



Transformations in Traditional Medicine Practice: An Example from the Practice of a Family of Bonesetters in Accra

Stephen Owoahene-Acheampong

Associate Professor and Dean, Faculty of Religions and Social Sciences, Catholic University of Ghana
Corresponding author: Stephen Owoahene-Acheampong. **E-mail:** stacheampong@gmail.com

Managing Editors

Prof. Daniel Obeng-Ofori
Rev. Fr. Prof. Peter Nkrumah A.
Prof. Kaku Sagary Nokoe

Citation: Stephen Owoahene-Acheampong (2023). Transformations in Traditional Medicine Practice: An Example from the Practice of a Family of Bonesetters in Accra. *International Journal of Multidisciplinary Studies and Innovative Research*, 11(2), 1-10. 10.53075/Ijmsirq/641435546

Abstract: There has emerged in Ghana, and in some other African countries, traditional medical practitioners (TMPs) who have diversified their practice of traditional medicine (TM) by the integration of other medical traditions. Using the practice of a family of bonesetters in Kaneshie, Accra, as an example, this paper shows the transformations that are taking place within the field and TM's place in healthcare delivery in Ghana. TMPs are now diagnosing diseases and ailments by modern methods of diagnoses, such as ultrasound, X-ray, blood and urine tests, scan and other laboratory tests; and they use biomedical techniques such as injections and drips as part of treatment. The paper suggests that in Ghana, the emergence of TMPs who have diversified their practices has come about largely because of the government's policy guidelines that emphasize the herbal and scientific aspect of TM, and which deemphasize TM's religious component. It also highlights some of the challenges that TMPs confront today in their practice as a result of the government's policy guidelines. TMPs confront the challenges of weaning TM practice of its mystical/religious component, which impacts unfavorably on TM practice as it loses its attractiveness and significance to many Africans whose sense of healing is both physical and spiritual (holistic healing); the high costs of establishing and running the herbal facilities and often the inadequate financial resources of practitioners; the challenge of massive production and sales of all kinds of inferior and unsafe herbal medicines (in the name of new discoveries) by quacks, whose activities undermine the work of genuine practitioners; the possible decline of patronage by clients due to the high treatment charges at the facilities. The paper thus situates itself in the context of the discussions on TM and its practice in Ghana today.

Keywords: Traditional medicine, herbalist, herbal clinic, herbal treatment, bonesetting, Ghana

1. INTRODUCTION

Today in Ghana and Africa generally, there have arisen many Traditional Medical Practitioners (TMPs) who largely treat their patients with plants, herbal and mineral and other preparations as in the traditional way, but diagnose diseases and ailments by modern methods of diagnoses, such as ultrasound, X-ray, blood and urine tests, scan and other laboratory tests (Ng'etich, 2005). Some of the practitioners also put their patients on devices such as treadmills, stationary bicycles, massaging and other exercising equipment, and use biomedical techniques such as injections and drips as part of treatment. They wear white overalls and hang stethoscopes around their

neck. They take patients' temperature with thermometers and measure their blood pressure with sphygmomanometers. They have "nurses" as assistants (Richter, 2003: 15). The herbal, plant and mineral medicines that they dispense to their patients are usually mechanically processed and are in tablet, pill, liquid, balms and capsule forms with their dosages and dates of manufacture and expiry inscribed on their packages. Because they use modern equipment and forms of diagnosis and treatment that are similar to orthodox medical systems, many of such herbal facilities in Ghana have names such as Agbeve Herbal Hospital, Amen Scientific Herbal Hospital, Traditional Orthopaedic

Clinic, Givers Scientific Herbal Clinic, Agyenkwa Orthopedic Herbal Clinic and so on. Similar of such names are also found in other African countries. For example, in Tanzania, Marsland (2007: 751) reports of a banner that hangs high above the main street of the town Kyela: 'The banner is advertising a "modern traditional clinic". The proprietor', as Marsland (2007) indicates, 'does not presumably consider the description to be oxymoron.'

Richter (2003) mentions a phenomenon of 'new "traditional" hospitals' that has appeared in the major cities of Durban and Pietermaritzburg in the KwaZulu-Natal Province of South Africa, which is different yet similar to the phenomenon prevailing in many other places in Africa today. The 'new "traditional" hospitals' in the KwaZulu-Natal Province diagnose ailments through a religious ritual: 'On admission the patient is diagnosed in a divination ritual in which bones are thrown. Through the pattern of the bones the ancestral spirits will reveal the patient's ailment and general condition' (Richter, 2003: 15). At the same time, the 'new "traditional" hospitals' (in the KwaZulu-Natal Province) are keen, like other traditional medicine establishments, to create 'an identity that resembles the Western medical system and the distinction between treatment and cure is therefore pronounced. Some of the healers have been influenced by Western religious new-age thinking and have diplomas in homeopathy.' They have as "nurses" young women in white uniforms who have taken first aid course (Richter, 2003: 15).

