RECOGNITION AND INTEGRATION OF TRADITIONAL MEDICINE IN GHANA: A PERSPECTIVE

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Abstract

The paper examines the processes of recognition and legitimization of traditional medicine in Ghana and indicates that in Ghana, indigenous medicine has been used as an instrument to help develop political consensus and consciousness and in the building of a national identity. The Ghanaian government recognizes traditional medicine and has a policy for the integration of indigenous medicine; the paper shows that the policy limits traditional medicine almost exclusively to herbal products and the scientific elements of it without taking into consideration its other dimensions of treating illnesses. Thus the policy leads to bureaucratization of traditional medicine. The paper calls for a policy of integration that will promote a parallel and full development of both orthodox and indigenous therapeutic traditions to enable them to continue to provide the health care needs of the people.

Résumé

Cet article analyse les processus de reconnaissance et de légitimisation de la médecine traditionnelle au Ghana et postule qu’au Ghana la médecine indigène permet non seulement de forger le consensus politique et la conscience politique mais aussi d’édifier une identité nationale. Le gouvernement ghanéen reconnaît la médecine traditionnelle et a mis en place des politiques en faveur de l’intégration de la médecine traditionnelle. Il ressort dans cet article que ladite politique limite la médecine traditionnelle quasi exclusivement à des produits à base d’herbes et à leurs éléments scientifiques sans prendre en compte ses autres dimensions thérapeutiques. Aussi la politique mène-t-elle à la bureaucratisation de la médecine traditionnelle. L’article plaide en faveur d’une politique d’intégration apte à promouvoir le développement parallèle des traditions thérapeutiques orthodoxe et traditionnelle en vue d’assurer aux populations des soins médicaux durables.
Introduction

The World Health Organization (WHO) acknowledges the difficulty in giving a precise description or definition of traditional medicine at the global level. It however sees it as useful to give a working definition that of necessity is comprehensive and inclusive:

WHO therefore defines traditional medicine as including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness.” (WHO 2002-2005).

WHO reports that the usage of traditional medicine (TM) as treatments or supplementary treatments of many illnesses is wide and is rapidly growing. According to WHO, about 80% of the population in Africa use traditional medicine to help meet their health care needs; and in China, it accounts for about 40% of all health care delivered. In the developed world, where traditional medicine is referred to as complementary and alternative medicine (CAM), its usage is becoming more and more popular and rapidly increasing in some countries. The economic importance of traditional medicine is also acknowledged by WHO. According to WHO, traditional medicine/complementary and alternative medicine expenditure in many parts of the world is not only significant but is also growing. Traditional medicine is also affordable and accessible in developing nations. The WHO therefore encourages member countries to formulate national

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1 “Traditional medicine may be codified, regulated, taught openly and practised widely and systematically, and benefit from thousands of years of experience. Conversely, it may be highly secretive, mystical and extremely localized, with knowledge of its practices passed on orally. It may be based on salient physical symptoms or perceived supernatural forces. Clearly, at global level, traditional medicine eludes precise definition or description, containing as it does diverse and sometimes conflicting characteristics and viewpoints.” (WHO Traditional Medicine Strategy 2002-2005).

2 “In countries where the dominant health care system is based on allopathic medicine, or where TM has not been incorporated into the national health care system, TM is often termed “complementary”, alternative” or “non-conventional” medicines.” WHO 2002-2005.

3 “The percentage of the population which has used CAM at least once is 48% in Australia, 70% in Canada, 42% in USA, 38% in Belgium and 75% in France.” WHO 2002-2005.

4 “In Malaysia, an estimated US$ 500 million is spent annually on this type of health care, compared to about US$ 300 million on allopathic medicine. In the USA, total 1997 out-of-pocket CAM expenditure was estimated at US$ 2700 million. In Australia, Canada and the United Kingdom, annual CAM expenditure is estimated at US$ 80 million, US$ 2400 million and US$ 2300 million respectively.” WHO 2002-2005.

5 Again, the WHO document indicates that in terms of accessibility, taking Uganda for example, “the ratio of TM practitioners to the population is between 1:200 and 1:400. This contrasts starkly with the availability of allopathic practitioners, for which the ratio is typically 1:20,000 or less.” In terms of TM’s affordability as a source of health care, research has shown that in Kenya,
policies, regulations and programs and integrate traditional medicine/complementary and alternative medicine with national health care systems.

