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Full Length Research Paper

A Study of Healthcare Opinion Leadership in Ghana

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Ghana is a developing sub-Saharan country in West Africa and it struggles with delivering health care within the universal health system. The primary barrier to medical care is the lack of access. The government of Ghana subsidizes universal health insurance for all of its citizens, but lacks technology, workforce, and more importantly access to sanitation and clean running water. Access to health care remains a challenge in Ghana, especially in rural areas. In this research, we conduct a study of the opinion leadership for healthcare in Ghana in May, 2014. Student investigators administer a survey to explore who is identified as the healthcare opinion leaders by the local community members. The respondents are asked to rank seven categories of healthcare providers by how often they speak to with that category about their health, from most often to least often, including medical doctors, chemical shops, herbalists, prayer camps, family members, midwives and shrines or voodoo priests. In total, 157 local community members respond to this survey, including 51 people in cities, 65 people in rural villages and 41 people in Kpanla, a remote isolated island.

Keywords: Access to healthcare providers, healthcare opinion leadership, healthcare in Ghana, regional differences in access to healthcare.

INTRODUCTION

Ghanaians have been insured under the National Health Insurance Scheme since 2005. All citizens are required to enroll into the universal plan which covers most medical procedures. Access and cost, though nominal, for medical care coverage has remained unattainable for most. Medical attention has remained a barrier for many citizens living outside of urban areas. Chemical sellers, traditional healers and voodoo priests have been providing healthcare for hundreds of years. Traditional healthcare is expensive. “[I]n the course of treatment, the sick can be asked to provide eggs, fowl or sheep to be

used in performing rituals to find the cause of illness or a treatment.” (Asenso-Okyere, 1995, p.88).

Due to Ghana’s national health insurance program, potential sustainability of the Ghanaian health care system exists. In 2011, a United States health organization identified Ghana as an attractive site for global expansion for long-term development and announced the development of a ten-clinic network to provide primary care to children and families. The health system believes that the political and economic stability of the country are external factors supporting such an expansion. Furthermore, there has been support for efforts leading towards a permanent healthcare infrastructure, particularly for Ghana’s rural areas. The health system’s structural strategy includes the

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development of hub, spoke, and micro clinic facilities and everyone will be tailored with accordance to the needs of the communities. Three clinics have been fully operational in Ghana by 2014. There is an ongoing need, however, to deepen the understanding of how Ghanaians perceive healthcare access and services. Because modern medical clinics are relatively new to Ghanaians, the diffusion and acceptance of innovative changes requires attention. Diffusion of medical clinics in Ghana constitutes social change because it is altering the structure and function of the traditional healthcare system in this country (Rogers, 2003). Successful diffusion of medical clinics in Ghana will require intentional communication over time with Ghanaians.

One way of understanding how innovation can be successfully diffused in Ghana is to learn the social and communication structures of Ghanaians through exploring the extent of healthcare opinion leadership. Opinion leadership is defined as the degree to which an individual(s) is able to influence others in a desired way, either through technical competence, social accessibility, or system norm conformity (Rogers, 2003). Understanding who act as the healthcare opinion leaders in Ghana can benefit healthcare organizations seeking to diffuse healthcare innovations in that country. The purpose of this study is to find out who are identified as healthcare opinion leaders by Ghanaians. The study is timely given the changes of Ghana's national health insurance and the introduction of new health care models into the market.