This paper uses the practice of a family of Bonesetters at Kaneshie in Accra—one of the prominent branches of a family practice which is headquartered at Larteh, Akuapim, Ghana—to illustrate and also to contribute to the discourse on the transformations that are taking place within the field of traditional medicine (TM) in Ghana, and Africa generally. Thus, this paper demonstrates the processes of preservation and development of the heritage as may occur within a family of practitioners. In other words, it looks at the interplay of personal and collective needs, endeavors and roles (dynamisms) of members of the family towards the growth of the practice. It also looks at the innovative ways traditional medicine practitioners (TMPs) are taking to respond to the demands on them by government and other stakeholders for transformation. For example, currently in Ghana, the government has instituted policy guidelines that 'limit traditional medicine almost exclusively to herbal products and the scientific elements of it' (Vasconi and Owoahene-Acheampong, 2010: 4), despite the fact that TM is holistic practice—it has religious/mystical and other cultural beliefs and

practices as its components (Owoahene-Acheampong, 1998). The government's policy thus eliminates from the practice important aspects of it. This paper suggests that the emphasis on the herbal and scientific aspects of TM by the government has largely given rise to the manufacturing of many herbal medicines and the establishments of many herbal treatment facilities in Ghana that have adopted the healing procedures that are patterned along the lines of orthodox and other medical practices.

2. MATERIAL AND METHODS

The practice of the family of Bonesetters in this study was selected because of its interesting historical development, reputation, and longevity. While it speaks generally about the practice, which has its center at Larteh, Akuapim, this paper looks at a prominent and popular branch of it located at Kaneshie in Accra. Ethnographic research techniques such as in-depth interviews, focused group discussions and informal conversations were employed in collecting data for this study. Formal interviews were scheduled with three main respondents who are also currently the practitioners at the Kaneshie branch. Many visits were made to the study area, which also serves as the residence of the respondents, and one-on-one interviews with each of the respondents were conducted. While the one-on-one sections offered much information, it also helped in ascertaining the correctness or otherwise of the information provided by each practitioner. Focus group discussions were conducted with the practitioners twice. Open-ended questionnaire was used as a tool in engaging the respondents, and that was useful as it offered them (respondents) the opportunity to add any information that they wanted, which in some cases were beneficial to the study. Respondents were asked for information about themselves and for the history of the family practice; the changes that the practice has witnessed over the years and how it has survived them; ways in which practitioners are dealing with the new policy of the government regarding the emphasis on the scientific aspect of TM; the challenges that they face today; and how the future looks for the practice. The interviews were recorded and the data were later transcribed and analyzed. The interviews were conducted in Twi and English languages. Scheduled and unscheduled visits to the facility were also made during clinic days to observe how treatments were done by the practitioners. Although there were some interactions between the researcher and some patients at the facility, interviews were not done with

patients since they were not the focus of the research.¹

3. RESULTS AND DISCUSSION

A brief history of the family practice and founding practitioners

Opanin Ayebofo started the bonesetting practice at Larteh, Akuapim (in the present-day Eastern Region of Ghana) in the mid-1800s. He bought and transported the practice with its associated spirit called Suma Ababia from Dahomey (now Benin in West Africa) to Larteh, Akuapim.² Thus, the practice is believed to have originated from Dahomey. After many generations of practitioners of the practice at Larteh, an individual who is credited to have made the practice more known beyond its environs was Nana Esi Ababio. She inherited and operated the practice from the early 1920s until late 1960s. As was a common practice by healers at that time, she treated patients without taking money, but, as will be indicated below, made them provide certain required items before and after treatment.

Sakyibea, the youngest daughter of Nana Esi Ababio, took over the practice in the early 1960s. She expanded the practice and made it a more popular and highly commercialized and patronized entity. The high patronage the establishment received could probably be explained by the frequency of human and vehicular accidents in Ghana at that time due to population growth and increased usage of motor vehicles. Many people also came from abroad (particularly, neighboring African countries) for treatment. Although at the time of Sakyibea the practice became highly commercialized, patients were still not charged adequately enough in monetary terms for treatment; the livelihood of the practitioners therefore did not depend on remuneration from the practice, but on the family's own resources. Also from their own resources, the family sometimes catered free of charge for patients who were on admission at the establishment. Sakyibea practiced the trade for over 50 years. Yaa Yeboah, a daughter of Sakyibea, took over the practice from her mother and practiced it for 25 years. Kofi Dankwa, who practices the trade at the site at Larteh where his great grandmother (Nana Esi Ababio) and her successors practiced it from the early 1920s, succeeds Yaa Yeboah. Today extensions of the practice are found at Suhum, Adweso (Koforidua), Adeiso and Asuaba, all in the Eastern Region of Ghana, and at Madina and

Kaneshie in Accra. Five households that form this family of bonesetters undertake the practice today.

