these presupposed some level of literacy.

These criteria certainly disqualified the very popular and well-established traditional healers in the area. The only candidate who seemed most qualified at the time was not practising at home (Vane). Though a native, this candidate had been living outside Vane for over fifteen years. He was invited back home to take the post. He was assisted by a literate trainee-herbalist at the time.

Comparatively, however, the people had more confidence in the "disqualified" traditional healers and would have preferred them to the choice of management.

During the first phase of the developmental sequence of the herbal department, the organizational strategy adopted aimed at de-emphasizing the practices of the original traditional practitioners in the locality. It is stretching the point too much, but the technique apparently aimed at eliminating these local practitioners by substitution. At the initial stages therefore, a closed systems approach, concerned about maximizing performance, and relationship within the limits of the NHC configuration was pursued. The members of the NHC configuration were not supposed to have any links with other health practitioners in the locality.

In line with this orientation, the herbal dispensary of NHC was stocked with popular prepacked herbal drugs "imported" from popular neo-herbal clinics and healers nation wide.

It was assumed that plant medications prepared elsewhere by other traditional practitioners could be "imported" into the NHC system and used as "medications" per se without the magico - ritual elements of traditional healing. What was important here is the need for clear labels giving instructions as to how to apply the drug. To the NHC management, as soon as this is known the essence of the traditional practitioner per se becomes unnecessary in the project. As Whyte (1988:229) noted when discussing modernized healers, "African healing is being measured with the standard of Western bio-medicine where interest is focused on the content of substance..." (1988:229). The basic assumption was that because these drugs were "imported" the very good will of these various healers would have been imported with their drugs into NHC. Other side attractions to this approach include the attractive packaging of these drugs and the added value that it is dispensed in a christian, and a more attractive environment by people who are recognised by modern health practitioners.

On the other hand, the local traditional healers who are the supposed rivals of the Herbal sector of NHC, depended solely on their own individual, relatively limited knowledge of medicinal preparations in the relatively crude form, relatively unattractive environment, and a non-Christian system.

During the first phase therefore, the herbalist-in-charge at the herbal department was not supposed to prepare his own drugs. His task was to read and understand the instructions on the labels of these prepacked herbal drugs and be able to dispense and prescribe. This was certainly a move towards standardization and control. An attempt to chip the practice into the bureaucratic wheel. This invariably meant that, like a modern medical doctor, the traditional practitioner examined and prescribed drugs in stock only. His procedures become routine fitting into the system of technicians.

Remarkably, this was the expressed fear of Traditional Healers studied by Twumasi (1984) in Zambia. The view of the healers was that:

"... though the field of modern medicine would benefit from cooperation especially in treating social and psychological illness ... bureaucracy, however, would in the long run destroy the organizational methods of the traditional healing system. The magico-religious rituals in treating ills would be minimized..."
(Twumasi 1984:102).

This assumption, as findings show, was not however, acceptable to the people. This may be perhaps because the NHC management failed to evolve adequate supportive mechanisms which could create the aura of conviction around the generalists. It is certainly true that medicaments are important to the client, but findings show that the reassuring context in which these are administered, and the relationship between client and practitioner are also crucial elements in the choice of therapy. This was lacking in the case of the NHC.

Apart from this, there emerged problems regarding the expectations of the people. The patients come from a background in which the proto-typical traditional healer has given some dominant image of what to expect from a traditional practitioner. Usually the traditional healer who was a storage of memory of the community in terms of the community's history and the case history of each family, discerned the health problem of patients who consult him without much questioning of the client. The client knows he (the practitioner) knows everything: In the case of the diviner healer, the complaint, cause and solutions are divined in "mystical and magical fashion". The client is often stunned, overwhelmed by details about his real image, his secret sins and the effect on his health.

The fact that this is revealed by another person who supposedly had no "prior knowledge" about the secrets of the individual gives the healer that professional aura, professional authority, the high degree of confidence and precision.

The client's subordination to professional authority invests the professional healer with a sense of authority. The client derives a sense of security from this guru who could see beyond; and he could tell the future from the past, predict and prophesy, and he could tell the client's enemies and could even insulate the client from "evil eyes". The proto-typical traditional healer is the very incarnation of the holistic model.

The Christian Herbalist of NHC on the other hand, has become, as it were, reduced to the level of a "technician". He is stripped of the mystery and myth and has lost most of his popular appeal. Even though the community is predominantly christian, habit formation and socialization may largely influence the perspective of clients. These elements of culture die hard.

On the other hand, (during the first phase), herbalists of NHC did not use the technique employed by others, especially, what some sociologists call the "New Healers" (Twumasi 1975, Jahoda 1969, Wondergem, Senah, Glover, 1989). These include such herbal clinics like Dr. Aphoto clinic in Tema and Dr. Ampofo in Nsawam.

Even though they also practice traditional medicine without the magico - ritual elements of the traditional Diviner/Healer, the success of these "New Healers" must be seen against the background of the confidence they invoke in the clients by the title - Doctor -. It must be noted that the neo-herbal clinics mentioned are not under professionally trained doctors as their titles might suggest.

This epithet invokes confidence since it is often associated with scientific, modern procedures. It lends appeal to clients. With widespread education and westernization in Ghana, many people tend to regard the doctor as the final arbiter in medical matters concerning physical ailments. [Wondergem, Senah, Glover: (1989: 41)]. This brought into being the unlimited confidence conferred on the doctor as it were, a transposition of the powers of the Diviner healer.

Coupled with the epithet, these practitioners use some instruments of modern medical practice:- including stethoscope, microscope, thermometer and sphygmomanometer for diagnosis even though they may understand little about the use of such instruments. In the Ghanaian community, much confidence and respect has come to be associated with these technologies as a sign of good medical practice. If people go to the doctor, they expect "a thorough examination" of the body, the blood, urine, the skin, the eyes and the ears. If they do not receive this treatment they often suspect that the doctor is not a competent medical practitioner.

The prescriptions are certainly not the crux of the matter. To the client, the doctor must find out the cause of the problem first.

The NHC Herbal sector, on the other hand, was neither equipped with the diviner's mystical airs and magico-religious means of diagnosis, nor the "awe inspiring" modern medical technologies of the neo-herbalist for diagnosis.

By design, the healer in-charge of NHC Herbal department was supposed to depend on the modern sector and the Faith healing department for any help necessary for diagnosis. However, as to be discussed later, the web or tissue of interaction of personnel and interrelation of the different parts of the NHC posed its own problems. Eventually therefore, the NHC Herbalist was almost reduced to a mere herbal drug store manager, a salesman whose task was to serve drugs from the counter. These were drugs he did not prepare himself, and drugs he may have little or no confidence in. Coupled with this, the prescription of remedies of other traditional healers invariably decrease the profit margin of the healer - because he must pay for the cost of these pre-packed drugs. However as a herbalist, his self-prepared drugs cost only time and labour for gathering the materials free of charge from the bush. A healer who is financially dependent on the income of his practice may not advertise the expertise of his competitors.

Related to the issue of stocking NHC herbal department with "imported" herbal drugs was the idea of subsidy on these drugs so as to make the prices relatively low. During the first phase therefore, attempts were made by management to "displace" the original traditional healers by the "dumping-off" method. In this sense, the services of the herbal sector were given at comparatively low prices to the patients.

Findings however showed that this technique failed to attract clients away from the original practitioners. It became apparent that the cost of treatment per se, does not decide patronage. Despite the relatively high price of the services of the original traditional practitioners, the patients still continue to patronise their services more.

This could be explained in terms of the community's identification of healers as specialists for various health problems, irrespective of the assortment of medicaments and the cheapness of these medicaments per se. Take for example the treatment of the Agorku boil. To the common man in Vane, (as discussed in Chapter 3), the Agorku boil is fatal, and only a specialist can handle the situation. In the people's conception, such a health problem cannot be treated at any modern medical system.

In this case therefore there is no known close substitute to the expertise of the herbalist who is popular with this treatment. His services in this wise become: fairly inelastic in demand. The practitioner therefore adopts a "price-discrimination" technique for his services. The more capable the individual patient is to pay, the higher the price of the treatment. In this wise, the poor are treated at a lower rate, and the rich are made to pay the difference.

The advent of the NHC could not change this trend mainly because of the attitude of the society toward these category of health problems; the comparative risk involved in the treatment of the Agorku boil for example, does not allow for any trial and error methods. The people want to consult the proper specialist only. In this regard, the experienced specialist is the sole authority. During such emergency situations, the average person does not mind whether the specialist is a Christian or not, or whether he uses magico-ritual methods or not. What is most important at the spur of that moment is ensuring that the patient's life is saved.

Apart from this, the treatment of the Agorku boil (as discussed in Chapter 3) is not just the application of the drug; it needs the expert hand of the specialist to examine and apply the right technique. Thus even if the NHC herbal stock is well equipped with various herbal drugs, there are some ailments which need more than just the instructions on labels. The expert hands of a professional is certainly crucial. This is what the NHC herbalist-in-charge lacks in the treatment of these specialist problems.*

* Another example may be the specialist knowledge of massaging. This is limited to the bone setter. Though the herbs may be made available, it takes the specialist and his trained hands to bring about the desired results.

There is yet another related issue: The fact that the herbalist-in-charge depends on labels on drugs in-stock for instructions in treatment, (as discussed above), means that, this practitioner is limited to the treatment of a certain class of physical ailments.

This class of ailments may be described as "simple physical problems" which may not need any specialist knowledge to treat. These ailments, according to the records (Chapter 3) include; malaria, snake bite, headache, cough, bodily pains.

In the Vane Community however, findings have shown already that there are very close substitutes in the treatment of these. Examples include, public health systems, pharmaceuticals and self-medication. Thus the services of the "NHC healers" become relatively elastic in demand. There are so many practitioners involved and as a result, there is competition for the few patients who seek health care.

On the other hand, there is the other category of traditional healers whose practices are fairly inelastic in demand. These original practitioners handle both physical and spiritual problems. The spiritual aspect is certainly an important element in the belief of the people. Any disease that defies modern treatment may plausibly have some spiritual connotations. This is the category referred to as the natural/supernatural problems (Fosu 1977).

