

Review

Traditional healers in Ghana: So near to the people, yet so far away from basic health care system

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ABSTRACT

Traditional healers in Ghana are so near to the health needs and aspirations of the majority of people who live mostly in the rural areas, yet have been excluded from the formal health care delivery system. Medical systems in Africa and around the globe have broad-ranging ties to the cosmology and the way of life of a people. However, in Ghana, colonialism and external orientation have had a negative influence on Traditional Medicine (TRM). Thus, in Ghana, Traditional healers can be described as a marginalized group and yet their roles in effective delivery of primary and mental health care cannot be overemphasized. This paper elucidates advocacy work toward medical pluralism in Ghana. First, the influence of colonialism on TRM is briefly examined, followed by highlights on advocacy work intended to include TRM in the health care system. Based on “small wins”, challenges, successes, and prospects of our advocacy are discussed.

Keywords traditional medicine, traditional healers, advocacy, complementary/alternative medicine

INTRODUCTION

There are two main therapeutic systems in Ghana: biomedicine and traditional medicine (TRM). Biomedicine is based on the ‘germ theory’ of modern or scientific medicine while TRM is based on the traditional beliefs of Ghanaians. Modern or scientific medicine is an import from Europe which approaches illness in a scientific manner, seeking to establish a diagnosis and on the basis of its findings, apply the most appropriate therapy and finally, sees to the rehabilitation of the sick. A point worthy of note is that this type of medicine developed out of TRM. The comprehensiveness of the term ‘traditional medicine’ and the wide range of practices it encompasses, makes it difficult to define or describe, especially in a global context (Mpfu, 2006). At a meeting in, Brazzaville in Africa, over 30 years ago, World Health Organization (WHO) experts defined TRM as “the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental and social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing” (WHO, 1978). Quite recently, TRM has been defined as “the sum of the total knowledge, skills, and practices indigenous to different cultures, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness” (WHO, 2013).

As a global phenomena, various names have been given to indigenous healing practices reflecting ‘the richness of the diversity in which they are appreciated: traditional healing, native healing, complementary and alternative medicine’

(Mpfu, 2006).

TRM includes a diversity of health practices, approaches, knowledge, and beliefs incorporating plant, animal, and/or mineral-based medicines; spiritual therapies; manual techniques; and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose, or prevent illness (WHO, 2000). TRM is based on the African traditional religion as well as the interconnections between culture, spirituality, humanness, and community (Marks, 2006). TRM is used interchangeably with Complementary and Alternative Medicine (CAM) (Khiljee et al., 2011). Like Ghanaians, it has been noted that “CAM practice is still popular among the Malaysian population nowadays although western or allopathic medicine is the first line of treatment” (Nurul et al., 2015).

There are two main categories of TRM practitioners in Africa namely 1) those who practice without invoking supernatural cause including herbalists, traditional birth attendants and bonesetters; and 2) those who rely on supernatural aid whether or not they use material remedies (Amzat et al., 2008). Some scholars are against the use of ‘traditional’ to describe TRM (Van der Geest, 1997). Despite this objection against using TRM to refer to African medical traditions, it appears that it is the appropriate term to use to describe medical practitioners that fall outside the realm of biomedicine (Van der Geest, 1997).

MATERIALS AND METHODS

Methods

This paper is primarily based on secondary data, and a documentation of on-going advocacy with health policy-makers. First, a computerized search was conducted in electronic databases such as Social Science Citation Index, MED-LINE, Psychological Abstracts and Retrieval Systems, and the Educational Resource Information Centre. The articles selected were focused on the integration of TRM into the healthcare delivery systems with special emphasis on the plight

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Received February 15, 2016; Accepted May 12, 2016; Published May 31, 2016

doi: <http://dx.doi.org/10.5667/tang.2016.0004>

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of traditional healers. Out of over 100 articles reviewed, only 32 of them were directly related to this article. Second, official reports and policy documents from the both the Ghana Health Service, and the Ministry of Health were reviewed. Third, four (4) main short face-face interviews were conducted with four (4) health policy-makers (two officials each from the Ghana Health Service and the TRM unit of Ministry of Health respectively) and other stakeholders such as three (3) TRM practitioners who are members of the Ghana Federation of Traditional Healers Association (GHAFTRAM). The short interviews that lasted between 60 - 90 min were intended to clarify some of the issues emanating from these official documents. Purposive sampling was used to select these individuals who had knowledge and answers to the questions.

