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Integrating Traditional Healing Practices into Modern Healthcare System in Jirapa and Bongo Traditional Areas of Northern Ghana

[1]Thomas Azagsiba Agana, [2]Samuel Adadi Akapule, & [3]Ismail Saani

[1]Department of African and Endogenous Studies, Simon Diedong Dombo University of Business and Integrated Development Studies (SDD UBIDS), Wa, Ghana

[2]Department of Marketing and Communication Bolgatanga Technical University, Ghana

[3]Department of Communication Studies, Simon Diedong Dombo University of Business and Integrated Development Studies, Wa, Ghana.

[1]https://orcid.org/0009-0003-0694-554X
[2]https://orcid.org/0009-0008-6641-0965
[3]https://orcid.org/0009-0002-0073-4760

***Corresponding Author:** tagana@ubids.edu.gh

ABSTRACT

Background: Ghana's healthcare system continues to operate within a dual structured space led by the traditional and Western science-based medicine. Despite their vital roles in healthcare, collaboration between the two systems remains underexplored. Few studies have examined how their integration could support a sustainable and culturally grounded healthcare framework in Ghana.
Objective: This study investigated how integration of traditional medicine with Western science-based medicine could lead to a more effective and sustainable healthcare system in Ghana.
Method: A qualitative research design was employed, using interviews and direct observations to gather data from traditional healers, biomedical practitioners, and health administrators. The data were presented through direct quotations and analysed using content and trend analysis techniques to identify emerging themes.
Results: The study found minimal integration between traditional and biomedical systems, largely due to the absence of strategic policy support. Traditional healers demonstrated greater willingness to collaborate and referred patients more frequently, while biomedical practitioners remained cautious. Nonetheless, prospects for cooperation and shared learning emerged.
Conclusion: The study concludes that integration of traditional medicine into Western medicine is both necessary and feasible; but this has been significantly hindered by policy and attitudinal barriers. Establishing a regulatory and collaborative framework would enhance trust, complementarity, and holistic patient care.
Unique Contribution: This study provides empirical insight into the dynamics of health system in Ghana by highlighting the potential for a collaboration between indigenous healing systems and modern medical practices to promote inclusive and sustainable healthcare.
Key Recommendation: The Ministry of Health should establish a policy enabling referrals between biomedical and traditional practitioners, recognize traditional healers through award schemes, and form a joint research committee to guide effective integration.
Key words: Healers, compatibility, integration, traditional, healing practices, health system.

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1.1 INTRODUCTION

Traditional medicine plays a crucial role in healthcare systems worldwide, particularly in rural and underserved regions. Its relevance, natural effectiveness, and integration with modern healthcare practices have attracted scholarly attention (Raja et al., 2024; Muoneke, & Nwafor, 2024). Despite its widespread use, particularly in African countries, research into the integration of traditional medicine with Western biomedical systems remains limited. Studies have primarily focused on geographical regions other than Ghana, using varied methodologies, and often overlook the intersection of government policy and cultural frameworks that could facilitate integration. This gap in the literature highlights the need for further exploration of how traditional and biomedical practices can be harmonised to create a more inclusive healthcare model.

Globally, an increasing number of people rely on traditional medicine. According to Raja et al. (2024), nearly 80% of populations in several African countries, 40% in China and Colombia, and 71% in Chile utilize traditional medicine for their healthcare needs. In developed nations, Complementary and Alternative Medicine (CAM) usage has also gained prominence, with 70% of Canadians, 71-75% of Germans, and a growing proportion of Australians spending more on complementary health products than on pharmaceutical drugs (Al Worafi, 2023). This global trend signals a growing demand for an integrated healthcare system that acknowledges traditional and modern medicine as complementary rather than conflicting approaches.