The art of treating ailments like sorcery, mental problems, the quest for spiritual protection from evil, ghosts, witchcraft, and general fears and anxieties, have become the sole monopoly of few elderly traditional practitioners. These category of practitioners had been harried with the advent of social change. They warily practice in isolation, and are consulted within the cult of secrecy.

However, for these same reasons, the demand for their services become more acute. To start with, factors of social change including christianity and formal education, made it difficult for the youth to be interested in apprenticeship to these practitioners. These healers were therefore initially relegated to the periphery; but time is stealthily sanctioning their role as a necessary, and indispensable aspect of the complete health of the people of Vane community; (in as long as the belief in witchcraft and sorcery persists, the role of these calibre of practitioners may remain).

The puzzle remains unsolved. The modernised youth have refused to apprentice these practitioners; the practitioners on the other hand are gradually dying out because of old age. But the demand for their services may keep on increasing with the increase of population. In the Vane community, findings have established that there are virtually no close substitutes for their services.

Patronage of professional faith healing - which is supposed to be a close substitute - is relatively low (3.3%). (Reasons for the low patronage will be discussed later). The modern sector of NHC does not treat spiritual health problems; the small shops, drug pedlars and general herbalists do not address such problems either. No doubt their role in health issues in Vane cannot be over-emphasised - though it is done in secrecy.

These explanations give the idea that the services of these category of traditional practitioners are fairly inelastic in demand at Vane. It may be safely argued that the advent of the NHC in its latent function, has strengthened the indispensability of the role of these category of practitioners, rather than eliminating them by substitution.

Apart from the limitations in the practices of the herbal department, the herbalist-in-charge of the NHC herbal sector was almost a stranger to his own people. He lacked adequate and prerequisite knowledge of his clients because he lived outside the community of Vane for the greater part of his life.

In the context of his profession, the traditional healer, in a homogeneous society is supposed to know everyone, and the medical history of each family for generations. Inherited from his mentors who practised before him, this knowledge was essentially part of the body of theoretical knowledge utilized for medical practice. Equipped with this, the traditional healer often needed no case-histories.

As a stranger to his own community, however, the NHC herbalist-in-charge had to start from scratch in establishing rapport. He was forced to resort to questioning clients. But by the culturally determined behavioural expectations of the clients, this attitude was not to be expected. The traditional healers do not normally ask questions like; age, marital status and name. These may already be known by the healer - being an elder of the community, and in most cases, the oracle is expected to reveal the unknown.

Baker's observation of this situation in his Zululand Mission Hospital explains the differential perception of roles. According to Baker;

Real difficulties arise from the patients' conception of a correct approach to the doctor. In Europe it is accepted as the patients' duty to put his doctor in possession of any relevant facts about his symptoms, their intensity and duration, the history of any other information which the doctor may require to guide his examination and arrive at a diagnosis. Among African patients such communicativeness is considered to be mere weakness, giving away far too much and leaving no opportunity for the doctor to demonstrate his skill for which he is being paid. (Barker 1959:65)

The herbalist of NHC lacked the social sanction, the stamp of confidence from the society. This stamp is supposed to evolve as a function of the interpersonal relationship that develops over time between a people and their medical practitioners. In a community where established practitioners exist already, a stranger who attempts to establish himself in the profession must be ready for a lot of problems.

Indeed Fasin and Fasin (1988) recently pointed out that healers who are the most inclined to search for official recognition are also those who have the weakest traditional legitimacy. No doubt in the case of NHC herbal practitioners vis-a-vis the established traditional healers of Vane as findings show, have relatively low popularity. These factors may be responsible for the eventual collapse of the first phase of the herbal department.

The Association of Traditional Healers of NHC

After three years, as discussed in Chapter 3, management realised that the role of the original healers in the community cannot easily be ignored. Attempts to eliminate their activities by substitution of a Christian approach was not acceptable to the people.

A reparation was attempted by incorporating seven other traditional healers - diviner/healer, herbalists and a bone setter - as consultants to NHC. The rationale behind this innovation is spelt out by the director/founder when he remarked that;

Herbalists, with some knowledge of faith/divine healing or in collaboration with spiritual (faith) healers, are better able to bring about a cure. In traditional practice, HUMANS ARE CONSIDERED AS SPIRITUAL BEINGS OCCUPYING PHYSICAL BODIES. So, to prevent or cure disease, God's help must be sought irrespective of religious belief.
(Contact 1988: 4)

In the second phase therefore, management adopted an open-systems model. In this sense, the herbal department is viewed as being inbedded in a structure that is highly interactive with the social environment of Vane.

An association of traditional healers of NHC was formed. The fundamental premise is that,

in some cases... a team effort (of different traditional healers) must be the best approach in helping someone in need. ... overlapping of interests, skills and services between these specialists is the common ground for a co-operative posture. (Contact 1988:4)

At the practical level however, co-operation between the members of the Association was not without constraints. It became evident that instead of co-operating, the healers proved to be competitors in gaining money and prestige and had little communal interest. There was also the element of secrecy which was religously protected by everyone of them. Thus in the Association could not be expected to exchange information and experiences with other members nor spread their knowledge of effective treatment in the community.

It was evident also that healers have great distrust for each other; each healer trusts his own medium of treatment and believes in his superior herbal knowledge - and prestige. Thus every healer considered himself more as a generalist than what the society members believe he is capable of. Each of the herbalists in the Association interviewed was of the opinion that he could cure almost every disease.

They all claim they have what we may call an "all purpose medicine" in their recipe. On the basis of this therefore, it becomes difficult for a healer to refer a case to other practitioners since it is a matter which would affect his pride and prestige.

The Association was also weakened by the fact that many members never fully understood the objectives of the Association, how it worked, what was expected of them and what they were entitled to. Indeed the idea of an Association did not evolve out of grass-root discussions but like the NHC itself, it seemed to be the idea of one person - the founder/director. Most healers agreed, not because they understood the plan and approved of it but perhaps because they are pragmatic; there was the built-in hope that eventually the Government and/or some western donors may fully take over the running of the project. This would mean that those whose names were associated with this project at the initial stages may be the lucky few to be co-opted into the service and rewarded accordingly. This is one explanation for the fact that though the consultants rejected the invitation to practise under the full direction and control of the NHC management, they conceded to the recording of their activities under the project without any form of remunerations accruing to them.

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The Association was also weakened by the fact that many members never fully understood the objectives of the Association, how it worked, what was expected of them and what they were entitled to. Indeed the idea of an Association did not evolve out of grass-root discussions but like the NHC itself, it seemed to be the idea of one person - the founder/director. Most healers agreed, not because they understood the plan and approved of it but perhaps because they are pragmatic; there was the built-in hope that eventually the Government and/or some western donors may fully take over the running of the project. This would mean that those whose names were associated with this project at the initial stages may be the lucky few to be co-opted into the service and rewarded accordingly. This is one explanation for the fact that though the consultants rejected the invitation to practise under the full direction and control of the NHC management, they conceded to the recording of their activities under the project without any form of remunerations accruing to them.

Thus from the point of view of the average member of the Association (the consultants), the Association was just a white elephant, to which they owed neither responsibility nor loyalty; but shared in the prestige that goes with the world-wide acclamations about the project.*

The failure of the Association is also a function of the fact that there was no platform created for the members of the Association to meet regularly and discuss problems and issues. Members of this Association invariably did not see themselves as a unit. Members were not loyal to one another and to the Association as a whole. It was a problem of solidarity and the internalization of the norms of the Association. These are important elements for integration and pattern maintenance in any organisation.

Thus the attempt to broaden the scope of the Traditional sector of NHC (Faith and herbal departments) does not accomplish what management intended because the motivation is poor and there is poor organisation and co-ordination. The participants are alienated and therefore lack any commitment to the programme.

* (CONTACT June 1988; International Samenwerking, September 1988; (12), The Weekly Spectator December 17, 1988.)

Let us now discuss the effect of external factors on the dynamics of the faith healing sector.

The Faith Healing Sector and its Rivals in the Community of Vane

One interesting finding (Fig. 4.1) is that faith healing forms a very negligible aspect of professional healing in Vane (3.3%). This is due to the fact that prayers are largely aspects of self-care practice by most Christians. To start with therefore, the proportion of the population that goes in for faith healing is very negligible. But it may be more insignificant for NHC if we realise that this relatively negligible proportion is shared among a number of competing, and rival faith healing groups in vane - including the NHC faith healing sector.

The initial attempts of the NHC to forge co-operation among all the prayer groups of the various churches in Vane with the faith healing sector did not materialise. A number of factors are responsible for this. One major factor is the fact that between the various churches there existed - as in the larger society - a quality of mutual distrust and suspicion which makes it extremely difficult for people to co-operate for the common goal.

As explained in chapter two, Christianity in Vane, is not just a religion of Sunday workshop. It is principally a manifest set of cultures which is uniquely perceptible. Thus belonging to a church means a significant integrated life pattern associated with a group, members of which look at one another as people, set aside. Time has sanctioned and validated the ways in which these churches and the individual members articulate with each other.

As explained already, the various Christian movements therefore see one another as belonging to different groups, and in a sense, there exists a level of mutual competition to get more people to one's group. In a situation like this, christians hardly see one another as having the same purpose. Therefore a new programme that presupposes a high degree of inter-church co-operation is obviously headed for trouble.

This finding is common in Anthropological literature. In his studies in Castilian Village, Aceves points out that,

when changes are introduced that depend upon the creation of new forms of social relationships as a necessary condition for change, strong resistance occurs (Aceves 1971:128).

In the same vein, Hollnsteiner, in discussing the problems of enhancing co-operation in community development projects in the Philippines observed that partisanship in rural societies could negatively influence the diffusion of innovations.

He remarked that:

Opposing factions will attack almost any project sponsored by their rivals, finding innumerable reasons why it is bad for the community... though the project may have the noblest aims, such as improving... health... (Hollnsteiner 1963: 190).

Looked at from this angle however, Vane Christian Fellowship which is an assemblage of the youth from different Christian denominations coming together to study the Bible and pray, and therefore forming a society, defies our interpretation. However, a critical appraisal of the factors responsible for the survival of this fellowship reveals the central role of charismatic leadership in bringing people together.