Ghana is one of WHO’s 191 member nations worldwide. It is considered as a country that practices an inclusive system of traditional medicine. It means, among other things, that Ghana recognizes traditional medicine and has a national policy which, however, is not fully integrated into all aspects of health care. Thus Ghana is a country where it is possible to observe and also analyze a policy for integration of traditional medicine.

It is argued that many African governments defend and legalize the use of indigenous medicine, relating their position to a general policy of revaluation of African cultural traditions, a position which, in a sense, affords them the opportunity to defend their own cultural identity which has been put into crisis by colonization and social-cultural changes (Schirripa 2005:123). In this paper, we will examine the processes of recognition and legitimization of traditional medicine in Ghana and show how indigenous medicine has been used as an instrument to help develop political consensus.

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Ghana and Mali “a course of pyrimethamine/sulfadoxine antimalarials can cost several dollars. Yet per capita out-of-pocket health expenditure in Ghana and Kenya amounts to only around US$ 6 per year. Conversely, herbal medicines for treating malaria are considerably cheaper and may sometimes even be paid for in kind and/or according to the “wealth” of the client.” WHO 2002-2005.

Ghana is one of the 25 countries out of WHO’s 191 member countries that has a policy for traditional medicine. The WHO has classified member countries into three groups according to the status of TM/CAM in each country. A country with “an integrative system, TM/CAM is officially recognized and incorporated into all areas of health care provision. This means that: TM/CAM is included in the relevant country’s national drug policy; providers and products are registered and regulated; TM/CAM therapies are available at hospitals and clinics (both public and private); treatment with TM/CAM is reimbursed under health insurance; relevant research is undertaken; and education in TM/CAM is available. Worldwide, only China, the Democratic People’s Republic of Korea, the Republic of Korea and Viet Nam can be considered to have attained an integrative system... An inclusive system recognizes TM/CAM, but has not yet fully integrated it into all aspects of health care, be this health care delivery, education and training, or regulation. TM/CAM might not be available at all health care levels, health insurance might not cover treatment with TM/CAM, official education in TM/CAM might not be available at university level, and regulation of TM/CAM providers and products might be lacking or only partial. That said, work on policy, regulation, practice, health insurance coverage, research and education will be under way. Countries operating an inclusive system include developing countries such as Equatorial Guinea, Nigeria and Mali which have a national TM/CAM policy, but little or no regulation of TM/CAM products, and developed countries such as Canada and the United Kingdom which do not offer significant university-level education in TM/CAM, but which are making concerted efforts to ensure the quality and safety of TM/CAM. Ultimately, countries operating an inclusive system can be expected to attain an integrative system... In countries with a tolerant system, the national health care system is based entirely on allopathic medicine, but some TM/CAM practices are tolerated by law.” WHO 2002-2005.
and consciousness and advance the building of a national identity. The Ghanaian Government’s policies concerning the integration of indigenous medicine, as they seem now, limit traditional medicine almost exclusively to herbal products and the scientific elements of it. We will point out that traditional medicine is more complex than that. There are some joint health programs that the various governments of Ghana have initiated and/or collaborated in with other agencies incorporating traditional medicine into the health care system for the health needs of the people. We will argue that the programs are directed not exclusively to a health strategy program for the people, but are driven also by political and economic reasons; and that they also are examples of integration that seem to continue to affirm the so-called “structural superiority” of Western medicine and the top-down relations that exist between biomedicine and indigenous medicine. In conclusion, we will call for a policy of integration that will promote a parallel and full development of the two different therapeutic traditions to enable them to become more adequate in playing their complementary roles of providing the health care needs of the people.

Recognizing and legitimizing traditional medicine in Ghana

The process of legitimizing traditional medicine in Ghana began with the independence of the country from the British in 1957, when Kwame Nkrumah, the first President of Ghana, carried out a policy of building up a national consciousness as part of his Africanization policies and programs. It was Nkrumah’s intention “to revive, develop and encourage traditional medicine.” He therefore instructed that “traditional healers come together and form an association whereby their practices could be improved and advanced, and their dignity and status in the society be restored.” (Owoahene-Acheampong 1998: 138). This directive by Nkrumah led to the creation of the Ghana Psychic and Traditional Healers Association (GHPTHA) in 1960. The aim of the association was to bring together the traditional healers – the akomfo and malams (priests/spiritual healers) and the nnunsifo (herbalists). It was also to promote the study of herbal knowledge and efficacy of traditional remedies in Ghana and in Africa for subsequent use in public health and other health programs, to establish a national institute for research into traditional medicine, and to set up clinics and locate them close to or within orthodox medical establishments in the different regions. The idea was to complement orthodox treatments of common diseases with traditional treatments, and also offer patients options for their treatments (Schirripa 2005:130).