India and China offer examples of integration, having achieved this through strong policy frameworks. The India government has formalized systems like Ayurveda, Unani, and Siddha within national health policies, ensuring their integration with modern healthcare practices (Awindor, 2017; Al-Worafi, 2023). Similarly, China's policy shift in 1949 granted equal status to both traditional Chinese Medicine (TCM) and Western medical practices, enabling them to coexist and evolve through research and evidence-based practices (Jingfeng, 1988). This has resulted in a pluralistic medical system that serves as a global reference.

However, many African countries, including Ghana, continue to struggle with fragmentation between traditional and biomedical healthcare systems. Traditional healers in Ghana are often excluded from key health programs, such as malaria or HIV/AIDS control, and rarely engage with public health institutions (Kuete et al., 2007; Xu et al., 2008). Cultural and social misunderstandings further complicate the integration process. Biomedical practitioners often lack an understanding of local health beliefs and practices, which leads to stigmatization of traditional medicine and missed opportunities for collaboration (Krah et al., 2017).

A significant barrier to integration is the high turnover of biomedical personnel, especially in rural areas, which hampers long-term relationships with traditional healers. Furthermore, young people are less interested in pursuing careers as traditional healers due to limited financial rewards and low social prestige, resulting in a generational decline in traditional medical knowledge (Krah et al., 2017).

Despite these challenges, Ghana has made efforts to formalize traditional medicine, including the establishment of institutions like the Ghana Psychic and Traditional Healers Association (1961)

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and the Centre for Scientific Research into Plant Medicine (1975), alongside various policy initiatives aimed at fostering collaboration between the two healthcare systems (Ministry of Health, 2001). However, these efforts have been inconsistent and lack concrete strategies for effective integration.

The dual healthcare system in Ghana remains largely fragmented, with traditional medicine serving as a vital first point of contact in rural communities, while biomedical institutions dominate formal health policy and funding. This study aims to bridge the gap in the literature by exploring the feasibility, opportunities, and challenges of integrating traditional and biomedical healthcare systems in Ghana. Specifically, it examines the perspectives of traditional healers and biomedical practitioners, shedding light on the potential for synergy between the two systems. Through this, the study aims to contribute to the ongoing discourse on building a more inclusive and sustainable healthcare system in Ghana.

OBJECTIVES OF THE STUDY

The study seeks to achieve the following objectives.

1. To investigate the barriers and opportunities for integrating traditional and biomedical healthcare systems in Ghana.
2. To assess the attitudes and perceptions of traditional healers and biomedical practitioners towards collaboration.
3. To evaluate the potential for policy reforms that would support the integration of traditional medicine into Ghana's formal healthcare system.

2.1 LITERATURE REVIEW

2.1.1 Indigenous Knowledge and Non-Western Ways of Knowing

Indigenous Knowledge (IK) contrasts with the formalised knowledge systems of Western institutions such as universities and research bodies (Warren, 1999; Lee, Yen, & Aikenhead, 2012). Despite increasing academic interest in IK, there is no consensus on its definition. IK combines practical knowledge derived from centuries of lived experience with a spiritual component rooted in cultural ethics and worldviews. While the practical aspect addresses environmental phenomena (e.g., wind patterns, water currents), the spiritual side is often unquantifiable scientifically but plays a crucial role in practices like resource conservation (Abele, 1997; Burgess, 1999).

Western scientific approaches have shown some interest in IK, with Bruyere and Bergland comparing both systems. While some scholars argue that both IK and Western science share an observational basis, others highlight fundamental differences. Cordova (1997) believes that both systems are intellectual constructs aimed at understanding the universe, but their integration presents challenges due to differing epistemologies. Table 2.1 summarizes key differences between Indigenous and Western scientific knowledge

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Indigenous Knowledge	Western Scientific Knowledge
Qualitative	Quantitative
Intuitive	Rational
Holistic	Reductionist
Spiritual	Value-free
Empirically observed	Experimentally verified

Although these distinctions are clear, Sallenave (1994) suggests that the boundaries between the two knowledge systems are not rigid, and both can overlap in practice.