According to William Catton (1957) any population "is likely to contain a number of individuals whose religious interests are intense, but are not adequately served by existing religious institutions". Such people may be prone to be attracted to charismatic leadership. We may apply this to the Vane situation.

In a society where people frown on participation in the activities of other "groups", a fertile soil for a broad programme of inter-church relationship may be effected through charismatic leadership; the ability to demonstrate what you believe and the fruits of this belief. People want signs, miracles, and the proof that the innovation holds a promise of something more beneficial than what is provided by groups they belong to.

The problem was whether the professional faith healer of NHC has this charismatic touch that breaks the clearly defined social barriers. Interviews with community members and opinion leaders show that the people hardly regard the faith healer as a charismatic figure. One important opinion leader of the community, commenting on the apathy of community members toward the NHC faith healing sector observed;

"The professional Healer and his practice are not awe inspiring at all; his personality does not evoke any feeling of confidence in the people, he is old, and weak... and many people even think they are more spiritual than he is... why should they then go to him for spiritual healing?"

Coupled with this the faith healer of NHC is a stranger to the Vane Community. He belongs to a different ethnic group with relatively different cosmological assumptions. He cannot communicate in the native language of the people of Vane, nor speak Ewe, the lingua franca of the Volta Region. He is forced to use English and Akan in his communication with the rural people. This certainly is a socio-cultural barrier between the people and the health practitioner. One may justifiably ask how the healer can offer adequate emotional support and counselling when he cannot converse with the client.

Other opinion leaders are of the view that, the general apathy towards faith healing at NHC should be seen against the type and mode of healing practices.

One church elder of the Evangelical Presbyterian Church observed:

... the people are very confused about whether the healer is using the Holy Spirit or he is using minor spirits and magic; it is only "spiritualists" who use such items like candles, incense, holy water, six flower lavender, sea water, oil, herbs, etc. for healing. Jesus did not use these. He only prayed for the sick and they were cured. The individual Christian has to develop the art of faith and healing through prayer, and in times of illness he must go on his knees, as well as call the elders of the Church to aid him in prayer alongside the use of drugs.

In this case, the reservation centres around differential perception of Faith Healing. The NHC faith healing is perceived as being related to a "pagan" background that dealt with "minor spirits", and the use of sweet-scented items to invoke their presence. But the NHC, as a project, is supposed to be responsible to the Evangelical Presbyterian Mission with an Orthodox mode of worship.

The church leaders and the clergy of the orthodox churches at Vane encourage members of their congregation to exercise their own faith in healing. Thus they indirectly discourage participation in the activities of the NHC faith healing sessions. There exists some level of ambivalence which more often produce a stalemate than co-operation.

On the part of the syncretic churches in Vane, adequate provisions seem to be made within the confines of the sects quite similar to what pertains in the NHC faith healing sector. The leaders therefore jealously protect themselves from losing members to the new "sect" of NHC.

Instead of co-operation therefore, there has rather emerged rivalry and competition between the different prayer groups, sects and NHC faith healing department.

The external factors for the failure of the NHC therefore include the preference for self-care to professional health care, as well as the preference for the services of health care facilities outside the NHC.

Let us now appraise the role of the herbal and faith healing departments together since in the real sense they are meant to be in combination, a replica of the traditional diviner-healer.

Relationship Between the Traditional Sector of NHC and the Social Structure of Vane

As mentioned in Chapter three, the traditional sector of NHC is made up of the Herbal and Faith healing departments, Jointly, they are ideally meant to be adequate alternative of the Diviner-healer of the prototypical traditional system. The Diviner/healer in the traditional Ghanaian society, as mentioned, is the very incarnate of holistic approach to health care.

The NHC's original plan was to give a Christian alternative of these traditional healing practices. According to the founder/director, the relationship between the two sectors is a spiritual one. The bond makes each dependent on the other.

The work (of the faith healing department) is based on Bible study, counselling and prayer: ... A person may first seek the help of the (faith healer) who prays for guidance. Through visions and dreams, herbs are revealed (to the faith healer) for treatment. This knowledge affords (the faith healer) the chance to work closely with the herbalist (contact 1988:4).

As it were the professional role of the traditional diviner-Healer has been split into two components. The Herbal department treats the body of the patient, while the faith healer caters for the spirit or the mind. Each is supposed to do only his part and refer the patient to the other personnel.

Indeed findings show (chapter 3) that the functional scope of these sectors in NHC are by no means mutually exclusive. Instead of this being the basis of co-operation, in practice, it is rather the cause of conflicts. The artificial separation of these aspects creates a situation in which it becomes difficult for the systematic arrangement of activities. Responsibility and the authority for specific well-defined duties could not be given respectively to these two departments.

Each of these two sectors has become reductionistic. The two together could not approximate the traditional model of the one-man charismatic Diviner/healer because the separation presupposes two personalities. The co-ordination of two individuals with different capabilities and attitude is not quite easy for a perfect prototype. In effect it became an ineffective simulacrum.

Another related issue is whether the two traditional healing sectors, cast in the frame of the christian belief system adequately create the same aura of faith for the client. On this issue, Hagan's observation becomes relevant for he analysis. According to Hagan (1986):

One may succeed in this restorative effort by substituting and using the symbolic system or rituals of another culture e.g., christianity - but this can be done only if the new symbols are given the same reference to traditional norms and universe - that they replace --. So long as new symbols do not achieve this reference such new rituals cannot totally replace the traditional rituals. (1986:2)

In the case of Vane, findings have shown that the majority of patients bypass the NHC traditional sector (herbal and faith healing systems) for other traditional healers elsewhere; perhaps an explanation may be in line with Hagan's observation.

In a capsule, the substitution of the holistic traditional diviner-healer with two institutions of Christian bias, has not caught on well with the people.

Remarkably, Whately (1857:225) advises that "except the necessity be urgent, or the utility evident", experimentation in rural societies must be avoided because "novelty ... (may) ... be held for a suspect". In a nutshell, the external factors responsible for the failure of NHC to meet the expectations of the people may be summed up in the observation of Whately;

It is true that what is settled by custom though it be not good, yet at least it is a fit; and those things which have long gone together, are, as it were, confederate with themselves; whereas new things piece not so well; but, though they help by their utility, yet they trouble by their inconformity; besides, they are like strangers, more admired, and less favoured (Whately 1857:22).

The discussions this far have dwelt on the adverse effects of external factors on the utilization of the NHC facilities. The rest of this chapter shall now be devoted to the appraisal of the internal problems facing the NHC and the implications of these for the achievement of the objectives of the organisation.

Internal Factors

Introduction

The internal factors comprise general organisational problems facing NHC and their effects on the coherence of the constituent parts of NHC. The pertinent questions we seek to address here include (1) How do the NHC constituent parts work in practice? (2) What is the nature of their interrelations?

The Organisational Problems of NHC

Structurally, the NHC is characterised by a high degree of task specialization and division of labour. It is a multispeciality approach, where, as discussed already, diverse healing systems are housed. As a result of the different specialities, and also because of the type of constituent parts that make up the NHC, the organisation finds it difficult to operate by strict bureaucratic rules.

Coupled with this, loyalties within the organisation are divided because there have emerged two authority structures. Originally, as mentioned in chapter three, the project is responsible to the Management Board of NHC with a management committee as its main representative at the local level. The authority at the local level is vested in the director of the NHC who is also the chairman of the Board of Directors of the whole complex including the modern sector.

In reality however, the influence of these bodies on the management of the project is very meagre. The administration of the project seemed to be in the hands of two personalities - the health centre superintendent (representing the MOH), and the founder/director of the NHC who is the representative of the Management Committee.*

* The members of the management committee interviewed gave the impression that they have little or no hand in the decision-making or the administration of the project. The committee merely, exists on paper.

These two personalities religiously protect the interests of the bodies they represent. Conflicts emanate basically because the various "interests" are generally not always similar. As mentioned in chapter three, the Ministry of Health claims full responsibility for the Modern sector of NHC (which is a public health centre). The NHC modern sector is therefore seen basically as any other public health centre in the country under the health superintendent at the local level and responsible to the District Medical Officer, and the Regional and National Directors of Health.

Conflicts in NHC emanate primarily from the fact that the modern medical sector does not recognize the legitimacy of the founder/director of NHC. The modern sector personnel do not regard themselves as members of the configuration of NHC, and they therefore do not gear their activities towards satisfying the ideals set down for this configuration. They become a separate entity, merely sharing premises, as it were, with these other health institutions, with some level of informal relationship between them perhaps as a sign of good neighbourliness. Consequently, a communication gap is created.

What is crucial here, which indeed may be responsible for the conflicts, is the fact that, the society sees the modern health system of NHC as the core element. The community is of the opinion that, the key to the configuration is the quality of care provided at the modern medical sector of NHC.

By the perception of the average person in Vane, the traditional sectors of NHC would be more acceptable if the patient is referred by an efficient modern medical personnel who could monitor the activities of the NHC and examine patients. The expertise of the modern medical personnel becomes the main pivot around which inter-sectoral referrals could be effected. It is assumed that if there is high quality care at the modern sector, there would be influx of sick people from the community and elsewhere into NHC. This would spill over and then set the wheel of the inter-sectoral referrals into active motion.

Thus the keen interest of the director/founder to exercise full authority over the modern sector, among others, is certainly a function of the strategic relevance of the modern sector to the achievement of the objectives of the NHC.

The ambivalence becomes more significant if we consider the fact that by MOH standards, the superintendent is not responsible to the director/founder of the NHC. The superintendent therefore claims sovereignty over the modern sector which is the perceived "core element" of the configuration. But for the purposes of achieving his goals, the director/founder, on the other hand, sees the control over the modern sector as the main key to the achievements of the ideals he has set down. In the name of the NHC as a whole, the director/founder thinks that the superintendent is responsible to him at the local level and must therefore take instructions from him.

Though not explicit, this strong undercurrent tension exists in the administrative structure of NHC. The dual administrative system made it impossible to formulate definite plans based on objective policies, standards and work procedures of the organization. It became difficult to put down any plan of action for the organization as a whole which could spell out the role and relationship between the different departments for the achievement of the goal.