The process of legitimizing traditional medicine in Ghana has followed the policies and guidelines of successive governments. The fall of the Nkrumah government, for example, impeded the previous initiatives meant to recognize indigenous medical systems. The initiatives were, however, reactivated in the 1970’s by Acheampong’s military government. In 1973, the process was accelerated and a move was made to concretize it by the establishment of the Centre for Scientific Research into Plant
Medicine (CSRPM) at Mampong in the Eastern Region. In 1991, the Ghana National Association of Traditional Healers (GNATH) was formed under the Rawlings government. Its purpose was to bring together healers who have profound knowledge in herbal medicine. In 1993, the Ghana Federation of Traditional Healers (GFTH) was founded. It was later reconstituted and became what we have today as the Ghana Federation of Traditional Medicine Practitioners Association (GHAFTRAM). This federation is the “umbrella body” of all traditional healers associations in Ghana. It grants the associations and their members recognition and legal status. Currently GHAFTRAM is composed of different associations, six of which are identified as “full members” and fifteen as “associated members”.

Today various associations of healers continue to emerge in Ghana but they have to be recognized and legalized by GHAFTRAM. The recognition of an association by GHAFTRAM is based on the condition that the association must be present and operating in two or more regions of Ghana. As will be shown below, practitioners of indigenous medicine are grouped according to their expertise and practice. Thus, every member association of GHAFTRAM is composed of different groups of traditional healers.

As is apparent from the above, the 1970’s and 1980’s represented a turning point for the practice of indigenous medicine in Ghana. They were the times when the country took greater interest and promoted the practice which began to reclaim its former (pre-colonial) status as an important profession. During those periods many joint health projects were carried out. The main goal was to use the traditional health resources within the program for primary health services, following the guidelines proposed by WHO. During the International Conference on Primary Health Care in Alma Ata (Kazakhstan) in 1978, the WHO recommended that member states promote and encourage the use of traditional medicine within their health care programs, and also

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7 Among the aims of the Centre are: “to improve plant medicines through promoting and conducting scientific research; to ensure that drugs that are extracted from plants maintain their purity; to help in the dissemination of useful technical information and research results; to act in co-operation with Ghana Psychic and Traditional Healers’ Association and other organizations; and to promote and encourage global exchange of ideas in the matters of plant medicine.” (Owoahene-Acheampong 1998: 139).

8 The six associations that are granted full membership are Plant Medicine Association, Ghana National Association of Traditional Healers (GNATH), Ghana Psychic and Traditional Healers Association (GAPTHA), Northern Sector of Traditional Practitioners, Traditional Service Association, and Essiama Association. The “associated members” associations include: Ghana Muslim and Traditional Healers Association, Kporlefa Association, Faith Healers Association, Ghana Priest and Priestess Association, Hukorku Association, African Healers Association and so on. What distinguishes a “full member” association from an “associated member” association is the level of spread of the association in the country. To belong to GHAFTRAM as a “full member”, an association has to be present at least in seven regions of the country, while the “associated member” must be at least in two or three regions of the country.
integrate it with the orthodox medicine (WHO 1978). This recommendation is reiterated in its *WHO Traditional Medicine Strategy 2002-2005* as indicated above.

The joint projects during the 1970’s and 1980’s involved herbalists, bonesetters and Traditional Birth Attendants (TBAs). This involvement of the TBAs in the projects was particularly important because Ghana was one of the first countries which organized educational courses and training for birth attendants to possibly integrate them into maternal and infant health care programs. The first project was the Danfa Comprehensive Rural Health Project, which started in 1970 on the coastal zone. It was a “joint project of University of Ghana (Legon) and the University of California, Los Angeles (UCLA). The project was established to train traditional birth attendants and also to gather information on their knowledge and practices.” (Owoahene-Acheampong 1998: 138). In 1975 another joint project of primary health care, named the Kintampo Project, was also started in the Brong-Ahafo Region. Although this program focused on TBAs, it allowed bonesetters to participate in it. Again, in the districts of Techiman and Dormaa of the same Region, collaborations between biomedical personnel and traditional healers were begun in 1979 and 1985 respectively. This collaboration led to the creation of the Primary Health Training for Indigenous Healers (PRHETIH) and the Dormaa Healers Project. Unfortunately, most of the collaborations and forms of integration, as will be shown below, did not bear much fruit and the structures that were set up failed to work.