The integration of IK into mainstream knowledge faces several barriers, including differing perspectives on what is deemed significant (Sallenave, 1994), scepticism from scientists regarding the reliability of indigenous data, and resistance from policymakers who may be unwilling to alter established decision-making processes (Sallenave, 1994).

2.1.2 Integration Initiatives

Globally, there is increasing recognition that no single healthcare system can meet all health needs. Western biomedicine excels in surgery and acute care, while traditional systems like Ayurveda are more effective in managing chronic diseases and promoting well-being (Hlongwane, 2016). The integration of both systems offers a potential pathway to comprehensive healthcare that can serve a broader range of conditions (WHO, 1978).

Despite this, traditional medicine has faced various criticisms. The terminology itself can create misunderstandings by suggesting mutual exclusivity between traditional and biomedical practices. This is especially problematic because the integration of these systems requires reconciling their differing frameworks (Jingfeng, 1987). The concept of "medical pluralism" is essential to understanding how patients and practitioners interact across systems (Press, 1969; Garrison, 1977; Waldram, 2000).

One major challenge in integrating traditional and biomedical medicine is the absence of universal frameworks to assess efficacy. Controlled clinical trials, typically employed in Western biomedicine, may not suit traditional practices, which are often based on experiential knowledge (Lewis, 1993; Morrell, 2008). As such, integrating traditional medicine within a standardized medical framework risk distorting its unique cultural context. See table below:

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Table 2.2: Key differences between traditional and modern medicine

Concept	Traditional medicine	Modern medicine
Knowledge protection	Open access. However, not all aspect is opened.	Closed, patent-protected
Formulation	Ad hoc during consultation with the patient	Pre-determined, and once tested in clinical trials cannot be changed unless re-tested
Regulation	Virtually none, though some countries are trying to introduce rules and standardization	Extremely tight, to the point that bringing drugs to market now costs billions of dollars
Testing	No formal testing as knowledge of the effectiveness is handed down through generations	Rigorous trials that happen in different phases, first testing for safety, then efficacy
Dosage	Unfixed: the amount of medicine given might be roughly similar, but the active ingredient (which is what dosage really is) can vary hugely	Fixed doses that tend to vary only slightly with age or weight, or disease severity
Consultation	Lengthy, and the patient is asked about a wider range of questions than just their symptoms	Consultations in both primary and secondary care tend to be brief and focused, especially as national health systems come under strain
Training	Both systems of medicine require lengthy training over many years but with traditional medicine, knowledge is often passed one-to-one through families, and practitioners are often born into a family of healers	Often vocational: health professionals go through formal training in schools and universities

Source: Soforowa (1982)

2.1.3 Sustainable Healthcare

Sustainability in healthcare has many definitions, but most emphasize approaches that are ecologically, economically, and socially viable over the long term (Sepetis, 2019; Zhang et al., 2024). Traditional medicine often aligns with sustainable practices by using natural remedies that

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have minimal side effects and help preserve biodiversity. However, the modern biomedical system, despite its advancements, faces significant sustainability challenges, including rising costs and unequal access to care (ANH, 2010; Sepetis, 2019).

Traditional medicine, in its ecological and holistic approach, has the potential to contribute to more sustainable healthcare, particularly in resource-limited settings where conventional medicine may be inaccessible (Sepetis, 2019). The blending of both systems could offer more efficient and environmentally friendly healthcare solutions (Egbo, & Nwafor,; Zhang et al., 2024).

2.1.4 Government Regulation on Traditional Medicine

Many post-independence African countries, including Ghana, have made efforts to incorporate traditional medicine into national healthcare systems. Since 1957, Ghana has created several institutions to promote traditional medicine, including the Ghana Psychic and Traditional Healers Association (1961), the Center for Scientific Research into Plant Medicine (1975), and the Traditional Medical Council (2000). Despite these efforts, the integration of traditional and biomedical practices remains limited, primarily due to a lack of legal frameworks and ongoing mistrust between practitioners of the two systems (Bodeker & Burford, 2007; Raja et al., 2024).