OPINION LEADERSHIP IN HEALTHCARE

Opinion leadership has been studied in healthcare to better understand its utilization in the innovation/diffusion process of health interventions and health programming, advancing the support for the application of diffusion theory in healthcare (Dearing, 2004). With regard to addressing the problems of sexually transmitted diseases (STD), studies have shown that the use of opinion leaders in prevention education has assisted in decreasing STD infections (Celentano et al., 2000; Kelly et al., 2000; Miller, Klotz, and Eckholdt, 1998). The use of opinion leaders has also revealed the benefits in promoting breast cancer screenings in minority populations (Earp et al., 2002), improvements in health behaviors in workplaces (Campbell, Tessaro, DeVellis, Benedict, Kelsey, Belton, and Sanhueza, 2002), decreases in cesarean delivery rates (Kravitz et al., 2003), and enhancements in infection control compliance (Seto, Ching, Yuen, Chu, and Seto, 1991). Specific to opinion leadership studies conducted in Africa, researchers have found empirical support for the use of opinion leaders in effecting positive change for HIV prevention and treatment (Boulay, Tweedie, and Fiagbe, 2008; Mathews, Guttmacher, Hani, Antonetti, and Flisher, 2000; Smith and Lanza, 2011), family planning programs

(Heath, Bekker, and Human Science Research Council, 1986), prevention and control of malaria (Meneca et al., 2013), laboratory quality (Cooper, DeJonge, Ehrmeyer, Yundt-Pacheco, Jansen, Ricós, and Plebani, 2011), and evidence-based obstetrics (Daniels and Lewin, 2011). The procedures by which opinion leaders are identified are critical to understanding the impact of opinion leadership in healthcare (Rogers, 2003).

HEALTH AND HEALTHCARE IN GHANA

Western medicine, introduced by Christian missionaries, did not occur in Ghana until the 19th century. Before that, village healers and clerics were the primary healthcare givers, offering herbal remedies. The Medical Department was formed in the 1880s. This early health system included a Laboratory Branch for research, a Medical Branch of hospitals and clinics, and the Sanitary Branch for public health.

Ghana has gained independence from Great Britain for 55 years and has a promising outlook with a growing economy and stable government. Yet focus on healthcare in Ghana has not kept pace. Deficient funding, by both the government and citizens, for preventable and infectious diseases have resulted in a continual cycle of poverty and disease. The number one cause of death in Ghana has been reported as malaria followed by HIV/AIDS, diarrheal diseases, lower respiratory infections, and prenatal conditions. These five diseases have accounted for 50% of all deaths in Ghana, and 70% of deaths in children under age 14 years (Makalo, 2010). Today, Malaria has been reported to cause 1 in 5 childhood deaths for those under age 14.

Access has been a challenge in Ghana, particularly for rural residents. The Ministry of Health reports that less than half of rural households, compared with nearly all of urban households, have had access to a medical facility. Access as defined by the Ministry of Health has been defined as within an hour's travel to a public or private facility through any means of transportation. The majority of those with access receive their healthcare from public, non-profit entities. These facilities have served only 10% of the population, which is comprised of the higher income households.

Ghanaians have utilized a variety of providers for healthcare needs, including chemical sellers, herbalists or traditional healers, shrines or voodoo/fetish priests, prayer camps, midwives, medical doctors, and family members. The preferred types of healthcare providers vary geographically throughout the country based on access and education. Medical care itself has been subsidized, but additional costs to consumers, including lost wages from time that has been spent traveling to and waiting in health care facilities and pharmacies, are not covered and make healthcare unaffordable to many. Medical practitioners are less common in rural and

remote regions than other types of healthcare options.

Chemical Sellers

One of the first options for Ghanaians to treat health conditions is chemical sellers and chemical shops. The Ghanaians who cannot access formally trained health providers have relied on licensed chemical sellers (LCS) for treatment and many unlicensed sellers as well. Generally, LCSs have not had formal training but have operated small-scale, family run drug stores. The Ghana Pharmacy Council has authorized licensed chemical sellers to dispense non-prescription drugs. Yet lax regulation has resulted in most common pharmaceuticals being sold at licensed chemical sellers as well as unlicensed sellers. Licensed chemical sellers are required to apply annually for an operating license. The criteria are simply that applicants should have proof of completion of senior secondary school or its equivalent, and have no criminal record. There have been approximately 8,000 chemical shops registered with the Pharmacy Council, and an estimated 2,000 unregistered chemical shops.

