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The Politics of Medical Syncretism in the Ghanaian National Healthcare System

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The Politics of Medical Syncretism in the Ghanaian National Healthcare System

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The Politics of Medical Syncretism in the Ghanaian National Healthcare System
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Thesis

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<u>Abstract</u>

Efforts to create public policy integrating traditional/indigenous medical practices and practitioners into national healthcare strategies are currently being pursued in a variety of nations in the Africa region. The purpose of this research is to present a historical case study of the social and political factors associated with the passage of the Traditional Medicine Practice Act of 2000 in the West African nation of Ghana. Research methodology included conducting a thorough examination of available archival and secondary data as well as an abbreviated interview series (N=5). Research findings suggest that significant factors associated with Ghanaian medical revivalism were the role of cultural nationalism in creating a policy platform in the early post-independence period concerned primarily with redeveloping indigenous Ghanaian arts and sciences and the role of individual leadership – personified by Kwame Nkrumah and Dr. Aku Ampofo.

<u>Acknowledgements</u>

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Introduction and Statement of the Research Problem

In the last fifteen years, international giving that supports public health initiatives in the world's poorest countries, particularly in sub-Saharan Africa, has seen dramatic increases. As wealthy nations increase foreign aid spending to support the development of public health infrastructure, private philanthropists such as Bill and Melinda Gates and Warren Buffet have made enormous contributions to the global struggle against poverty and illness. However, what will be the outcome of the recent surge of international generosity focused on public health initiatives?

In the recent January/February edition of *Foreign Affairs* magazine, Laurie Garrett (2007) points out the need for a new strategy in the global struggle against disease and illness in the world's poorest nations. According to Garrett, "much more than money is required. It takes states, health-care systems, and at least passable local infrastructure to improve public health in the developing world."(p.19) Put simply, Garrett's point is that increased international focus on a few specific diseases, while well intentioned, is in effect limiting the ability of national healthcare systems in the world's poorest nations to provide for the primary healthcare needs of their populations. The isolation of specific initiatives from the larger socioeconomic climate, which catalyzes the potential dangers of certain categories of illness, has resulted in an imbalanced and uncoordinated healthcare environment in many of the world's poorest nations. This trend is particularly applicable in the sub-Saharan Africa region, where many of the world's poorest nations are located and which has been most devastated by a variety of infectious diseases. In sub-Saharan Africa, many HIV-positive mothers are now able to receive the antiretroviral

medications necessary to prevent potentially fatal infections, but are unable to provide for their own basic primary healthcare needs as well as that of their children. This is despite the fact that infant and maternal mortality are still the leading causes of death in the region.

The international prioritization of specific diseases has also contributed to increasing the drainage of the local talent pool of healthcare workers in poor countries. As private foundations contribute huge sums of money to local or international NGO's, public sector healthcare workers, tasked with the provision of primary healthcare services, are drawn to the higher salaries and more advanced technologies of the private, non-governmental sector. This further drainage of the local talent pool only adds to the problem of "brain drain" that has had an enormous negative impact in the world's poorest nations for the past several decades.

Garrett points out that in Ghana, "604 out of 871 medical officers trained in the country between 1993 and 2002 now practice overseas." Similarly, Zimbabwe "trained 1,200 doctors during the 1990s, but only 360 remain in the country today." Kenya "lost 15 percent of its health work force in the years between 1994 and 2001 but has only found donor support to rebuild personnel for HIV/AIDS efforts; all other disease programs in the country continue to deteriorate."(p.22) As the demand for trained physicians, nurses, and other healthcare workers continues to increase in the world's richest and most developed nations, healthcare workers from the world's middle and lower income countries step in to fill the gap. Beyond this, as the dollars pour in for specialized projects that have been prioritized by Western philanthropists, primary healthcare workers from public sector ministries of health in the world's poor countries

are further absorbed by the newly wealthy non-government sector, leaving public initiatives for primary healthcare barren of both funding and personnel.

A third criticism that has been leveled against recent international healthcare development initiatives focuses on the ways in which the new international generosity may affect the long-term development of private-sector healthcare industrial and service providing organizations in the world's poor countries. While Ministries of Health face increasing competition from the non-government sector due to the new international flow of finances being directed to NGO's, few of these dollars are being directed towards local private sector, profit making healthcare industries. Again, Garrett notes:

> This should be troubling, because if no locals can profit legitimately from any aspect of health care, it is unlikely that poor countries will ever be able to escape dependency on foreign aid. (p. 28)

Without the development of profit making healthcare industries that can employ local healthcare workers and contribute to national economic growth as well as population health and well being, the current international funding strategy is left without an exit strategy. Meanwhile, poor countries are now, more than ever before, being overrun with international actors who undermine local control over health policy coordination and implementation.

The current trend of spending huge amounts of money on specific diseases is draining the local talent pool of health workers away from the primary healthcare efforts of the public sector while creating a dependency on a level of generosity from the world's core nations that is unlikely to last forever. In place of this current trend, international global health financing should prioritize the long-term development of health care systems that can provide for the primary health needs of all populations. In doing so,

infant and maternal mortality rates could be used as indicators of successful implementation. But many questions remain unanswered. Where are the large numbers of healthcare workers needed to develop local healthcare systems going to be drawn from? What sectors of local industry are to be developed in order to create a sustainable healthcare infrastructure that is not dependent on core nation philanthropy?

What is conspicuously missing in the debate surrounding these issues is an acknowledgement of the potential role of the indigenous physician/healer as community health worker. Why has the international community, while searching frantically for a much needed source of healthcare personnel in the developing world, turned a blind eye to what could be a valuable resource in developing a community-based approach to primary healthcare? Traditional herbal medicines also promise great potential to replace some Western pharmaceuticals, creating a domestic source of revenue within the healthcare sector while also providing a low-cost, readily available, and culturally accepted alternative to expensive Western pharmaceuticals.

The research problem of this thesis is the exploration of the social and political underpinnings of the modern, cosmopolitan healthcare system's discrimination against indigenous physician/healers and the traditional use of indigenous herbal medicines in the world's poorest countries. Utilizing secondary sources from the fields of medical sociology and anthropology to support the foundation from which the thesis will build, I will describe how non-Western medical practices have been marginalized by the dominant cosmopolitan medical system, which expanded throughout the modern world system during the height of the colonial era. In doing so, I argue that the reasons underlining the near total exclusion of the indigenous medical practitioner from the

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formal healthcare infrastructures of all but a few of the world's non-Western nations is rooted in racially constructed assumptions about the validity of non-Western medical knowledge.

Despite the racially defined discrimination of non-Western medical traditions in the colonial and modern, post-colonial periods, several nations have been successful in pursuing the development of pluralistic medical systems in which the indigenous physician/healer is an empowered partner and essential healthcare provider. The thesis will draw from the scholarly work of social, political and medical historians of West Africa, particularly of the nation of Ghana, to examine the historical experience of the indigenous healer in the Ghanaian national healthcare system. In Ghana, the efforts of the indigenous medical system, as well as political insiders and international organizations sympathetic to the indigenous Ghanaian healer, have brought about the creation of a pluralistic medical model in which collaboration between the modern, Western physician and indigenous practitioner is beginning to become a reality. Though the majority of data presented in this thesis is historical and has been collected from secondary scholarly sources, a series of interviews with local stakeholders from the Ghanaian Ministry of Health and the Ghanaian Centre for Scientific Research into Plant Medicine contribute personal perspective and insight into the more recent developments in the revival of indigenous medicine in Ghana. In collecting the interview data, particular attention was given to the social and political factors that influenced the advancement of an ideology sympathetic to medical syncretism in the Ghanaian national healthcare policy agenda.