In 1999, the implementation of the program for recognition of traditional medicine was reintroduced by the Government of Ghana through the creation of the Traditional and Alternative Medicine Division under the Ministry of Health. Among the important functions of the Division are to draw up and promote laws and policies to govern traditional and alternative medicine, and to encourage integration among the different therapeutic systems. In 2000, parliament approved the Traditional Medicine Practice Act 575, and thus by law recognized traditional medicine. During the years following the approval of the practice, the Traditional Medicine Practice Secretariat was set up. The Secretariat worked as a unique agency under the Division until April 2010 when the Council was inaugurated. The Council’s mandate is to manage, organize and regularise the “practice” of traditional medicine. It is also charged to define standards and criteria by which practitioners are identified, recognized, registered, and licensed. It is to

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9 The purpose of both projects was “to augment the knowledge and skills of indigenous healers and bring about closer cooperation and understanding between indigenous and Western-oriented health workers” (Ventevogel 1996: 58). These two programs are compared and critically analyzed by Giarelli (1995).

10 The term “alternative medicine” is used here to refer to all the external (both Western and Oriental) unorthodox therapeutic resources introduced to Ghana and now deep-rooted in the country.

11 The registration of traditional healers at the Ministry of Health was inaugurated in February 2009. The Traditional Medicine Practice Council Secretariat came out with the forms and the
disseminate the 2004 Ethical Code of the Practice of Traditional Medicine of the Ministry of Health (Ministry of Health 2004) and ensure that all the practitioners abide by it. The Council is to promote on a national scale knowledge of herbal medicine, particularly in the areas of cultivation, picking and use of the herbs. It is to collaborate with appropriate agencies for large scale cultivation of medicinal plants and for the preservation of bio-diversity, and to co-operate with the Ministry of Health (MOH) to establish centers to provide traditional medical care within the national health care delivery. The Council will consist of the following members:

(a) five nominees of the Association at least one of whom shall be a woman; (b) two persons nominated by the Minister one of whom shall be the Director of the Traditional Medicine Services Division of the Ministry; (c) two representatives from the universities and research institutions one of whom shall be a pharmacist with interest in traditional medicine and the other a person with an interest in the preservation of biodiversity; (d) the Director of the Centre of Scientific Research into Plant Medicine; (e) the chief executive of the Food & Drugs Board; and (f) the Registrar appointed under section 29 of this Act who shall be the secretary to the Council (Government of Ghana 2000: 4).

It can be inferred from the above that the policy for recognition and integration of traditional medicine, to be implemented by the Traditional Medicine Practice Council, tends to place emphasis on the herbs and the scientific elements of traditional medicine. Thus, the Council, in order to recognize and integrate traditional medicine into the biomedical system in Ghana seems to seek to transform it into “real and proper science”, considering only practitioners who will have their herbal products tested or will undergo training as recognized practitioners.

**Integrating traditional and orthodox medicines: some considerations**

Traditional medicine embraces different forms of therapeutic knowledge and practices. To use a plural form—“traditional medicines”—to refer to the practices of an indigenous people may seem appropriate. In other words, it may seem more fitting to talk about “medicines” or “therapeutic practices and knowledge” rather than “medicine”. However, although these terms may underline the various symbolic and empiric practices that

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12 With particular reference to a pharmacist from the Department of Herbal Medicine of the Faculty of Pharmacy and Pharmaceutical Sciences, College of Health Science, Kwame Nkrumah University of Science and Technology, Kumasi.

13 This information was given to Elisa Vasconi in 2007 during an informal interview with Mr. Peter Arhin, Director of Traditional and Alternative Medicine Division in Accra.
characterize traditional medicine and its practitioners, traditional medicine can still be spoken of in the singular as we speak of Western “medicine” and not of “medicines”. Western medicine, as we know, has different categories of practitioners with different specialties. In traditional medicine, classification is also made according to the expertise of healers. Healers who provide various health needs of the people are referred to by the terms doctor/physician (commonly regarded as the herbalist); diviner, or diagnostician; traditional birth attendant; bonesetters; and exorcist, known in the literature as the witch doctor (See Appiah-Kubi 1981: 35-36; Owoahene-Acheampong 1998: 68ff.). It must be noted here that the classification of practitioners in this way does not mean that the practices are unconnected. In fact, the practices of the healers quite often overlap, and are more importantly guided and shaped by a common traditional cosmology. (Bonsi 1977: 30).