According to Felix D. Yellu, Chief Pharmacist, Ghana Ministry of Health, there are over 1,000 pharmacy outlets, both retail and wholesale, and about 8,000 chemical retail sellers. Some 75% of the retail pharmacies are located in Accra, Kumasi, and Secondi Takoradi, which together have less than 30% of the population, indicating a very small coverage of the country by retail pharmacies. In other words, there is heavy dependence on chemical sellers by rural communities. In over 60% of the cases, rural chemical sellers are first-line providers of medicines (Sergre, J., and Tran, J., 2008., p. 3). Chemical Sellers have not always been structured or regulated to provide the quality, accessibility, and affordability that patients require, especially in rural areas. Licensed Chemical Sellers lack standardization. While they are an indispensable part of the healthcare system, some also present a threat to public health through the provision of incorrect, expired, substandard, or counterfeit drugs.

Herbalists or Traditional Healers

The popularity of traditional healers has been noted since the earliest research of healthcare in Ghana. Herbalists have remained a fixture today. For thousands of years, Ghanaians have credited causes of numerous illnesses to social and spiritual causes. There has remained a greater reliance on traditional healing in northern Ghana due to continued belief in spiritual origins of illness. People in the North have traditionally been less educated and have lived great distances from hospitals. A 1973 study indicates that almost all (97%) persons with a mental health diagnosis sought other treatments before accessing medical treatment. Among these patients, 64% consulted herbalists, 26% talked to prayer camps, and

2% turned to fetishes or voodoo priests for help. A more recent study in 2004 finds that a smaller proportion of patients consulted other forms of treatment (including hospitals), and a greater number reported consulting a pastor. This study reports that 5.9% of those with mental health illness consulted a traditional healer (Read and Doku, 2012). These studies conclude with recommendations to collaboration with traditional and faith healers in the treatment of illness as access to medical care become available. More comprehensive care could be offered to a patient if the dialogue includes herbal and traditional treatments as well as those from chemical sellers.

Shrines or Voodoo/Fetish Priests

Voodoo originated in the African kingdoms of Fon and Kongo at least 6,000 years ago. The word "voodoo" from Fon, has been defined as "sacred", "spirit" or "deity". Other words used in Voodoo practice today have also been derived from the Fon and Kongo languages such as mambo or manbo, a Voodoo Priestess. This is a combination of the Fon word for "mother" or "magical charm" and the Kongo word for "healer". The Fon kingdom, now southern Benin, has been a region referred to as the "cradle of Voodoo" (Neuenhofer, 2012).

Voodoo has been recognized as an official religion in Benin, where as many as 60% of the population are followers. Approximately 30 million people in Togo, Ghana and Benin practice Voodoo today (Neuenhofer, 2012). Voodoo is represented in each village in Ghana by at least one priest or priestesses that contact a supreme being and seek advice from their ancestors for the community. Fetishes, rituals, and alcohol are used by the priest to communicate with the ancestors during ceremonies. Ghanaian priests have also been guided by small hairy spirits that walk backwards and are not seen by ordinary people.

Priests often become community leaders, providing guidance and settling disputes. Priests and priestesses with their attendants have dedicated their work to ministering to others and providing medical care in the form of folk medicine. There is an influx of voodoo priests from the Republic of Benin into the Volta Region of Ghana.

Prayer Camps

Two studies in 2007 confirm that at least 10% of the population in Ghana (about 2.4 million people) have disabilities. Disabilities, real or perceived disorders, are usually attributed to curses or justified as punishments for offenses committed by the afflicted individuals or their ancestors. The stigma and past transgression theory have led thousands of families to abandon relatives in "prayer camps", or spiritual healing centers, to "heal". Prayer camps have been established privately by

Christian religious institutions rooted in the Evangelical or Pentecostal denominations; created for prayer, counseling, and spiritual healing services.

Managed by self-proclaimed prophets who receive no medical training, these camps operate completely outside of government control. The afflicted have been isolated from the community physically, emotionally, and psychologically in restraints in the prayer camps for weeks, months, and even years. Once admitted residents of prayer camps may only leave when the "prophet" deems them healed. More than 25% of Ghanaians are members of the charismatic and Pentecostal denominations typically associated with these camps.