Ghana's healthcare policies concerning the role of the indigenous physician/healer in a modern national healthcare strategy represents a model for those nations in the sub-Saharan Africa region seeking to create a healthcare strategy that will be responsive to the needs of its people and not to the demands of international donors. As such, a series of policy recommendations for the development of truly pluralistic and cooperative medical systems throughout the Africa region are advanced in this thesis. Here, I will attempt to clearly define the proper role of the state policymaking apparatus in the professionalization process of an indigenous medical system. Of primary importance will be the construction of a policy model advocating a balanced primary healthcare policy strategy that recognizes the importance of both community-based, socially accountable healthcare policies as well as clinical-oriented, profit-making healthcare industries within the national healthcare infrastructure.

I. Review of the Literature

Medicine in the Context of Culture

Any conversation concerning medical services, whether they are hospital based, community based, or home based, must first seek to define the ideas and institutions that are associated with terms "medical care" in one's own individual understanding of medicine. In a Western context, the thinker will immediately envision the familiar hospital or clinical settings in which the doctor-physician is the central character, around whom a myriad of healthcare workers and technical instrumentation revolves. Maclean (1971) describes the modern, Western medical encounter:

> He (the patient) sits warily down in the uncertain atmosphere of the waiting room... Once his turn arrives, and he crosses the threshold of the surgery, events take an altogether more positive turn. Ranged around the

consulting room are all the familiar appurtenances of modern practice: scales and gauges of one sort or another, bottles, phials, dishes, balls of cotton wool, a syringe lying casually upon a desk, the examination couch against the wall…In next to no time our friend is out in the street again, already feeling considerably easier in his mind. His formerly vague symptoms have been given a name and he himself has been given a prescription, which he proceeds with all haste to exchange for the appropriate medicament. With his doctor's observations and advice still sounding clearly in his ears he steps out with renewed confidence. His uncertainty is over… and he now knows precisely what he ought to do. (p.12)

Though grandiose, this description of the modern medical environment will not seem unfamiliar to the North American or European reader. However, it is not a medical environment that is to be found in many other cultural systems. Therefore, in beginning a discussion of so-called "indigenous" or "traditional" medicine in the modern world, we must first expand the horizons of our own cultural definitions of the term "medicine". We must begin to conceptualize the "metamedical" aspects of this term as a group of ideas rooted in our own peculiar cultural environment. In doing so, we will be able to move beyond the limitations of our cultural assumptions about what medicine is or should be and envision the image of what medicine could become given the variety of evolutionary experiences that cultural systems from throughout the world have experienced.

The Socio-cultural Evolution of Healers and Healthcare Workers

Birth, illness, injury, and death are universal phenomena. They were historically, as they are now, experienced by every plant and animal species of the globe. In response to these universal occurrences, cultural systems and various plant and animal species have created, over the course of their historical and evolutionary development, methods of combating and coping with these phenomena. Within each particular cultural system

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from throughout the globe there can be identified specific materials and practices that have been recognized for their usefulness in this coping strategy. As the recognition of the healing potentials of specific materials and practices are passed down in oral and written traditions, medical systems become formalized and medical practitioners; adept at utilizing culturally accepted materials and practices, emerge as the legitimate authority of medical practice within their cultural system. Over the last several thousand years, varying cultural systems of the human species have developed a wide range of medical strategies for coping with the occurrences of birth, illness, injury, and death. (Fabrega, 1997)

Personalistic and Naturalistic Medical Systems

It is important to distinguish between some of the dichotomous elements that characterize all of the medical traditions from throughout the globe. Scholars in the field of medical anthropology generally distinguish medical systems as practicing either naturalistic forms of medicine or personalistic forms of medicine. (Foster and Anderson, 1978) Naturalistic medicine perceives the etiology of medical illness to be rooted in the imperfect functioning of the body itself. In naturalistic medical systems, internal disorders of the body are generally thought to be the result of non-intentional interactions with the surrounding physical world.

On the other hand, personalistic medical systems perceive the etiology of illness to be the result of malevolent actors within a supernatural, or cosmic, world. Personalistic medical beliefs are often symbolically related to one's interpersonal relationships with living family members, ancestors, community members, or religious deities. Although many of the world's ancient and contemporary medical systems belong

to the category of personalistic medical systems, modern European and American medical systems reject the beliefs and values that explain the etiology of illness in a personalitic framework.

Similarly, medical anthropologists commonly distinguish actions of medical curing from actions of medical healing. (Strathern and Stewart, 1999)   According to this distinction, acts of medical curing refer to medical practices that aim to treat specific conditions within the biological organism. By contrast, acts of healing refer to medical practices that focus on the maintenance of the whole being as an integrated part of his/her socio-cultural environment.

While modern biomedicine is concerned solely with acts of medical curing, acts of medical healing are more commonplace in the personalistic medical systems of the non-Western world. Defining the historical point that marked the original departure of modern, Western medicine from the personalistic, healing traditions of the past, Capra (1983) states:

> The greatest change in the history of Western medicine came with the Cartesian revolution. Before Descartes, most healers had addressed themselves to the interplay of body and soul, and had treated their patients within the context of their social and spiritual environment… Descartes' philosophy changed this situation profoundly. His strict division between mind and body led physicians to concentrate on the body machine and to neglect the psychological, social, and environment aspects of illness. (p.42)

In defining "traditional" medicine and examining its potential role in indigenous, non-Western societies, we must challenge the assumptions of Descartes and critically examine the scientific outgrowth of these assumptions within our Western cultural system. Particularly, we must attempt to move beyond our cultural assumptions as they relate to

the medical division of body and mind, and the expulsion of social and religious psycho-emotive elements as etiological factors in disease and illness manifestation.

Medical Systems and Medical Pluralism

Medical pluralism currently exists in nearly every cultural system throughout the world. Strathern and Stewart (1999) state that medical pluralism "exists in any arena where competing forms or systems of medical practices coexist." (p.23) Though it may be argued that there remain some societies and cultural groups that have not been penetrated by the modern, cosmopolitan medical system, it will likely be found that within these cultural systems there exist multiple interpretations of illness etiology and perhaps even a variety of pathways or possibilities for medical treatment. Frederick Dunn (1976) suggests that there are three distinguishable types of medical system that may be found in any one cultural system. Local, or folk, medical systems, refer to the particular medical beliefs and practices of a national or sub-national ethnic group. Regional medical systems, by contrast, are those medical systems whose influence has spread across a larger geographical setting. Examples of regional medical systems are the Unani and Ayurvedic medical systems, which coexist within the Indian subcontinent. Finally, the cosmopolitan medical system refers to the modern, Western medical system that has, over the course of the last two centuries, expanded into nearly every region and cultural system in the world as an extension of the European colonial heritage.

Though Dunn's classification of medical systems into these three groupings is convenient for our study, Bradley Stoner (1986) argues that this type of classification oversimplifies what is in many circumstances a much more complex array of medical systems and subsystems. Though scholars of medical pluralism often present a

dichotomous relationship between the modern, cosmopolitan system and the traditional medical system, representing both regional and folk medical traditions, Stoner suggests "the use of the term 'traditional' is inadequate for a thorough understanding of the range of health care alternatives in pluralistic societies."(p.6) Citing the Malaysian peninsula as but one example, Stoner notes the presence of cosmopolitan medicine, Ayurvedic medicine, Unani medicine, traditional Chinese medicine, and local/folk Malay healing techniques in one geographical region. The common tendency to separate the modern versus the "traditional" in this circumstance, combining all non-Western medical systems or sub-systems into a single alternative category, is inappropriate. Similarly, within the African continent, the so-called "traditional" medical system is often a combination of a complex array of indigenous healing modalities that include bonesetters, midwives, herbalists, spiritual healers, shamanic healers, and Islamic faith healers. According to Stoner:

> Pluralism can now be examined as a multiplicity of healing techniques, rather than of medical systems; the study of health care choice in pluralistic societies can then proceed with reference to these various identifiable therapeutic alternatives, with less emphasis on the particular "system" from which they derive and in which they operate. The labeling of healing methods as "traditional" or "modern" becomes less important than the development of an understanding of the contextual, metamedical nature of the illness experience, the healing process, and the decision to utilize one health care resource over another. (p. 8)

The Emergence of Modern Medicine in Europe and North America

The rise to dominance of Western medicine according to the "germ theory" of disease can be characterized as a process that has centered on technological as well as ideological advancement. Baer (2001) asserts that biomedicine's focus on germ theory as the sole explanatory model of disease and illness allowed corporate and government

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elites to "neglect the social origins of disease while at the same time…restoring workers back to a level of functional health essential to capital accumulation." (p.28)) As such, the author portrays the development of the American Medical Association as an organization dominated by the political economic goals of ruling government elites and the corporate class that supported them.

