Women and Medicine: A Historical and Contemporary Study on Ghana

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ABSTRACT

Women have always been central concerning the provision of healthcare. The transitions into the modern world have been very slow for women because of how societies classify women. Starting from lay care, women provided healthcare for their family and sometimes to the members of the community in which they lived. With no formal education, women served as midwives and served in other specialised fields in medicine. They usually treated their fellow women because they saw ‘women’s medicine’ as women’s business. They were discriminated against by the opposite sex and by the church, which regarded it as a taboo to allow women to practice medicine. This study points to a Ghanaian context on how the charismas of women have made them excel in their efforts to provide healthcare for their people. The study also focused on the role of indigenous practitioners who are mostly found

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in the rural areas and modern practitioners who are mostly found in the peri-urban, urban areas and larger cities in Ghana.

KEY WORDS: Ghana, medicine, medical practice, society, women

Introduction

The traditional Ghanaian society confined the core functions of women to childbearing, farming and petty trading. Their social and economic security was guaranteed by their reproductive capacity especially when they gave birth to male children. In many rural areas of Ghana, people engaged in subsistence farming as their main economic venture and women played significant roles. Prior to the industrial period, women in different ethnic groups around the world performed different functions in the society in general and in particular, their contributions to agriculture (GIULIANO 2015:33). However, the type of agricultural technology prevalent in a region dictated the different functions performed by the women. There was specialisation of labour in terms of gender; men worked in the field outside of the home and women were exclusively responsible for domestic chores even if they had to lend a hand in the field (GIULIANO 2015:33). These arrangements became institutionalised with time and thus generated norms about women's role in society.

In the Ghanaian traditional societies, people predominantly believed that supernatural beings had power over their lives. To that extent, every disaster or calamity was believed to be caused by the gods. The sick were sent to the shrine for healing because of the belief that they might have offended the gods (ADU-GYAMFI 2015:9-10). As time went on, the pre-modern man began to question and doubt the power of the supernatural and relied more on their own observation of the world around them. They began to acquire the necessary skills and appreciated the need to study the diseases that affected them to proffer solutions to them in accordance with how they understood these diseases and ailments.

The education of women in traditional Ghana might have been constrained simply because such values predominated society. Female education was trivialised because of the understanding that women would eventually get married and be supported by their husbands (OPPONG – ABU 1984:21-39). It was said that females were meant to be in the kitchen and males were meant to be in school. In view of that, women were placed in the private sector while men functioned in the public sector (MANNATHOKO 1999:448). As children went through the process of socialisation, they were viewed as going through training for adult

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life; this was to enable them to fit into gender roles. Significantly, the view of the private sector has been construed as that of an endless round of tedious, senseless, unpaid and undervalued activities linked to child rearing, housework and support of adult men. Mannathoko has described the public sector as that which produces rewards of social life in the form of status, power, money, freedom, self-esteem and personal development (MANNATHOKO 1999:448).

Recent commentaries show that currently women appreciate the feminine power and their uniqueness beyond traditional categorisation. However, the transition from women's view of the traditional self to the modern self has been slow. Nevertheless, the modern Ghanaian woman has all the right to participate in several activities including economic, social and political activities. Comparatively, in Europe before the twentieth century, women who had the technique to heal or cure would have access to medical text through oral reading (GREEN 2008:343-346). This access however came as a result of the mediation of men. This then, raises issues about the contribution of women to the generation of medical texts, medical reading and practice even during the twentieth century and beyond (GREEN 2008:343-346).

In the past, women's health did not receive the due attention as a significant topic. Studies conducted into diseases focused on male cases. Today, matters related to the health of women take center stage in society and people have come to realise that although both men and women tend to have identical diseases, their symptoms and treatment need not be the same. This emphasises the significance of research into the health of women and related matters. Besides the need to pay attention to the health of women, their role as healthcare practitioners must continuously receive attention in historical research. From time immemorial, women have cared for the sick, the new-borns and the elderly in their homes as trained midwives took charge completely of childbirths. Women were midwives and gynaecologists even without any formal education. They thus operated as medical practitioners without formal education, and that many acts of healing and therapy were possibly performed outside the context of the textual tradition of knowledge. Given the widely held belief that women in pre-modern times took charge of their health, they were viewed to exclusively control gynaecology and obstetrics. The implication of this is that women might have generated the written text on women's medicine with the sole intention of using them. Some women could not simply attend to male medical practitioners for medical care involving their sexual organs due to sheer embarrassment. Diseases such as cervical cancer, breast cancer and childbirth were attended to by women. This notwithstanding, women could not get qualifications needed to become proper doctors.