RESULTS

Historical perspective and marginalization of TRM in Africa

Modern or scientific medicine evolved out of TRM, and prior to the contact with the outside world, Africans were solely relying on the services of traditional healers. There is a growing concern that the history of medical pluralism in Ghana with its associated colonialism, globalization or internationalism is marked by evil intentions (Senah, 2001). According to this author, globalization has had a negative impact on the development of Africa and this should be resisted.

The concerns of Senah have implication for the development of TRM in Ghana. According to Waldron, 'western society constructed a hierarchy of knowledge whereby diverse, but equally valid forms of knowledge were ranked unequally based on their perceived value' (Waldron, 2010). Consequently, non-western knowledge systems that are evaluated using Western epistemologies are ultimately devalued and delegitimized (Dei, 2000). In view of this, most traditional healers went underground to practice their trade to the detriment of the holistic health needs of the indigenous people. It has been observed that most health promotion programs designed in the Western Nations (often with good intentions) for the developing nations in Africa fail because the initiators neglected indigenous knowledge as part of the process (Airhihenbuwa, 1990). According to Waldron (2010), "when health care systems present Euro-Western health approaches as standard and universal, the consequence is the denunciation, devaluation and marginalization of the cultural belief systems and traditions that shape the health ideologies of culturally and racially diverse groups" (Waldron, 2010). Thus, in Ghana, traditional healers can be described as a marginalized group and yet their role in effective delivery of primary and mental health care cannot be overemphasized.

Senah (2001) has identified two main categories of the development of health care in Ghana: 1) The colonial health system, and 2) The post-colonial health system.

The colonial health service

In his book, 'Towards Colonial Freedom', the first president of the Republic of Ghana notes that colonialism is a policy whereby the colonial powers bind her colonies to herself by politico-economic ties ultimately working to the advantage of the colonialists (Nkrumah, 1962). As a British colony, the history and development of TRM in Ghana may be partly explained by the nature of the political and economic relationship that prevailed between the Gold Coast and Britain, the evolution of the colonial health service is in three major phases (Senah, 2001). The first phase (1474 - 1844) was

characterised by 'medical apartheid' whereby white settlers were physically segregated from the local people and given medical coverage. Initially, the apartheid policy was intended to provide health care services to missionaries and the white settlers, but after the bond of 1844, it was extended to cover native military personnel and domestic/civil servants.

In 1868, the first hospital was built at Cape Coast, the then colonial capital and subsequently rural dispensaries sprang up in several communities. Korle-Bu hospital was built in 1923 for use by Africans and research into tropical diseases. The local people did not fully embrace the new health care system, they used these services with caution while they continued to use TRM. In 1878, in an attempt to neutralize the influence of healers and to promote the new health dispensation, the Native Customs Regulation Ordinance was passed (Senah, 2001). This ordinance banned traditional healing and all other indigenous practices, which offended Western sensibilities. African civil servants were compelled to obtain a certificate of disability from colonial medical officers only. Christian converts were often threatened with ex-communication if found to have consulted traditional healers (Senah, 2001).

Post-colonial health service

At independence in 1957, Ghana inherited a colonial health care service. At the time, the President, Dr. Kwame Nkrumah set the agenda for the whole nation by declaring that: "we shall measure our progress by the improvement in the health of the people. The welfare of our people is our chief pride and it is by this that my government will ask to be judged" (Nkrumah, 1962). After independence, a majority of African countries (including Ghana) did not change the health policies emanating from colonial rule. Perhaps, this may help explain why African countries were not able to meet the 2000 deadline which was set aside by WHO for achieving 'Health for All' humankind. In their attempt to help developing nations to solve their health problems, most international experts have focused their attention on the biomedical knowledge (Dei, 2000). Thus, they have overlooked a valuable source of rich information-indigenous knowledge. Ocholla (2007) described indigenous knowledge as a dynamic archive of the sum total of knowledge, skills and attitudes belonging to and practiced by a community over generations and it thrives in several domains including beliefs, medicine, community development and art and craft (Dei, 2000). Indigenous people having lived and interacted with their environments since time immemorial are experts in their own rights as far as their health conditions are concerned.

