AWARENESS OF TRADITIONAL BELIEFS AND TABOOS ON PREGNANCY AND LACTATION IN SOME SELECTED AREAS OF ASHANTI REGION IN GHANA: THE ROLE OF THE MEDICAL LIBRARIAN

Kwabena Ofori
College of Health Sciences, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana.
***Email**:asiamahof@yahoo.com*

Asiamahafia Densi Asare-Kyire
University Main Library, Kwame Nkrumah University of Science and Technology, Kumasi, Ghana.
***Email**:densiak@yahoo.co.uk*

Abstract

This paper assesses the extent of internalization of beliefs and taboos regarding pregnancy and lactation in some selected areas in Ashanti Region of Ghana. Copies of a questionnaire were administered on 200 pregnant women, 100 lactating mothers and 50 traditional birth attendants. Responses were analyzed with the SPSS in simple percentages. Some of the findings were: pregnancy and child-birth were shrouded in mystery; the belief in ancestors having influence on the living; children were regarded as reincarnated beings; wearing talisman and charms, drinking herbal concoctions, inoculation with black powder were all forms of protection. Finally, the paper recommends strategies to be employed by medical librarians to collect, process, organize and disseminate information on such beliefs and taboos to health personnel to facilitate improved health care.

KEYWORDS: MATERNAL BELIEFS, ORAL LITERATURE, CULTURAL BELIEFS, DOCUMENTATION, INFORMATION DISSEMINATION.

Introduction

The agro-based nature of the Ashanti culture, the pre-establishment war threats, famine and epidemics compelled the founders of the Ashanti Kingdom to cherish large family sizes. As a result a body of beliefs, rites, taboos and other life styles were instituted to support the belief in having large family sizes (Ampofo, 1975). In order to ensure the protection of the pregnant mother and child as well as the safe delivery of the child, many beliefs and taboos had to be observed by the mother. Information on the beliefs and taboos reside in the minds of elders, traditional birth attendants, fetish priests, medicine men, and diviners just to mention a few. Basically traditional knowledge is passed on by word of mouth and through experience. As a result the death of an elder in the family is the loss of a repository of knowledge.

The Ashanti Region accommodates one of the major ethnic groups in Ghana, the 'Ashantis'. The dominant spoken language is Twi, an Akan language which is similar to Fante, another Akan language. Prior to European colonization, the Ashanti people had a large and institutional empire in West Africa. They later developed the powerful Ashanti Confederacy. The Ashanti Region with Kumasi as its capital is located in the central part of present day Ghana about two hundred and seventy kilometers from Accra. According to the census conducted in 2000, the total population of Ashanti Region was 3,612,950. The Region has twenty seven districts. The territory is densely forested, mostly fertile and to some extent mountainous. The Region is one of Africa's matrilineal societies where the line of descent is traced through the female (Edgerton, 1995).

The Ashantis, like most developing societies, depend heavily on agriculture. They have traditional reasons for the desire for large families. The most important of these is the survival of the community and society as a whole. The Region was threatened by famine, epidemics and institutional wars during the pre–colonial periods around the 16^{th} and 17^{th} centuries. On account of the high death rate especially among children, the concept of large family size was therefore emphasized in the society (Kyerematen, 1996).

Pregnancy and child birth are shrouded in mystery in the sophisticated as well as the simple minded. Ashantis basically believe in the existence of ancestors who although have died, live in the land of the dead from where they can influence lives on earth. Children are regarded as reincarnated beings sent into this world from the spiritual world (Addy, 1970).Therefore in indigenous antenatal care steps are taken to protect the pregnant woman and her baby from

all evil forces. The belief is held so strongly that it is considered a curse if one dies without having children. The corpse is maltreated with the belief that by disgracing the dead body she/he will make sure that she/he produces children on returning to the world through reincarnation.

Problem Statement

Traditional and orthodox medicines have existed side by side for centuries. In typical traditional settings the orthodox medicine is resorted to as a last remedy. Some of the traditional set-ups combine both traditional and orthodox medicines as means of solving health care problems. Health personnel and students ought to be informed on the "modus operandi" of traditional medicine which is shrouded with beliefs and taboos. Medical librarians, as professionals providing information within the medical sector, could codify some of the beliefs and taboos and document them to make them available to health personnel and medical students. These are very important cues for solving health issues For example, the increase in child mortality, anemia and postpartum haemorrhage are all rooted in the observance of beliefs and taboos (Berko, 1991). Having knowledge of the beliefs and taboos could avert many deaths. This study therefore seeks to primarily elicit information from selected traditional settings in the Ashanti Region of Ghana with the hope to reveal traditional practices that conflict with orthodox medicine especially during pregnancy and lactation. With this knowledge and insight, health personnel would be better informed as they diagnose and treat cases associated with pregnancy and lactation.