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Significantly, the health of women and their participation in the delivery of healthcare is influenced by several factors including poverty, employment status, and family responsibility. Women are limited in their quest to provide adequate protection for their health and achieve optimal health status by gender-based inequalities like education, income and employment. Power relations are unequally distributed in society and this translates into unequal access to and control of health resources. Gender disparities in social and economic resource allocation like income, education, health care, nutrition and political voice correlate strongly with women's poor health and reduced well-being. Girls and women encounter differential exposures and vulnerabilities across a range of health problems that are often poorly recognised (ROSENFIELD – FIGDOR 2001:703).

It has also been reported that the health needs of women and matters related to their human rights in developing countries continue to decline. The increase in poverty among women corresponds with increase in diseases and death among them. Women's participation in the profession of medicine has been significantly restricted historically and in modern times. However, their informal practice of medicine in roles such as caregivers or as allied health professionals has been widespread. Women currently have equal access to medical education in most countries, yet they do not have equal employment opportunities and gender equality within medical specialties around the world (REICHENBACH – BROWN 2004:793). Meanwhile, several studies on healthcare place the performance of female doctors in the provision of higher-quality care (MORANTS-SANCHES 2000:297). This calls for the need to research into the contribution of women in the medical profession specifically as healthcare practitioners and the generation of textual tradition of knowledge. Against this background, the objectives of the study are to highlight some of the contributions made by women in pre-modern Ghana in the field of providing healthcare, some challenges they faced in their attempt to provide healthcare and how education has had impact on the transition of women who practice medicine in the modern world.

To achieve the set objectives, primary and secondary sources related to the subject under study were used as data collection instruments. The primary sources include reports on the history of medicine in the Gold Coast and in some cases, oral interviews. The secondary sources on the other hand include articles and books. The oral interviews featured indigenous female healthcare practitioners as well as clients who patronise the services of these practitioners. The criterion for the selection of participants for the interview was based on the longevity of practice, knowledge and experience specifically over a decade and the testimonies provided by their clients about the perceived efficacy of their medicine. A sample

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size of thirty practitioners including modern health practitioners, traditional birth attendants and clients were selected for the study in Kumasi and its environs. In order to cover a wide variety of issues on the subject under study and to allow participants to express themselves, open-ended questions were asked accordingly. The affiliated healthcare institutions of participants include the Komfo Anokye Teaching Hospital, Kwame Nkrumah University of Science and Technology Hospital and the South Suntreso Hospital all in the Kumasi metropolis. The interviews were transcribed manually and presented in a narrative form to describe the healthcare services provided by women.

Synthesis from Related Literature

Women's Developing Identity

According to Anderson, women's developing identity refers to women's personal identity irrespective of society and the identity observed by people in the immediate family (ANDERSON 1986:43). She argued among other things that a woman's way of living might be influenced by her society. However, she maintained that the identity of a woman is a choice she makes irrespective of any external influence. The features of a woman's identity help to identify several general characteristics of stereotyping, role playing and sex differences that have exemplified the demise of women in the past and continue to do so today. The characteristics of women's identity place them in opportune positions for managerial work and to successfully pursue career in science and engineering. The skills with which women go into negotiations to define their professional identities in the historically male-dominated arenas have been receiving growing interest (GREED et al. 2000:181-185).

Women have been contributing to the changing world in relation to continuity and change in the evolving identity of women. In the earliest times, women were subordinate to men. Women had no right to make choices contrary to what has been assigned to them by their husbands or family. On the contrary, women in modern times have developed certain potentials that have affected their choices in life. The development of women's potentials has created cooperative patterns of behaviour that contrast with competitive modes established by men (MORANTS-SANCHES 2000:294).

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Women in Medicine

Women in the preindustrial period have been defined in terms of the type of technology used in agriculture and forms of agriculture their societies practiced (GIULIANO 2015:33; BOSERUP 2013:V). In the earliest times, farming was a very dominant activity which identified the ethnic group of a particular family (GIULIANO 2015:33-34). Two technological regimes, shifting cultivation and plough cultivation broadly defined gender-based division of labour. Shifting cultivation made women to engage in majority of agricultural work whereas men mostly dominated plough cultivation (BOSERUP 1970:4). Oppong and Abu though not contrasting the argument of Giuiliano (op. cit.) and Boserup (op. cit.), argued that women in pre-modern period were not defined according to their type of agricultural practice only but also they were seen primarily as child bearers (OPPONG – ABU 1984:21-39). A female's ability to reproduce was the most important means to ensure social and economic security for themselves, especially if they bore male children (OPPONG – ABU 1984:21-39). Women worked to plough back the profit made into what was essentially an extended family enterprise. This traditional division of wealth placed women in positions subordinate to men.