The spirit of bone-setting and items for healing rituals

The family of Bonesetters in this essay believes that there is the spirit called Suma Ababia—which has no shrine or a special sacred space constructed as its abode—that guides and guards the practice and the practitioners. As indicated above, the practice with its spirit Suma Ababia was bought and brought from Dahomey to Larteh. Suma Ababia is believed to be the main spirit behind the practice. However, the practitioners believe that there are also other spiritual entities that assist the practice of bonesetting and the healing processes of patients generally.

The practitioners, except those at Kaneshie, have maintained a tradition whereby patients are required to provide some specified items before and after treatment. Before treatment, a patient provides to the practitioner(s) firewood, charcoal, a chicken, a bottle of schnapps or gin or rum or akpeteshie (a local gin). The drink is used for libation to the Supreme Being (God), to the spirit Suma Ababia, to the other spiritual forces of bonesetting, and to the practitioners' ancestors to solicit guidance for the practitioner and recovery for the patient. It is believed that because the individual has had an accident, broken a limp or a bone, evil has visited itself on him or her and therefore there is a need for purification to physically and spiritually cleanse the person. The chicken is slaughtered and its blood is used for that purpose. The blood of the slaughtered chicken is sprinkled on the patient. This act points to the belief of the African in the power of blood in cleansing (see Nabofa, 1985; Mbiti, 1969). The charcoal is used to boil the water for massaging the patient. After they have been healed, patients provide to the healer a half piece of white calico cloth, a new knife, powder, a bottle of schnapps, a fowl and some small amount of money. It can be inferred that by making patients provide some items at the beginning of treatment the practitioners rid themselves of the burden of carrying the initial cost of providing care.

Although the items are used in physical terms to aid the healing of the patient as indicated above, the practitioners agreed with me when I suggested some possible African interpretations (meanings) that could be ascribed to some of the items if we see them as ritual (symbolic) items. The practitioner meant the knife provided by the patient for cutting herbs and ferns and peeling of backs of trees from the forest. However, it can be symbolically regarded as a weapon to chase away evil spirits from the patient. Thus, it can symbolize defense, an instrument of

¹ Data collection for this study was done from 2015 to 2018.

² In Africa, it was not uncommon in the olden days to buy a deity and transport it to another place.

protection from re-attack by the evil spirit of illness. Again, the blood of the slaughtered fowl can be understood to provide complete healing—to permanently wash away the illness and drive away the power of the evil spirit that inflicted it on the patient. Hence, it symbolizes cleansing, fortification, wholeness and thus life. In fact, in African societies blood is 'not only conceived as a natural symbol of life, but it is life itself' (Nabofa, 1985: 390). Blood gives health and happiness, it is well-being. The piece of white calico cloth and the powder can signify victory—the patient has been healed and therefore has overcome illness and the evil associated with it. They can also mean freedom—that the patient is discharged and is free to go home, and that he or she has paid off all that is due and is no longer indebted to the practitioner.³

The *nkonwahene* (high priest)

The practice has a high priest, who is referred to as *nkonwahene* (chief of stools) by the family. But unlike in the African and some other priesthood traditions where some persons are 'set aside from birth to dedicate their lives to the priesthood, ...[or] are called or appointed through the medium of spirit possession' (Quarcoopome, 1987: 74), the high priest is chosen by members from among the five households that form the family. The position of the high priest is rotated among the five households. The high priest is not formerly trained as in the case of a traditional priest and no shrine is built for him. The high priest, *nkonwahene*, is the supreme head of all the practitioners, however, each of the five households has its own family head, *abusua payin*. The current practitioners do not know when the concept of the high priest was introduced into the practice.

The practitioner who is elected as the *nkonwahene* is taken into a special room where stools of predecessors are kept. The family does not regard this stool room as a shrine. The individual is asked to sit on any of the stools. The name of the stool on which he will sit becomes his stool name. As in African traditional understanding, the stool symbolizes his power and authority. Thus, the person acquires a stool and a new name and therefore a new status when he becomes the high priest. On election to that high position of authority, the individual continues to practice as a bonesetter. The functions of the high priest, as the head of all the

practitioners are, among other things, to: reside permanently at Larteh; oversee the day-to-day activities of all the practitioners; counsel the practitioners especially on ethics of their work; pray (and pour libation occasionally) for the wellbeing and success of the practitioners. The high priest is regarded as a model for the family and the community and therefore the one elected must be a responsible individual and a person of integrity. Unlike a traditional priest in the African traditional religion, the high priest is not assigned, called, or appointed to his position by a divinity or a deity. Again, unlike the traditional priest, the high priest does not experience religious phenomena such as trances or possessions by an agency of a deity. The authority that the high priest wields are akin in some respects to those of a chief in many African communities except that while the latter can be destooled the position of the *nkonwahene* is for life.