Objectives of the Study

This study seeks to:

1. Identify and document traditional beliefs on pregnancy and lactation in the areas under study;
2. Identify and document taboos and beliefs about pregnancy and lactation;
3. emphasize the essence of networking and collaboration in information sharing among health workers; and
4. recommend ways in which medical librarians can conduct research on oral literature and document them for easy access by health professionals to improve health care delivery in Ghana.

Methodology

The study was conducted in June 2008 by the researchers. The areas selected for the study were Adanse and Fomena in Adansi North District and Kokofu in Bosomtwe District. These three towns are among the most important traditional Ashanti towns that provide the chunk of Ashanti history. They are easily accessible as they are located within the same geographical vicinity though far apart from one another.

Copies of a structured questionnaire were purposively given to 200 pregnant women, 100 lactating mothers and 50 traditional birth attendants. The purposive sampling technique was employed in selecting the respondents because it provides a more convenient method of making subjective selection targeted at a particular group of people.

The questionnaire was administered by the researchers. The researchers visited the sampled communities several times before getting the needed number of respondents to respond to the questionnaire. In responding to the questionnaire the researchers had to assist 300 of the respondents by explaining the questions in vernacular and recording their responses as they spoke. This method was employed because most of the respondents could not read and write. However, 50 of them who were literate completed the questionnaire unaided. Apart from finding out their ages, communities of residence and levels of education, most of the questions centered on the beliefs and taboos that are associated with pregnancy and lactation and the reasons for such beliefs and taboos.

All the respondents responded to the same questions. All the targeted 350 respondents responded to the questionnaire making a response rate of 100%. The responses were then coded and analyzed with 'SPSS' making use of simple percentages. For purpose of clarity, some of the responses have been graphically represented.

Results

In eliciting opinions on the beliefs and taboos associated with pregnancy and lactation, the following categories of people were purposively selected to respond to the same set of questions. These included 200 expectant mothers, 100 lactating mothers and 50 traditional birth attendants. For purposes of collation, the responses were grouped them into two; pregnancy and lactation. The responses were further divided into three. These comprised taboos associated with food, behaviour and others. If the same response is given by

different category of people, it was coded as one. For example, one of the lactating mothers expressed that it is a taboo for a pregnant mother to eat eggs. This same taboo was also given by three pregnant mothers and two traditional birth attendants. These six different groups of people offering the same response to the same question is captured as one. The same criterion was employed when collating the reasons for the observance of the mentioned taboos. The trend of the questionnaire was such that for each taboo that was expressed the reason(s) had to be documented. As a result of this, the data collected were synthesized and presented along the same trend.

Taboos during Pregnancy

The following are the responses gathered on taboos linked to pregnancy with regard to Food:

1. The pregnant woman is not supposed to eat egg(s) because it will block the cervix during the second stage of labour;
2. Groundnut, sugar, sugarcane and oranges are forbidden because they pose dermatological and abortion problems;
3. The pregnant woman must eat more palm-nuts because witches hate palm-oil; this helps drive away evil spirits;
4. Coconut oil and groundnut oil – cause fever and jaundice and so should be avoided by pregnant women;
5. Ripe plantain causes prolonged labour as the woman is sleepy and cannot push. The baby is born weak;
6. Sugarcane causes vaginal bleeding and makes one lethargic during labour.
7. Mango causes diarrhea and fever; and

Behavioural

A pregnant woman:

1 Should not make prior preparations for the unborn baby because the baby may die. For example, buying of clothes for the child in anticipation of delivery;

2 Should not quarrel with her husband. If she does, it should be settled within twenty four hours because she cannot deliver normally if she is on bad terms with her husband;

3 Should not use an axe to split firewood or the child would be born with a widened sagittal suture;

4 Should not squat or stoop to eat, she should always sit down or else the child is born with rhinorrhoea as water accumulates in its head;