The suggestion that the indigenous medicine must be recognized, legitimized, and promoted must not only be based on the fact that it has traditional and moral value to be saved, but that it has also more therapeutic potency in treating some ailments than bio-medicine and resonates with the people’s understanding of health, illness and healing. The traditional healer uses a therapeutic system that takes into account the cultural, social, and biological aspects as well as the existential experience of the human being in its interpretation of diseases and illnesses. (Appiah-Kubi, 1981; Twumasi, 1975). For this reason traditional medicine must not be seen exclusively in terms of herbal remedies (which is a component of it), but as a therapeutic practice that embodies many symbolic and spiritual aspects of the universe of which the individual forms a part.

14 According to Twumasi (1975:119), “Traditional medicine has persisted in the area of chronic or psychosomatic ills where scientific medicine has either failed to produce equally good results or has simply ignored the need for systematic attention and research. The functional scope of each medical system has been largely determined by its ability to get results in specific cases of illness.” Green has shown in a table how in Swaziland the people categorize diseases and ailments according to which treatment (biomedical practice or ethnomedical practice) is better (Green 1992: 21-130). Or see the table in Owoahene-Acheampong (1998: 156).

15 Illness is regard by the people as “an imbalance, a disequilibrium in the order of the nature of the person’s existence. Illness is believed to affect the whole person—body, mind, and soul—and not just part of the person.” Healing, or treatment of an illness, also takes “cognition of the social, emotional, spiritual, psychological, economic and intellectual realities” of the person. In other words, it is the whole human person who is healed. (Owoahene-Acheampong 1998: 130-132).

16 Giarelli (2000: 207) observes that the therapeutic efficacy/potency constitutes a central problem both for the trans-cultural study of medicine and for the study of indigenous health professions. Moreover it (therapeutic efficacy) induces reflection on the so-called symbolic efficacy. The latter generally makes reference to the capacity of symbols to act on something that is numerically measurable. (An important study for understanding the meaning of symbolic efficacy is the study done by Claude Lévi-Strauss. Lévi-Strauss (1958) examines the problem of how the shaman can achieve the health of the patient through a ritual action among the Cuna of Panama. To do it he analyzes a long shamanic song recited for the success of a difficult delivery. The shaman presents
The act of recognition of traditional medicine should take into consideration the complex universe in which the practice resides and the many levels on which it articulates. The Ghanaian Government’s policies, concerning the integration of indigenous medicine, as they seem now, tend to limit traditional medicine almost exclusively to herbal products. The apparent attention that the Government and the research agencies are giving to herbal remedies, the future coverage of herbal products by the National Health Insurance, for instance, and the opening of “Dispensaries” within medical institutions in the country, and the recognition which herbal products will gain through the Council, all seem to advance the perception that traditional medicine is dichotomous, that it has two different separable aspects, the magico–religio, on one hand, and the herbal on the other hand. Such attempts at splitting traditional medicine into two aspects could devalue its significance and also its therapeutic and symbolic efficacy, which are often what drive its patronage and usage among the larger Ghanaian population.

From the programs that the Ghanaian government has initiated and/or collaborated in with other agencies that have been mentioned above, it can be argued that the programs are not directed exclusively to a health strategy program for the people, but are driven more by political and economic reasons. The recognition of traditional healers through the legitimization of the different healers’ associations by the various Governments was a means of building up a national identity and also controlling indigenous therapeutic systems. The emphasis on herbs, the promotion and selling of herbal products, and the touting of scientific tests on herbal products are all based on an idea of business and profit hidden behind the revalorization of the “tradition” and the “true” Ghanaian culture. Thus the policy of testing products instituted by the Traditional and Alternative Medicine Division is producing, in a sense, economic and business systems: there is now increase in patronage and also revenues for the Research Agencies, the CSRPM of Mampong, the suffering of the parturient through the imaginary story of a supernatural trip that she does in a symbolic space, corresponding to the metaphoric representation of the parturient’s body. The efficacy action resides in the language used by the shaman by which the woman can express some conditions otherwise not communicable. Severi’s (1977) reflections substantiate Lévi-Strauss’s theory. He notes that shamanic songs are formulated in a language that is almost incomprehensible to ordinary people. This is an element that induces the author to reflect on the different meanings that the belief assumes for the patient and her therapist. The author focuses on the active role played by the parturient as the real promoter of the symbolic efficacy of the song. It is the patient herself who, exposed to the song, assumes the position of one who observes an image and acts according to her perception of the image (Pizza 2005: 205-211).