Midwives

Midwives are important providers of reproductive healthcare in Ghana. The midwife population is aging. Seventy-nine percents of midwives are over 45-year old. The combined challenges of an aging midwife population and insufficient salaries have resulted in few incentives to practice in rural areas. There are twice as many midwives as physicians. Midwives practice throughout the country and physicians are congregated in large cities. Two-thirds of the midwives practice in the public sector in facilities of the Ghana Health Service (GHS). Midwives have been providing the majority of antenatal, delivery, and newborn and postpartum care, including emergency obstetric care, especially in rural areas. Midwives in Ghana have been critical healthcare providers in communities and have provided additional services in family planning, post abortion care, treatment of sexually transmitted infections (STIs), nutrition and breastfeeding counseling, and child health services.

RESEARCH METHODS

The purpose of this study is to identify which types of healthcare providers are viewed as healthcare opinion leaders by Ghanaians. A survey is conducted by faculty and student investigators during a faculty-led program to study health care in Ghana, Africa in May, 2014. Our student investigators surveyed local community members in various settings including remote areas of medical outreach, cities, and rural villages. Community members are asked to rank their healthcare providers by how often they speak to them about health issues from most often to least often, including family member, midwife, shrines/voodoo doctor, medical doctor, chemical seller, herbalist/traditional healer, and prayer camp. We give our survey questionnaires to the community members from three broad groups, urban, rural, and remote areas. The healthcare providers who the local community members choose to speak to most often about health could act as healthcare opinion leaders and affect local people's choices in healthcare. The inclusion of varied regions

could help indicate whether the access to public healthcare will affect people's choice of healthcare opinion leaders.

RESEARCH FINDINGS

A total of 157 of community members respond to our survey. Our survey sample is composed of 51 respondents from cities, 65 respondents from rural villages and 41 respondents from Kpanla, a remote isolated island.

The selection of community members to survey is determined through research of medical treatment in Ghana and input from a large healthcare system that has pledged to build medical clinics in Ghana. The study is limited by the local people's willingness to answer this survey, our investigators' access to community members, and the availability of translators in remote regions. The respondents in remote and rural areas require a translator and reader, who travel with the group as a guide. Many community members in these areas, especially women, are illiterate and speak a local dialect only.

We find striking differences between cities, rural villages and the isolated island in who the local people would like to speak to about their health most often. In cities, 82% of the respondents choose to speak to medical doctors or chemical shops most often about their health. Out of the 51 respondents in cities, 23 choose medical doctors and 19 choose chemical shops to talk about their health most often. That is, medical doctors and chemical shops are the most prevalent healthcare opinion leaders for the Ghanaians in cities. Medical doctors, in particular are used most often by most respondents in cities. Thirty-nine out of the total 51 respondents in cities (76.5%) choose to speak to medical doctors most often or second most often.

Medical doctors and chemical shops are also used most often for healthcare opinions by the respondents in rural villages. Yet the percentage of choosing a medical doctor or chemical shop to talk about health most often declines to be 63% (82% in cities). Out of the 61 respondents in rural villages, 22 speak to medical doctors and 19 speak to chemical shops most often about their health. Family members are another prevalent resource for healthcare opinions. As many respondents choose to speak to family members about their health most often or second most often as chemical shops (31 respondents for each). Forty out of the total 65 respondents in rural villages (61.5%) report to speak to medical doctors about their health most often or second most often. This percentage for using chemical shops and family members are 47.7% and 47.7%.

On Kpanla (the isolated island), only 46% of the respondents report to speak to medical doctors or chemical shops most often for healthcare opinions.