In the Western world, women's status was founded in the civilisation of Greece and Rome where the men had the public status (MILES 1991). The women's role on the other hand was to bear children and manage the household. Gender discrimination exists at all levels in Ghana including the health of women. Gender disparities in social and economic resource allocation like income, education, healthcare, nutrition and political voice correlate strongly with women's poor health and reduced well-being. Women tend to lack access to job security and do not benefit from social protection, including access to healthcare because of the high probability of being left out of the formal market (ROSENFIELD – FIGDOR 2001:703-704).

The historical perspective and recent trends of women in medicine has received attention in the literature (JEFFERSON et al. 2015:6-7). Medical care before 1600 was based on the theory of humours, which involved "a wide variety of tactics, holistic lifestyle, prescriptions and diet" and it also involved "diet application of various substances alone in combination, bloodletting, cauterisation and cupping, use of holy relics and prayers as well as other ritual or magical actions" (ACKERKNECHT 1942:546-547). In pre-modern times in Ghana, diseases were believed to have been caused by the gods, witchcraft and malevolent spirits. The priest healers consulted the gods for solution and prepared medications for their patients (ADU-GYAMFI 2015:9-10).

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Historically, from the ancient world through to present day, women have played significant role in medicine and healing. This has manifested in various forms and resulted in various conflicts along the way. Women took care of their children when they were sick without taking them to traditional healers (JEFFERSON et al. 2015:6-7). As ‘peasant healers’ became more successful, the church became increasingly fearful that the reliance on prayers would reduce. The church was thus much involved in discrediting the role of women as healers and encouraged witch-hunting throughout Europe. Women were only allowed to practice in one clinical profession – midwifery during the period of witch-hunting. This was due partly to the fact that midwifery was considered as a lower status occupation and thus did not attract male practitioners (JEFFERSON et al. 2015:6-7). However, over the period men were acknowledged as possessing more technical skills and allowed to attend to pregnant women in childbearing.

According to Kilminster et al. and Morants-Sanches, the contribution of women in medicine has not received significant consideration. This is because of the perception people have about women as weak and unqualified (KILMINSTER et al. 2007:39-40; MORANTS-SANCHES 2000:301). Concerning same, other scholars base their argument on the weakness of women on societal perception without considering the efficacy of their treatment. Other studies emphasise that women are being regarded as weak because they are compelled to look after their children which makes them less experienced with medical practices since health practitioners need enough time to be more experienced with medicine. Others also argue that changes in certain occupations may be responsible for discrediting the role of women as healers (KILMINSTER et al. 2007:39).

The existing literature further attests to the central role women have played to support the provision of medical care through domestic prescription of medication. In traditional/indigenous societies, their roles as herbalists cannot be gainsaid. Women acted in various capacities in the medical profession for which they were paid although they were not formally trained. These services which they rendered to the public included sick-nursing and wet-nursing, midwifery, performing minor surgery and general physician roles. Nursing itself manifests as caring and nurturing and as such, it was viewed as an aspect of the social role of women. However, the same understanding did not support the incidence of women becoming doctors (KILMINSTER et al. 2007:39).

It is now established that there is a large segment of women in the medical profession in general who were in the majority in some specialised fields. The Association of American Medical Colleges adds that the number of women who are training to pursue career in

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medicine keeps increasing. Forty-six percent of women are training to become physicians and form about half of all medical students. In the academic faculty women constitute about a third (MORANTS-SANCHES 2000:292-293).

The status of women has always been a challenge to their choices in life. Studies of women in communal politics, formal education and wage labour show that women often face great problems in rising above ‘household boundaries’ (MORANTS-SANCHES 2000:293). This emanates from the demand of coping with local ideologies that define women as mothers and wives on one hand and national ideologies that emphasise women’s contribution to national development (MORANTS-SANCHES 2000:294). Women and men in traditional Ghanaian society were relatively equal, but the growing division of labour in the modern economic sector is widening the gap in the productivity and in the income between them and men (TABI et al. 2006:54). Women’s status is therefore lower in relation to that of men.