> The dominance of biomedicine rests on an alliance between medical practitioners and the state, which in turn represents the interests of the corporate class. (p.34)

With financial support from private donor organizations such as the Carnegie and Rockefeller Foundations and a dominant level of influence in government policy making, biomedical physicians were able to limit the expansion of competing systems of medicine by preventing their participation in medical societies, boards of health, hospitals, and teaching schools and universities across the nation.

The Expansion of the Global Medical System

While traditional medical systems from diverse regional locations may differ greatly in their beliefs and practices concerning the etiology and treatment of disease and illness, they share similarities in their historical interactions with Western culture and the Western biomedical system. Western dominance in the colonial era and the emergence of biomedicine within the Western cultural tradition in this same period resulted in the expansion of biomedical philosophy as the dominant medical philosophy in the world system. Throughout the colonial period, traditional systems of medicine and their practitioners were portrayed as primitive and inferior to their Western counterparts. Moreover, traditional medical systems were systematically de-legitimated as colonial

powers attempted to impose Western cultural beliefs and values onto their colonial subjects.

Discussing the role that biomedical domination played in strengthening the British colonial rule of India, Maneesha Lal (2003) states:

> Heralded as an emblem of benevolence and civilization, medicine served a powerful function in legitimizing the colonizing process and facilitating imperial dominance over indigenous populations in cultural and social as well as scientific domains…Colonial doctors typically depicted "natives" as dirty, ignorant, and superstitious, thereby authorizing assumptions of racial and cultural superiority. Asian and African healing specialists – and the forms of medicine they practiced – began to be routinely denounced, viewed as barbaric and unscientific, while Western medical practice was presumed to rest on an enlightened and rational basis. Western medicine thus helped to constitute fundamental aspects of European identity in the age of Empire. (p.176)

In a similar account, David Gordon (2003) describes biomedicine's expansion into the British colonial territory of modern day South Africa as a "new 'modernizing' project that constructed African medicine as its 'primitive' Other." Under the British controlled Supreme Medical Committee, African healers were forced out of practice and their hospitals and medical institutions closed. Perhaps most significantly, "African patients lost their ability to control and guide their therapeutic quest."

> Thus there were two distinct groups of professionals: the orthodox medical practitioners who were the real beneficiaries of the white man's colonial rule and the indigenous herbal medical practitioners who were the silent majority for whom the British colonial rule was a negation of all they held dear in the indigenous realm. (Lambo 1977:112)

In the middle decades of the twentieth century, nationalist movements sparked revolutions throughout the colonial world that overthrew European colonizers and returned social and political control to indigenous populations. Again, medicine played an important role in the nationalist independence movements that argued for the return of

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pre-colonial cultural institutions and values. However, despite the strength of the nationalist ideologies in the early years of post-independence, Western, orthodox medicine had been firmly institutionalized throughout the world system. In the final decades of the twentieth century, as well as the early years of the twenty-first century, the struggle for legitimacy of indigenous medical systems in their relationships with the orthodox medical system mirrors that of alternative and complementary medicine throughout Europe and North America.

Similar to the account provided by Baer of the relationship of alternative and complementary medicine to the orthodox medical system in Europe and North America, indigenous medical systems have attempted to professionalize their structures and practices in an attempt to reclaim legitimacy within their individual cultural environments. However, under the rhetorical guise of integration, indigenous medical practitioners are compelled to conform to the institutional guidelines created by the dominant medical system. Moreover, the process of professionalization is characterized as a process that instills the underlying political economic ideology of corporate capitalism into indigenous systems of medicine and often results in the inevitable absorption of these systems into the economically dominant, hegemonic system of biomedicine. (Baer, 2001)

Re-examining the Role of Indigenous Medicine in Non-Western Cultural Systems

While there is little argument that Western medical systems have the capacity to yield impressive health outcomes in the developing world, individual nation-states have historically struggled to finance the construction of the hospitals and rural health clinics

that are at the center of Western medical infrastructure. Furthermore, the dependence of developing, peripheral nations on European and North American core nations for medical materials, equipment, pharmaceuticals, and personnel has crippled efforts in the developing world to develop and maintain comprehensive and effective modern medical systems.

Nigeria's experience as a peripheral nation in the world system is aptly described by Alubo's (1993) article concerning the government of Nigeria's repeated failed attempts to implement the World Health Organization's "Health for All by the Year 2000" development program. Alubo uses the Nigerian experience to clearly portray the dominance of core Western power in the world system and the ability of the core to dictate the healthcare policies of peripheral nations by means of international organizations such as the World Health Organization and the World Bank.

The HFA/2000 program, which highlighted the construction of medical treatment facilities such as hospitals and rural health clinics and the purchase of medical equipment and pharmaceutical products from core regions of the world system, was little more than an attempt to Westernize Nigerian health care systems and establish Nigerian dependence on the core dominated medical industrial complex for the supply of health-care treatments, technologies, and specialist personnel. Alubo states, "it is clear that the implementation of HFA/2000 has neglected health care and concentrated on medical care."(p.34) Here, Alubo uses the term "medical care" to point out the liberal political economic philosophy underpinning Westernized healthcare systems which envision the patient primarily as a consumer and care less for his/her health and well being than for his/her continued participation with the market economy.

As the short-lived wealth of the oil boom period passed, Nigerian health officials were encouraged, by World Bank and IMF incentive packages, to enforce fee for medical service policies that effectively removed access to medical care from rural and poor populations while at the same time enlarging Nigerian debt and dependency on core Western nations for the continued supply of medical products. "In contrast to its purported goal, the implementation of HFA/2000 in Nigeria might provide medical care to some while denying health care to most."(p.35)

Medicine and Ethnic Identity

Many other scholars have pointed out the dramatic improvements in national health indicators that have followed public health policies focused on developing Western, biomedical infrastructure. In one such study, Subedi and Subedi (1993) describe the dramatic reductions in infant mortality rates and increases in life expectancy that accompanied a national strategy to develop modern medical infrastructure in the urban centers of the nation of Nepal. However, the authors also point out the reluctance of rural populations to utilize a medical system based on foreign beliefs and values.

In a more structured study focusing on the relationship of ethnicity and health care seeking behaviors among the Malay, Hindu, and Chinese sub-national ethnic populations of Singapore, Quah (1993) demonstrates the "persistent differences in health behaviors" among varying ethnic groups. Taken together, the two studies highlight the potential challenges facing Western, biomedical systems in non-Western and/or ethnically diverse populations. Can the medical models of the Western world be applied wholesale to nations that are resource poor and/or culturally diverse?

Challenges and Limitations to the Development of Traditional Medicine

Despite the dominance of Western medicine in the modern world system, the important role that traditional medical systems play in providing primary health-care services to a large percentage of the Africa region's rural populations cannot be ignored. The World Health Organization estimates that, in Africa, up to eighty percent of the rural population continue to rely on traditional medicine for their primary healthcare needs. (WHO, 2002) Addressing the need to encourage the utilization of traditional medical systems in the developing world, the World Health Organization declared its Primary Health Care (PHC) strategy in 1978.   The strategy called for the promotion and development of traditional medical systems. (WHO, 1978) Despite the WHO's effort to encourage the development of traditional medicinal practices in each of its member states, few states have actually been successful in developing their traditional medical systems.