Another related issue is the attitude of the director/founder towards community participation in NHC. Community apathy towards the project was found to be immense. This could be explained by the fact that the town Health Committee - which represents the voice of the individuals in the community - could not influence the founder/director in matters related to the administration and direction of the project. He is accused of regarding himself as the sole decision maker and allowing no argument, logical or otherwise, to sway him from the goal and methods which are part of his ideals.*

* On this issue, Twumasi's advice to innovators in rural communities becomes very important. Twumasi noted: "One should not pretend to have monopoly on expert knowledge. In this context, rural life should be respected and (one) should not attempt to impose any ... superstructure, so to speak, on the existing one. To be really effective therefore, health programmes should evolve within the framework of each society's own culture". (Twumasi 1975: 97)

Naturally, the director/founder has some level of emotional attachment to the project he built and nurtured all by himself. Perhaps for ego-gratifying reasons, he becomes desperately anxious to produce results. He becomes autocratic in demanding the implementation of his ideals against popular opinion. This attitude naturally alienates the people from taking part in the decision making process of the project.

The project also lacks administrative staff to cater for the files and other administrative tasks that are essential for any organisation as an on-going concern. The financial administration of the project for example, may best be described as prodigal, since the founder/director is the only one who knows how much the project has and how much has been spent on what. All monies from donors go into a bank account to which the founder/director is the sole signatory. Interviews on the issue of finance on the project has not yielded much for discussion.

In light of the dual authority structure therefore, there developed intra-management conflict, non-co-ordination and mutual distrust which invariably destroyed the subtle co-operative posture, the very life-blood of this project.

Having discussed the dual-administrative structure of NHC, the rest of this section will be devoted to the discussion of the effects of this on the interplay between the various sectors of the NHC.

The Interplay of the Constituent Parts

The structurally-induced conflict is more explicit in terms of patient treatment of the NHC. As discussed already in Chapter three, the basic purview of the NHC stresses joint effort, and respect between the three constituent parts of Faith, Herbal and Modern sectors. The thrust of this model is the interplay of these various parts.

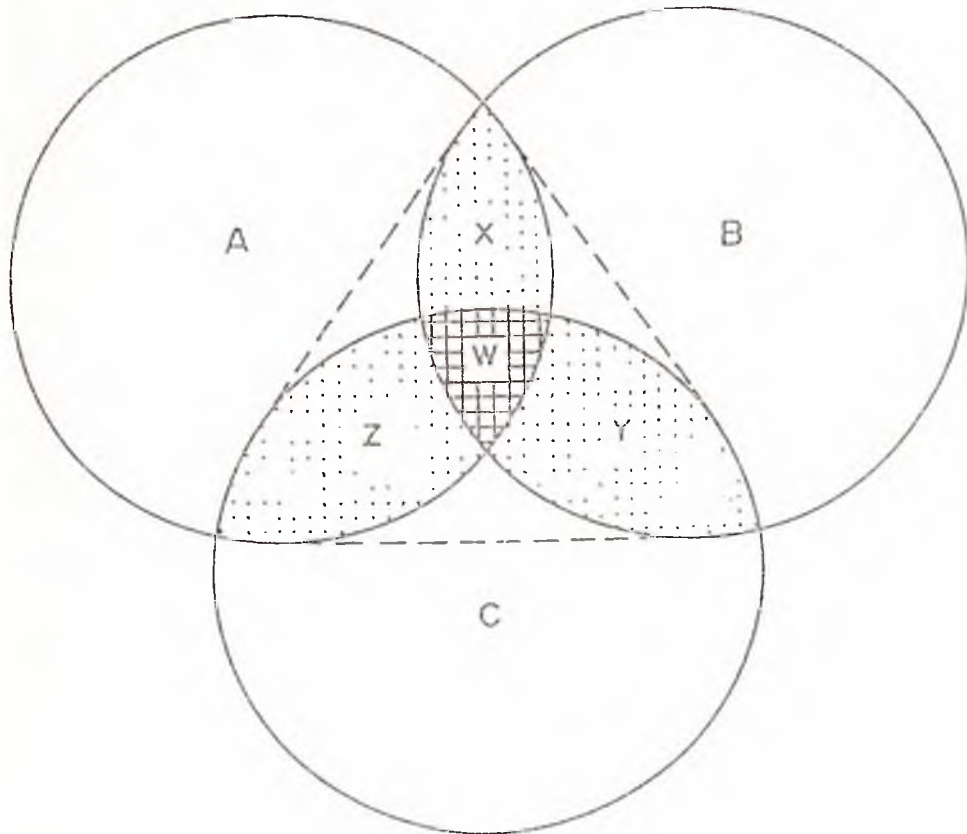
According to the director:

the 3 departments seem very different on the surface. But ...looking more closely, much over-lapping of interests, skills and services can be seen. These areas in common are what we feel is the strength of the Nazareth Healing Complex. (contact 1988:4).

In terms of patient treatment, the NHC is therefore a "flat" organization within which members are expected to work harmoniously, within the inter-sectoral referral system institutionalized for the benefit of the patient. Rank is blurred, and people from the various sectors are to plan together without friction for the benefit of the patient. In this sense, a 'patient care team' (made up of personnel from the different sectors) forms around the entering patient to plan and implement the care needed and dissolves when the patient leaves. In NHC this 'patient care team' is supposed to be effected through the intersectoral referral system (Fig. 5.1)

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FIG. 5.1



As can be seen from Fig 5.1, the symbols of A,B,C represent the technical norms of the Herbal, Modern Health Care, and Faith Healing Sectors respectively. The relationship here is horizontal. In the nominal scale, this equivalence is reflexive based on the principles of exclusive validity. However, the basic philosophy of NHC - interdependence - brings into focus a symmetrical relationship between the constituent parts. The symmetrical relationship is identified in Fig. 5.1 by X,Y,Z. Members of the various sectors are in principle, supposed to form a team to cater for complete health need of every client who enters the orbit of NHC.

On the ground however, the split administrative structure adversely affects the inter-play of the different sectors of NHC. The MOH, to which the modern sector of NHC is responsible, has a set down procedure and referral system from the lower levels to higher and more sophisticated echelons in the public health system - (community-based services to Basic Health Care systems, to District, Regional and Research/Training Hospitals). In respect of this therefore, members of the NHC modern sector are clear about their attitude towards co-operation with other departments. They claim they are only allowed, according to medical code of ethics, to refer cases to higher levels of the official health system.

It means that, should the modern sector of NHC consent to act in concert with the traditional sectors of NHC, the rules and regulations of the MOH must be bent regularly to accommodate to the NHC process. This brings about ambivalence and considerable uneasiness.

It also means that, the health superintendent at NHC modern sector may have to take decisions and initiatives about cases that would be referred to what sector of the NHC or to hospitals. The problem is whether he is qualified enough, or competent enough according MOH terms to take this crucial decision.

Again, the choice of personnel for the modern sector is completely in the hands of MOH. This means that, like all other public health centres, personnel may be posted to the NHC without prior knowledge about the peculiarities of the project. Such personnel need not be interested in co-operating with the other sectors, and since one is not obliged to do so, the central premise of this configuration is relegated to the background. It becomes a function of secondary and informal relationships.

The dual administrative system also makes it difficult for management to have the newcomers, (especially personnel of the modern sector on transfer) socialized and enculturated to accept the fundamental premises, values and goals of the project. Thus without any cultural identity therefore, the personnel of NHC do not see one another as belonging to a unit. As Parsons (1951) observed, an organisation cannot stand when no modicum of recognition is given to its cultural patterns.

Related to the above is the problem of selective perception which emanates from the differences in professional training and experiences of personnel from different orientational backgrounds. Students of the Hospital social structure are agreed that, because of the diverse specialists - physicians, clinical psychologists, physical therapists etc., "ambiguities of all sorts creep into the functioning of a hospital that is designed with split authority." (Christman et al 1981).

However, these different specialists of the hospital at least have one thing in common - they are all science-based. This may serve as their point of reference.

In the case of NHC however, the situation is much more complicated. The objective of satisfying the total health needs of the people presupposes a complex network of specialities of diverse theoretical orientations. Whilst the modern medical sector appeals to the germ theory and in its main, it is "scientific, rationalistic and analytic" (Coulter 1977); the traditional medical sector depends on faith, the social causation theory, and the dirt theory of disease (Hagan 1982, Twumasi 1975). With these diverse theoretical orientations in NHC, the same patient care problem is apt to be defined differently by each member of the health team.

Take for example, the case in which a thirty year old woman reported sick at the NHC health centre. The symptoms included the tumescence of the whole body. The modern medical sector, after some examination and treatment for some time referred the case to the Regional Hospital for further examination and treatment. One herbalist (a member of the association of healers) however had a contrary view of the problem. He diagnosed the problem as "Fototoe"; supposed to be punishment for the breach of local taboos. Seen from this perspective, the traditional healer insisted that the hospital treatment may be fatal to the patient.

He prescribed a ritual cleansing rite as the therapy for the problem. The personnel of the modern sector initially attempted to obstruct the intention of the family of the sick to seek help from this traditional healer. The problem almost degenerated into a quarrel between the two medical practitioners. Each of these asserted his integrity. In the long run however, the therapy managing group of the sick person decided to consult the traditional practitioner - perhaps because of the relatively high cost of travelling, hospital fees and the fear that the patient may be operated upon at the hospital.

The rituals were performed and some herbal drugs were also administered. Nevertheless, our interview revealed that despite the rejection of the suggestion given by the modern medical personnel, the sick fellow combined the rituals and herbal concoctions with the use of the drugs and anti-biotics given at the modern sector initially.

Within two weeks of the ritual treatment, the patient returned with some gifts as tokens of gratitude to the traditional healer. She claimed recovery. What is important in this case study is the conflict that emanates from differential definition of health problems in NHC.

Another related problem in NHC has to do with differential perceptions of how drugs act on the body. In traditional herbal prescriptions of NHC, it is a common practice to use one remedy for a wide range of diseases.

Take for example two herbal drugs prepared by the healer-in-charge of the NHC herbal sector which he called "All purpose medicine" and "the Aparico original black medicine", (which apparently are the same). These are held to be capable of solving ninety-nine health problems.