5 Should not perform any vigorous activity including running, because an abortion may result;
6 Should not lift a load unto her head or the child may develop *asenam;*
7 Should not carry water in a basin; a bucket should be used instead to prevent *asenam;
8 Should also not lie on her chest or back but rather on her side to prevent vomiting through the nostrils of the baby. This could lead to weakness and even death. An abortion may also occur;
9 Should not quarrel or fight because the child may be charmed or hurt;
10 Should also not tie-up a bundle of firewood with a rope or use sticks with twines on them to make fire or cross her legs. In all these cases, the umbilical cord could tie around the baby and she/he may die or labour may be difficult;
11 Should not beat children;
12 Should not chop any meat; as this results in prolonged labour;
13 Should not allow her outstretched legs to be crossed or the child may be bewitched;
14 Should not stretch; else an abortion may occur;
15 Should not deliver in the hospital because it is both a disgrace and a sign of a weak physical constitution; and
16 Should use enema with various herbs to prevent excessive bleeding after delivery; protect the baby from *asenam, induce foetal movements if the onset is delayed or the frequency is reduced; make the baby strong; make labour easy; make the mother strong; remove any dirt that may be on the baby. The expecting mother also goes through a process of sanctification to protect the baby from *asenam.

Taboos Associated with Lactation

The following are the responses gathered on lactation with regards to Food:

* *Asenam is a disease of the newborn which is believed to be caused by psychic means. It manifests itself in various forms: the child may be born very small in size and continue to grow at a very slow rate or may be born with an abnormally big head. It may also manifest as very profuse diarrhea with vomiting and a high temperature or convulsions and spasms especially of the jaw.*

1. Lactating mothers should not eat the following foods and fruits because they cause diarrhea in the child: oranges, mangoes, pawpaw, cassava fufu, boiled fresh corn and rice.

There is also the belief that:

2. Eating okro causes the passage of mucoid stools in the child;
3. Eating roasted plantain prevents the child from weight gain;
4. The mother should not eat any food that is taboo for the child's father; and
5. Eating snails stops lactation.

Behavioural - Lactating mothers should not:

1. Expose their breasts, hair or thighs, in public places (like the market) or have their hair plaited in public. The reason is that the baby may be charmed by anyone with some powers who sees a pregnant woman doing the above things. The child may also suffer from *asenam;
2. Bath with cold water because it stops lactation;
3. Have sexual intercourse because it will make the child ill;
4 Allow breast milk to drop on to the floor because when an ant steps on it, it will lead to pain in the breast; and
5 Ingestion of alcohol causes diarrhea in the child.

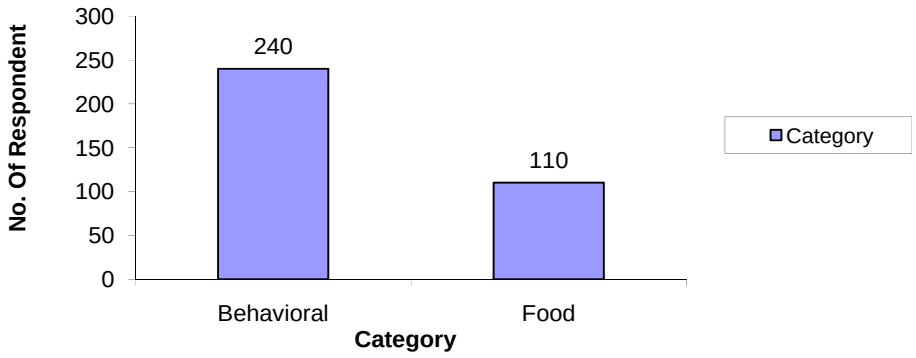
Table 1: Summary of Respondents

	Numbers from Selected Areas						
	Adanse		**Formena**		**Kokofu**		
Category of respondent	**No**	**%**	**No**	**%**	**No**	**Totals**	**%**
Pregnant women	70	58.3%	70	60.9%	60	200	52.2%
Lactating Mothers	30	25.0%	30	26.1%	40	100	34.8%
Traditional Birth Attendants	20	16.7%	15	13.0%	15	50	13.0%
Total	120	100%	115	100%	115	350	100%

Source: Field Survey, June 2008

Table 1 gives a summary of the number of respondents and their respective communities. As shown, out of one hundred and twenty (120) women who participated in the study at Adanse, 58.3% of them were pregnant while 25% and 16.7% of them were lactating mothers and traditional birth attendants respectively. Even though, Fomena and Kokofu had the same number of respondents each, Fomena had as many as 70 pregnant women representing 60.9%, while Kokofu registered 60 pregnant women representing 52.2%. Both communities had 15 traditional birth attendants representing 13.0% each responding. With regards to lactating mothers, Kokofu had 40 representing 34.8% as against 26.1% recorded at Fomena.