In an interview with Dr T.A. Lambo (1975), the former Deputy Director-General of the World Health Organization and the primary developer of the WHO's 1978 Primary Health Care strategy, Philip Singer discusses the importance of including traditional healers in primary healthcare services and the challenges facing the developing policy strategy. The following is an excerpt of that interview.

> **TAL:** You're quite right. Things are moving rapidly. So much so that only yesterday I signed the paper of the traditional healing – the Executive Board paper, which, if you see, you'd be absolutely staggered.
>
> **PS:** *Can you tell us a little bit about this?*
>
> **TAL:** Yes, we're now proposing to the Executive Board which will go to the Assembly that there should be some measure of integration of traditional healing. That each Member State should examine critically all the modalities in their culture, at their disposal, and that at the same time

be able to salvage as much as possible to syncretize and integrate this. And this is completely unusual. In fact, for the time we are laying ourselves wide open.

PS: *In fact, I'd say it's a manifesto; it's a revolutionary manifesto.*

TAL: Absolutely revolutionary. And there is going to be a great deal of resistance, antagonisms; there'll be the mafia of the world…

PS: *The mafia of the world – I like that. Who'd you describe as the mafia of the world?*

TAL: I wouldn't like to mention them. I'm sure…ha, ha, ha…

PS: *Alright, alright. Well, for the benefit of the listeners who may not be as knowledgeable as to the medical mafia of the world. I won't identify them per say. I would simply say that they represent the dominant medical organizations in that they represent the dominant medical organizations in whatever country where the medical profession happens to be dominant. I suppose though as an American, I'd have no hesitation in saying that in America it represents the American Psychiatric Association and the American Medical Association…(p.249)*

Lambo's anticipation of the dominant professional group's (Physicians Associations such as the American Medical Association) strong resistance to policy initiatives aimed at empowering a competing professional group (indigenous healers) has proven to be extremely accurate. Over the past thirty years, the relationship of the modern professionalized physician with the marginalized indigenous healer has been extremely turbulent, and, despite the WHO's 1978 declaration, only a few nations have been able to create a truly cooperative medical system capable of fully utilizing the strengths of both the modern and indigenous medical subsystems.

Discussing the relative failure in traditional medicine policy development among the member states of the Africa region following the passage of the 1978 WHO Primary Health Care strategy, Airhihenbuwa and Harrison (1993) point out that development attempts have primarily been based on a "donor-deficit model" for traditional healers.

According to this model, traditional healers have been primarily portrayed as having little to donate to modern medical systems. Instead, traditional healers are seen as being in need of education and training so that their services may be utilized by the dominant modern medical system. Though traditional pharmacopoeias have been eagerly sought out for their potential market value in the corporate dominated European and North American pharmaceutical industries, Airhihenbuwa and Harrison state; "seldom is the traditional healer pictured as a health provider with adequate or superior knowledge that will benefit the allopathic provider (the physician)." (p.86)

Medical Syncretism

In global regions where diverse cultural beliefs and values combine with economic poverty to limit the expansion of European medicine into the rural communities or into the socio-cultural fabric of the community, social scholars point out the relative successes that some nations have had with integrating their traditional and modern medical sectors. Gerard Bodeker (2001) points out the potential to learn from the experiences of the nations who have been successful in developing and implementing medical integration strategies. In a comparison of the East and South Asian nations that have actively pursued the integration of modern and traditional medical systems, Bodeker points out two basic policy models.

The first of the two policy models, most successfully achieved in the Chinese healthcare system, stresses the integration of the dual medical systems into a singular, yet cooperative, medical system by creating state-sponsored educational and institutional structures combining traditional and modern medical knowledge and practice. Additionally, by creating a medical referral system between the two medical sub-systems,

the nation of China has created a pluralistic system that allows traditional and modern physicians to work in a collaborative and cooperative fashion.

The second model, pursued with a relatively high degree of success in both India and South Korea, encourages the independent development of each medical system as distinct, competitive medical sub-systems. While these later nations have installed licensing procedures and educational infrastructure for traditional medical practitioners, state support for the institutional and educational resources necessary to develop traditional medical knowledge and technologies has been inconsistent. This lack of adequate budgetary support for the institutional needs of traditional systems of medicine has resulted in the absorption of a large percentage of traditional medical practitioners into the modern, Western medical system.

While Bodeker fails to present a comprehensive analysis of the subject, he does highlight an important gap in the literature. Scholarly work to present historical-comparative analyses of policy attempts to professionalize and integrate traditional medical practices and practitioners into the formal healthcare infrastructures of individual nations can contribute valuable feedback for modern efforts to develop similar policy strategies.

II. Conceptual Framework and Research Methodology

Research Question and Conceptual Framework

What social and political factors influenced the development of policies to professionalize and integrate traditional systems of medicine into the formal healthcare infrastructure of Ghana? What lessons might policymakers from those nations in the

Africa region who are currently seeking to develop the role of traditional medicine in their national healthcare infrastructures learn from the Ghanaian experience?

In order to analyze these questions, it is necessary to first identify and define some key terms and concepts. In the previous chapter, traditional medicine was defined as the indigenous strategies that an individual cultural system has developed over the course of its historical and evolutionary development to cope with the universal phenomena of illness, injury, or death. It was also pointed out that within each individual cultural system certain individuals or groups have been elevated to positions of respect for their ability to better utilize and maintain these strategies. While individual cultural systems' specific coping strategies have been defined as "traditional" in their relationship to "modern" or "Western" medicine, individuals within "traditional" cultural systems who have been recognized for their ability to utilize and maintain traditional medical practices are here referred to as traditional medical practitioners, traditional healers, or traditional doctors. Lastly, it has been shown that medical pluralism, defined as the coexistence of multiple medical subsystems in a single cultural system, is universal.

At the center of any policy strategy to professionalize traditional systems of medicine is the relationship of the state bureaucracy with traditional medical practitioners. Paul Unschuld's (1976) distinction between the primary and secondary resources available to a given medical system provides a clear picture of how state policymaking affects the relationship of traditional and modern medical systems in a medically pluralistic society. Unschuld defines primary medical resources as the medical knowledge, including therapeutic objects, techniques, and facilities available to medical practitioners. Secondary resources are defined as the remunerations received for medical

service. Therefore, multiple medical systems existing in competition with one another vie for the political support, in the form of primary medical resources, which will allow them to succeed in their competition with other medical systems for secondary medical resources.

The inevitable form of the politically structured coexistence of multiple medical systems is the result of state policymaking that can assume one of three forms. The first form of structured coexistence is structured competition. Structured competition refers to the political regulation and supervision of multiple subsystems that compete for the same primary and secondary medical resources. This form of coexistence is most notably present in India and South Korea where licensing and regulatory policies have been established for traditional medical practitioners. Structured competition is also prevalent in both Europe and North America. However, in these later regions, liberal political-economic ideologies often guide policymaking that provides vastly higher levels of support for the peculiar primary medical resources desired for the development of Western, biomedical infrastructures which encourage higher levels of market participation from the public.

The next form of structured coexistence is structured cooperation. Structured cooperation is defined as a political organization of multiple medical subsystems that rely on different primary medical resources and collaborate through an extensive system of medical referral from one subsystem to the other based on the need of the patient. Structured cooperation is most clearly represented by the Chinese healthcare system in which traditional Chinese physicians work, often side by side, with modern physicians without concern for secondary medical resources. Importantly, Unschuld notes:

This cooperation probably cannot take place in an economic system with a free health market, where the interests of certain large industries such as pharmaceutical manufacturers are dependent on one rather than another subsystem's performance. (Unschuld 1976:10)

Lastly, structured integration allows all primary medical resources to be available to practitioners of each of the individual medical subsystems. As concerns the structured integration of medical subsystems, the inevitable questions are: Which system is being integrated into which other system? And, what is the role of the state in regulating the integration process? Unschuld correctly notes that in the case of non-Western nations, it is normally the practitioners of traditional medicine that are viewed as a medical manpower resource that should be integrated into Western medical systems. The structured integration of two medical subsystems has been advocated in both Asia and Africa at certain historical moments. However, this form of structured coexistence has only once been aggressively attempted in early twentieth century China before that nation changed its policy strategy in favor of a more cooperative approach.

