Author’s response to reviews

Title: The use of Traditional Medicine by Ghanaians in Canada

Authors:

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Author’s response to reviews: see over
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Title: The Use of Traditional Medicine by Ghanaians in Canada
Reviewer: Gerry Bodeker
1. Page 2 Conclusion, Line 3: “on African of immigrants”, the “of” should be deleted
Authors: “of” deleted to read “African immigrants”
2. Pages 2 & 3: TM is a registered international trademark for Transcendental Meditation, itself a traditional technology from India. Use of this abbreviation is in violation of this trademark. WHO uses TRM. It would be better to use this or some other appropriate abbreviation.
Authors: “TRM” used instead of “TM” is used throughout the text. Apart from direct quotes/references where the original authors have used TM.
3. Page 3, Background, Line 4: “does modern life affects should read “does modern life affect”
Authors: “affects” corrected to read “affect”
4. Pages 3 & 4: The terms “refugees” and “immigrants” are used interchangeably. However, they have distinctly different meanings and the status of the Ghanaian population in this study should be clarified. And if some are refugees and others not, the circumstances leading to these different patterns of migration also need to be elucidated.
Authors: On page 4, these lines have been added to address the issue as follows:
The terms “immigrants” and “refugees” have been used interchangeably in this paper because studies among Ghanaians in Canada point to the fact that there is really no significant difference between the experiences of these different patterns of migration during their acculturation process in Canada [5]. Indeed, some researchers [5] have raised some doubts about the genuineness of most of these “refugee” claimants, and consequently, we did not find it necessary to differentiate between “immigrants” and “refugees”. The issue of “illegal refugees” has been elucidated elsewhere in this paper (see section [will put in paragraph number in final on-line version] on acculturation and TRM). Thus, it is conceivable that a majority of those who claim to be “refugees” (forced migration) during the study period may have actually entered Canada through routine migration or conventional channels.
5. Page 5.
Does the probability sampling method take into account the different reasons for migration? I.E. Forced migration i.e. refugees; routine migration through conventional channels. Might these different experiences of migration lead to different patterns of adjustment in Canada and hence to perceptions of TRM & its use?
Authors: The response to point 4 above (referring to text on page 4) also takes care of this issue. In addition, this quotation from page 8 elucidates further our position on this issue: “stories about events that have shaped the experiences and identities of immigrant women changed as the context changed. For instance, the pressures of immigration policy elicited stories that created a specific identity to suit an immigrant’s claims while informally the same person presented an identity different from what is officially known. Sometimes, during off-tape conversations, some interviewees explained how they had to claim some status in order to match their sponsors’ stories to the immigration officials. Although these tensions suggested how life stories may be narrated differently according to context and circumstance, the real problem lay with how these contextual narratives could be reconciled in terms of writing a meaningful historical account” [5].
6. Pages 6 & 7: It should be noted here that a correlation sought between the level of education and likelihood that views on TRM will change. Results should be presented here rather than much later on page 11. The ambiguous results on education need to be highlighted and dissected here along with the other correlations. Authors: This has been done on pages 11 & 12 as follows: From Table 2, we can see that 33.1% of those with educational levels up to the secondary level reported a change in attitude towards TRM as a result of their staying in Canada. Of those who had post-secondary education, 22.55 reported a change. There may be a causal relationship between educational level and a change in attitude towards TRM as a result of staying in Canada. Ghanaians with higher levels of education are less likely to report a change in attitude toward TRM. It has been documented that the level of a Ghanaians’ education coupled with exposure to the Western World (where medicalization is rule rather exception), has had an influence on their views and opinions about TRM [8], although their cultural beliefs might still be intact; [1] the more educated Ghanaians are, the more likely they will be sceptical toward TRM. In our research, there was a significant relationship between educational level and change in attitude toward TRM. Those whose educational level was below the secondary school level were more likely to view TRM negatively. However, a subtler notion appeared the focus group discussions, where participants with university level education (acquired in Ghana and/or Canada) had mixed feelings about TRM. The following contradictory statements were made by university educated Ghanaians. Some saw downsides to TRM:
“I have lived in the village before and in fact I like living in the village and so I know how they prepare TRM. Sometimes within dirty things...for instance dirty dishes or calabash, they won’t wash it, they pour portion upon portion into it and so because of that it is really a concern and we should improve the potency for us. Maybe, the medicine may have power to do great work, but because of dirt and other things that we add, it reduces the potency. Secondly, when you buy the white man’s medicine, he tells you that in the morning, take one, in the evening, take one and as for our people’s medicine, there is no dosage. For the “alafia bitters”, people can drink as much as they want. But if they can specify that you take a spoonful every morning or evening it will go a long way to help” (37 year-old male, university graduate, Group 3). And, others had good experience of TRM, 4

“As I said, for me, I used to have severe asthma and I could not do anything with my cousins. They say, in Fante-land, there is somebody there with bitter medicine, but if you are able to drink it, you will vomit all the time, you will vomit and only phlegm will come out and if you finish vomiting, you will be okay and it will not come again... For ten years now, I have not got any asthma, from ten years now, I have not got asthma at all” (33 year-old female Christian, Group 3).