The skewed view of women has persisted from the middle ages (GREEN 2008:343; MORANTS-SANCHES 2000:295). A widely held belief in the Middle Ages was that women’s medicine was business for women. Women exclusively took charge over gynaecology and obstetrics, indicating that they might have created the written texts on women’s medicine purposefully to use them. The Middle Ages were thus considered as the ‘golden age’ for women’s control over their own health care by those working in modern Europe or even doing cross-cultural comparisons. From the earliest times when compassion was the only medicine, women were the nurses for the sick and caregivers for the new-born and elderly. Trained midwives took control of childbirth. Catholic sisters tenderly cared for and comforted the sick and the dying. Nuns served in various capacities as cooks, laundresses, nurses and scrubwomen. Whereas there is a high probability that women collectively might have created the text on women medicine for use, they constitute the least likely group to have had the exposure to literate culture that will allow them to create or use such text. The evidence from medieval period does not support a supposition that ‘women’s health was women’s businesses’ (GREEN 2008:343; MORANTS-SANCHES 2000:292-294). A female may be predominant in a particular field but may not have voice enough to be heard given the fact that they have been underrepresented in academic leadership.

Challenges Women Face in Medicine

The wisdom of women, their experience and expertise in medicine have been known since the ancient cultures, which believed and placed medicine in the domain of women. Priestesses were the earthly representatives of the omnipotent goddess with control over life,

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sickness and death. Women in all the cultures of the world have practiced medicine. They have equally been subjected to discrimination in their practice of medicine. The case involving the presentation of a petition to King Henry V to prevent women from practicing medicine was recorded in 1421 (BOWMAN et al. 2002:1). The most common type of health care giver until the nineteenth century was the female midwife. Labour and delivery were considered too 'dirty and debasing' for men. It was not until the nineteenth century that men began to enter into obstetrics/gynaecology in large numbers. At the same time, there was also strong vocal and open discrimination against women who were either practicing as physicians or wanted to enter the medical practice (BOWMAN et al. 2002:138).

Bowman, Frank and Allen have argued that women's wisdom, experience and expertise in medicine dates back to ancient cultures. Their beliefs were that medicine was the prerogative of women, as priestesses were recognised as the earthly forms of the omnipotent goddess who themselves commanded life, sickness and death (BOWMAN et al. 2002:144). Dankelman and Davidson, though not contrasting the idea of Bowman, Frank and Allen, stated that women's knowledge and skills are also consistently undervalued. Yet, women have always played the central role in informal education as custodians and transmitters of indigenous knowledge and culture. In all parts of the world, women have been actively involved in traditional medicine, farming, as well as the processing and preservation of food (DANKELMAN – DAVIDSON 1988:IV). Historically, the participation of women in the medical profession has been subjected to significant restrictions despite the widespread engagement of women informally practicing medicine as caregivers or as allied health professionals. Women currently have equal access to medical education in most countries, yet they do not have equal employment opportunities and gender equality within medical specialties around the world (REICHENBACH – BROWN 2004:793).

Three largely independent developments have been responsible for the increasing number of women who were studying to practice medicine from the 1970s. These include the elimination of institutional constraints to women's entry into medical education, the sharp expansion in the capacity of medical schools and the end of military draft for young men (ADAMS 2010:459; MORANTS-SANCHES 2000:292-293). Women were mainly constrained by legal and social norms in the periods that the practice of medicine was going through the process of becoming a profession. The same period also delivered the 'modern medicine' through scientific discovery and new laboratory techniques (ADAMS 2010:459-460).

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Historically, in the Gold Coast, the inferior educational status of women was illustrated by the fact that the ratio of girls to the total number of pupils in primary schools in 1945 in the Gold Coast was 1:4. Formal education prepares the individual for employment in the economically and socially regarded formal sector of the society. Essentially, since women have less chance to enter the higher levels of educational system, their chances to enter formal employment, especially higher-level positions, are predominantly lessened (DSISI 2008:255). Social researchers and physicians have asked questions about what the growing presence of women in the medical profession imply. This concern emanates from persistent biases and prejudices against women which took the forms of issues about the reputation of women in professional medicine and their status (HURD-MEAD 1938:221-222). The subjective behaviour towards women in the medical profession aggravated as it manifested in denying women the professional opportunities, malicious gossips, sexual slurs and even sexual advances. It is significant to share that this is not only limited to the medical profession.

Women are directly and indirectly adversely affected by ‘gender order’ in society which handles matters related to men and boys ‘normally’ but views those related to women as ‘special’ (HAMBERG 2008:237). This order attaches greater significance to matters concerning men and boys than to those of women and girls and therefore, it subordinates the latter to the former. These tendencies may slow the advancement of women and girls and keep them in low paid jobs and low paid scales and could also have adverse psychological effect which may lower their self-confidence (HAMBERG 2008:237).