On the first Monday of January every year, which they have made a day of festival, all the practitioners assemble at Larteh to feast and to renew their oneness as a family and their allegiance to the high priest. At the gathering, they discuss and exchange new ideas and new discoveries of traditional medicines and share information on their uses and treatments. They also discuss about their welfare and progress as practitioners and as a family. Before the meeting ends, the high priest blesses all practitioners by sprinkling on them a concoction prepared with herbs. The practitioners then wash their hands and faces with the same preparation to ward away evil acts and evil spirits from themselves and from their practices. (These acts can be seen to signify cleansing, fortification and protection). Sharing a meal and also washing themselves with concoction from one receptor is a reminder to them of their common ancestry, the bond, trust, unity and brotherhood that bind them together as a family. Membership to the practice is only by virtue of birth into the family or through marital relationship with a member of the family. Unlike the other specialties of TM, nonfamily members cannot learn the trade and become bonesetters (Kuubiere et al, 2015).

Only male members of the family become high priests even though, as mentioned above, there have been and there still are women practitioners among them. Women have contributed and still contribute immensely to the establishment and maintenance of the practice, but they are excluded from holding the high priest position. The explanation given to this exclusion by both the male and the female practitioners (respondents) is the cultural belief of the impurity of women when they are in their menstrual period. In fact, in many African societies, as in some

³ In Ghana and in many African countries, when a person is exonerated from an accusation, or wins a court case, or is delivered from a danger, powder or white clay is smeared on the body of the individual and he or she is wrapped with a piece of white calico to indicate victory or exoneration.

other societies elsewhere, a menstruating woman is regarded as 'impure'. It is worth noting however that in some places in Africa menstruating women, although seen as 'impure', were also considered as very potent and their potency sustained the societies. Sackey (2006) indicates that in Dahomey (modern day Benin), for instance, menstruating women were the guards of kings (see also Akyeampong and Obeng, 1995). In Africa, blood is regarded as a powerful substance. While it is 'conceived as an embodiment of a positive mysterious power,' blood could 'sometimes inhere a negative force which could pollute one, depending on where it originates' (Nabofa, 1985: 394). It is believed that menses can pollute powerful medicines and sacred places (Brempong, 2006; 2002). As Nabofa (1985: 394) indicates: 'In fact, blood is believed in many places in Africa to be capable of rendering whatever and wherever it touches unwholesome ritually, and that is why traditional believers are suspicious of women when it comes to religious activities.'

A brief background of the founder and the beginnings of the branch at Kaneshie

E. A. Pimpong, the father of three siblings who are currently operating the place, established the practice at Kaneshie, which is a suburb of Accra, in the early 1960s. E.A. Pimpong acquired the skill for bonesetting at a tender age when he was living with his grandmother, Nana Esi Ababio. Later as an adult, his interest and expertise in bonesetting made him quit a job as a clerk that he held at the United African Company (UAC) in Accra. It is said that E.A. Pimpong used the herbs and plants that he had learnt in treating patients, but also obtained knowledge of plants and herbal medicines and their uses—recipes for medicines—in dreams and visions. One of such medicines he received in dreams is named *olubibi* (literally translated black medicine). It is applied on swollen limbs or when the broken bone is setting or healing. It is also used to treat arthritis and rheumatoid pains. The formulae and medicines he received in this manner are what the practitioners at Kaneshie mostly use today. The practitioners at the other locations are not taught the formulae and preparations of those medicines but are provided some to administer to their patients when needed. The reason behind that is that the formulae and preparations of the medicines are a secret revealed exclusively to E.A. Pimpong, which he claimed are to be a preserve to him and his children who practice at Kaneshie. Although he was born a Christian, E.A. Pimpong was a strong traditionalist. And so, while he was in Accra, his interests in African traditions and traditional medicine did not wane and the establishment at Kaneshie was a result of that. However, unlike his predecessors who required items

such as charcoal, chickens, bottles of schnapps or gin or rum or akpeteshie (local gin) before treatment, E.A. Pimpong asked patients to deposit some money from which he purchased the items. Patients who could not afford to pay were however treated without charge. He devoted over 30 years of his life to the practice. It is of interest to note that E.A. Pimpong did not insist that his children learn the practice; he put them through school. It was only when school was not in session that the children helped to sort, clean, grind and mix medicines that were to be dispensed to patients.

Current practice and practitioners at Kaneshie

Today, the practice at Kaneshie has two treatment centers, which are located on the same compound where E.A. Pimpong practiced it. They are run by his three children—Joe Appiah Pimpong, Joyce Adwoa Adadewaa Pimpong, and Yaw Apreku Pimpong. Like their father, they are also Christians. Joe Appiah Pimpong runs his treatment center called Traditional Orthopaedic Clinic with his sister, Joyce Adwoa Adadewaa Pimpong. Yaw Apreku Pimpong has his treatment center, which is called Ababia Clinic (Orthopaedic).