Thus, the focus group discussions did not support the view that more educated Ghanaians are more likely to change their view of TRM.

7. Also, was a correlation sought between income level and change of views?

Authors: Yes, a correlation was sought between income level and change of views and this has been reported on page 12 as follows; Table 2 shows that 31.8% of those who earn $29,000.00 or less reported in attitude towards TRM as a result of staying in Canada. Of those who earn $30,000.00 or more, 24.4% reported a change in attitude. There may be a causal relationship between income level and a change in attitude toward TRM as a result of staying in Canada. Ghanaians who earn 29,000.00 or less are more likely to change their attitudes toward TRM.

Page 9. Ref. 23. Personalistic Medical System needs a line of explanation.

Authors: We have added the following lines on page 15 for explanation: The “Personalistic Medical System” applies in situations where community members believe that punishment or aggression directed at a person or a patient is due to the deliberate interventions of agents who may be supernatural (gods, spirits or ancestors) or human beings with evil powers.

Page 12: The male-female differences in change of views should be elaborated early on pages 6 & 7 and not left to the end. They warrant further analysis & explanation

Authors: We agree, this has been done, and the relevant portion on page reads:

There was no statistically significant difference between change in attitude towards TRM and the gender of the respondents (see Table 2), which is not consistent with previous findings [1,13,26,46]. However, the gender of the respondents had no influence on the way they thought about TRM as indicated elsewhere [34]. The results of this research is not surprising in view of the fact it may be conceivable that the females may have discussed their “public” views on TRM as opposed to their “private” views which may not be appropriate as far as socially constructed ideas of health and illness are concerned [28]. The responses of the females may also be partly due to “the pressure associated with the socialisation of women into the gender-specific roles which the Ghanaian society expects from them” [44].
Reviewer: Isaac Luginaah
Include a more detailed review of the literature on the use of traditional medicine

Authors: We have provided a more detailed literature on the use of TRM has been provided on pages 4-8 under the following sub-headings: acculturation; acculturation and traditional medicine as follows:

Acculturation

Although this paper was based on a theoretical framework of “acculturation”, the concept of ‘inculturation’ emerged as the main link between evangelical Christianity and acculturation. More recently, acculturation has also been defined as the: “movement from a situation in which one is a member of a group having its own well-internalized culture to a situation in which the individual is a non-member of a different identity group” [9]. Acculturation has also been criticized on the grounds that it is too aggressive, and does not convey the aspects of dialogue and mutual fusion essential for the meeting of two cultures.[10]

According to Owoahene-Acheampong [11], the concept of ‘inculturation’ has influenced theologians in their analysis of what happens when two or more cultures meet. From an anthropological point of view, the process of ‘inculturation’ is said to have the characteristics of acculturation [12].

Acculturation and Traditional medicine

Although descriptive studies point to a ‘healthy immigrant’ effect, suggesting that immigrants, especially recent ones, are less likely than the Canadian-born population to have chronic conditions or disabilities [13], the longer immigrant populations stay in Canada the more their health converges with that of other Canadians [14]. Length of stay in Canada also affects the extent to which a new immigrant may adapt to the wider Canadian culture [15]. Within the first 18 months, the difficulties experienced relate to variables pertaining to reception given by Canadians in terms, for example, availability of jobs and housing. Longer-term acculturation problems include, for example continued loss of social status, continued inability to speak English or French (the official languages) and differential rates of acculturation within families [15]. However, in a study on acculturation and health behaviours among Latino immigrants to the US, it was indicated that: “increased years of residence in the United States had the predictable impact of increased competence in English and increased use of English, but had differing impact by country of origin on the cultural orientation of the respondents' environment and the ethnic identification” [16].