According to western medical terms, most of the diseases included in this number have extremely varying characteristics; diarrhoea fever, jaundice, piles, lower abdominal pains, paralysis, hernia, mental disorder, dizziness, rheumatism, stomach ulcer and toothache, to mention but a few. To a western trained medical practitioner, it is quite difficult to understand this pattern.

The differential theoretical bases of the various sectors of NHC therefore create some level of tension which destroys the sense of commonality of purpose and makes consensus difficult to attain.

From the average person's standpoint, three alternative traditional medical approaches to the treatment of health problems have now become available in the NHC. These include the faith healing approach, the herbal clinic and the "consultants of NHC." On one hand, both the faith healing and the herbal clinic are supposed to be christian-based and interdependent.

All problems relating to bizarre ailments, psychosomatic problems, and even physical ailments which have some emotional implications for the sick person are supposed to be referred to the faith healer for prayer and counselling.

The herbal approach of NHC (as explained elsewhere) is supposed to focus its interest on the content of the herbs as therapeutic ingredients per se. It is a clinical approach using herbs. Thus the mythical connotations of herbs are supposed to be disregarded, and all spiritual problems referred to the faith healing sector of NHC.

On the other hand, the "consultants of NHC" are generally regarded as practitioners who have no limitations in respect to the use of magico-religious practices in healing. To start with, between the "NHC healers" (herbalists) and the faith healer, on the one hand, and the consultants attached to NHC on the other, there are basic differences in theoretical orientations.

Whilst the former seek to substitute christian symbols and principles of healing for magico-religious healing practices, the latter lean heavily on magico-ritual practices. The theoretical basis of these two categories are therefore not the same. In its logical sense, referrals between these two approaches have its own inherent conflicts. The "Christians" naturally find it improper to refer patients to a religious orientation they have contempt for.

What aggravates the alienation of the different sectors of NHC is the lack of any adequate arenas for airing differing viewpoints. The personnel do not have the opportunity to discuss issues together, as one people, and to iron out differences where necessary. With the differentiation and conflicting ideologies of the sectors of NHC, it is not surprising to find that communication is difficult among the various sectors.

Related to this problem is the lack of a co-ordinator at the level of patient-professional contact. In the tradition of NHC, the choice of therapy, at least the first contact, rests solely on the decision of the lay patient. In essence, it is assumed that the patient in need of health care will recognize and correctly interpret symptoms and cause. It is also assumed that the patient will have the knowledge and initiative to locate or choose and contact the appropriate sector. In a system where intersectoral referrals have become ineffective, such a tradition limits greatly the benefits open to the lay patient.

Interviews with patients and community members reveal that one limitation of the NHC has been the lack of expert personnel to advice on the choice of therapy within the NHC. Respondents argue that, the individual patient who enters NHC is but a layman. The decision on the choice of therapy during the precarious situation of illness and emergencies should not be left solely in the hands of the patient.

As must be appreciated, the average person as well as the traditional practitioners are of the view that the role of the consultant/co-ordinator should not be occupied by a lay administrator but by a medical doctor whose referrals to the different sectors must be based on scientific examinations in the cases of physical ailments especially.

The director/founder who plays the role of consultant on such issues is quite inappropriate because he is a layman. Price (1968:93) argues that;

... if the non-professionals attempt to make decisions about professional issues, incompetent decision will probably be made because the non-professionals will lack the necessary knowledge, and productivity will be decreased.

This observation tallies with what the people of Vane see as the "missing link" of the NHC - a doctor. This idea and request by the people may have its own practical and theoretical problems; but to the community members, until the MOH gives the green light by allocating to the project a medical doctor for this purpose, the ideals of the model cannot be realized.

Another basic problem that comes to mind about the alienation of the sectors of NHC relates to differential motivational incentives for the various sectors. The initial problem that faced management was not only how to select adequate and appropriate personnel to cover the total health needs of the community, but also how to motivate the personnel within the socio-economic constraints of the project.

For such a model of co-operation to be effective, the traditional healer for example, must be motivated to feel that his art is respectable and that collaboration with the modern system would give him security. He is pragmatic. He wants to be accorded the same working conditions - salary, fringe benefits, respect, titles and social sanctions etc., as the doctor and nurse. He also desires to be entirely free to practice his art in accordance with his own ethics without constraints.

Apparently however, due to economic and structural constraints, the NHC could not meet these principles. The motivation system of NHC seems to run counter to its publicly declared goals because there has emerged discrimination in incentives for the different component sectors. The personnel at the modern sector on the one hand are rewarded according to their clinical competence, while the personnel at the traditional sector are paid far less or nothing for their therapeutic care of patients.

Thus the latter are forced to choose between their desire to work fully within the NHC and the desire to put more energy, time and resources into private practice at the expense of the NHC as an organisation. No wonder, personal goals and quest for economic survival of personnel often conflict with the organisational goals of NHC.

The tension created by the lack of economic incentives therefore, leads to alienation and high absenteeism as well as subversion of organisational goals that are perceived as threatening to personal goals.

Quite related to this issue is the discrimination between sectors in terms of prestige or the satisfaction of ego-gratification needs. Every professional, in a way, craves for some kind of recognition from peers, clients and superiors for his self-image and role. As discussed already, even in the sharing of prestige, and recognition in terms of social sanctions, the traditional sector of NHC seems to be relatively ill-rewarded for their services.

Besides these, the structure of the organization also makes it difficult for the personnel at the traditional sector to earn some esteem - in terms of promotions. They seem to be static without any opportunity for social mobility in their career. For the traditional practitioner in NHC, there is no on-the-job training for social mobility. They have no way to rise above the confines of the task for which they were originally hired. Their counter-parts, the modern medical sector - however have this built-in dynamic system.

Due to these diverse problems therefore, instead of an effective interdependence on one another, the relationship between the sectors of NHC regressed to the level where each sector continuously strives to become internally self-dependent.

Summary of Discussions

The chapter dealt with some sociological explanations for the low performance of the NHC facilities. This was discussed in terms of external and internal factors.

External factors discussed include the health seeking behaviour of the people of Vane. Findings show the prevalence of self-care (especially self-medication) over professional health care, utilizing both pharmaceuticals and herbs.

Under professional health care, modern medical care is clearly the most preferred option in Vane. Findings however show that the people prefer the utilization of other public modern health facilities in the vicinity to the NHC modern sector. This has been explained in terms of the comparatively low quality of services offered by the NHC modern sector.

Recourse to professional herbal treatment in Vane is low (12.1%) and patronage of professional faith healing is negligible (3.3%). Findings show that this is due to the fact that herbs and prayers are largely used at the self-care level by the people.

With the relatively low proportion of the population who seek traditional health care, findings show that traditional medical services outside NHC facilities were much more preferred. This is because, comparatively, the traditional practitioners outside the NHC are more popular and respected by the people for their expertise than those of the NHC.

From the trend of observations, we may conclude that the NHC was unable to eliminate by substitution the original traditional medical systems of the community. These institutions have rather (relatively) dwarfed the activities of the innovation by maintaining their monopoly.

Analyses show that the NHC as an innovation seemed to have ignored the crucial socio-cultural factor of the health-seeking behaviour of the people during its planning stages. To the average individual in Vane, it may appear that the basic health need is a high quality modern medical care unit (a hospital) to complement self-care as a first aid box. It is when these fail that the people shop around for health care. Thus an innovation that seeks to offer traditional professional care and first aid treatment at the health centre level may not be regarded primarily as an added value by the people.

It was also established that community participation in the decision making process of NHC is low in practice. This perhaps may also contribute to the general community apathy towards the utilization of the facilities.

Under the internal factors, findings show that the internal organisation of NHC has some inherent conflicts which make the co-operation of the different specialists and departments difficult.

Structurally, the NHC is characterised by a high degree of division of labour and task specialisation. Because of the different specialities, and different orientations, the NHC finds it difficult to operate by strict bureaucratic rules and hierarchical patterns.

Structurally, the NHC administration could best be described as a "split-administrative system".

The modern sector is responsible to MOH, but nominally the entire project is responsible to the management board of the NHC. In practice therefore, there are two structures of authority involved in the daily operations. They are formally unrelated.

Since many a time these two structures are working for different goals and purposes, there emerges disequilibrium within the organisation.

Added to this, the NHC as an organisation lacks any adequate mechanism for the socialization of new-comers into the NHC. It means that little recognition is given to the NHC cultural patterns which should have the power of knitting the different personalities into a commonality.

Related to the above issue is the problem of intersectoral difference in theoretical orientations. The different sectors of NHC have different ways and means of diagnosing, defining and treating ill-health. As a result of these differences, the same health problem is often defined differently by various sectors. Conflicts emanate because each sector claims to know best what should be done in a given case.

The NHC as an organization also lacked any adequate channels for easy and clear communication between parts. There are no platforms for airing differing viewpoints in discussions or regular meetings to establish conflict prevention strategies. In effect therefore, there emerges the problem about pattern maintenance and tension management within the organisation.

The dual authority structure is also the source of differential motivation incentives between different sectors. A central feature of the NHC social system is a stratification system that is quite rigid with regard to the right and privileges of the two major sectors of NHC (the modern sector on the one hand and the traditional sector on the other). The personnel at the modern health system have benefits like prestige, regular and fixed salaries, social mobility and other fringe benefits associated with their clinical competence. The personnel of the traditional sector on the other hand lack any regular sources of finance, equipment, social sanctions, and social mobility.

Using Christman's term therefore, the NHC could best be described as a "loose holding company" in which various sectors reside by each other but not very peacefully. (Christman 1968).

In sum, findings show that the NHC as a model in health care delivery is not effective. The NHC has not been able to achieve equilibrium both within - in terms of the coherence of its parts and without in terms of the social environment, i.e. the values, attitudes and expectations of the social milieu in which it is established. This may be responsible for its low acceptance by the community. In conclusion, Foster's advice becomes relevant;

...in order to achieve maximum success ... it is essential to realize that barriers to change are at least as prevalent within the innovating organization as within the target group. We need consciously to face up to the fact that bureaucracy places absolute limits on what we can do ... and that it must be studied just as thoroughly as a target group if results are to be optimized.

(Foster 1973, 180).