As observed above, E.A. Pimpong did not enforce the practice of bonesetting on his children. The question that one may obviously ask is why the interest of his children in the practice? Yaw Apreku Pimpong recounts the circumstances that brought him into this family business:

After I completed school, I got a part-time teaching job at a school in Accra. I had an annual leave from work and I had no intention to vacate my position at the school after the period of the leave. However, something happened. There was a group being formed for a show. I was interested in the show (and in arts generally) so I joined the group. I was asked to play the part of Herod. On the last day of rehearsal—that was in 1985, we were heading towards home and I had an accident: I was knocked down by a car. I was taken to the hospital. At the hospital I remembered that my dad was a bonesetter who could easily give me a quick and a better treatment. So, I went back home and my dad took care of me. After my recovery, my appointment at the school was terminated—my father had started assigning me work on patients and so I was always late to school. So, I was

dismissed. It was with that that I decided to make bonesetting my full-time job.⁴

Joe Appiah Pimpong also narrates that:

I was once sent by my father to treat a woman who had fracture of the left tibia. She was a nurse and also the president of a Women's Fellowship of a Methodist Church in Accra. The woman did not have any idea of the efficacy of traditional medicine and so did not believe in it. I treated her with some of the medicine I had brought along and within three days she was healed. It was this woman who told me after her treatment that I have a gift of healing from the Holy Spirit. I was in my 30s at that time. I started to study how the Holy Spirit works and gives gifts to people. After this episode, I had a dream in which it was revealed to me that I was destined for a purpose. I prayed over this revelation for some time. It became clear to me that healing (bonesetting) was my vocation in life.⁵

According to the practitioners, they have kept the traditions that their father E.A. Pimpong and his predecessors bequeathed to them. In an attempt to emphasize that they have kept the legacy of the family, Joyce Adwoa Adadewaa Pimpong says that, 'We have kept trust with our forebears. I started this work when I was in my teen years. Nothing really changes here. We virtually use the same herbs and treatment procedures that still work effectively: just some changes here and there so we can advance the trade to suit demands of changing times. Those who will come after us will do the same things that we are doing.'⁶ When asked if they employ the spirit Suma Ababia and/or any other spiritual power(s) of bonesetting in their practice, the siblings were emphatic that they acknowledge the holistic nature of African traditional healing—it is intertwined with religious and other cultural beliefs and practices, and that they also know that Suma Ababia and other spirits of bonesetting exist, they do not however employ them in their practice. According to them, although their father (who was a Christian) employed Suma Ababia and also attached some spiritual dimensions of African traditional healing to his practice, they do not. Their family practice at Larteh,

⁴ Yaw Apreku Pimpong was interviewed on 15 May, 2018).

⁵ Joe Appiah Pimpong was interviewed on 15 October, 2012.

⁶ Joyce Adwoa Adadewaa Pimpong was interviewed on 29 May, 2018.

however, still employs Suma Ababia. Madam Joyce Adwoa Adadewaa Pimpong recounts how in the past evil spirits and evil persons that might want to attack patients protected the entrances to the rooms of patients on admission at the Larteh practice against entry. A pot filled with water and some herbs was placed at the entrance of each room to that effect. The practitioners (at Kaneshie) explain that their Christian religion and also modern demand for transformation that are taking place in the practice have influenced their position against using spiritual entities. In other words, they have abandoned the spiritual dimension of the practice. However, as Christians they do pray to God for successful healing for their patients. They make their work suit modern needs and therefore they integrate "traditional" and orthodox therapeutics in their practice. For that reason, they have abrogated the practice whereby patients were asked to bring some specified items before and after treatment, because, according to them, people see that as fetish. When Yaw Apreku Pimpong was asked why he uses the name "Ababia Clinic (Orthopaedic)" for his establishment if he does not employ the spirit Suma Ababia, he explained that: 'We use Ababia because we want to maintain our identity and our practice. When you ask why Ababia, then I will tell you that I am a Guan. The other meaning of Ababia is "where bones are set." The name is symbolic: that I am a Guan, Larteh, and I am a bonesetter.'⁷

There are certain practices and rituals that all the practitioners are to observe. As indicated above, the first Monday of January every year members of the entire family meet at Larteh to feast and to renew their allegiance to the *nkonwahene*. The family at Kaneshie participates in all the activities that take place there on that day. However, because of their Christian upbringing and also the changes and demands on them that have come with time, certain practices that were part of the practice are no longer kept by them. For example, previously—depending on the seriousness of a case—the practitioner was required to refrain from sexual intercourse the first three days of treating a new patient. In other cases where sexual intercourse was not prohibited, a practitioner who indulged in the act was to bathe thoroughly with soap before attending to a patient. According to the practitioners, today the practice of abstinence from sex is irrelevant and impossible. As Yaw Apreku Pimpong puts it: 'If you have to abstain from sex for three days for each new case that you get, you will never have sex with your spouse.' He argues that, 'assuming you get a new case each day