In Ghana, government policies have fluctuated between promoting traditional medicine and limiting its role within the formal healthcare system. For example, the New Patriotic Party's (NPP) 5YPOW emphasized influencing public health choices without clearly addressing traditional medicine (MOH/GOG, 2001). While governmental recognition of traditional medicine is increasing, the lack of formal regulation and the informal nature of traditional practice continue to pose challenges to integration (Bodeker & Burford, 2007).

2.1.5 Theoretical Framework: Social Interface Analysis

The concept of an "interface" is useful in understanding the integration of traditional and biomedical medical systems. Social Interface Analysis focuses on the interaction between diverse social interests and values to promote social change (Villarreal, 1994; Long, 1999). This framework helps analyze how different actors can navigate cultural and power disparities to work together.

Through an interface analysis lens, the integration of traditional and biomedical practices becomes a dynamic process of negotiation where new identities and relations are formed. The key task is to understand the knowledge and power implications of this interaction and how they might lead to either cooperation or continued division (Long, 1999). This approach is critical in examining how to create a balanced healthcare system that incorporates both indigenous and biomedical practices.

2.1.6 Communication Accommodation Theory (CAT)

To facilitate the integration of traditional and biomedical systems, Communication Accommodation Theory (CAT) can provide insight into the dynamics of interpersonal interaction. CAT examines how individuals adjust their communication styles based on their

social relationships, which can be critical in overcoming tensions between practitioners of both systems (Giles, 1991).

In the context of traditional medicine and biomedicine, convergence occurs when both groups find common ground, sharing knowledge and collaborating. Divergence happens when one group resists cooperation. Factors such as power, historical context, and cultural norms influence the extent to which convergence or divergence occurs. CAT can help analyse how these interactions shape the development of a sustainable healthcare system (Simmons & Dei, 2012).

Through the lens of CAT, the success of integration depends on the ability of both medical practices to negotiate their differences and work together for the collective benefit of patients. The theoretical insights from CAT provide a framework for understanding the dynamics of this integration and the conditions under which it may succeed.

3.1 METHODOLOGY

The study was conducted in two districts in two regions of Ghana; Bongo District in the Upper-East Region and Jirapa District in the Upper-West Region. The two regions were chosen based on the following generalized reasons; the geographical distinctions that is, the climate and vegetation, history of healers' practice, and also the fact that the healers use more savannah-derived medicines than the forest derived (Konadu, 2007). The guinea savannah woodland is predominant in the northern and north-eastern parts of the region. The level of development and variations in economic activity are largely due to the vegetation type. It has a long history of Local Health Traditions (LHT) and believed to be a hub for traditional healers. This setting made it ideal for the study.

A qualitative research approach was adopted for this study. The qualitative research method has the practical ability of being useful when it comes to understanding the key participants, their actions and experiences within the context in which they act and the influence this context has on their actions (Maxell, 2008). Secondly, this research process has the ability to identify and explore the unanticipated phenomena of events surrounding these actions (Maxwell, 2008) and lastly, the ability to address the quest of this study, which is to explore the knowledge acquisition of traditional healing practices.

The qualitative research model therefore best suited this study because it incorporates a comprehensive multi-method approach which aimed at describing, understanding experiences, ideas, beliefs and values, and other intangibles of key participants and their functions. To accomplish this, in-depth interviewing was conducted since the study was largely an explorative and descriptive type research. Interviewing is at the heart of any qualitative study especially when it integrates documentary filmmaking and for that reason the interviews were reflexive with semi-structured open-ended questions eliciting information based on their knowledge acquisition and functions as traditional healers.