17 In 2006 a Commission (comprising of CSRPM of Mampong, Food & Drugs Board, Noguchi Institute, GHAFTTRAM) was instituted and it wrote the Essential Herbal Medicine List. The latter is a national list of herbal products that will be shortly recognized by the National Health Insurance Council and added to the list of drugs that users of National Health Insurance can access. After the list is approved by the National Health Insurance Council, the Ministry of Health will set up the “dispensaries” of herbal medicines within medical institutions in the country.
and the Food and Drugs Board. Again, the numbers of “professionals” who are licensed to prescribe and sell herbal products, the outlets for selling the products, and sales of the products themselves have increased considerably, thereby opening avenues for taxable income generation on the part of the government. It is also important to emphasize the fact that the policy fashioned for the integration of traditional medicine with its orthodox counterpart, as indicated above, operates from a different logical perspective that is far removed from the logic from which the indigenous medicine operates and the planes on which it articulates itself. This policy favors the logic of biomedicine because it is rooted in the Western concepts of health, illness and healing. In particular the policy tends to apply Western conceptions of drugs to herbal products, and as a result subject the herbs to numerous scientific tests and paradigms thereby reducing them to (chemical) drugs. In other words, Western conceptions of treatment and perceptions of efficacy that are far removed from the complex understanding of treatment and efficacy of the indigenous medicines are emphasized by the policy makers. Thus, it is easy to observe here an attempt at a process of westernizing these medicines, reducing their understanding and usage to western conceptions and paradigms. Such an attempt can lead to bureaucratization of traditional medicine, where science is used as a mechanism to control the social body, and sets itself up as a principle of an economic logic, where disease and healing and health are regarded as commodities that can be sold for profit (Ongaro Basaglia 1982: 155).

The issues raised above call for some reflections on the methods and processes of integration of traditional medicine and bio-medicine in Ghana. For example, one may want to know the kind of integration the policy makers would promote in the context of Ghana, where there is medical pluralism; and what might be the relationship between or among the medical systems that the Ministry of Health would establish. The above queries become relevant in the face of what has been the situation in Ghana. The “policy” in Ghana concerning medical practices has seemed to be that firstly, the recognition, development and promotion of traditional medicine is under the supervision of western medicine, and secondly its recognition and acceptance is dependent on scientific proof of its (herbal) quality and efficacy, without any modicum of consideration for other dimensions of its treatments.

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18 Every healer has to pay a determined monthly fee to the association in which they are registered; 5 Ghana cedis to GHAFTRAM every year; 5 Ghana cedis to the MOH for the new registration and to obtain the licence. (This information was given by Mr. Obiri, National Organizer of GHAFTRAM, to Elisa Vasconi in an interview on 23rd March, 2010).

Every healer has to pay also 150 Ghana cedis to obtain the license valid for three years from the Food & Drugs Board. (This information was given by Mr. Abu Sumaila, Head of Herbal Unit of Food & Drugs Board, in an interview by Elisa Vasconi on 18th March, 2010).

Again, every healer has to pay 125 Ghana cedis for the Mampong test. (Information from Dr. Settie, Deputy Director of Center for Scientific Research into Plant Medicine at Mampong, to Elisa Vasconi in an interview on 11th May, 2009).
Even though in the different projects in Brong Ahafo—the Danfa, Kintampo, PRHETIH and Dormaa projects—that we have mentioned above, efforts were made towards the recognition of traditional medicine and the integration of it with the biomedical system, the latter still today remains the dominant system in those areas; traditional medicine is still kept in “a secondary position” (Dozon 1987: 10). For example, even though the PRHETIH is often considered as one of the most important projects of collaboration between two different medical traditions providing primary health care in Ghana, there is still evidence of internal hierarchy and lack of fruitful and reciprocal exchange of knowledge and experience among practitioners—the transmission of knowledge and the exercise of authority are unidirectional; they exclusively emanate from biomedical personnel to traditional healers (Ventevogel 1996: 60-61). But, as Ademuwagun (1979) argues, indigenous medical practitioners included in projects should be utilized as “front line health-personnel” and considered as support for the medical team. Even though in some cases some orthodox medical practitioners show some form of respect towards traditional healers, they still do not accept and consider them as colleagues in the medical trade (Ventevogel 1996: 62). Traditional Healers, on the other, would have liked to improve upon and broaden their knowledge and enhance their profession through their contact with orthodox practitioners.