Unschuld's distinction between the various forms of structured coexistence of medical systems provides a clear framework from which to analyze the political support of medical systems, whether traditional or modern, in a given nation. What is the level of legitimacy offered to traditional medical practitioners and traditional medical practices by the organized nation-state bureaucracy? Has the state established processes of licensure and regulation of traditional medical practitioners and traditional medical practices? What is the level of state-sponsorship of educational infrastructure for the training of medical practitioners and for the research and development of traditional medical practices? Has the government established systems of referral from one medical subsystem to another that allow for cooperation between the two medical subsystems? If

so, what is the mechanism of control for the remunerations of both traditional and modern medical practitioners? In defining the dependent variable of this investigation, policies focused on traditional medicine in Ghana, the investigator will answer each of these questions as they apply to the Ghanaian healthcare system.

Now that the factors that will characterize our dependent variable have been clarified, I shall concentrate on defining the independent variable(s). It has previously been stated that the independent variable or variables are the social and political factors that influenced the development of policies focused on the structured coexistence of traditional and modern medicine in the Africa region. As the research has primarily been an exploration of the historical social and political factors that influenced the development of policies focused on traditional medicine in the nation of Ghana, the research did not lend itself to conventional hypothesis testing, requiring a precise definition of the independent variable prior to variable manipulation. Instead, the investigator relied on qualitative methods of inquiry in order to identify and examine the historical factors that influenced the development of policy focused on traditional medicine in this state. The purpose of this research has therefore been to highlight a group of socio-political factors, which have influenced the development of a particular policy strategy in an identified nation-state within the African continent. Social and political factors examined included the role of cultural nationalism and its relationship to medical revivalist movements, the role of individual leadership, the form and use of accepted and identifiable policy agenda setting strategies, the role of conflict among ethnic minority groups, and the structure and strength of international resistance. The research contends that the factors highlighted are significant and will be of value to future

comparative research efforts as other nations within the African continent attempt to implement similar policy strategies.

Research Methodology

In order to construct a historical narrative of the development of traditional medicine policy in the nation of Ghana, the researcher first gathered primary archival data from a variety of printed news sources. Using a targeted search engine specifically designed by the investigator to isolate historical news articles focused on traditional medicine/traditional healers in Ghana, the researcher gathered numerous articles dating from the early 1960's to early 2007. The sources of these articles included the Ghanaian Chronicle, the Accra Mail, the Xinhua General Overseas News Service, and the Global News Wire's Pan African News Agency.

Primary data from historical printed news articles was a valuable resource in generating an introductory timeline of the events, times, places, and socio-political actors influential in developing traditional medicine policy in Ghana. However, the development of a true narrative of this historical development required the collection of additional data utilizing available secondary data sources. These sources included selected book chapters and scholarly journal articles focusing on the historical development of traditional medicine in Ghana from a historical, anthropological, sociological, and/or political/public policy perspective.

Further data was then collected through an abbreviated series of semi-structured interviews (N=5). Data collected from interviews served the essential purpose of contributing data concerning recent developments in Ghanaian traditional medicine

policy development. Equally important, data collected from interview participants was utilized to confirm the accuracy of data previously collected from primary archival news sources and other secondary data sources. Due to multiple instances of conflicting data, triangulation of multiple data sources was an essential component of the project's research methodology. Interview participants included current and former officials from the Ghanaian Ministry of Health as well as members of the Ghana Traditional Medicine Council. Current and former leaders from other non-governmental organizations such as the Ghana Federation of Traditional Healers Associations and the Center for Scientific Research into Plant Medicine were also interviewed. Names of potential interview candidates were gathered from the primary and secondary data sources that had been previously analyzed by the investigator. A snowball sampling technique was then utilized to gather data from a larger sample of interview participants. The investigator initially contacted candidates for formal interview via telephone or e-mail. Informed consent was then received for each individual interview participant. Due to an insufficiency of funds to provide for the investigator's travel to Ghana, interviews were conducted via telephone.

All interviews were recorded and transcribed by the investigator. Telephone interview questions focused primarily on issues relating to the development of traditional medicine policy in the Ghanaian national healthcare system which have occurred over the last fifteen years and which have not been adequately documented as yet by the available literature concerning this area of inquiry. Specific areas of inquiry included the formation of the Ghana Federation of Traditional Healers Associations, the creation and current role of the Ghanaian Traditional Medicine Council and Centre for Scientific

Research into Plant Medicine. Interviews also focused on the role of the Ministry of Health and the National Food and Drugs Board in promoting the development of a national and international market for Ghanaian herbal medicine. Coding of interview transcriptions revealed multiple significant social and political factors influential to the historical development of traditional medicine policy in the Ghanaian national healthcare system. These factors will be highlighted in the subsequent sections of this research thesis.

III. Research Findings

A Political History of Ghanaian Traditional Medicine

Introduction

In the past decade, a number of African nations have begun to design policy strategies to expand the role of traditional African medicine in their formal healthcare systems. These efforts involve policy processes that include the education and licensure of traditional healthcare practitioners and the regulation of traditional medical practices. The aim of these policy strategies is the professionalization of informal medical systems and the integration of these systems into the formal healthcare systems of these nations. It is hoped that the integration of the formal, modern healthcare system with the informal, traditional healthcare system will create a more capable network of healthcare practitioners in order the meet the demanding healthcare needs of the Africa region.

Within the Africa region, the nation of Ghana has, since its independence in 1957, worked to develop and implement a comprehensive policy strategy to professionalize its traditional medical system and develop that system's role in the nation's formal healthcare infrastructure. This chapter will provide a socio-historical case study of the

medical revivalist movement that has occurred over the course of the past four decades in the nation of Ghana.

Colonialism and the Repudiation of Indigenous Medical Practice

Before contact with European colonial powers, indigenous medicine was the only form of medical care in Ghanaian society. Warren (1986) suggests that among the pre-colonial Asante, extensive medical systems were highly influential at all levels of society in health promotion and disease prevention initiatives. However, similar to the experiences of colonized territories around the globe, British colonizers of the Gold Coast systematically worked to reduce the influence of traditional doctors and replace indigenous medicine with European medical institutions and practices.

Prior to the establishment of British control over the Gold Coast region, Chief J.O. Lambo (1977) describes the role that missionary influence had in denouncing traditional African cosmology, including traditional medical practices.

> The missionaries intensified their activities to destroy all things native. The motive behind all these was to wipe out completely all indigenous powers and African Science so that God the Father (Government) might find it easy to acquire and colonize many countries in Africa with no fear of opposition or resistance. (p.127)

In 1878, after solidifying control over the Gold Coast territory, the British colonial government enacted legislation formally denouncing indigenous medical practices and, in its place, began to develop the colony's medical infrastructure based on Western medical tradition and philosophy. In urban areas where the colonial presence was greatest, indigenous medical practitioners were forced to work in secret. In the rural areas where colonial presence was less pronounced, however, traditional medical practice continued unabated.

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The Reemergence of Indigenous Medicine

In 1961, four years after the nation's independence, the newly independent Ghanaian government oversaw the creation of the Ghana Psychic and Traditional Healers Association. This government mobilization of an organized and socially recognized group of traditional healers was a significant first step in the revitalization of an indigenous medical system that had been socially and politically marginalized throughout the period of colonial rule. Though the GPTHA consisted of traditional healers from the region immediately surrounding the capital city of Accra, its formation sparked the creation of five other traditional healer associations representing traditional healers from throughout the nation. It also legitimized a powerful political lobby that would continue to push for the further development and professionalization of the Ghanaian indigenous medical system even beyond the overthrow the Nkrumah government.