The concept of health is a community affair in traditional societies, and the community is made up of both the living and the dead. Nearly every member of an ethnic group in Ghana tries to be positively involved with the activities of the community so that the gods may not be displeased. There are varied reasons why TRM is of value to indigenous people including Africans. Among Africans for example, illness and healing are shaped by social, cultural and spiritual variables within the person. Mental illness for example in non-western societies is conceptualized as intrapersonal rather than naturalistic (Waldron, 2010). Hence in such societies, the traditional worldview holds that there is an interrelationship between the living and the non-living and there is much emphasis on spiritual phenomena (Waldron, 2010). African health systems could therefore be described as pluralistic or holistic, where good health and illness are seen as arising from the actions of individuals and ancestral spirits (Erah, 2008).

Medical systems in Africa and around the globe have broad-ranging ties to the cosmology and the way of life of a people (Twumasi, 1975). In Ghana as well as in most parts of

Table 1. Pilot hospitals with access to herbal medicine in Ghana

REGION	HOSPITAL
Greater Accra	LEKMA Hospital, Teshie Police Hospital, Cantoments
Eastern	Eastern Regional Hospital, Koforidua
Volta	Ho Municipal Hospital, Ho
Ashanti	Obuasi Municipal Hospital, Obuasi Suntreso Government Hospital, Suntreso, Kumasi Kumasi South Hospital, Kumasi Tafo Government Hospital, Tafo
Western	Tarkwa Municipal Hospital, Tarkwa
Central	Cape Coast Metro Hospital, Cape Coast
Northern	Tamale Central Hospital, Tamale Salaga Government Hospital, Salaga
Brong-Ahafo	B/A Regional Hospital, Sunyani

Source: Ministry of Health, 2012.

Africa, colonialism and external orientation have had a negative effect on the development and practice of TRM that is based on the cultural values of the local people. Most Ghanaians prefer healers who have “third eye” (the ability to foretell the future or make accurate predictions) and this has also been confirmed elsewhere (Barimah et al, 2008) in a study on the attitudes and opinions of Ghanaians in Toronto, Canada toward TRM.

Current status of TRM in Ghana

Since 1978, the WHO has continued to call for more cooperation, and in some cases for the integration of TRM and biomedicine. This is partly based on the fact that there is evidence to show that there is increased use of TRM in Africa. Slightly over ten years ago, the WHO indicated in Johannesburg, South Africa that over 80% of Africans rely on traditional healers (Barimah, 2013). It has also been noted that historically and contemporarily, indigenous medicine is the first recourse for treatment and well-being for a majority of the world's population (Mpofu, 2006). The Ministry of Health is controlled by biomedical practitioners who are less enthusiastic about medical pluralism and only created token departments of TRM and established a Traditional Medicine Practice Council (TMPC) in 2010 to regulate the practice of TRM. The placement of TRM under the Division of Drug Management and Policies is killing its development. Even though over 70% of Ghanaians rely on TRM, consumers of TRM still have to pay for these services from their own pockets despite the introduction of a National Health Insurance Scheme (NHIS) that has replaced the cash-and-carry system (Barimah, 2013). The incipient NHIS does not cover the services of TRM practitioners. Consultations with health policy-makers suggest that in as much as government recognizes the invaluable contributions of TRM practitioners and would like to incorporate them in the incipient scheme; the provision of TRM in the country is still too unorganized, with little or no formal protocols and codes of conduct. Consequently, the inclusion of TRM practitioners in the NHIS is premature. There have been calls for the inclusion of traditional healers in the NHIS (Barimah, 2013).