Sharma paid attention to the family as a great challenge to a woman’s choice of profession. She purports that families can be negative powerful force responsible for stereotypes and discrimination against women (SHARMA 1983:25). In many families, a daughter is constantly told that medicine is a man’s profession because a woman would not be able to combine a medical career with the family life. In addition, parents would want to finance their sons for medical education rather than their daughters. A mother has a great deal to do with the daughter’s decision to enter medicine. Various family obligations have made some women physicians to specialise in some areas they did not originally anticipate. Usually if the mother is a professional herself, she serves as a role model of a woman combining a career with marriage. The guidance counsellor can also turn a girl away from medicine. Over the years, women have received the counsel that medicine is not a suitable profession for women. The girl child has been counselled that medical programme is a lengthy one; the girl

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would not be able to combine marriage with medicine and possibly can cause a delay in her marriage (SHARMA 1983:25).

McDonald explained gender system as "the socially constructed expectations for male and female behaviour that are found in every known human society" (McDONALD 2000:427). He added that, "gender system's expectations prescribe a division of labour and responsibilities between women and men and grant different rights and obligations to them" (McDONALD 2000:427). The upbringing of women itself tends to generate social restrictions and confinement of women from childhood until they become helpless, mindless and dependent adults (MANNATHOKO 1999:448).

Earlier on, Aristotle laid the philosophical basis for this tradition when he defined justice as treating "equals equally, and unequals unequally" (OLUWOLE 1997:98). This definition by Aristotle later caused some intellectuals to claim that they had rationally and scientifically established the existence of permanent inequalities between male and female. From the Middle Ages down to the time of the Renaissance, scientists concluded that the entirety of the female members of the species are physically and intellectually inferior to the entirety of the male members of the species (OLUWOLE 1997:98).

One will have to review gender theories about education and training, activists, educators and policy makers in order to appreciate some of the contradictions and tensions that arise out of the interactions between men and women. These gender concepts and theories provide a basis for the descriptions and explanations on why and how the gendering of education and training leads to gender injustices (MOSER 2012:15). This provides some explanations to upward mobility attributed to differences in the quantity and quality of the opportunities available to women and minority groups.

A new tradition, called gender planning has emerged with the objective of facilitating women self-empowerment to achieve equality and equity with men in developing societies (MOSER 2012:15). The conceptual rationale for the key principles of gender planning was developed through emerging feminist theories and contemporary debates on women, gender and development. The debates explore the contribution of women to the overall development of society . roles and needs socially and politically. The socio-political dimension of gender roles and needs thus explores gender participation in decision-making about resource use both domestically and in public (LEFTWICH 2008:6).

As reported by Hurd-Mead, the valuable contributions of women in medical practice in terms of discovery, addition to knowledge, and the generation of the textual tradition over the

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centuries has been lost together with the personalities behind these works. The compilation of the history of women in medical practice has thus been always difficult and for some ages remains obscure (HURD-MEAD 1938:221). It is therefore relevant to study women and women's roles in healthcare wherever they might be. The case of Ghana for that matter cannot be gainsaid.

Discussions

This section of the paper focuses on women's role in healthcare with particular emphasis on their traditional and biomedical contributions under thematic areas. The discussion section is presented under thematic areas in order to give a clear and intelligible account on women's contribution to healthcare as well as the challenges they face in the course of discharging their duties as healthcare practitioners in Ghana.

Indigenous Female Healthcare Practitioners

Healthcare in Ghana is essentially provided by traditional healers. Conservative figures indicate that traditional healers cover about 80% of cases in Sub-Saharan Africa (KASILO et al. 2010:8). The power of the traditional healer in the traditional African healthcare system is not determined by the ability to diagnose the causes of the diseases and the prescription of remedy. It is rather by their ability to establish the intricate relationships between the patient and the broader environmental context. This context is defined in social, natural and spiritual terms (KASILO et al. 2010:8).

The traditional healthcare system in Ghana is a general one that integrates social ethics, religious morals and cultural values. The belief system establishes a link between people's health with the metaphysical and supernatural world with the Maker, divinities and ancestral spirits. Diseases in traditional Ghana are thus not just pathological but spiritual. The scientific theories of disease hold true and thus constitute an element in the admixture of a complex belief system. This explains why the traditional health care system applies both herbs and other natural products and spiritual and psychic powers for the treatment of diseases. In ancient times and even today in many societies and many cultures, every natural occurrence in man's environment, whether good or bad including natural calamities, pestilences and diseases of man was and still is attributed to either acts of God or deities and spiritual or mystical demons (ADU-GYAMFI – ANDERSON 2019).