One primary duty of the six original healer associations was rooting out charlatan practitioners. In Ghana, as in many other countries in Africa, charlatan healers pose a major threat to the professionalization process of the indigenous medical system. In order to reestablish their own social and political legitimacy, the members of the GPTHA and its counterparts needed to restore the respect for traditional medical practices that had been undermined during the colonial era. To achieve this goal, the medical practices of the traditional system needed to be standardized. Therefore, shortly after their individual inceptions, the associations began a process of self-regulation and self-licensing.[1] Even today, this process of self-regulation is ongoing.

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[1] Personal Communication

Building Strength in the 1970's and 80's

The second priority of the Nkrumah government in the early post-independence period was furthering the knowledge of the potentialities of traditional medicine. Therefore, in 1975, the Centre for Scientific Research into Plant Medicine was established under the leadership of Dr. Oku Ampofo at Mampong, just North of the capital city of Accra. The first officially recognized institution created to research traditional medical practices, the creation of the Centre was a major victory for the Ghanaian indigenous medical system.

Under the leadership of Dr. Ampofo, the Centre quickly became a place for traditional practitioners to gather and contribute to the creation of a compendium of traditional Ghanaian medical practices. Though some healers were skeptical of the Centre's intentions and refused to relinquish knowledge that was considered to be the sacred possession of themselves or their family, many others chose to contribute to the reconstruction of a medical philosophy based on traditional Ghanaian knowledge and values.

By the end of the decade of the 1980's, the Centre for Scientific Research into Plant Medicine had developed into a major research agency under the Ghanaian Ministry of Health. As more and more healers sought the legitimacy of scientific evaluation concerning the efficacy and safety of their herbal products, the Centre's findings began to demonstrate the true potential that traditional medicine could play a significant role in the nation's healthcare strategy. In the early 1990's, the early leaders of the Centre began to play a significant role in lobbying the Ministry of Health to develop the institutional structure of traditional medicine within the Ministry.

The politically turbulent decade of the 1970's, as described in the brief political history provided earlier in the chapter, meant that developing government policy concerning traditional medicine was less of a priority than it had been in the early 1960's under the Nkrumah administration. Leaders of the traditional medicine movement would instead begin to capitalize on the increased interest of international organizations in indigenous medicine, particularly traditional birth attendants. Therefore, in the early 70's the University of Ghana began collaboration with the University of California, Los Angeles (UCLA) to develop a project that would train traditional birth attendants (TBA's) to recognize potentially high-risk pregnancies and to practice safe delivery techniques. With major funding from USAID and the World Health Organization, the Danfa project provided training and materials to traditional birth attendants in the Danfa region, near Accra, and in the rural Kintampo district.

The Danfa project was successful because it created community-wide investment in the project. Demand for TBA training would come from the community and not from the trainers themselves. The community-based orientation of the project solicited a high TBA turnout for training sessions and raised the level of community awareness concerning correct TBA practice and the dangers of charlatan healers in general. The Danfa project shows how community-based primary healthcare programs can be successful if they focus on creating broad community support, and perhaps demand, for the development of a traditional medical system by collaborating with community stakeholders and developing training procedures that are sensitive to traditional beliefs, values, and customs.

Although the Danfa project was limited in that it was concentrated specifically on traditional birth attendant training, its success led to the development of other initiatives to continue the expansion and development of the traditional medical system in Ghana. In 1979, the Primary Health Training for Indigenous Healers (PRHETIH) Project expanded the training that the Danfa project had begun. Unlike Danfa, the PRHETIH project included all categories of indigenous medical practitioners. Importantly, the PRHETIH project was the first project to incorporate various categories of indigenous healers in the planning and implementation processes of the project. In collaboration with Ministry of Health officials, the Catholic Bishop and the Holy Family Hospital in Kintampo, and volunteers from the United States Peace Corps, indigenous healers from the Ghana Psychic and Traditional Healers Association and the Centre for Scientific Research into Plant Medicine formed the leadership for the project. (Warren, 1986)

Implementation of the project consisted of an initial training of trainers program for a select group of traditional healers at the Centre for Scientific Research into Plant Medicine. Indigenous healers who had completed special courses, staff from the Holy Family Hospital, and Peace Corps Volunteers led fourteen-week training sessions for indigenous healers in the Ghanaian Techiman District. Several years after the program's implementation, Warren notes:

> Follow-up surveys have indicated a high level of information retention, a rapid diffusion of information on topics such as oral rehydration to numerous healers who have not yet had the opportunity to take part in training sessions, and considerable improvement in the relationships between the Western allopathic health workers and the indigenous healers. Increased numbers of referrals of patients in both directions have resulted. In the past several years the immense outpatient load carried by Holy Family Hospital has declined dramatically, from a high of more than 120,000 outpatient visits in 1980 to 65,000 in 1985. (p.83)

Establishing Legitimacy: the 1990's and Beyond

Beginning the early 1990's, the Ministry of Health, largely because of the research being done at the Centre for Scientific Research into Plant Medicine, began to take a more proactive role in the further development of the indigenous Ghanaian medical system. In 1991, the creation of the Directorate for Herbal Medicine within the M.O.H. provided a place for ministry officials to meet with herbal practitioners to discuss the development of correct practice within the field of traditional medical practice. The early mandate of the Directorate was the education of traditional practitioners and the regulation of traditional practice.

In 1997, the creation of the national Food and Drugs Board provided practitioners an avenue for formally licensing their herbal products. By 1997, the Centre for Scientific Research into Plant medicine had approved a wide array of traditional products for safe consumption, and the Directorate for Herbal Medicine had worked alongside traditional practitioners to educate and regulate the traditional medical practices. The mandate of the Food and Drugs Board, in relation to traditional medicine, was to consult with traditional practitioners on areas of concern such as product packaging and distribution. In doing so, the Food and Drugs Board allowed practitioners with demonstrably useful products the ability to market their products not only across the nation of Ghana, but also throughout West Africa and the rest of the cosmopolitan marketplace.

Perhaps equally significant was the unification of the six traditional healers associations into a single, national association. The Ghana Federation of Traditional Medicine Associations was formally created in 1999. Shortly following the unification of GHAFTRAM, the organization began work on a practitioner Code of Ethics and a

national strategy for traditional, alternative and complementary health care in Ghana. The unification of the regional traditional medicine associations into a singular political lobby and the production of a Code of Ethics, which clearly outlined the role that traditional healers desired within the national healthcare strategy, and resulted in the Ghanaian Parliament's passage of the Traditional Medicine Practice Act in 2000.

The most recent development in Ghana has been the creation of a Bachelor of Science Degree in Herbal Medicine at Kwame Nkrumah University (KNUST) in 2003. The degree's curriculum offers students the option of combining courses in both modern and traditional medical practice and is expected to produce medical practitioners who are capable of working alongside either modern physicians in urban area hospitals or traditional practitioners in rural villages.

Traditional Medicine and Public Policy Agenda Setting in Ghana

In an analysis of traditional medicine in Africa, Nancy Romero-Daza (2002) states, "Ghana exemplifies efforts to truly incorporate traditional medicine into primary health care," however, "Ghana appears to be the exception rather than the norm in fully supporting traditional medicine."(p.583) The previous discussion examined the socio-historical development of policies focused on the indigenous Ghanaian physician/healer and the traditional Ghanaian medical system of which s/he is a part. At this point it is imperative to question whether there are lessons to be learned from the Ghanaian experience?

This review will examine the development of policies focused on indigenous medicine in Ghana from a public policy perspective. Particular attention will be given to the policy process and the setting of a policy agenda that includes development initiatives

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for the indigenous medical system. Building from the significant factors identified in this section, a series of policy recommendations will be advanced. Policy recommendations advanced in this thesis have been designed to inform public policy agenda setting strategy for the development of the role that indigenous/traditional medicine can potentially play as a provider of both primary healthcare and psychosocial healing throughout the African continent.