Table 1. The healthcare provider that the respondents talk to most often

		Doctor	Chemical Shop	Family Member	Prayer Camp	Herbalist	Midwife	Shrine/Voodoo
Cities	1st	23	19	6	3	0	0	0
	2nd	16	14	5	10	0	0	0
Rural Area	1st	22	19	15	9	0	0	0
	2nd	18	12	16	8	2	2	0
Kpanla	1st	15	4	14	3	5	0	0
	2nd	13	9	3	9	8	0	1

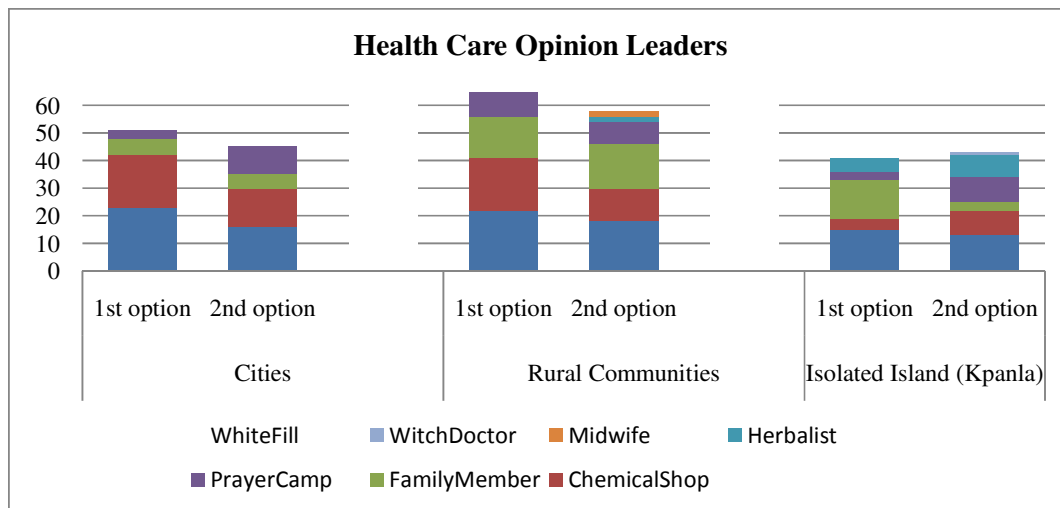


Figure 1. The healthcare provider that people speak to most often about health

Though medical doctors are still the one who the respondents on the island speak to most often about opinions for healthcare, family members take the place of chemical shops to be the second popular resource for healthcare opinions. Out of the 41 respondents on the island, 15 speak to medical doctors and 14 speak to family members most often about their health. In other words, medical doctors and family members are the two most popular healthcare opinion leaders on the isolated island.

Another difference in healthcare opinion leaders between cities, rural villages and the isolated island is that community members in rural villages and on the isolated island use more diverse resources for healthcare opinions, compared to people in cities. In cities, no respondent reports to talk to herbalists, midwives or witch doctors about their healthcare. Family members act as an important healthcare opinion leader in rural areas and on the isolated island. Compared to the rural areas, people on the isolated island use even more diverse healthcare opinion leaders. Besides medical doctors, herbalists, prayer camps, family members, and chemical shops all play an important role on providing healthcare opinions.

CONCLUSION

Because of its commitment to improving access to healthcare services to all ghanaians and introducing national insurance and reimbursement schemes for services, Ghana has the opportunity to act as a leader both regionally and internationally by championing the importance of providing comprehensive healthcare to combat maternal and infant mortality and provide primary care to children and families. Information regarding the perceived opinion leaders in healthcare assists in an understanding of the degree to which a healthcare opinion leader can influence healthcare choices of community residents.

Our research finds that people in cities are more likely to speak to medical doctors most often about their health than people in rural villages and remote isolated areas do. People in the latter two areas, especially on the isolated island use more diverse resources for healthcare opinions. These regional differences can be attributed to the availability of medical doctors. Our survey results show that people prefer to consider medical doctors as their healthcare opinion leaders when they have the

access, like people in cities. People are willing to accept healthcare opinions given by medical doctors. Therefore, more clinics and medical care facilities should be developed to facilitate the local people accessing medical doctors.

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