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The forebears of Ghanaians and indeed across the world have practiced traditional medicine since time immemorial. The spiritual healers are the custodians of the knowledge and pass it on from generation to generation through 'on the job training'. It is possible to argue that many families across the country have some knowledge of traditional medicine, which they inherited from their ancestors. In that regard, Madam Afia Asantewaa echoed:

"I don't know why my family especially my children have refused to inherit the practice from me. None of the members of my household has knowledge of the practice; they feel proud about this. They describe it as old fashioned meanwhile they all used my medicine when they were pregnant or sick. This disinterest in our medical practice has reduced the number of female indigenous practitioners unlike it was in the previous century" (MADAM AFIA ASANTEWAA, personal communication, April 23rd 2018).

Older women with a great deal of experience in treating the health needs of their own children as well as of other adult household members often offer volunteer advice to young mothers and are frequently consulted for problematic illness. People see old women as equipped with the knowledge of medicine. Old women can prescribe medicinal herbs for both the young and old even though they are not formal practitioners (AMPONG, personal communication, April 23rd 2018). The community respects such women but they do not accept any form of payment in the form of cash for their services.

Women have always been healers. Women in their position as midwives, mothers, sisters, aunts and neighbours were another key component of the world of healing. As midwives, they travelled from one house to another and from village to village to render their services. They were the medical practitioners of the time and were acknowledged by their societies in various ways. In some places, people called them 'wise women' but the authorities called them 'witches or charlatans' (EHRENREICH – ENGLISH 1973:3).

Female indigenous practitioners who have acquired knowledge of different health problems but are more confident and have a long experience with treating pregnant women also play essential part in maternity care for pregnant women (MCKAY – WANGCHUK 2018:204-210). Other healers were identified by the range of diseases or conditions they could treat. These included both physical and non-physical diseases. In an interview with one Madam Dwomoh, an indigenous medical practitioner at Tafo[1], she hinted that she is very experienced

[1] Tafo is a suburb of Kumasi in the Ashanti region of Ghana.

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with treating pregnant women and postpartum issues. Madam Dwomoh affirmed; *"I have medicine for women who cannot give birth. Once I give a barren woman my medicine, she will get pregnant."* (MADAM DWOMOH, personal communication, April 23rd 2018).

The origin of medicine is closely linked to the supernatural. The primitive view of medicine has more to do with magic than what is considered medicine today (ACKERKNECHT 1942:552). Witchcraft or the practice of magic could be used to inflict illness or to take it away. Significantly, women who practice traditional medicine have always been tagged as witches by their male colleagues. People usually associate them with the use of some kind of magic in their practice. Our informant, Madam Dwomoh hinted that she is a Christian indigenous medical practitioner. In view of this, before giving her patients any concoction, she prays to the almighty God to guide her through the process (MADAM DWOMOH, personal communication, April 23rd 2018).

Testimonies about Female Health Practitioners

Women are very compassionate and can be described as good practitioners. Most people prefer to be treated by women more than men because they see women as more understanding than men. Women have always been practitioners by starting as lay carers to being qualified practitioners. Mothers cater for the sick members in the family which makes them special and respected. In an interview with Akua Frimpong, she stated that her mother has always been the first person she consulted for medical advice when needed which usually turns out to work for her in a good way (AKUA FRIMPONG, personal communication, April 23rd 2018). She hinted that she prefers a female indigenous practitioner to a male one. Largely, we infer that female indigenous practitioners are very knowledgeable and are very skilful in their practice especially in the area concerning prescription of herbs.

Female indigenous practitioners are the best when it comes to issues concerning pregnancy and childbirth. Indigenous traditional midwives deal with issues both physically and spiritually when it comes to pregnancy and childbirth. During pre-natal care, these practitioners give their patients potions to take which is believed to protect them from the pregnancy stage to the labour stage (SARPOMAH, personal communication, February 2nd 2018). After childbirth, babies are usually attacked with several diseases, both physical and spiritual. The physical diseases include yellow fever and measles while illnesses ascribed to

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the spiritual include '*asram'*.[2] These indigenous midwives known as the traditional birth attendants (TBAs) give herbal preparations for the prevention and cure of these diseases. Akua Frimpong, a client, testified that when her child was attacked with '*asram'*, she was given herbal potions prepared from '*akonfem tikoro*'[3] which healed the baby completely (AKUA FRIMPONG, personal communication, April 23rd 2018).