This research was on a specific individual and specific context. It is a type of research methodology aim to analyze specific issues within the boundaries of a specific environment,

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situation or organization; hence a case study was suitable (Millar & Deribile, 2018). Case study is typically seen in social and life sciences. Case study can also be described as an intensive, systematic investigation of a single individual, group, community or some other unit in which the researcher examines in depth data relating to several variables. Case study can be divided into three categories, namely explanatory, descriptive and exploratory. There is no single way to conduct a case study. Combination of methods such as unstructured interviewing, direct observation, can be used (Millar & Deribile, 2018). This combination was used during the research.

Purposive sampling was used to sample the units based on the objective of the study. Here members in the areas of study that can provide relevant information regarding the study objectives were purposively sampled. It was used to sample the traditional healers, heads of units of scientific medical workers, religious leaders, chiefs and elders in the study communities. This is because they are the main actors in this study.

In some cases, it was not possible for us to locate some of the traditional healers. Hence, snowball sampling was used to secure a good sample for our study. In this approach the researchers choose a few respondents, using any possible method and ask them to recommend other people who meet the criteria of the research and who might be willing to participate in the project. This process is continued with the new respondents until saturation- that is, until no more substantial information can be acquired through additional respondents or until no more respondents are available (Sarantakos, 2005).

We used interviews in the collection of our data. Interviews are suitable for follow-up studies for which a few areas considered to need further study are pursued more intensively. This is particularly used in Case Studies, Social Work, Legal Practice, Relief Work and other situations needing assistance on the basis of particular circumstances. In interviews, the number of respondents is necessarily restricted due to time constraints. They can either be structured interviews and unstructured interviews (Kumekpor,2002). We used both. We used it because in interview is practical in the sense that, it is face-to face, in the form of a conversation where a kind of rapport can be built. Probing is possible in an in-depth interview. This method is suitable for collecting data from an illiterate population and helps the interviewer to assess the mood of the respondent and can therefore appraise the validity and reliability of the answer. Data were obtained from the traditional healers through interview, on the nature of traditional healing, how and why they acquire the knowledge of healing.

We also made used of anthropological research as it basically played the role to study the culture, worldviews and knowledge of peoples outside their own culture. Different schools and approaches have put different emphasis and used different methods (Millar & Derbile, 2018). We used direct observation in our data collection. Technology becomes very important in direct observation because one can video-tape the phenomenon. Direct observation tends to be more focused than participant observation. The researcher is observing certain sample situation or people rather than trying to become immersed in the entire context (Millar and Derbile, 2018). Direct observation was used to observe instance of healing and the clients moving in and out, and we listened keenly to hear if they are referred to the scientific health personal. However, his

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was not possible on the part of the scientific medical practitioners as we were not allowed into the consulting rooms.

RESULT

4.1.1 The Incorporation of Traditional Healing Practices into Modern Health Systems

The findings from the series of life interviews conducted with traditional healers and biomedical practitioners, along with the responses collected from questionnaires, indicate a strong inclination towards collaboration between the two healthcare systems, contingent on mutual respect. Interestingly, traditional healers appear more open to the integration of their practices within modern health systems than their biomedical counterparts. This observation aligns with the argument advanced by Giles et al. (1991), who posit that while there are existing opportunities for collaboration between traditional and modern medicine, the lack of a formal framework for integration remains a significant barrier. According to Giles et al. (1991), the two systems must enter into dialogue with clear and mutually agreed goals. Although these goals need not always be identical, if they are focused on achieving sustainability, the collaboration can be beneficial. This model further suggests that for integration to be sustainable, certain societal and cultural norms must be instilled, including mutual respect, a commitment to the common good, and the ongoing sharing of knowledge and resources (Awindor, 2017; Al-Worafi, 2023).