⁷ Yaw Apreku Pimpong was interviewed on 29 May, 2018.

or every other day or even every three days, which is the case today in our practice, does it mean that you are not going to have sex whilst taking care of the patients? Your spouse will simply leave you.⁸ Also, according to him, those practices were aspects of the religious component of the practice, but they do not subscribe to them any longer. A prohibition from using rainwater to treat patients is also not observed by them again. The practitioners could not explain the reason behind those prohibitions. They felt however that the prohibitions might have some religious reasons behind them. Certain prohibitions are however still followed by the practitioners and by patients. These include the prohibition of sleeping with other people's wives or husbands by practitioners, and the requirement of patients to refrain from sexual intercourse while receiving treatment. The reason for the prohibition for patients is that in the act of sexual intercourse the patient may twist and dislocate or re-open the broken bone(s) or limb(s) that is set for healing.

According to the practitioners, although they are independent of each other in their work, they support one another. If a case for one of them turns out to be a difficult one, they put their heads together to find an appropriate procedure to treat it. As Joe Appiah Pimpong puts it, 'There is collaboration among us. We exchange ideas. In fact, sometimes all of us work on a patient. As you know, nobody finishes learning, so we keep on learning from one another.' They also refer patients to one another for treatment when it becomes necessary to do so.

According to the practitioners, their profession requires good practices. Therefore, they strive to do the right things as are required of practitioners today.⁹ They maintain that they refer patients to hospitals and likewise some orthodox medical doctors refer patients to them on some occasions. The practitioners do not however have any partnership or collaboration with other TMPs. In other words, they do not refer their patients even to other bonesetters. With regard to medications, they provide patients with medicines from their own preparations, but in situations where patients suffer severe pains, they refer them to the pharmacy to get some analgesics. The practitioners maintain that they are members of the Ghana

⁸ Yaw Apreku Pimpong was interviewed on 15 May 2018.

⁹ See Ministry of Health (2005) Policy Guidelines on Traditional Medicine Development, <http://www.moh.gov.gh/wp-content/uploads/2016/02/TRADITIONAL-MEDICINE-POLICY.pdf>

Psychic and Traditional Healers Association (GHAPTHA).

Concerning their requests of X-rays and scan images from their patients and how they learnt to read them, Joe Appiah Pimpong and Yaw Apreku Pimpong explained that they learnt that through some medical doctors and technicians. According to Joe Appiah Pimpong:

Over the years, when the patients came to us, we followed some of them to the hospital to take X-rays. The X-ray technician taught us how to read the X-ray images little by little. Moreover, because of our educational backgrounds, we have to know how to read them. Some doctors, particularly a doctor at a private clinic and another medical consultant in Korle Bu Teaching Hospital taught us how to read and interpret X-rays images and other stuff. Therefore, we are very much inclined to radiological diagnosis.¹⁰

They have also learnt to read and understand reports on cases written by orthodox medical practitioners that patients submit to them. They indicated that the use of X-rays and scan images are relevant today for their work in many ways: they help them to properly identify patients' ailments when they come to them; they make their practice more professional, scientific and modern; the use of images make them (practitioners) feel more confident of what they do and patients also have trust and satisfaction in treatments they receive.

According to the practitioners, what they do today conforms to government's regulations. However, they indicated that conforming their practice to the government's regulations comes with some challenges. Speaking generally about TM practice today, Joyce Adwoa Adadewaa Pimpong indicated that the regulations are 'good for the government and not for our work: the work is no longer the same; patronage has reduced, and the revenue from our work has gone down.' When I informed her that government is integrating some TMPs into some health facilities, her response was, 'then government should indeed assist us and incorporate us into hospitals and clinics. Today, we face difficulties [in our practice].'

¹⁰ Joe Appiah Pimpong was interviewed on 29 May 2018.