[...] It is important that we work together, because I believe that there are some sicknesses that when you take to the hospital, the doctor can never treat, but when you come to us we can, and likewise. So I want to tell the MOH we [traditional healers and orthodox practitioners] must work hand in hand, we can collaborate. If it is possible a clinic can be created at the hospital where there are traditional priests or traditional healers who can practice there. [...] I want to say that the Government should accept us, the traditional healers, to open our special clinics where we can use the herbs, but in our own way. [...] I want the MOH to give us a special license, so we, traditional priests and traditional healers, can open clinics and learn from each other and also from the [orthodox] doctors. So that when the patient goes to the hospital and the doctor thinks that this patient can be treated with the traditional medicine, they bring the patient to us. [...] (S. N. Komenle, an herbalist at Half Assini – Jomoro District, interviewed by Elisa Vasconi on 7th April, 2010.)

The integration of and the cooperation between biomedical and traditional medicine that the Dormaa and PRHETIH projects sought to reach still seem very distant. Courses that are run for traditional practitioners still concentrate exclusively on the use of herbs and those aspects that can be easily put under scientific control. Again, as indicated above, the processes used in the integrations in the Danfa, Kintampo, PRHETIH and Dormaa programs were unidirectional. For example, while the TBAs and sometimes herbalists and bonesetters, (whose practices are empirically observable and “easily” understood), were taught the rudiments of Western medicine—reducing them, in this way, to “primary health care workers” in the Western sense—biomedical practitioners
are not made to learn the methods or rudiments of traditional medical practices. These are examples of integrations that seem to continue to affirm the so-called “structural superiority” of Western medicine and the top-down relations that exist between biomedicine and indigenous medicine.\(^\text{19}\)

We propose that the policy and process of integration of the different medical systems should be inspired by the “informal integration” that already exists among traditional practitioners, orthodox practitioners and their patients especially in the rural areas. In fact the use of different medical systems by people when they are ill already exists in practice, through the freedom patients exercise in choosing the kind of therapeutic system that they prefer, and referrals of some cases to hospitals by traditional practitioners when the need arises. The integration and recognition of the different medical systems are important and fundamental to providing health care needs of the people and also reducing the rapid rate at which knowledge and relevance of indigenous medicines are decreasing. A strategy to achieve this can be steady and mutual exchanges of important information and knowledge among traditional healers themselves, and between the latter and biomedical practitioners. Furthermore, there is the need, on the part of policy makers, for respect for indigenous medical knowledge and practices and the different ways that health, illness and healing are understood in the different medical traditions, even where they (medical systems) may seem incompatible with one another (Schirripa & Vulpiani 2000: 25-26).

It must be reiterated that the kind of integration that the Ministry of Health is intending to pursue already exists in practice in some areas where both the traditional practitioners and their clients use both systems simultaneously or interchangeably when the need arises. Thus the attitudes of the traditional practitioners and their clients and that of the Ministry of Health and the WHO toward “integration” present different pictures—for the former “integration” already exists and for the latter “integration” is yet to be implemented. (Vasconi 2008a; Vasconi 2008b).

Indeed, there is a need for integration. But the process and the integration itself, we propose, should not lead to bureaucratization of traditional medicine whereby it becomes expensive and inaccessible to people who may patronize it. Again, the kind of integration

\(^{19}\) Lee (1982) observes that an evident hierarchic order emerges in the relations between biomedicine and traditional medicine and that they are more or less in competition. He demonstrates that the western system, with its scientific ideology and support by the social and political élites, always achieves the dominant position and “leads gradually”, as Van Der Geest (1985: 61) humourously expresses, “to a process of ‘medical absorption’”. In fact Lee talks about a “structural superiority” of biomedicine when compared to the other therapeutic traditions, not only in terms of its economic/financial capacities but also the technological capacities that make society recognize its efficacy. At the same time, Lee observes that the superiority and “functional power” of indigenous medicines by reason of their availability and wide usage among the local people can be compared to the social prestige of orthodox medicine.
that we propose is collaboration, but not subsuming of indigenous medicine into biomedicine. In the event of introducing indigenous medical practice into hospitals, measures must be instituted to protect its identity, autonomy, dignity and usefulness. What is being suggested here is a parallel but systematic collaboration, and even and peaceful coexistence of the two systems. Also, provision must be made in the health policy that guarantees positive and equal developments of both medical systems. In other words, research and advancement of knowledge must be encouraged, and improvement of facilities and human capacity building must be assured. In fact, both the indigenous healers and biomedical practitioners themselves ask for some interventions and improvements in their working conditions. Particularly, indigenous healers insist that they be assisted by the government to develop and improve the conditions of the places where they operate. And some healers, unlike Mr. S. N. Komenle quoted above, insist that they not necessarily to be removed from their places of work.

[…] We want to be recognized and supported by the government, but we have to continue to work in our compounds, where our gods come to us. The Ministry of Health can accept us and work with us, but we have to do it [work] in our own way. (M. A. Ninsinli, an herbalist at Awiebo – East Nzema District, interviewed by Elisa Vasconi on 1st May, 2009).