One traditional healer from the Asooligo community in the Bongo traditional area expressed the following:

> Concerning our working together with the hospitals, I don’t see how this cannot be possible. We can work together if only we want to. However, it may not be possible because of the attitude of the medical doctors. I have had several experiences with them. In my practice, I have sent many patients to them for blood and water transfusion, because I know this is not our area of work. When I treat patients and realize they need other help I cannot provide, I send them to the hospital. I will expect that they do the same, but instead they do not respect us and when we cure their patients who come here voluntarily, they won’t even acknowledge it. I believe that we should be recognized and be assisted to do our work better. I know that there are a lot of things that the hospital doctors do not understand, but that is the way we do our things. For instance, when you come to me as a patient and you tell me what worries you, I first of all consult my ‘mothers’, because they are the source of my knowledge, then I give you water from my hen coop to drink, which you will bath too. It will surprise you to know that my hen coop water has been criticized. They said it will worsen the ailment. But the patients are not complaining and can even testify as to the efficacy of this preparation. You see, when you come here dying whatever medicine we provide you will accept it because you are afraid to die, and you need cure. So, if you tell me I should ignore some of my practices, then, we cannot work together. This is because, if I ignore an aspect of my healing practices, the medicine will not work. I would have no option than to move away from collaboration. (Key Informant, 2021).

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This healer's frustration is not an isolated case. A significant number of traditional practitioners share similar experiences with biomedical professionals. The healer's concern lies in the tension between traditional practices that are deeply intertwined with spiritual and ritual beliefs, and the secular, evidence-based practices of modern medicine (Awindor, 2017; Al-Worafi, 2023). The healer's refusal to compromise on their cultural practices exemplifies what Giles and Giles (1998) term an asymmetrical dyad, where the two parties are unwilling to alter their respective practices in a way that would foster collaboration.

As noted, traditional practitioners appear more willing to accept modern medicine, possibly due to the historical legacy of colonialism, which has led to a pervasive sense of inferiority regarding indigenous practices. However, the biomedical system often maintains a neo-colonial attitude towards traditional medicine, viewing it as unscientific and incompatible with modern healthcare principles. One healer from the Jirapa traditional area reinforced this sentiment:

> For us to work together and if we are to collaborate with our hospitals our knowledge will have to be sacrificed; we will dilute and destroy the practice. What I believe is possible is for us to be where we are and accept whoever comes to us for treatment. (Key Informant, 2025).

This statement highlights the healer's preference for symmetrical maintenance (Galios & Giles, 1998), where traditional practices remain intact and unaltered, thus avoiding the potential dilution of their cultural heritage.

A critical challenge in the integration of traditional and modern medicine arises from the fundamental differences in the underlying knowledge systems. Traditional medicine is inherently holistic, incorporating spiritual and ritualistic elements, while modern medicine is rooted in the empirical and clinical sciences. The following quote from a healer regarding their traditional bone-setting practice sheds light on some of the difficulties in collaboration:

> Bone setting for us is a family practice that has been handed over to us from generations. We practice it as a right and also as a way of preserving the knowledge. It is not to make profit. So, we do other businesses such as farming to survive. When our parents were asked to set up the bone-setting clinic at the Government health facility, it seemed a good idea at first because they were given a small quarter to operate within the hospital. It was soon realized that there were lots of things that were being done, which was not helping them. Their farms were left unattended because they had to sit at the clinic almost all day waiting or tending patients. The hospital was also charging the patients money before sending them to us, which of course, was against our practice. Some of the patients did not also understand why we demand certain items from them. As long as we were within the premises of the hospital, we were to abide by their regulations and not ours. So, our parents had to pack and leave. Can you imagine if, for instance, we were to be registered under the National Health Insurance, how would you expect us to operate using the NHIS system? It is just impossible. Would you be able to state in your claims that you brought a foul and purchased cowrie for the bone setting? I think that finding ways to get us and the hospitals to work together is not feasible. The best way is to assist us to do our work.

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> That way, people will be comfortable to come here, and even if they happen to go to the hospital and the doctor fails, the doctors should be in the position to send the patient to us and vice versa. (Key Informant, 2025).