Some challenges TMPs face

The difficulties that Joyce Adwoa Adadewaa Pimpong mentions above are not difficulties peculiar to their facility only. The transformations that are taking place in TM and the government's policy of recognition, which is based on the herbal and scientific aspects of the practice potentially present some challenges to TMPs generally. As has been observed in this study, the policy challenges them to wean TM practice of its mystical/religious component. These impacts unfavorably on TM in the sense that TM practice loses its attractiveness and significance to many an African consumer whose sense of healing is both physical and spiritual (holistic healing). As emphasized elsewhere: 'Such attempts at splitting traditional medicine into two aspects could devalue its significance and also its therapeutic and symbolic efficacy, which are often what drive its patronage and usage among the larger Ghanaian population' (Vasconi and Owoahene-Acheampong (2010: 9)). The high costs of establishing and running the herbal facilities and often the inadequate financial resources of practitioners pose challenges to TMPs. Also, the failure of government to support and also permit the use of the national healthcare coverage (National Health Insurance Scheme (NHIS)) by consumers for treatment at herbal facilities present financial challenges to TMPs as that again impacts on client patronage and growth of the industry. Again, the possible decline of patronage by clients due to the high treatment charges at the facilities is a potential challenge to the development of the practice.¹¹ Also, the industry confronts the challenge of massive production and sales of all kinds of inferior and unsafe herbal medicines (in the name of new discoveries) by quacks, whose activities undermine the work of genuine practitioners.¹² As intimated in this study, as TMPs tend to fail to share their medical knowledge and treatment procedures with other medical practitioners beyond their own small circles of family practitioners, they place barriers for

¹¹ It has been argued that the cost of traditional treatment can be more expensive than orthodox medicinal treatment. See for example, Labhardt et al. (2010); Preux et al. (2000); Njamnshi et al. (2009).

¹² A Senior Regulatory Officer of Food and Drug Authority (FDA), Mr. Joseph Yeboah, disclosed to the Ghana News Agency in an interview that, the FDA has disposed of some hazardous products in the Eastern region of Ghana: "The non-conforming products accounted for 11 tonnes and included allopathic medicines, medical devices, herbal products, household chemicals, cosmetics, food products, and homeopathic medicines." Ghana News Agency. 'FDA disposes 11 tonnes of hazardous products in Eastern Region.' Regional News of Friday, 12 August 2022.

advancing their practices through continuous training, research, and constant exchange of ideas and collaboration with other therapeutic practitioners and healthcare providers. In other words, the fear that they would lose their individual autonomy over their knowledge (intellectual property rights) hinders them to open up for professional advancement and proper engagement with government and other stakeholders. Proper engagement with government and other stakeholders would entail the challenge to TMPs of allowing a regulatory body to directly supervise and monitor their activities.

4. CONCLUSION

This paper has shown how a TM practice as a heritage has been preserved and developed over the years by a family of practitioners. It has used the practice of a family of bonesetters as an example to show the transformations that are taking place in the TM practice and in healthcare provision in Ghana, and Africa generally. Today, many governments in developing countries and the WHO have lauded TMPs' contributions to healthcare delivery.¹³ In Ghana, as in some other African countries, doors are open for recognition and integration of TMPs into government healthcare facilities for the provision of healthcare to the people. However, as indicated above, in Ghana the integration of TM is subject to government's policy of integration, which reduces 'traditional medicine almost exclusively to herbal products and the scientific elements of it' (Vasconi and Owoahene-Acheampong, 2010: 4). In other words, the Government for one's possible integration into a healthcare facility recognizes the herbal and scientific aspects of a practitioner's practice. As indicated in this study, TMPs are therefore trying to thrust aside the magico-religious component of TM, an act that is resulting in the establishment of many herbal facilities that are operating like orthodox medical establishments. The pressure on TMPs today to transform their practice to meet the government's policy for recognition and integration and modern demands on them is immense. It will be interesting to see in the future how TM practice would be—and how it would cope—with the increasing changing and advancing medical technology and practices in other medical traditions and the renewed and greater responsibility that is placed on it by the government and the people for transformation and scientific advancement.

¹³ WHO Traditional Medicine Strategy 2002-2005. Geneva: World Health Organization. (http://whqlibdoc.who.int/hq/2002/who_edm_trm_2002.1.pdf). Accessed June 30, 2021.

ACKNOWLEDGEMENTS

I am greatly indebted to Joe Appiah Pimpong, and his two siblings Joyce Adwoa Adadewaa Pimpong and Yaw Apreku Pimpong, who are currently operating the Kaneshie branch of the family practice for devoting their time for interviews with me and generously answering my questions and providing the necessary information for this paper. I am very grateful. I am also very grateful to Belinda Nyarko Agyemang, who was my Teaching Assistant from 2017 to 2019 at the Institute of African Studies, University of Ghana, Legon and currently a PhD candidate at the University of Cape Coast, Ghana, for assisting me on some occasions in conducting interviews and also for transcribing some of the data that were collected.