CHAPTER 5SUMMARY AND CONCLUSIONSIntroduction

This Chapter presents the summary and conclusions of the study. It considers a summary of the salient features and gives some practical as well as some theoretical implications of the study.

1. Summary:

The prime concern of this thesis has been the investigation of a novel phenomenon in health care delivery at Vane, in the Volta Region of Ghana, called the Nazareth Healing Complex (NHC). Designed to provide comprehensive health care at one location, the NHC combines faith, herbal, and modern medical systems. This is in a bid to satisfy the psychological, social and physical health needs of the people.

The central aim of the NHC multispeciality group practice, is to allow association for the communication of ideas and for consultation with other health practitioners within the same facility. The assumed advantage is the greater continuity of care where referrals between different specialists are effected within the same facility.

The purpose of this study is to discover the role of the NHC in meeting the psychological, social and physical health needs of the people. It is aimed at investigating the nature of the interrelationship between the constituent parts of the NHC and also to find out the nature of interrelation between the NHC on the one hand, and the larger community of Vane, on the other.

The methods used to elicit data included participant observation, conversational interviews and questionnaires. The records of the different sectors of NHC were also analysed.

To determine fully the relationship between the community and the NHC, it was important to understand the social setting within which the NHC as an innovation in health care delivery was established.

To this end, the Vane Social structure was outlined. It was shown that Vane, in many respects, is an agricultural community where people live very close to nature and the soil. It was also noted that the early introduction of formal education and Christianity into Vane were important factors in Social Change.

A review of the cosmological assumptions show an admixture of traditional, and Christian ideas. The medical systems of Vane therefore include traditional and modern systems, however, with some measure of preference for the modern medical system.

In Chapter 3, the historical overview and social structure of the NHC was given. This served as the backdrop against which the analysis in Chapter 3 and 4 are pitched. An appraisal of the historical background shows that, the NHC is the private initiative of Mr. Emmanuel Baku, a retired Engineer who hails from Vane. His personal experiences in participating in both the modern and traditional religious orientations, as well as his experiences in India as a student were very crucial determinants in shaping his ideas. He observed that because of some limitations in both the traditional and modern health systems co-operate must be complementary and efficient.

The NHC project was built through the founder's own private funding with members of the community offering some communal labour for the construction. The three departments are housed in separate structures, which adjoin each other in the same yard.

The Government of Ghana and some non-Governmental organizations like the Christian Medical Commission of the World Council of Churches, The Christian Health Association of Ghana, and the Inter-Church Co-ordinating Committee for Development Project in the Netherlands; have contributed towards the provision of equipment for the project.

Structurally, the NHC administration could be described as a "split-authority system". Nominally, the management board of NHC is the central authority for the control of the whole project. On the ground however, the modern sector - which is a public health centre, is under the full administration of the Ministry of Health (MOH).

Thus two authorities have emerged in practice. These two administrative authorities have no formal relationship to one another. The governing body of NHC is therefore based on a dual authority system enforced through an informal relationship between the representatives of the two governing bodies.

The analysis of the utilization behaviour survey showed that the rate of acceptability in relation to the utilization of the NHC facilities is appreciably low. Using 1982 attendance as a base, the utilization of the modern sector in subsequent years (1983-1988) declined steadily and steeply. In 1988 for example, the total number of patients recorded was 556 which is less than 3 patients per working day. For a staff of 19 personnel, this is certainly not cost-effective.

The records of the modern sector indicate that, the facility is largely used for malaria/fever, diarrhoea and general accidents. It was noted that the utilization of the NHC health centre was inversely related to age. The younger the patient (between 0-14 years), the more likely he is to be sent to the modern sector when sick.

Explanations may be given in relation to the use of self-care methods and the preference for other public health care facilities in the locality by the adult group (15-60+ year group). Coupled with this, the younger generation have been found to be more positively oriented towards western and scientific influence than adults (Busia 1964). Analysis by sex shows that slightly more males (50.8%) than females (48.2%) utilize the NHC modern sector. However, the difference is too negligible for any further analysis.

The dynamics of the NHC herbal sector was discussed. During the first phase, the preoccupation of management was to de-emphasize the potency of the traditional practitioners in the locality. In line with this, the closed-systems approach was adopted. The herbal stores were stocked with popular prepacked herbal drugs supplied by traditional healers and neo-herbalists nation-wide. The NHC herbal personnel then became generalists and consultants - prescribing drugs they did not prepare.

After three years, it was realised that the original closed-systems approach of limiting the activities of the herbal sector to Christian principles was not popular with the people. The acceptance, measured in terms of patronage, was appreciably low (an average of six patients per month in 1980).

A reparation was attempted by enforcing a more open approach which incorporated seven other traditional healers - including general herbalists, a diviner healer and a bone setter - as consultants to the NHC. The aim was to give a more comprehensive service to clients by including all specialists in this department.

Findings however showed that the Association of healers did not completely meet the health needs of people who were disposed towards the use of traditional therapy. It was concluded therefore that comparatively, the innovation of an Association of healers in NHC was not perceived by the people as an added value. The people still shop around for traditional health care and they preferred this to the Association of healers.

Analysis of the faith healing sector showed that patronage of the facility was appreciably low (35 regular members). The people who utilize the services were largely females of the age group between 40 and 49 years. Most of the members were illiterate. Reasons for patronage included health problems, lack of employment, and security against real or imagined evil forces.

The case studies cited show that many of the clients were those who have tried other health institutions - including hospitals, modern clinic, herbalists and diviners but did not obtain satisfaction. There were also those who wanted spiritual protection from evil forces including witchcraft and sorcery.

The faith healer, apart from prayers, used other means of therapy. These included ritual bath, prescription of herbs and certain fruits as well as the use of incense, candles, potions and lavender.

Analysis of the records of the three sectors therefore show that the rate of the acceptance of the NHC facilities by the people is low.

Explanations for this were given in terms of the confluence of external and internal factors. The external factors include the lack of any prior feasibility studies on the health seeking behaviour of the community members. Findings show that the people preferred self-medication using pharmaceuticals and herbs (57.9%) to consulting professionals - traditional and modern medical professionals (42%).

The evidence from the survey confirmed the experience in most developing countries regarding the widespread use of self-medication using pharmaceuticals (Melrose: 1982: 25-26)

The sources of these pharmaceuticals for self medication in Vane have been found to be legion. These include unofficial sales from the public system and drug stores in the cities.

Apart from the illegal sources of pharmaceuticals, herbs have been found to be largely used for self-medication (31.3%). Explanations were given in terms of availability, accessibility and general personal and family knowledge of the medical use of herbs in the community.

Perhaps the most prominent external factor responsible for the low acceptance of the NHC has been the inability of the NHC to compete with the original health systems in the locality. The quality of care provided at the NHC modern sector has been perceived by the people to be of low quality. The people complained about the lack of quality drugs other than what the illegal drug sellers have to offer, and lack of any thorough medical examination to justify the hospital fees collected for the services. Comparatively, the people feel more at home with the personnel at other public health facilities where they claim adequate examinations and attention is given at relatively the same price. Irrespective of the distance, and the cost involved, the people of Vane prefer to consult these other public health systems to the NHC modern sector.

On the other hand, the traditional healing sector of NHC (herbal and Faith Healing Sectors) does not appeal much to the people as an added value. The NHC traditional sector, is an attempt to provide an adequate, modern, and Christian copy of the traditional diviner healer. The model of the proto-typical diviner/healer has been the holistic approach. The diviner/healer, as a person, combines both spiritual and physical healing approaches. But in its approach, the NHC has departmentalised the herbal healing and faith healing systems. This split - in what has originally been the profession of one person - has created its own problems.

Ambiguities in duties and role definitions create friction between the members of the two groups. At the back of the friction lies the fundamental fact that in any human population important differences are to be found in the social abilities of individuals. Each of these two sectors appears to be quite isolated from the other and co-ordination is ill-effected. The herbal side becomes comparatively reduced to a clinical system, and the faith healing sector - compared with the spiritual role of the diviner/healer - has become reduced to a very limited role with Christian principles.

Findings have shown that the original NHC approach* therefore was basically perceived by the people as reductionistic in its entirety. No doubt therefore, findings show a near monopoly of professional healers (modern and traditional practitioners) outside the NHC.

Attempts were made to provide a broader traditional health care by attaching traditional practitioners to the NHC during the second phase. However, the socio-economic limitations of the project made it impossible for adequate integration of these into the programme. Data showed that those marginally attached as consultants were patronised more than the "NHC healers". This goes to emphasise the limitations of the NHC model of health care.

*Excluding the consultants attached to the herbal sector of NHC.

These external factors are also aggravated by some inherent structural or internal problems of the organization of NHC. The organizational problems confronting the NHC emanate essentially from the conflicting power structure built around it.

The MOH which is responsible for the modern sector of NHC regards the health centre as any other public health facility, which at the local level must be responsible to the Health Superintendent. On the other hand, the director/founder of NHC who is the representative of the board of directors of the entire project regards the personnel of the complex, including the health centre as responsible to him. As a corollary of the dual administrative system, the employees of the modern medical sector of the NHC do not recognize the authority of the director/founder of the NHC.

As a follow-up, the modern medical sector of NHC sees itself as a separate entity; what makes this difference more pronounced has been the deontological codes governing the exercise of the modern medical profession. Under the official code of ethics of MOH, the modern medical sector is not allowed to refer patients to the other sectors of the NHC. It is obvious that the personnel at the modern sector are faced with a dilemma; that of choosing between self-interest and concern for the deontological codes. This ambivalence is made more poignant because, as it were, personnel of this sector, are being called upon to forsake their medical ethics so as to give way for experimentation.

But such experimentation means using patients, as it were, as guinea pigs for trying the integrated model involving traditional remedies which are not scientifically tested and approved.

Related to this issue is the problem of differential definition of health, illness and disease within the NHC system. Structurally, the NHC is characterised by a diverse division of labour and task-specialization. Relationship between personnel of different levels, backgrounds of education and orientations is a source of constant friction in NHC. Because of the differences in the theoretical basis of the sectors, the same health problem is apt to be defined differently by members of the health team. There is therefore no grounds for consensus by which the different sector could co-operate as a team for the benefit of the client.