Bibeau (1985) takes a similar position and argues that the healers should not be removed from the environment where they live and practice their trade. According to him, a break between the healer and his environment would mean risking the possibility of people giving up their personal responsibilities for taking charge (financial or otherwise) of their own health needs and expecting that everything comes from outside and from the state.

In this sense, the integration we are calling for here is a parallel development of medical resources and also a simultaneous planning and development of the two different therapeutic traditions. In this way, both the traditional medicine and the orthodox medicine in Ghana would be improved to become more adequate in playing their complementary roles of providing the health care needs of the people. In this way too, collaboration and relationship between the two systems would be enhanced and there would be equality and mutual respect which will contribute in the end to a reduction of suppression and dominance.

The implementation and promotion of such a kind of policy of integration would not be an imposition on the people who patronize both practices but would be more responsive to their needs and desires. Improving the medical systems and the provision of health care through listening to the people and giving them space in decision making could enable them to decide or negotiate what to keep or change of traditional behaviors and what to accept or refuse of the modern medicine. In this way what Warren (2000: 241) has defined as “conscious integration” could be attained, because all the parties involved would already be in communication. It is necessary to emphasize here again the
importance of parallel development and also coexistence of different therapeutic resources that cohere and resonate with the exigencies of the people. Thus it is important to put in place a system that is capable of recognizing and accepting each medical system as a complete whole—a system inspired by this form of informal integration already present in the communities. But above all it needs to be stressed that biomedicine and traditional medicine are not really two incompatible realities. They are two realities that are in continuous and constant communication—as evident by their usage by the people—despite the political and other interventions and decisions sometimes made by the government.

Toward a Conclusion

Integrating different medical systems, in this case traditional medicine and orthodox medicine, is a complex project. There are various difficulties that come up in an attempt to plan and formulate strategies for developing a comprehensive medical pluralism. For instance, even for a country like Ghana where there is a national policy for the integration of orthodox and indigenous medicines, the obstacles and resistances are many. Barbara Pillsbury (1982: 1828-1831) has attributed the difficulties in such integrations to different factors. According to her: 1) the national policy of integration cannot have any effect if there are no individual and group interests or administrative authorities that are able to execute it; 2) the non-existence of structures to evaluate the efficacy of indigenous medical practices and the effectiveness of their use in modern health care facilities poses a problem; 3) the national health programs do not have the same incisive effects in the reduction of morbidity and mortality in rural areas as in urban areas; 4) the ineffectiveness of the rural health programs and the dissatisfaction of the medical and paramedical personnel in Africa contribute further to the poor development of the traditional medicine component; 5) the structural crisis of many developing countries obstructs the complete adoption of the national programs of primary health care, and this contributes to the exclusion of traditional medicine from the programs’ priorities; 6) the planners’ political and personal priorities and attention in matters of health programs are more on consolidating the consensus of the rural people on priorities or conditions set by the international organizations that financially support the various national health programs and professional needs of the medical doctors than on the implementation of the programs themselves. The doctors prefer not to work in the rural areas where working and living conditions are poor; and they regard also as waste of time the period spent in the training and development of traditional practitioners.

The health policy in Ghana must reflect the fact that traditional medicine is efficacious in its own way and that it is one of the most used therapeutic resources in the communities. In fact it is the first line of health care delivery for most people, and it can be argued that in every village in Ghana one can find at least one traditional healer whose services, in one way or the other, are sought by the people. Again policy makers need to take into consideration the fact that traditional medicine is holistic; its improvement and
development must therefore be holistic. Traditional medicine is still practiced and is highly patronized by the people; it means that it has adapted and is capable of adapting itself to the changing society. It also means that practitioners of the age old tradition of healing must realize that they have a role to play in health care delivery in present day Ghana, and they must play it assiduously and conscientiously.

Ghana is a clear example of a country where medical pluralism exists and where traditional and other alternative medicines are accepted by the people and the government. However it is also one of the countries where the limitations of a health policy are easily observable, and are challenged by its own social actors who seem not to accept the policy promoted by the government. It will be interesting to observe during the next years how the modalities will evolve—how indigenous medicine will change and the way in which both the patients and practitioners will adapt to the new conditions and continue to use and practice the different medical traditions. But above all it will be interesting to examine the future political changes and the changes that will occur within the health care delivery system and the new power relations among medical systems that will evolve thereon, and the different factors that will encourage their use by patients.

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