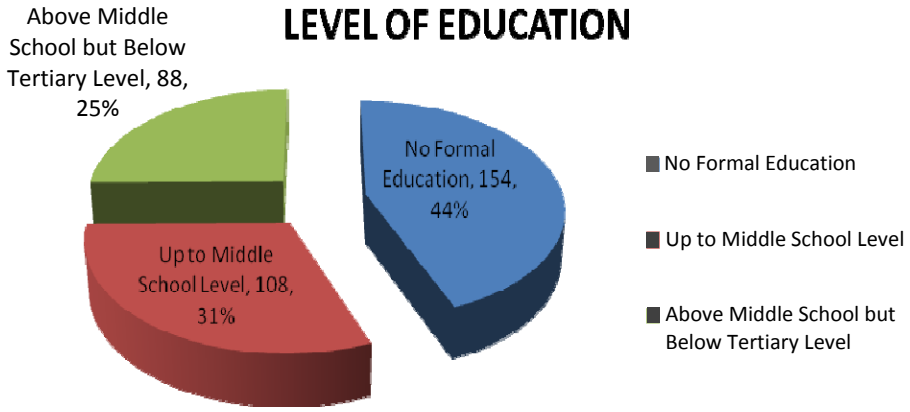
Figure 1: Cumulative Content Of Respondents



Source: Field Survey, June 2008

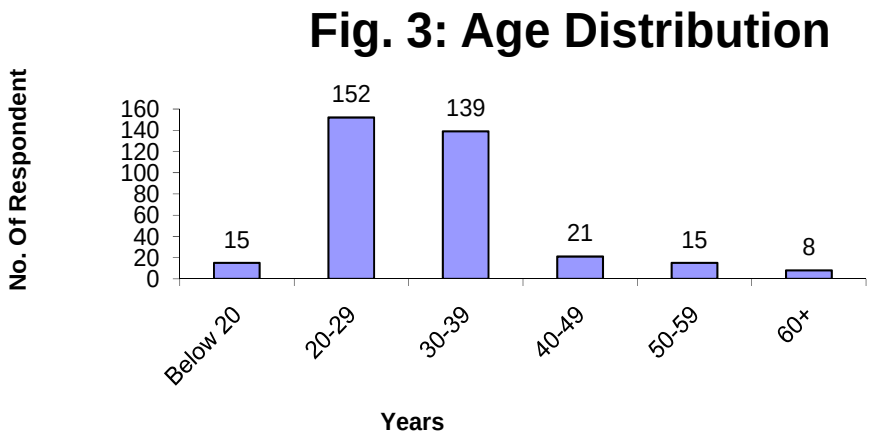
Figure 1 shows that two hundred and forty (240) responses out of a total of three hundred and fifty (350), representing 68.57% touched on behavioural issues while one hundred and ten (110) respondents representing 31.43% stressed on food. It must however be noted that some respondents mentioned food and behavioural issues at the same time but such responses were not considered as part of the data for this graph. This shows clearly that the bulk of beliefs and taboos in the selected areas hinge on conduct and attitudes. Subjecting attitudes to empirical evidence to prove or disprove their validity is difficult. The impression created here is that, the behavioural beliefs and taboos will continue

to impact on the health needs of pregnant and lactating mothers positively or negatively for a very long time.



Source: Field Survey, June 2008

As shown in Figure 2, one hundred and fifty four (154) respondents had no formal education. One hundred and eight (108) had up to middle school level education while only eighty-eight (88) had gone beyond middle school but below tertiary level. The indication is that close to 69% of the respondents had very low educational backgrounds. It could be common to associate superstitious beliefs with people with low levels of education.



Source: Field Survey, June 2008

Fifteen (15) of the respondents representing 4.3% had not turned twenty (20) years but were about to deliver. One of them was already lactating. This presupposes that the women internalize the beliefs and taboos at early stages of their lives. They could therefore adopt what has been passed on to them. This also indicates the presence of teenage pregnancies in those communities. There were also eight (8) respondents above sixty (60) years representing 2.3% who were traditional birth attendants. The dorminant age group of the respondents as evidenced from figure 2 ranges between 20-29 years. These recorded one hundred and fifty-two (152) responses representing 43.4%. This was followed by those in the 30-39 age bracket who recorded one hundred and thirty-nine (139) responses. This suggestively puts the productive ages of the respondents between 20-40. The lowest responses,which were eight (8) were obtained from those above 60 years.