The dual administrative structure is also responsible for intersectoral discrimination in terms of the distribution of benefits and motivations. The traditional systems of NHC are not only relatively ill-equipped, but their various personnel are also ill-motivated for the services they render. The herbal practitioners hardly get any pecuniary benefits for their services.

In the case of other incentives like prestige, social recognition and promotions, the personnel of the traditional sectors are discriminated against unlike their counterparts, - the personnel of the modern medical sector, who have all these facilities and opportunities for social mobility.

Another constraint has been the expectation of the people in terms of the status of the NHC and the type of personnel to manage it. The inadequacy of appropriate staff for all the sectors has been noted as one principal reason for the low acceptance of the facilities to the people. Originally, the expectations of the people was that the NHC would be a complex hospital with medical officers and scientific gadgets with retrained herbalists in the traditional sectors.

In reality however, the people were disappointed. The hospital status was not granted by the MOH because of limited resources. On the other hand too, the limitation imposed by socio-economic factors made it impossible for the NHC management to employ a large number of traditional specialists to cater for the health needs of the people who seek for traditional health care in Vane. The co-ordination of the activities of the few traditional healers attached to the NHC also became a problem due to lack of effective management and control.

As mentioned already, the roles of the herbal and faith healing sectors also overlap so much that, it seems difficult for the personnel to systematically arrange their activities so that responsibility for specific well-defined duties could be delegated between these two sectors. They essentially seem to be competing for the same patients.

As a result of these, the original idea of an interlocking and an interdependent tripartite medical system do no function in practice. In line with Wessen's (1958) observations, three important elements for good communication are lacking in NHC.

- (1) adequate channels of communication between all members
- (2) agreement on goals and means to achieve these goals and
- (3) clear role responsibilities and authority.

Given these problems the NHC has degenerated to a level of a caste system in which communication generally takes place between members of the same sector and conversely, the greater the social distance between sectors.

Poor administrative network, lack of adequate sources of finance for the project, and lack of any adequate financial administrative system are other factors discussed as problems in NHC.

Contrary to the views expressed in the Contact (1988), we may say that the approach of the NHC as an innovation in health care delivery is not holistic after all - since the services do not include all the ingredients the people need - nor could we describe NHC as integrated since the co-ordination of the different parts is non-existent. The tripartite medical system of NHC may be best described as a supermarket of therapeutic systems and not a configuration.

In conclusion, lessons to be learnt include the fact that the low acceptability of NHC, despite its ambitious goals, suggests and supports the widely held view that the siting of health care facilities in a community does not necessarily mean that people will flock to it (Polgar 1962). No matter how well intended its objectives, an innovation must be presented afresh to the community in a way that will command conviction and acceptance.

This means that the people's way of life, must be understood and their expectations respected. Within the innovating organization itself, members must be convinced of and be clear about their role. They must be motivated to keep being loyal to the goals set for the organization. It is this cognitive orientation which provides the members of any given organization and/or community with basic premises or postulates, that places them within the system and governs their behaviour and participation in any innovation.

It may be said also that, people who are used to resorting to a variety of health systems may find the idea of concentrating all the health systems at one spot strange and disturbing. It seems that the latent function of shopping around for health is a crucial element which has been ignored completely by the very idea of NHC. Do the people really need the concentration of all the health elements under one roof? Has shopping around for health got some intrinsic values which the NHC is threatening to remove?

It would appear from our analysis that the act of shopping around for health is part of the healing process, especially in a kin-based society like Vane where acute health problems become the responsibility of the entire extended family. The intrinsic role of such a problem as a central rallying focus of the family cannot be over-emphasized. At least, shopping around means psychologically that something is being done about the problem, and that the family is strongly behind the individuals even in times of crises. The NHC approach is certainly a threat to this cultural disposition.

Relating the findings to the social systems approach as done in the initial Chapter, it may be concluded that Foster's advice is of underscoring relevance for any venture into effecting innovations in communities.

Forster noted;

... development programs run more smoothly and more successful when the socio-cultural patterns and the premises, values, and motivations of the members of both the innovating bureaucracy and the recipient peoples are known, and when the social dynamics of the project setting are understood and utilized in planning and operations (Foster 1973: 198).

From trends so far observed, it can be hypothesised that the diffusion of the NHC innovation is a function of the extent to which it meets the socio-cultural expectations of the people; both those within the community (recipients) and members of the innovating organisation itself.

It would be interesting for future research work to find out how management is adapting to the initial problems in introducing the three-in-one health care model into the Vane social structure. This would be the basis of the author's future research work.

Practical Implications

Despite the many limitations, the NHC and its initiators should be credited with their contributions to health care delivery system for the satisfaction of the total health needs of the rural society in a way that the people would accept.

One salient contribution of the NHC has been the encouragement this project gave to the traditional medical practitioners in the rural community of Vane. As a result of social change (Christianity and formal education), the traditional practitioner was harried and isolated.

He was relegated to the periphery, with some appreciable level of stigma attached to his practice. The advent of the NHC sought to instil confidence in the traditional healer and his practice and also to bring some awareness to the society about the relevance of the traditional medical practice even in the modern era.

A look at the national plan and its major objectives show that, the government has policies for extending rural health coverage. Given the key role of the Primary Health Care Programme in this policy and its implications for the role of both traditional and modern medical systems, it may be in place for the government to fully adopt and encourage experiments into a more comprehensive health care system. In this respect, the NHC programme may fall in line with these considerations and this may be of great help to this project.

Analysis of events in NHC show that the constraints that hamper this project from being fully operational and effective, among others, are mainly organizational problems, which invariably have implications for both its internal coherence and external relationship with the community.*.

*The internal problems, as delineated, show a split-administrative structure, and problems with management of resources within the socio-economic constraints of the project. At the external level, what seems crucial is the people's expectation for a medical doctor as a co-ordinator between the two medical systems. Thus the acceptance of this project, among other things, hangs on the role of a doctor in the project.

A crucial assessment of these problems may tend to show that one plausible solution may be the full co-operation of MOH in this experiment. The attitude of the government, and the medical profession is important if real progress is to be made. A political will from the top is indispensable in this respect.

Integration of any sort cannot be successful until official policy towards traditional medical practice changes. As at now, traditional medical practice is accommodated but not legalised.

In line with this, we would suggest the integration of the NHC into the more elaborate national science-based experiment into herbal drugs at the Centre For Scientific Research Into Plant Medicine at Mampong. In this experiment, medical officers under MOH administer traditional medicaments which are scientifically tested to patients after thorough examination of patients. The relevance of this technique for the acceptance of herbal drugs has been mentioned in our discussions of the limitations of the NHC herbal department.

It is suggested that attempts be made to adopt the NHC under the PHC programme as a field research unit of the science-based experiment. In this respect, a medical doctor from the Mampong Valley Experiment may be seconded or made to visit and supervise the field unit frequently and co-ordinate activities.

It means therefore that, unlike what the case has been, the NHC traditional practitioners would be retrained to use these scientifically tested drugs under the supervision of a medical doctor who has some background knowledge already in this.

It also means that the traditional sector of NHC would become responsible to the MOH, and Management problems may be minimised by a more elaborate administrative system. It must be noted that this is very similar to the original plan of the initiator/director of NHC.

One of our goals is to popularise the use of herbal medicines in Primary Health care programmes. Therefore, mass production of rare or very important drugs from herbs and plants, standardization of dosage and research into the preservation of local herbal medicines allow much opportunity for cooperation between Herbalists and Modern Medical Doctors..." (Contact 1988:4)

Findings have shown that this is also in line with the expectations of the people of Vane. It is therefore one instance in which the interest of the people, management of NHC and probably the modern medical sector of NHC may meet and therefore be exploited to enhance co-operation.

However, the author is aware that this suggestion may not adequately help accomplish the objective of meeting all the health needs of the people. This is where the role of the other traditional healers becomes important. There is the need for an effective and legally established association of local traditional healers - including faith healers and Diviner/Healers.

This would mean the preparation of a code of ethics adapted to their practice, ways, and means of enhancing their dignity and role in the society. It calls for some further research into the activities of traditional healers in the society.

Theoretical and Research Implication

The theoretical focus of this thesis adopted both the Social Systems Approach in social change and the Institutional theory. Against this background, findings have established that the failure of the NHC to meet the total health needs of the people is due to the fact that it did not take into consideration the values, expectations and cultural needs of the people. Thus the weak reception of the NHC programme is due to its inability to fit into the socio-cultural expectations and values of the people. Findings also show that there was disequilibrium and lack of cohesion between the constituent parts of NHC.

The theoretical significance of this study is therefore the conclusion that the diffusion of any innovation is a function of the extent to which the cultural values, expectations and motivations of the members of both the innovating organization and the recipient people are understood and are used for the planning and implementation of the programme.

For the research implications of this study, findings have shown that one of the major problems confronting the NHC related to the diverse theoretical orientations of the modern medical sector and the Traditional medical systems. Mutual understanding could be achieved through the creation of an arena for the discussion of these orientations. This presupposes that enough information is gathered on these orientations.

In the case of the modern sector, adequate literature is available to be used. The problem is with the traditional medical system where there is lack of adequate literature to cover the diverse specialities and orientations. In future studies, there is the need to conduct a more thorough census of traditional healers and their various specialities in the local area. Their healing activities should be closely monitored for a number of years towards the delimitation of the capabilities of each of these practitioners. This may improve the co-operation between the scientific and the traditional medical systems.

Another area that calls for further investigations relates to the endemic nature of self care especially self-medication in rural societies. Indeed, Kasl and Cobb, (1966) noted that:

Utilization studies generally omit two aspects of illness behaviour: self medication--and the use of the various non-medical functionaries, omissions which may not bother a public health official but are rather serious in trying to understand all the sociological aspects of illness behaviours. (1966:258-268).

It may be worthwhile for further research to consider the potential role of self-medication in rural health care. Findings show that these informal practitioners are playing some important role in Vane. Their services seem quite acceptable to the people. It may be worthwhile to find out what the public medical system could learn about their approach especially what makes them acceptable. Such feedback may be necessary for the Primary Health Care policy.