This illustrates a significant issue: the deep-rooted cultural practices in traditional medicine, such as the demand for specific offerings or spiritual rituals, often conflict with the procedural and regulatory constraints of modern healthcare systems.

Many biomedical practitioners expressed strong reservations about collaborating with traditional healers, often dismissing traditional medicine as unscientific. Eight of the twelve medical professionals interviewed stated that they would never refer a patient to a traditional healer, citing concerns over the lack of regulation and scientific validation of traditional treatments. One medical doctor stated:

> I do not want to work with any traditional healer. This is because conflict can arise between us during the treatment process, in the sense that the traditional healer will like to use his/her herbs in treating the patients whereas I will also think the condition needs medical drugs. I do not support the local herbs because, the herbs have not been approved by the Food and Drugs Board. Also, I cannot quantify the dosage of the herbs that will be given to the patient. Two patients were ever referred to me by the traditional healers, but I returned the patients to them because they were almost dead. We need to be independent. If we cannot handle any health problem, refer the patient to the medical facility. I cannot refer any patient to a traditional healer. (Key Informant, 2025).

This biomedical perspective reflects symmetrical maintenance (Galios & Giles, 1998), where there is no willingness to compromise or integrate traditional practices into the biomedical framework.

However, not all biomedical practitioners share this negative view. Some see the value in cooperation. One such doctor stated:

> I think if traditional medicine is prescribed and given in the right dosage, it will have fewer side effects as compared to orthodox medicine. To me, the question of who should work under whom will depend on the situation at hand. When it comes to infusion of water and blood, surgical issues, I think I should lead. We live in a spiritual world. If a patient comes with spiritual issues, I think the native doctor should lead. It is a matter of cooperation. Saving lives is what matters. (Key Informant, 2025).

This approach reflects symmetrical convergence (Galios & Giles, 1998), where both systems are seen as complementary, each taking the lead in areas of expertise while maintaining mutual respect.

4.1.4 CONCLUSIONS

The findings suggest that integration between traditional and modern medicine is hindered by several factors, including the scientific community's limited understanding of traditional practices, miscommunication, and prejudice, as well as the lack of formal mechanisms or policy

support for such integration. Furthermore, traditional healers remain reluctant to dilute their practices or abandon core aspects of their cultural heritage. Despite these barriers, there are opportunities for collaboration, particularly if both parties acknowledge each other's strengths and develop frameworks for mutual respect and understanding.

4.1.5 RECOMMENDATIONS

The first step towards an integrated system is to invest in systematic identification of healers who, on the basis views of clients and biomedical health workers, can be recognized as professionals with recognized competence in managing diseases/illnesses.

The Ghana Ministry of Health should provide a policy document that permits the scientific health personnel to refer patients from the health centres to the well-recognized traditional healers any time there is the need. This policy document should be made available to all stakeholders in the health care system.

The Ghana Ministry of Health, NGOs and Philanthropists should organize award schemes on yearly bases for the traditional healers as a form of recognition.

The Ministry of Health in collaboration with NGOs, should set up Research Committee, to find out from the two partners (Traditional Practitioners and Biomedical Practitioners), either integration or cooperation is the best option. This will help to formulate an appropriate policy document to form a synergy for a proper convergence of the two actors in the health care delivery system.

Ministry of Health should ensure that the acquisition of cultural competence skills should be incorporated into the Nursing and Medical training curricula.

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

Ethical clearance
Ethical consent was sought and obtained from the participants used in this study. They were made to understand that the exercise was purely for academic purposes, and their participation was voluntary.

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Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Authors' Contributions

Thomas Agana conceived the study, including the design, Samuel Akapule collated the data, and Ismail Saani handled the analysis and interpretation, while so and so the initial manuscript. All authors have critically reviewed and approved the final draft, and are responsible for the content and similarity index of the manuscript.

Availability of data and materials.

The datasets on which conclusions were made for this study are available on reasonable request.

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