Examining the Policy Process

In the early decades of the twentieth century, the focus of the vast majority of political science inquiry centered on the analysis and comparison of political structures, constitutional frameworks, and key political figures. However, in the post World War II era Harold Lasswell (1951), among others, began to advocate a new perspective on political actions that focused primarily on the factors that influenced the development and implementation of public policymaking. Public policy analysis thus seeks to explain how and why governments execute policy. As such, public policies are defined as the intentional actions that are undertaken by governing agencies or officials in order to address the needs and demands of the public body.

In democratic societies, the study of public policy begins with the understanding that policy demands are made in a heterogeneous political landscape in which a multiplicity of political actors compete for the political prioritization of their own peculiar needs and demands. Although political systems differ cross-nationally, a simple policy cycle can be observed in all democratic societies. Specific demands first enter the policy cycle by being elevated from the vast list of competing demands and placed onto the formal policy agenda. Secondly, policymakers and policy analysts debate the true

definition of the problem and formulate the necessary policy responses. Lastly, policy responses are implemented and evaluated for their relative success or failure. Therefore, the policy process is described as proceeding through the following five stages: agenda setting, policy formulation, decision-making, policy implementation, and policy evaluation. (Adolino and Blake, 2001)

Studying the potential role of indigenous medicine in the formal healthcare infrastructure of a given nation-state, we are here primarily concerned with the initial agenda setting phase of the policy process. In doing so, it is firstly important to note the distinction between the systemic and institutional policy agendas. As was mentioned earlier, in any governing system there exists an almost infinite number of competing policy initiatives. This broad list of policy options is defined as the nation's systemic policy agenda. However, only a relative few policy initiatives merit the attention of policymakers. These few policy options are therefore moved from the nation's systemic agenda to what is referred to as the nation's institutional agenda. The focus of this analysis concerns the question: How are policies to professionalize and integrate indigenous medical practices and practitioners into the formal healthcare system moved from the systemic to the institutional policy agenda in a given nation-state?

Policy Agenda Setting

According to the "inside initiation model", public policy agenda setting is characterized by the presence of powerful interest groups who pressure government policymakers without relying on public awareness campaigns to strengthen broad public support for their desired policy initiatives. (Adolino and Blake, 2001 p.13) Inside initiators often represent corporate interests and strengthen support for their policy

preferences by presenting policymakers with scientific and economic findings supporting their claims over those of the competition. Inside initiators from wealthy corporate sectors may also further their policy desires by offering campaign donations in return for political support.

In the history of Ghanaian traditional medicine, inside initiation has taken two primary forms: colonial discrimination and corporate domination. There is no clearer example of inside initiation than that of colonial politics in the Africa region. Colonial politics were and are characterized by the presence of a foreign elite who controls public policy regardless of popular domestic support. In colonial Ghana, minority European rulers, following the lead of the missionary explorers who had preceded them, enacted policy to undermine the indigenous medical system that had sustained the Ghanaian people for thousands of years. Following the collapse of the colonial period, Ghanaian indigenous medicine began a resurgence movement. However, the legacy of colonization has left behind powerful inside initiators who take the new form of elite corporate investors and a foreign trained professional class who are dependent on the societal position of the modern, Western medical system for the maintenance of their own socio-economic position.

Medical revivalist movements can therefore be understood as social movements that seek to displace powerful inside initiators and create policies that move away from the status quo. The forms that such political movements may take generally fall into one of three models. The outside initiation model of policy agenda setting examines the presence of interest groups who work outside of the formal political system to promote their policy demands. Outside initiators often use community education initiatives to

raise public awareness of a specific issue to increase their legitimacy and lobby for government support. A second model for explaining policy agenda setting is the mobilization model. According to this model, internal government actors unilaterally push for policy development in a particular area. Policies resulting from internal mobilization generally reflect areas of public concern that lack strong interest groups but maintain broad public support. Lastly, the consolidation model of policy agenda setting combines elements of the mobilization model with elements of the outside initiation model. According to this model, government actors work to move policy initiatives onto the institutional agenda by consolidating outside interest groups into a cohesive movement that will assist government mobilized policy initiatives.

The Role of Nationalism in Legitimizing Medical Revivalism

The empowerment of the Convention People's Party (CPP) over the elite social class of the colonial Gold Coast, many of whom had been educated in European universities, was due in large part to the ability of the CPP leadership to rally the nationalist sentiments of the Ghanaian people. His various biographers describe Kwame Nkrumah, the leader of the CPP, as not only one of the most charismatic leaders of the Ghanaian independence movement, but also as a leader of the much larger pan-African decolonization movement of the 1960's. Barbara Monfils (1977), commenting on Nkrumah's efforts to rebuild Ghanaian nationalist culture in the years immediately following its gaining independence in 1957, states:

> Nkrumah's extrinsic rhetorical strategies in the period immediately following independence were thus directed toward the fulfillment of Operation Psychology. Politically, Ghana was independent, but the resulting symbols of nationhood had not been adequately formulated. A flag had been chosen, and a national motto, "Freedom and Justice," had

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been adopted.   However, a psychological vacuum resulted from the rejection of British institutions...(p.315)

Under Nkrumah's leadership, a push for the reemergence of traditional medicine began to form within the government and among the people. Just as the European colonizers had systematically de-legitimized traditional cultural symbols and practices, including traditional forms of medical practice in the early years of colonial rule, Nkrumah's government would advocate for the reestablishment of a medical system based on African cosmological beliefs and values.

In breaking from the status quo in healthcare policymaking, the Ghanaian case study suggests that the nationalist, independence movement led by Kwame Nkrumah and the Convention Peoples Party (CPP) of the 1950's and early 1960's was particularly significant in resuscitating the indigenous Ghanaian medical system. In doing so, the goal of the broader nationalist movement was the restoration of the cultural values and symbols that had sustained the Ghanaian people throughout their historical evolution prior to colonial interference. Prior scholarly research in the field of medical revivalist movements suggests that the link between cultural nationalist movements and the resurgence of medical systems is not limited to the Ghanaian example.

In an analysis of the political mobilization of traditional Chinese medicine in early twentieth century China, Ralph Croizier (1968) points out the role that nationalist sentiments played in legitimizing traditional Chinese medicine in the national medical system of China. As the debate over traditional Chinese medicine evolved in the early decades of the twentieth century, Chinese cultural conservatives appealed to the cultural nationalist sentiments of the people by referring to traditional Chinese medicine as the "national medicine [of China]" and by claiming that preserving traditional Chinese

medicine was paramount to preserving the "national essence" of the country. As Marxist ideology began to dominate the political environment in the middle decades of the century, proponents of traditional medicine once again framed the debate over the integration of traditional medicine by appealing to the cultural nationalism of the period. Denouncing Western medicine as colonial, imperial, and unacceptable while at the same time advocating traditional Chinese medicine as the "the medical legacy of the motherland," Chinese cultural conservatives were eventually able to achieve full integration of traditional Chinese medicine into the national Chinese healthcare system.