There is also the need to critically assess the possibility of retraining these lay practitioners in the rural areas and their being co-opted into the PHC programme instead of training new people as village Health Workers in these communities who may be virtually new and may lack any previous knowledge of their role in the community.

The author is aware that critics will raise many objections as to the feasibility of these suggestions. It may be necessary then to take these criticisms into consideration in order to build a more acceptable model for health care delivery in the rural communities of the developing countries.

APPENDIX A
DISEASE EPISODE QUESTIONNAIRE

DATE.../.../88 NAME INTERVIEWER:.....

CORRESPONDING HOUSEHOLD INTERVIEW NR:.....

NUMBER OF HOUSE:

1. WHAT IS YOUR DISEASE?

2. SYMPTOMS:

3. WHEN DID IT START?

4. WHAT DO YOU THINK IS THE CAUSE OF YOUR DISEASE?

5. WHAT DID YOU DO TO GET CURED?

(write down the disease history and give particulars on why certain treatments were chosen)

6. (Fill in the sequence of the sections by putting numbers between the brackets)

- [] Home treatment with herbs (including from market)
- [] Home treatment using pharmaceuticals(e.g. from shops)
- [] Sought advice from the chemist
- [] Have been to hospital/clinic where?
- [] Bought drugs from peddlars
- [] Visited a herbalist. Who?
- [] Visited a spiritual healer (name:?)
- [] Other

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7. WHAT TREATMENTS HAVE BEEN USED?

QUANTITY	SOURCE	COSTS
----------	--------	-------

8. ARE YOU CURED NOW? 1. Yes [] 2. Improved []
3. No [] 4. Can't tell []

9. IF CURED OR IMPROVED

WHAT TREATMENT DO YOU THINK CURED OR IMPROVED YOUR
CONDITION?

10. IF NOT CURED: WHAT DO YOU WANT TO DO ABOUT IT NOW?

11. NAME: 12. AGE:

13. SEX m/f 14. RELIGION

15. PLACE OF RESIDENCE

16. MAIN OCCUPATION

17. HIGHEST EDUCATIONAL LEVEL

18. RELATION OF PATIENT TO HEAD OF THE FAMILY:.....

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APPENDIX B
COMMUNITY SURVEY

DATE: ../../88

NAME OF INTERVIEWER:.....

TIME:HOUR

INTERVIEW NO.

HOUSE NUMBER

for the first 50 interviews only

1. IN YOUR VIEW WHAT ARE THE MAJOR PROBLEMS IN THIS TOWN?
(write down the first three problems mentioned)

1.

2.

3.

2. CAN YOU INDICATE WHAT THE MAJOR DISEASES IN YOUR AREA ARE?

3. AND WHAT ARE THE MAJOR DISEASES PECULIAR TO WOMEN IN THIS AREA?

1.

2.

3.

4. AND FOR CHILDREN?

1.

2.

3.

10. HOW DO YOU THINK THE NHC CAN BE IMPROVED?
(to get the people's perception of NHC)

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

11. PEOPLE SOMETIMES GO FOR TREATMENT AT LIATE INSTEAD OF NHC. WHY DO YOU THINK THIS IS SO?

1. Personnel [] 2. Drugs [] 3. Both [] 4. Don't know []

Other reasons/remarks

12. PLEASE, MENTION ALL PLACES WHERE ONE CAN OBTAIN AFRICAN MEDICINES (ameyebor tike) IN THIS AREA. (probe: is that all?)

Where:

What:

(when more places are mentioned use backside and circle this X)

13. HAVE YOU EVER USED ANY AFRICAN MEDICINE? 1. YES [] 2. No []

if yes, FOR WHAT PROBLEMS? (Probe)

14. HAVE YOU EVER BEEN TO A HERBALIST?

NUMBER OF TIMES: 0/ 1 2/ 3 4 5 6/more than 6

15. FOR WHAT COMPLAINT?

Complaint

Healer Name

- 1.
- 2.
- 3.
- 4.

16. AND HAVE YOU BEEN TO THE HOMES OF THE NHC HEALERS?

0 / 1 2/ 3 4 5 6 / more than 6

17. FOR WHAT COMPLAINTS?

- 1. 2.
- 2. 4.

18. HAVE YOU EVER BEEN TO THE BUILDING NEAR THE NAZARETH HOSPITAL WHICH IS CALLED THE HERBAL SITE?

0/ 1 2/ 3 4 5 6 / more than 6

19. FOR WHAT COMPLAINT?

- 1. 2.

20. WHAT DO YOU THINK IS THE MAIN DIFFERENCE BETWEEN NHC HERBAL TREATMENT (of the NHC Healers) AND TREATMENT OF OTHER HERBALISTS IN TOWN? (open question)

.....

.....

21. APART FROM THE DIFFERENCES YOU HAVE MENTIONED, WHAT OTHER DIFFERENCES ARE IMPORTANT FOR GOING TO THE NHC HERBALISTS INSTEAD OF OTHER HERBALISTS IN TOWN?

APPENDIX C

OTHER RELATED PROJECTS OF NHC3.1.2 Satellites

At the time of this research, the NHC - Vane was supposed to have links with about 30 satellite PHC centres of over 45 kilometres radius. These satellites were supposed to operate with similar structure like the NHC - in terms of its holistic programme including Herbal, modern and Faith Healing Departments.

The NHC serves as the mother institution, and as originally designed, it is supposed to serve as the referral centre and the mentor of these satellites. It is also supposed to help in the provision and supply of modern drugs from the CHAG allocations.

However, for all practical purposes, these PHC satellites were responsible to the various communities in which they are situated in terms of management and finances.

3.1.3 Others

The NHC has also dug 6 fish ponds since 1984, and cultivated a five-acre herbal garden to supplement the herbs from the bush.

A set of wind-string instruments and jazz drums for orchestral and religious music has been provided for purposes of raising funds to support the project. It plays at funerals and during festivities for a fee.

APPENDIX D

EDUCATIONAL STANDING OF RESPONDENTS - FAITH HEALING SECTOR

Level of Education	Male		Female		Both Male and Female	
	No.	%	No.	%	No.	%
Illiterates	1	2.9	18	51.4	19	54.3
Tech. School	5	14.3	9	25.7	14	40.0
Sec. School	0	-	2	5.7	2	5.7
Others	0	-	0	-	0	0
Total	6	17.2	29	82.8	35	100

APPENDIX F

DRUGS SOLD IN VANE IN THE SMALL SHOPS

There are 5 shops in Vane that deal with general goods. These also sell certain drugs. On the average, drugs sold in these shops are in 4 categories:

- I. Antibiotics
- II. Malaria/fever
- III. Energy drugs/Strength
- IV. Painkillers

These drugs include the following:

<u>Name of Drug</u>	<u>Quantity and Price</u>
1. Paracetamol	3 tablets for C10.00
2. B. compound	4 tablets for C10.00
3. Top tabs	1 tablet for C10.00
4. Butazolidin	1 tablet for C10.00
5. No.3 (sulphatrite)	1 tablet for C20.00
6. Anancin (capsules)	3 tablets for C10.00
(for fever, headache)	3 tablets for C10.00
7. Chloroquine Tablets	1 tablet for C5.00
8. Chloroquine injection	1 for C80.00
9. Aspirin	4 tablets for C10.00
10. Ampicilin	1 tablet for C15.00
11. Alagbin	1 tablet for C15.00
12. Codeine	3 tablets for C10.00

APPENDIX F (contd.)

	<u>Name of Drug</u>	<u>Quantity and Price</u>
13.	M & B	1 tablet for C20.00
14.	Phensic	1 tablet for C15.00
15.	Procaïn injection	C150.00
16.	Franol	2 tablets for C20.00
17.	Telemecin	1 tablet for C10.00
18.	Alligoa-garlsic pills (for pains and strength)	2 tablets for C10.00
19.	Tricilicate	3 tablets for C10.00
20.	Indocide	3 tablets for C10.00
21.	Inthomethacide B.P.	1 tablet for C10.00

APPENDIX G

SERVICES AND JOB DESCRIPTION OF STAFF: NHC HEALTH CENTRE

TYPE OF PERSONNEL	: NO.:	
1. Health Centre Superintendent	1	<p>Responsible for the curative service of the Centre except for minor trauma requiring only dressing. He was obliged to effect early referrals of more serious cases to the nearest hospitals since curative services at the centre were provided at the level of advanced first aid and for infectious diseases and injuries using a limited pharmacopoeia.</p> <p>-Other duties include administration of the whole Health centre. He was to supervise and organise staff meetings, order drugs, supplies and equipment return records and fees to the district hospital. The staff were responsible to him at the local level.</p>
2. Midwife	1	<p>She was the next most senior Staff at the Health Centre. She managed routine pre-natal and post-natal health care provision for the womenfolk, and the babies. She heads the maternity wing of the Health Centre and is responsible for health education under this wing.</p>

APPENDIX G (Contd.)

SERVICES AND JOB DESCRIPTION OF STAFF: NHC HEALTH CENTRE

TYPE OF PERSONNEL	NO.:	
3. Midwifery Assistants	2	They were responsible for the maintenance of labour ward and assisted the Midwife in her duties.
4. Community Health Nurse	4	They were running the child welfare clinic alongside the maternity wing. They also took part in health education which included care of babies dietary habits, personal hygiene, environmental hygiene, preparation for confinement for expectant mothers etc. etc. They also visited schools and performed auxiliary functions and provided curative care for minor ailments within the villages they visited. - They were responsible for immunization.
3. Enrolled Nurse	3	They assisted at the curative wing of the Centre. They gave injections and also acted as the dispensers of drugs prescribed by the superintendent. They also performed general auxiliary functions.
4. Medical Record Clerk	1	She maintained daily attendance register, prepared, retrieves and filed patient medical records.

APPENDIX G (Contd.)

SERVICES AND JOB DESCRIPTION OF STAFF: NIIC HEALTH CENTRE

<u>TYPE OF PERSONNEL</u>	<u>NO.</u>	
5. Health Inspector	1	:He was in charge of :general environmental :sanitation and health :issues including :facilities related to :good drinking water, :toilets, and sanitation.
<u>Non-Medical Personnel</u>		
Watchmen	2	:Security duties night :and day
Compound Labourers	4	:General sanitation of :the compound of NIIC.

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