The ratio of Traditional healers in Ghana to the population is 1:400, while that for doctors to the population is 1:12,000, and a similar trend has also been reported in Pakistan (Farooqi, 2006). With over 100,000 TRM practitioners uniformly distributed nationally, they are not only more accessible to the public, but also form the backbone of the health care delivery system (WHO, 2000). Thus, traditional healers are very close to the public, and yet very far away from the basic healthcare delivery system since they have been excluded from the NHIS. Currently, Ghana's health care system is operating under the

“Tolerant Medical Orthodoxy”. Under this system, traditional healers are informally recognized and tolerated, and they are not fully recognized, but are free to practice on condition that they do not claim to be registered medical doctors (Twumasi, 1975). In some selected regional hospitals in Ghana, herbal medicine is accessible to the general public on a pilot basis. For instance, since April 2012, Clinic Two at the Regional Hospital at Sunyani, the Brong Ahafo Regional capital has been side aside to enable patients to have access to herbal medicine. Currently, the Ghana Health Service in collaboration with the Ministry is piloting herbal medicine services in 15 government hospitals across the country. About 30 Kwame Nkrumah University of Science and Technology (KNUST) trained herbal medicine graduates in the category of Physician Assistants (herbal) are involved in this pilot project. These Physician Assistants are currently prescribing about 30 registered herbal products from the essential herbal medicine list.

Table 1 shows the locations of other hospitals in eight regions in Ghana with access to herbal medicine. It appears that with the exception of the Upper East and Upper West regions, all the regions have pilot hospitals with access to herbal medicine with the Ashanti region having the highest with four (4) hospitals.

DISCUSSION

Advocacy with health stakeholders in Ghana

Our advocacy for the inclusion of traditional healers in the basic health care services is based on the global call for the recognition and legitimization of indigenous healing practices due to the fact that Traditional healers have a central role to play in the twenty-first century (Marks, 2006). The biomedical world dismisses the knowledge of Traditional healers because this knowledge was not given in recognized academic institutions, but the former have been going through rigorous apprenticeship training that makes them masters of their own.

The Catholic University College of Ghana in active collaboration with the GHAFTRAM and the Centre for the Empowerment of the Vulnerable have continued to advocate a role for traditional healer in the NHIS to revive the spirit of “health for all” to bring health care to ‘where people live and work’. This takes the form of action-oriented research, empowerment of traditional healers, and advocacy with policy makers, politicians and Health Insurance administrators with a focus on ‘small wins’ (Akotia and Barimah, 2007; Payyappallimana, 2010). Further, the newly established Centre for Health Systems and Policy Research at the Ghana Institute of Management & Public Administration has designed special training programs for health practitioners and other health

stakeholders with a view of strengthening health systems and policy research in West Africa, as a whole, and Ghana in particular within the concept of TRM.

The author and the Centre for the Empowerment of the Vulnerable have since 2007 continued to collaborate with the Sunyani Co-operative Traditional Healers Society Limited of GHAFTRAM. The latter is made up of 150 members, out of which 130 are active members. The Sunyani Co-operative Traditional Healers Society has been spending its resources mainly on supporting its members to send their herbal products to research and standardization centres for quality testing; organizing capacity building and training for its members and advocacy for official recognition by the government. The advocacy work is funded by the Business Sector Advocacy Challenge (BUSAC) Fund. The latter is supported financially by the Danish International Development Agency, European Union and the United States Agency for International Development. The initial grant for the Sunyani Co-operative Traditional Healers Society's advocacy activities was received in May 2007. This enabled them to dialogue with the Ministry of Health, Ministry of Health's Expert Committee on Traditional Medicine, Food and Drugs Board; Standards Board; parliamentary Select Committee on Health; The Brong Ahafo Regional Co-ordinating Council, and the TMPC. Ultimately, the goal is to work towards a policy of Collaboration between two fully recognized health systems (TRM and biomedicine). Under this policy (Bodeker, 2001), there is the assumption that there would be mutual respect between TRM practitioners and medical doctors who are fully recognized by the Ghanaian health authorities.

First, an advocacy and position paper on medical pluralism in Ghana entitled "Traditional Medicine in Ghana: Practice, Problems, and Prospects" was drafted and this was validated by representatives of GHAFTRAM from all the 10 regions in Ghana at the Tropical Hotel, Sunyani, Ghana in 2008. Then, there was a stakeholders' workshop at the South Ridge Hotel, Sunyani involving representatives from Ministry of Health, Ghana Medical Association, Food & Drugs Board; Standards Board, as well as GHAFTRAM. The extensive discussions resulted in the revision of the Advocacy tool.