Female indigenous herbal practitioners do not only deal with issues of childbirth but other diseases like menstrual disorders and sexually transmitted diseases. According to Madam Dwomoh, a traditional healthcare practitioner, menstrual disorder is something that affects the physical well-being of women making them weak and unable to do any work. It comes in two types, '*ne bedie*'[4] which is classified as the female type and starts on the first day of one's menstruation and '*ne nnyini*'[5] which is the male type which also start after the sixth day of menstruation. These menstrual disorders, according to Madam Dwomoh can cause barrenness if not treated early (MADAM DWOMOH, personal communication, 23rd April 2018). Mrs Akua Adomakoh, a client affirmed that:

"I had serious menstrual pain during my menstrual periods, which sometimes cripple me. I tried a lot of modern medicine but it did not work until I visited a female indigenous practitioner at Asante Agogo for treatment. At first, I had doubt concerning the use of herbal medicine because I regarded it as old fashioned. I paid GH₵ 50.00 for the treatment, which is less expensive than what I was charged at the hospitals. After taking the potion prepared from herbs by the healer, I was completely healed in less than a month" (AKUA ADOMAKOH, personal communication, April 23rd, 2018).

There are people who have been seeking treatment from female indigenous practitioners not because they do not have money but because of the efficacy of their medicine. The amount charged for treatment varies among practitioners in accordance with the treatment given. According to Madam Josephine Frimpong, there are some diseases which the modern

[2] '*Asram'* is a traditional illness, which is believed to be caused by spiritual forces. The illness affects infants and has no clear scientific explanation. It causes the child to grow lean with big head and black/green veins and may eventually lead to death.

[3] The *'Akonfem Tikoro'* is a special kind of herb used by indigenous herbal practitioners to prepare herbal potions for the treatment and prevention of childhood diseases especially those with spiritual connotations.

[4] This term is used to describe the first day of a woman's menstruation in the Akan language.

[5] This term denotes a woman's menstruation after the sixth day.

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practitioners charge millions of cedis for treatment but the chances of you getting treatment is less than 50% as compared to indigenous medicine where your chances of getting healed are 70%, with less expenses (MADAM JOSEPHINE FRIMPONG, personal communication, 23rd April 2018). This is to emphasize the less expensive treatment cost of diseases and ailments in the traditional medicine milieu.

Modern Female Healthcare Practitioners

Women now constitute a large part of medical students and the general medical practitioner workforce. The current discussion of the 'feminisation' of the medical workforce is a new phenomenon since men have for centuries dominated the medical profession (JEFFERSON – BLOOR – MAYNARD 2015:5). In the 1990s, public workers in the health sector constituted 59% of females (DOVLO 1998:40). On the other hand, the percentage of females who practiced as medical doctors were 17% as compared to their male counterparts who constituted 83%. However, the situation differs when it comes to specialisations such as Midwifery and Public Health Nursing where the number of females outweighed the number of males (DOVLO 1998:37).

It is apparent that the role women have played in healing and medicine is historically manifested, albeit in diverse forms and fraught with various conflicts along the way. The nineteenth century generated the era of 'modern medicine' through scientific discovery and new laboratory techniques. The time was also marked by professionalization and continued male domination of the medical training and practice. Women were excluded from undertaking the university medical training that was required to practice. There was historically a class and gender division in treatment. The university-trained medical practitioners who were predominantly men treated the rich who could afford their services. Other members of society received medical care from female healers also referred to as the 'wise women' or even 'witches'.

In the past few decades, the number of females involved in the healthcare practice has seen a sharp increase. Restrictions placed on the type of work that women could have undertaken in the field of medicine during the early nineteenth century led to most of the female labour force in the homes of well-to-do families working as household maids and home nurses. Some women went to great extents to hide their identity and pursue male professions incognito such as joining the army (ABABIO, personal communication, April 2nd, 2018).

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Challenges of Female Healthcare Practitioners

Today, the number of women in the field of healthcare has undoubtedly increased. However, that increase does not mean the healthcare sector can be considered as completely unbiased. Despite relatively better representation in the field, women nevertheless face challenges that come with their choice of career. A very big challenge women face in modern healthcare practice is connected with marriage and work life. Thus, trying to combine the work of a wife, a mother and healthcare practice is quite tedious and very challenging. It even gets so difficult to the extent that female practitioners sometimes have to compromise and it comes with consequences. Both marriage life and work life require undivided attention and often can lead to frustrations with an unquenchable desire to quit marriage, commitment or medical career just to give one thing to focus on fully. Knowing when to quit obviously requires a careful thought and consideration which can be difficult to arrive at and most women can spend a lot of time on this leading to a sense of sometimes considering themselves as failures (ARKOH, personal communication, April 2nd, 2018).