Discussions

The sharp contrast revealed by this study is that traditional beliefs and taboos discourage pregnant women from the consumption of fruits during pregnancy, while orthodox medicine encourages it. Even though there has not been any empirical evidence to prove most of these beliefs, respondents hold on to them tightly.

By the Ghana Statistical Service Report (2007), more than half the population of Ghana live in the rural areas. Illiteracy in the rural areas is also higher than those of the urban areas. Women slightly outnumber men. Therefore it will not be far from right to assert that rural women who are mostly illiterate are more vulnerable to myths and superstitions than their literate counterparts. Anaemia has been one of the major causes of admitting pregnant women and lactating mothers to health facilities in most rural health centres (Ghana. Ministry of Health, 2007). The observance of beliefs and taboos might have contributed to their plight.

Child mortality continues to be high in Ghana. After an initial decrease of 81.3 per 1000 children in 1988 to 61 after 10 years, the situation declined to 64 in 2003. Children below five years recorded a decline from 155 per 1000 in 1988 to 110 after 10 years before increasing marginally to 111 in 2003(GDHS, 2003). Pregnant women would want to deliver at home. However few of them are sent to the hospital when complications develop. This and other problems have compelled the Health Ministry to embark upon the Community Health Planning and Services Programme dubbed 'CHIPS COMPOUND' to help curb the high death rate of children in such communities. This programme began in 2005.

Awareness of all these should push health personnel who drag their feet when posted to rural areas to change their minds in order to save lives. It would also be an eye opener to non-governmental organizations working in health related fields to also know where to focus their operations. Medical librarians could employ data gathering strategies expounded in making sure that information such as this study has shown reaches a wider health audience as much as possible to improve upon the health care needs of pregnant and lactating mothers.

The Role of the Medical Librarian

In broad terms the medical librarian assists in the improvement and development of medical education. This is done through the collection, processing and dissemination of medical and health related literature. The collections should have the capability to support teaching, learning, research and knowledge dissemination. Their working environment is special and therefore they are expected to provide special information services. However depending on the trend of user queries and the needs of society, the librarian could generate information on rare but needed areas through research. The

pursuit of such exercises repositions the medical librarian as not only a custodian of information but a creator of scholarly works as well. This gives credence to the indispensability of the medical librarian.

Making Use of Data Gathering Tools

There are also a number of ways the medical librarian can assist by providing relevant information to assist health personnel to do their work efficiently and effectively. In Ghana, with particular reference to Ashanti Region, the following were the possessors of such information: elders, chiefs, fetish priests, diviners and traditional birth attendants. This valuable information could be made available to health personnel through data gathering tools such as transcription of tape-recorded messages during interviews, collating responses from administered questionnaires and the employment of focus-group discussions. Whatever information is gathered could be documented and communicated to partners, collaborators, known patrons and other affiliated institutions through the World Wide Web and the Internet.

Creating Access

Oral communication is ubiquitous and carries important information but its documentation is time consuming. Given the development of diverse storage media and networks one could just record and store a conversation for documentation. The question, however, is how an interesting information piece would be found in a large database (Human Language Technology, 2001).

Access to orally communicated information is becoming an interesting research area since recording, storing and transmitting large amounts of audio (and video) data is feasible today. While written information is often available electronically (especially since it is typically entered on computers), oral communication is usually only documented by constructing a new document in written form such as a transcript (court proceedings) or minutes (meetings). Oral communication is therefore a largely untapped resource, especially if corresponding written documents are not available and the cost of documentation using traditional techniques is considered high (Human Language Technology, 2001).

Documentation

Good documentation facilitates effective checking and preservation of a dataset and ensures that the research community will be able to use the data. It reduces the likelihood of misuse or incorrect use of the data. It can even help data

creators, should they return to the dataset for further analysis at some stage in the future (Hamilton, 2002).

Employing Focus Group Discussions

According to Krueger (1994), focus groups have been a mainstay in private sector marketing research for the past three decades. More recently, public sector organizations are beginning to discover the potential of this procedure. Educational and nonprofit organizations have traditionally used face-to-face interviews and questionnaires to get information. Unfortunately, these popular techniques are sometimes inadequate in meeting information needs of decision makers (Krueger, 1994). The use of focus groups is unique from the others in that it allows for group interaction and greater insight into why certain opinions are held. The sampled respondents could be stratified and the discussions held in series. Once the respondents are reasonably homogeneous and unfamiliar with each other the perceptions gathered would be qualitative (Grudens-Schuck et al, 2004). The use of this technique by medical librarians is more appropriate because it is a socially oriented research procedure that allows the moderator to probe respondents for in-depth information. Discussions have high face validity and can be relatively low cost. The medical librarian stands to gain a lot from applying this technique, because not only can this technique provide speedy results, it also enables him to increase the sample size of qualitative studies as well.