Second, there was a media campaign in the form of radio talk shows, radio panel discussions with phone-in segments; shooting and showing a brief documentary film on the constraints, economic potential and the important role being played by Traditional healers in the national health care delivery system on major TV stations. All these activities were designed to create public awareness while sending pressure signals at the same to targets identified earlier.

Third, we engaged in dialogue and negotiations both at the local and national levels with the Ministry of Health, The Ghana Health Service, Food & Drugs Board, the Centre for Research into Plant Medicine, and health service providers. In addition, papers were presented at both local and international conferences. For instance, the author presented papers at the World Day on TRM at Takoradi, Ghana in 2009 and at the 18th Canadian Conference on International Health in Ottawa, Canada in 2011.

Ironically, none of the members of the GHAFTRAM has been engaged in the provision of herbal medicine under this pilot project being administered by the Physician Assistants. The big question is: "are these Assistants, traditional healers or pharmacists"? It is noteworthy that traditional healers who practice with the aid of the supernatural powers were not included in this pilot arrangement. In a speech read on behalf of the Ministry of Health at the BUSAC sponsored business meeting for GHAFTRAM at Gomoa Fete, Ghana on April 25,

2013, it was indicated that the use of spirits and magical art or anything that would jeopardize the beliefs, rights, businesses and health of individuals or any group would not be part of the pilot hospitals although each individual is encouraged to seek spiritual support that are in consonance with their belief. Although the Ghana Health Service and the Ministry of Health have made a very significant move towards a policy of Medical Pluralism, there is the need for them to review the exclusion of professional traditional healer from the current pilot project. This stems from the fact that it has been documented elsewhere that majority of Ghanaian customers of TRM prefer a traditional healer who also has the ability to foretell the future or make accurate predictions about health (these category of healers are said to have a "third eye") (Barimah et al, 2008).

The practice of medicine is closely tied up with the practice of religion in Ghana, and Africans are said to notoriously religious (Opoku, 1978), and so is their concept of medicine. Apart from the purely organic causes of diseases which are recognized and accepted, there are also traditional explanations given to them (Evans-Anform, 1986). As an institution, TRM has its own set of patterns of behaviour and purpose which were established since time immemorial when human beings started "to enquire more closely into the forces of nature and soon learnt that the environment consisted of two parts, the physical world, which is seen, and the supernatural or spiritual world, which is unseen" (Mbiti, 1990). Thus, the world's early medicine was mixed up with magic because of the concept of supernatural, hence, the practitioners were looked upon more as magicians than as doctors. The social and cultural phenomena of medicine have been discussed elsewhere (Whyte et al., 2002).

It is conceivable that the use of the Trained Health Assistants in herbal medicine in the ongoing pilot project may be due to the misconception that most traditional healers are not well educated. Contrary to the notion that traditional healers are not adequately trained in most cases, Twumasi has elucidated the training procedure of traditional healers in his book, *Medical Systems in Ghana* (Mbiti, 1990). It must be noted that this account pertains to the Akans of Ghana. Prior to this, Evans-Pritchard (1937) had provided an elaborate account of the training of medicine-men in *Witchcraft, Oracles and Magic among the Azanda* (Opoku, 1978). The assumption is that this account is perhaps "the best study of medicine-men in a given African society" (Buor, 2008).

The government of Ghana through Act 575 (the TRM Practice Act) is making an attempt to regulate the practice of TRM in Ghana. The intent of the Act is to establish a Council to regulate the practice of TRM to register practitioners and license practices, to regulate the preparation and sale of herbal medicines and to provide for related purposes. Specifically, the TMPC has been mandated among other things to:

- set standards for the practice of TRM; issue a certificate of registration to a qualified practitioner and license premises for a practice;
- determine and enforce a code of ethics for TRM practice in conjunction with an association of TRM practitioners recognized by the Minister of Health;
- promote and support training in TRM;
- collaborate with the Ministry of Health to establish centers for provision of traditional medical care within the national health care delivery system; and
- approve in consultation with such educational and research institutions as it may determine the curriculum for training in TRM in institutions.