In addition, the relationship between female healthcare practitioners and patients seems on the average to be very cordial (KYERE, personal communication, April 2nd, 2018). Notwithstanding the fact that they are females, they almost never face any form of doubt from patients when it comes to providing treatment and care. Majority of male patients feel very comfortable to disclose their illness to women medical practitioners, which is surprising considering the gender inequality that plagues some indigenous communities. Nevertheless, there have been instances where patients, both male and female, were annoyed because they were assigned to female healthcare practitioners (DUAH, personal communication, April 2nd, 2018). These are challenges women health practitioners face. However, they focus on helping patients and closely work with their male counterparts at the hospitals.

Another challenge is male dominance. Interviewees hinted that some male colleagues have respect for female healthcare practitioners. However, the choice of a career which comes with many transfers where women meet different kinds of people, they meet some male practitioners who are problematic and create uneasy environment for their female counterparts. In some settings, male practitioners take over all the practice leaving women with barely nothing to do. According to a respondent, men in some hospitals in Ghana have hijacked delivery of babies. Even in the medical schools, a female who proves herself better than male colleagues is actually disliked by her male counterparts. This is strange in contemporary times as the realities are sometimes damning.

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Concerning the issue of marriage, an interview with an expert informant (a paediatrician) at the Komfo Anokye Teaching Hospital showed that females in the healthcare practice are happily married like other women pursuing different professions. She hinted that healthcare practice is quite demanding considering the day and night shifts you need to run from time to time. However, she finds means to balance work with marriage life. Due to this, her husband is very supportive and comfortable with her choice of career. In another interview, we inferred that some female healthcare practitioners feel the need to prioritise their profession. In order to maintain this, they choose to remain single. Prioritising their profession has sometimes led to unhealthy marital life and sometimes divorce (ABABIO, personal communication, April 2nd, 2018).

An interviewee reported: *"When I first got married, things were a bit easier but the moment I become a mother, things changed drastically. I had to put my family first. Because of this, I started doing part-time work to always have time to spend with my children. Seeing fewer patients each day at the hospital brought about a reduction in my salary because I had taken bulk of responsibility at home and I had little decision-making power not only my work hours but also in my practice as well. It got to a time that I started feeling guilty about getting pregnant and no one will give you a motherhood schedule except yourself. I had to go through all these waiting for my children to attain reasonable ages before I started full-time work when my husband and I carefully saw the need to hire outside help necessary for the toil of household life"* (ABABIO, personal communication, April 2nd, 2018).

Conclusion

Women in pre-modern Ghana were seen as bearers of children, retailers of fish and farmers. A female's ability to reproduce was the most important means to ensure social and economic security for them especially if they bore male children. In the field of healthcare, women really believed they had special skills to treat their fellow women in health matters more than men did. Women were midwives and gynaecologists even without any formal education. Many female medical practitioners were probably unlettered or many acts of healing and therapy were probably performed without recourse to any texts or textual tradition of knowledge. Being unlettered did not hinder many female practitioners from playing key roles in the evolution of medicine globally and also in the Ghanaian context.

Women's involvement in healthcare comes with great challenges; over the years, we have witnessed some marked improvements. Female practitioners still face discrimination from their male counterparts and some patients who also regard women as unqualified to be health

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practitioners aggravate the situation. Some contributions made by women in the provision of healthcare have been over looked; sometimes the chauvinists consider them as weak and dull. This notwithstanding, women have gained access to equal education that they hoped for and are graduating in equal number with their male counterparts. Modern female health practitioners are indeed assets to healthcare in Ghana. Therefore, there is the need for health policy makers and stakeholders in Ghana to pay attention to the challenges that affect women in healthcare to achieve quality healthcare delivery in the country. There should be effective affirmative action strategies including quota system to admit women/girls into medical schools and hitherto specialised fields which were the sole preserve of men. These among strategies like public education aimed at empowering mothers and girl-children in Africa and Ghana in particular can yield many useful results in the health sector and the larger Ghanaian society.

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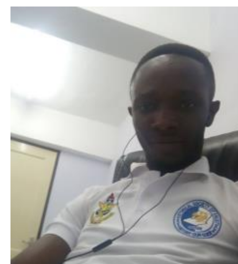

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