According to Hiebert, after a period of approximately ten years in a new country, immigrants report a distinctive sense of familiarity with their new country, but those from non-European backgrounds (such as Ghanaians) tend to experience more difficulties which may be attributed to cultural and language differences between their native country and Canada.[17] At the same time there is evidence among some immigrant groups that the longer they stay in their adopted the more they focus on the original culture and its values. For example, it was found that as Koreans’ length of time in Canada increased, they tended to identify more with their Korean identity [18]. This stems from the fact that as some Koreans entered the university setting, where ethnic identity was encouraged and their physical features were acknowledged as a unique characteristic of Asians. Consequently, Kim and Berry have suggested that the higher the Koreans’ level of education, the more they became aware of conflict, prejudice, and hardships, which then reinforce their desire for their cultural values [18]. However, these might be idealized versions of Korean identity. Kim and Berry surveyed the acculturation attitudes of highly educated Koreans in the Greater Toronto Area (GTA) and concluded that there are several variables that are significant predictors of integration and assimilation respectively [18]. For the former, reading more Canadian newspapers, preferring to be interviewed in English, coming directly to Canada, and participating more in Canadian organizations were the main predictors. The predictors of assimilation were: reading fewer Korean newspaper, viewing fewer Korean television programs, having more Canadian and fewer Korean friends, hoping their children maintain less of Korean language, and migrating independently to Canada. The degree of
participation in the Canadian culture was a reliable predictor of both assimilation and separation, while less education was found to be the predictor of marginalization and integration among the Koreans in the GTA [18]. According to the Canadian Task Force on Mental Health of Immigrants and Refugees (CTFMHIR), age at the time of migration affects the adaptation process. Young adults, adolescents, and older immigrants (seniors) find it difficult to adapt for different reasons. [19]. Developmental tasks and maturational identity crisis make it difficult for the young to adapt while the seniors or older persons are vulnerable to the stress of migration. Moreover, non-White immigrants often had lower educational achievements than other Canadians, for example: “immigrants were significantly overrepresented in the ‘no schooling’ and ‘completed bachelor’s education or more’ categories, and non-immigrants were overrepresented in the ‘some high school’ category. On the whole, immigrants’ educational attainment is polarized, and non-European well-established immigrants are less likely to be very poorly educated” [13]. Socio-economic status plays an important role in the adaptation process. Some studies have demonstrated that a majority of immigrants are at the lower end of the socio-economic ladder leading to problems in acculturation [13,20]. In a study on the illness experience, meaning and help-seeking among Chinese immigrants in Canada, Lee and his colleagues noted that underemployment was prominent among perceived causes of illness experience [20]. According to Opoku-Dapaah, a majority of Ghanaian immigrants (51.4%) were not happy with the acculturation process in Canada and this stemmed from “loss of pre-migration socio-economic status, discrimination and the lengthy immigration process” [3]. In a study to examine how Ghanaian immigrants constructed their social world within Canada (the first of its kind among Ghanaian immigrants abroad), Opoku-Dapaah’s impression: “of the behavioral practices of Ghanaian refugees was that they involve a considerable degree of cultural retention, with some adjustment or modification made based on circumstantial demands, or when deemed crucial for meeting personal motives. The extent of such retention and modification of behavior varies from individual to individual and remains contingent on the particular situation” [3]. It appears that being a refugee must relate to the expectation of being in Canada for a short period due to involuntary migration. This must lead to lower levels of acculturation. Based on the above observation, it is therefore, not surprising that illegal refugees do not readily disclose their personal information to outsiders. For instance, it has been observed among Ghanaian women that:
“stories about events that have shaped the experiences and identities of immigrant women changed as the context changed. For instance, the pressures of immigration policy elicited stories that created a specific identity to suit an immigrant’s claims while informally the same person presented an identity different from what is officially known. Sometimes, during off-tape conversations, some interviewees explained how they had to claim some status in order to match their sponsors’ stories to the immigration officials. Although these tensions suggested how life stories may be narrated differently according to context and circumstance, the real problem lay with how these contextual narratives could be reconciled in terms of writing a meaningful historical account” [5]. Despite these concerns, the socio-economic status of the immigrant is also an important factor in the acculturation process. Immigrants living in Canada less than 10 years are significantly overrepresented in the lowest and lower middle income groups, and are significantly underrepresented in the highest one [13].

2. Beyond immigrant acculturation, include informative section that describes the challenges of the Canadian Health Care System that may be pushing immigrants to traditional medicine.

Authors: The following section on page 16: “Implications for TRM practice, Health care policy and Research in Canada” takes care of this concern: Implications for TRM Practice, Health Care Policy and Research In Canada Although this paper did not explicitly investigate Ghanaians’ satisfaction with the current Canadian health care system, there is enough evidence to suggest that Canadian immigrants are not receiving culturally-appropriate or culturally-sensitive health care services [47,19]. Therefore, this paper is advocating a Multicultural health care system in Canada. Multicultural health care is a “health care which is cultural, racially and linguistically sensitive and responsive” [48]. The evidence in this paper indicates that Ghanaians have adopted a ‘mix and match’ approach by utilizing the services of both TRM and modern medicine practitioners depending on the nature of the health problem. Therefore, this paper recommends a policy of ‘Parallel Development of Multiple Health Systems’ in the short run, and ultimately, a policy of ‘Active Collaboration Between Fully Recognized Health Systems’. Under the former health system, both TRM and modern medicine practitioners are officially recognized and they serve their patients through separate but equal systems [49]. Under the latter health care system, there is an assumption that there is equity, mutual respect and understanding among TRM practitioners and doctors [50]. This paper raises questions that need to be addressed in further research on TRM in Canada given the attitudes and opinions of Ghanaians who have had the opportunity of experiencing the advantages and disadvantages of both traditional and Western medical systems on a much larger scale. For instance, further research should be conducted to determine under what conditions Ghanaians would use TRM if it became part of the Canadian health care delivery system. It has been suggested that: “fieldwork needs to be done at the community level to arrive at a better understanding and assessment of the community’s opinion concerning a possible role of Traditional medicine in basic health care” [51]. In a plea for a community perspective on the integration of TRM and modern medicine, Van der Geest observed that local communities do not expect any improvement in basic health care when TRM practitioners are integrated into the system [51].

3. Use the above in the methodological deliberations as well as in the analysis and discussions of the findings.

Authors: This has been done in the analysis and discussions of the findings under the results and discussions section on pages 10-17.