REFERENCES

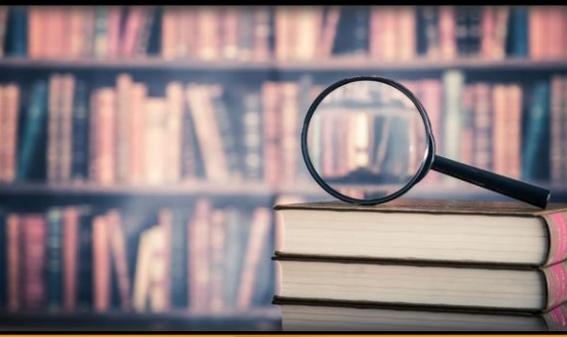
- Akyeampong, E. and Obeng, P. (1995). Spirituality, Gender, and Power in Asante History. *The International Journal of African Historical Studies* 28, 3: 481-508.
- Brempong, O. (2006). Chieftaincy and Traditional Taboos: An Empirical Approach. In Odotei, I.K. and Awedoba, A.K. (eds). *Chieftaincy in Ghana* Accra: Sub-Saharan Publishers, pp. 213-239.
- Brempong, O. (2002). Menstruation Myth. *Amemmeresem*, Ghana Folk Magazine, Volume 1.
- Ghana News Agency. (2022). FDA disposes 11 tonnes of hazardous products in Eastern Region. Regional News of Friday, 12 August 2022.
- Ghana News Agency. (2015). Unbridled adverts on herbal products, FDA to prosecute Radio Stations, March 13. Available at <http://www.ghananewsagency.org/health/unbridled-adverts-on-herbal-products-fda-to-prosecute-radio-stations-86917> (accessed 6 April 2016).
- Kuubiere, C.B., Abass, A., and Majeed, S.F. (2015) Patients preference for traditional bonesetters in Northern Ghana. *Al Ameen Journal of Medical Sciences* 8 (2): 115-118.
- Labhardt, N.D., Aboa, S.M., Manga, E., Bensing, J.M., and Langewitz, W. (2010). Bridging the gap: how traditional healers interact with their patients. A comparative study in Cameroon. *Tropical Medicine & International Health* 15, 1099-1108. doi:10.1111/j.1365-3156.2010.02575.x
- Marsland, R. (2007). The Modern traditional Healer: Locating 'Hybridity' in Modern Traditional Medicine, Southern Tanzania. *Journal of Southern African Studies* 33 (4): 751-765.
- Mbiti, J. S. (1969). *African Religions and Philosophy*. New York: Fredrick Praeger. Ministry of Health (2005). Policy Guidelines on Traditional Medicine Development. Available at <http://www.moh.gov.gh/wp-content/uploads/2016/02/TRADITIONAL-MEDICINE-POLICY.pdf> (accessed 7 September 2018).
- Nabofa, N.Y. (1985). Blood Symbolism in African Religion. *Religious Studies* 21 (3): 389-405.
- Ng'etich, K.A. (2005). Indigenous Knowledge, Alternative Medicine and Intellectual Property Rights Concerns in Kenya. 11th General Assembly, Maputo, Mozambique, 6-10 December 2005. Theme: Rethinking African Development: Beyond Impasse, Towards Alternatives. Available at <https://www.codesria.org/IMG/pdf/ngetich.pdf> (accessed May 2016).
- Njamnshi, A.K., Tabah, E.N., Yepnjio, F.N. et al. (2009). General public awareness, perceptions and attitudes With respect to epilepsy in the Akwaya health district, south-west region, cameroon. *Epilepsy and Behavior*, 15, 179-185.
- Owoahene-Acheampong, S. (1998). *Inculturation and African Religion: Indigenous and Western Approaches to Medical Practice*. New York, N.Y: Peter Land Publishing, Inc.
- Preux, P.M., Tiemagni, F., Fodzo, L. et al. (2000). Antiepileptic therapies in the Mifi province in Cameroon. *Epilepsia*, 41, 432-439.
- Quarcoopome, T.N.O. (1987). *West African Traditional Religion*. Ibadan: African Universities Press.
- Richter, M. (2003). Traditional Medicines and Traditional Healers in South Africa. Discussion paper prepared for The Treatment Action Campaign and AIDS Law Project 27 November, 1-29.
- Sackey, B.M. (2006). *New Directions in Gender and Religion: The Changing Status of Women in African Independent Churches*. New York: Lexington Books.
- Vasconi, E. and Owoahene-Acheampong, S. (2010). Recognition and Integration of Traditional Medicine in Ghana: A Perspective. *Research Review* 26 (2): 1-17.

WHO Traditional Medicine Strategy (2002-2005).
Geneva: World Health Organization.
(http://whqlibdoc.who.int/hq/2002/who_edm_trm_2002.1.pdf). Accessed June 30, 2021.

**International
Journal of Multidisciplinary Studies
And Innovative Research**

CALL FOR PAPERS



Editor-in-Chief: Prof. Daniel Obeng-Ofori
ISSN: 2737-7172 (O), 2737-7180 (P)
Gmail: editors.ijmsir.UseGmail.Com
Frequency (BI-Monthly)
NASS Rating: 4.47
Start year: 2020
Subject: Multidisciplinary
Submission: Open
Published by Catholic University of Ghana