Currently, the TMPC has not been functioning fully and effectively, and consequently, various forms of TRM

practitioners including quacks have been practicing their trade under the Tolerant Medical Orthodoxy (Busia, 2005) to the detriment of the general public. In recent years however, the use of herbal medicine has been on the increase in many developing and industrialized countries. It is known that between 65 and 80% of the world's population use herbal medicine as their primary health care (WHO, 2000). However, regardless of public opinion, there is often little more than anecdotal evidence on the economic implication of traditional herbal therapies. The question of whether or not traditional herbal medicine may provide a cost-effective choice in the treatment of health problems is important for patients, physicians, policy makers and academicians.

Globally, there is now a general recognition that traditional herbal medicine, the medicines once described as primitive, could be mankind's saving grace-and, therefore, within the past three decades, the changing view of herbs in particular, as medicines moved from that of "witches brew" to major medicine (Busia and Kasilo, 2010). This growth in consumer demand and availability of services for complementary medicine has outpaced the development of policy by governments and health professions (Akotia and Barimah, 2006). The 11th ordinary session of the Assembly of the Economic Community of West African States (ECOWAS) Health Ministers organized by the West African Health Organization (WAHO) in Freetown, Sierra Leone among other issues, called on stakeholders to conduct research to assess the cost-effectiveness and toxicity of herbal medicines and to include the expenditure of traditional medical care in National Health Awards (Weick, 1984).

A related challenge in our engagement is how to convince health policy makers in Ghana about the role of spirituality in health. Despite enough evidence that spirituality plays a major role in achieving positive effects on health and wellbeing (Mpofu, 2006), those who practice TRM with the aid of the supernatural have limited audience with health policy makers in Ghana. Around the globe, attempts to integrate TRM into the health care delivery system have faced some challenges in the area of safety, rational use, availability, preservation, efficiency, quality, to mention a few (Akotia and Barimah, 2006).

Despite these challenges, there have been significant successes on our advocacy campaigns based on 'small wins' as espoused by (Weick, 1984). Weick's idea that breaking down a social problem into a series of small wins may induce greater acceptance than trying to attack the full-scale problem was used to achieve some success. For instance, the TMPC was formed in 2010, and since 2012, major regional hospitals have been providing patients access to herbal medicine. Around the globe, there are success stories to emulate. For instance, WHO has collaborated with countries in the Western Pacific Region to develop policies to support the use and development of TRM in Papua New Guinea, Mongolia and Fiji (WHO, 2002). Thus, there are prospects for the development of TRM in Ghana in active collaboration with WHO.

CONCLUSION

The WHO and various African governments have now realized that the success of the primary healthcare delivery in developing countries depends very much on TRM. Indeed, the number of traditional healers in many African countries far exceeds the number of qualified orthodox doctors (Airhihenbuwa, 1990). Consequently, it will be in the interest of the Ghanaian government to provide the necessary resources to the TMPC to enable it to perform its mandate effectively and

efficiently. Already, the Ministry of Health is aware of the efficacy of herbal medicines and the potential dangers that may emanate from misapplication or abuse of herbal medicines, and this calls for a strong code of ethics based on "do-no-harm" as practiced by modern medical practitioners. Further, there is the need for community health professionals and other stakeholders of TRM to play important roles in all of these. They could serve as advocates for the "voiceless" Traditional healers and working with them to ensure that their voices are heard. There is also the need for health professionals to call for greater respect for the views of TRMs in the formulation of health policy in Ghana. They should make adequate demands to ensure that Traditional healers are included in the delivery of basic health services in the country.

ACKNOWLEDGEMENTS

I am very grateful to my colleague, Professor Charity Akotia, the Dean of Social Sciences at the University of Ghana, Legon for her useful suggestions towards the development of this manuscript. Special thanks to Mr. Eric Adu-Gyamfi, a Research Assistant at the Office of Research Services & Innovation at GTUC.

CONFLICT OF INTEREST

The authors have no conflicting financial interests

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