Dissemination Strategies

The documented information from the described data gathering tools become valueless if they are not disseminated to the targeted patrons as well as other beneficiaries. The information must be oriented towards the needs of the users, incorporating the types and levels of information needed into the forms and language preferred by the user. Varied dissemination methods must be employed; including written information, electronic media and person- to-person contact. The package should include both proactive and reactive dissemination channels- thus, they include information that users have identified as important, and they include information that users may not know of to be able to request but that they are likely to need. It must be emphasized that the goal of dissemination is utilization (Research Utilization Support and Help, 2009).

The strategy employed must satisfy the elements of dissemination which leads to utilization: spread, exchange, choice and implementation. The strategy must

draw upon existing resources, relationships and networks to the maximum extent possible while building new resources as needed by users. In doing these the medical librarian must make sure the strategy includes effective control mechanisms to ensure that information to be included in the system is accurate, relevant and representative. In the same way, the information package should be sufficient so that the user can determine the basic principles underlying specific practices and the settings in which these practices may be used most productively.

Selective Dissemination of Information

According to Prytherch (2005) "selective dissemination of information is a system, usually automated, whereby literature items are matched against the interest profiles of individuals or corporate users of an information service and relevant documents or abstracts are supplied to the user immediately**.**" Contemporary terms for SDI services include 'alerts', 'current awareness' or 'trackers'. Also in place are systems that provide automated searches that inform the users of the availability of new resources meeting the users' specified keywords and search parameters. Alerts can be received in a number of ways including emails, voicemail, instant messaging, and text messaging.

In sum, all the procedures and techniques used in SDI are applicable to the medical librarian as he attempts to disseminate information. The only major difference is that unlike the known practices, which is usually based on "collected information" this time the information being disseminated is created or authored by the medical librarian and the targeted beneficiaries are mono-dimensional: health workers. The medical librarian should therefore be able to devise strategies to document this knowledge and keep it for posterity. The medical practitioner working in the village or in the city needs such information to be able to function effectively. The dearth of traditional knowledge on medicine in Ashanti exists as oral literature (Addy, 1970).

Conclusion

The study found that pregnancy and child-birth were shrouded in mystery. Besides, the study has confirmed the belief in ancestors as beings who continue to influence the lives of the living. There has also been the revelation that mothers in the rural areas do all they can to protect their babies with all kinds of charms, herbal potions and talismans as a result of superstitious beliefs.

Again, this study has documented numerous traditional beliefs and taboos on pregnancy and lactation in the communities under reference. These beliefs and taboos have negative health implications for pregnant women, mothers and children. For example, they discourage pregnant women and mothers from eating some food items which are good and promote healthy living. When pregnant women and mothers do not eat a balanced diet, the fetuses and infants do not grow well. This makes it imperative that health practitioners should become aware of traditional beliefs and taboos which have implications for improved health care delivery especially for pregnant mothers and the unborn babies.

Finally, the medical librarian also has a role to play since he can make use of information strategies to facilitate and disseminate research findings on health issues inherent in oral literature.

Recommendations

It is recommended that medical librarians conduct scientific researches in oral literature. The reason is that, extensive but rich information exists as oral literature in some parts of the globe. The access to such information might improve the quality of health services rendered by health workers. This will go a long way to also reduce some of the health hazards confronting the world.

In addition to the usual task of acquiring, processing and disseminating medical information to users, the medical librarian could personally delve into oral traditions, which embody the belief systems, taboos and other inherited traditions of some societies. Those that are of medical importance could be documented through appropriate data gathering methods.

The information gathered then could be made available to users through the appropriate dissemination media. The perception of librarians in general, in the information age has not been the best. Therefore creating scholarly works and reaching out to clientele with such information repositions the relevance of the profession. These unique services and tactics employed in the performance of duty will contribute in making the medical librarian indispensable. Furthermore education on beliefs and taboos especially in rural areas need to be intensified. This would enlighten mothers on the do’s and don’ts regarding pregnancy and lactation.

Finally, medical librarians could also present papers on their findings at scientific and medical seminars and conferences to facilitate knowledge sharing and dissemination of oral literature, which will lead to improvement in health care.

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