Charles Leslie (1976) has described the similar role that cultural nationalism had in placing Ayurvedic medicine onto the policy agenda in India. In the final decades of the nineteenth century, traditional Ayurvedic practitioners in India had begun to realize the decline in importance and capacity of their medical trade within the Indian subcontinent. Years of oppression under British colonial rule, predated by the intrusion of the Muslim Unani School of medicine and the general decline in Ayurvedic knowledge associated with the Buddhist period had left the classical practice of Ayurvedic medicine in a state of steady decline that had lasted for several centuries. Ayurvedic revivalism in the early decades of the twentieth century was, therefore, both a movement advocating the revitalization of a classical medical philosophy and a professionalization of the modern practice of a traditional medical system. In the case of India, the isolation of traditional physicians from the national healthcare agenda setting and policymaking processes and the resulting frustration can be characterized by the following statement, which was made by a leader in the Ayurvedic revivalist movement in India in the early decades of the twentieth century:

Our National Government is bent upon making us slaves of modern civilization resting on apparatuses, instruments, injections and inventions…. We are out for that system of treatment, which wants to keep us healthy independently of drugs and medicines. We shall accept only that system of treatment the promulgators of which ask the Government to turn out of the land those physicians and surgeons who aim at collecting and amassing money. There is now no place in the country for those medical practitioners who have squeezed crores of rupees out of the lifeblood of millions of our poor countrymen and have dignified themselves with Degrees and Knighthood. (Brass, 1972:350)

Despite the strength of the Ayurvedic revivalism movement within the broader independence movement in India, Leslie (1963), states "Since the struggle for Independence has been won, the revival has lost the vivid context of the times in which it originated and matured."(p.72) India's Ayurvedic revivalist movement would, similar to indigenous Ghanaian medicine, rely on the growth of an outside initiation movement in order to eventually achieve the integration of Ayurvedic medicine into the national healthcare system.

In each of these three examples, cultural nationalist sentiments within the broader public were crucial to the reestablishment of the indigenous medical system onto the national policy agenda. Although the cases of India and Ghana do not result in the immediate acceptance and integration of the indigenous medical system, the nationalist movements in each of these countries laid the foundation for the emergence of the broader outside initiation movements that would follow. In the case of Ghana, it has here previously been shown that the creation of the Ghana Psychic and Traditional Healers Association and the Center for Scientific Research Into Plant Medicine was the foundation from which a more prolonged outside initiation movement eventually emerged. Therefore, from these examples it can be hypothesized that medical revivalist movements are dependent, at least in part, on the presence of a larger nationalist

movement which establishes a renaissance of the cultural beliefs and values of a historical period in which the indigenous medical system was at its peak of cultural influence.

The Role of Individual Leadership

In the context of newly independent, post-colonial nations, the transfer of indigenous knowledge from the tribal or familial system to central government regulation presents a particular challenge to the professionalization of traditional medical practice. In the case of Ghana, the efforts of Dr. Aku Ampofo demonstrate the important role that individual leadership ability played in overcoming this challenging obstacle.

In 1969, Dr. Aku Ampofo was an orthodox physician struggling to establish a career practicing medicine in white-male dominated medical establishment in England when he was called upon by Kwame Nkrumah to return to the newly independent Ghana and serve as a consultant to the development of traditional medicine. Dr. Ampofo, who claimed to have been cured of asthma by a traditional healer in his boyhood, knew very little of traditional herbal medicine but accepted the request of his nation's leader. Seven years later, in 1976, he became the first director of the Centre for Scientific Research into Plant Medicine in Ghana.

The work of Dr. Ampofo would not be accomplished by staying in the laboratory. Despite the new national government's interest in traditional medicine, the networks of traditional healers practicing medicine throughout the nation were reluctant to divulge medical knowledge that had for centuries belonged solely to familial or tribal systems. Realizing the challenge presented by this fact, Dr. Ampofo would spend the next decade traveling the country, staying with traditional healers, discussing their medical practices,

and collecting samples of their products to bring back to the Centre in Mampong. A top

official from the Centre for Scientific Research into Plant Medicine stated that:

> Initially, he sought permission from the local herbalists and some of them
> voluntarily would give information. So some of them were willing to give
> information without asking for any reward. He [Dr. Ampofo] documented
> all of this information and also gave credit to the source of information.
> And so we have a lot of documentation where the names and addresses of
> traditional healers who provided information have been recorded. There
> were also instances where he had to actually pay for the information. At
> the time intellectual property rights as such were not really well known
> and so people were not advocating for that. So the information Dr.
> Ampofo collected, I believe they knew it was being used for the common
> good.[2]

> Essential to the accomplishments of Dr. Ampofo was his ability to garner the trust

of individual healers. A former student of Dr. Ampofo had this to add:

> He would travel to them and he would sleep with them. They would feed
> him. Aku didn't know anything about herbal medicine. So what they did
> was offer their services to him for free, including their formulas, and he
> would write them down. For instance, their plants, and how many plants
> go into a recipe. They allowed him to write them down. Aku learned
> about five Ghanaian languages because it allowed him to build that trust
> that he wasn't going to dupe them. So they gave information freely to
> him.[3]

 Their secrets would not be shared without their consent. Their products would

not be sold without their being reimbursed. Although the informal arrangements reached

by Dr. Ampofo and the hundreds of healers that he met in those years of research would

not be sufficient in the modern context, which has begun to formalize the development of

intellectual property rights for indigenous medical knowledge, in the 1970's in Ghana the

individual leadership of Dr. Aku Ampofo resulted in the creation and scientific

investigation of a national pharmacopoeia of herbal medicine. Dr. Ampofo's ability to

gain the trust of a diverse group of traditional healers can also be argued to have given

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[2] Personal Communication
[3] Personal Communication

greater legitimacy to the central Ghanaian government's efforts to develop the indigenous medical system. This legitimacy would continue to play an important role in the later decades of the twentieth century.

Outside Initiation: Maintaining Political Pressure

Certainly, the reemergence of traditional cultural values and symbols, including the indigenous Ghanaian medical system, within the larger nationalist/independence movement was particularly important to the reemergence of traditional medical practice in the early post-colonial period. However, the second phase of the revivalist movement, lasting through the decades of the 1970's and 80', was marked by the actions of outside initiators who, through a variety of research and extension activities, highlighted the legitimacy of traditional medicine in delivery of primary healthcare throughout the Ghanaian nation-state. According to Adolino and Blake (2001), the term outside initiator is used to refer to "organized interest groups [who] attempt to raise the profile of an issue on the systemic agenda" of a national, sub-national, or international public policy debate. The elevation of policies concerning the role of traditional medicine in the Ghanaian national healthcare system has been largely dependent on the actions of outside initiators such as the Centre for Scientific Research into Plant Medicine, the Ghana Psychic and Traditional Healers Association/Ghana Federation of Traditional Medicine Practitioners, as well as international research and advocacy organizations.

After decades of organization, the work of these outside initiators began to come to the attention of the political leaders of the country in the early 1990's. In doing so, outside initiators have been portrayed in this case study as the political actors responsible for moving policy focused on indigenous medicine in Ghana from the systemic agenda to

the institutional agenda in Ghanaian national healthcare policymaking. How were outside initiators for policy focused on indigenous Ghanaian medicine able to successfully gain the attention and support of national policymakers?

Clearly, the research findings flowing out of the Centre for Scientific Research into Plant Medicine provided a significant boost to the movement to institutionalize traditional medicine within the nations formal healthcare strategy. A former director of the Centre stated:

> By the late 1980's, it was quite obvious that this Centre had come to stay. It was contributing tremendously on everything involving herbal remedies.[4]

However, other outside initiators were able to successfully demonstrate the potential of the indigenous physician/healer as an actor within this strategy by creating successful models of community-based healthcare utilizing the indigenous Ghanaian physician/healer as an integral member of the community healthcare system. In the early 1970's, the University of California Los Angeles' Danfa project was the first attempted model of community based primary healthcare delivery in which integration of the indigenous Ghanaian physician/healer was a fundamental principle. Although the Danfa project focused specifically on the training of the traditional midwife/birth attendant, the success of the project relied on its incorporation of community stakeholders into project design as well as the monitoring and evaluation of project implementation. Based on the success of the Danfa project, the Primary Health Training for Indigenous Healers (PRHETIH) Project included a variety of indigenous practitioners.

Perhaps equally important, the PRHETIH followed the lead of the Danfa project by incorporating community stakeholders, including indigenous physician/healers, into

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[4] Personal Communication

project design, monitoring, and evaluation. Throughout the 1970's and 80's, the organization of outside initiators, based on the successes of such influential projects as the Danfa and PRHETIH projects, expanded the implementation of educational programming and community based indigenous healthcare throughout the various regions of the nation. By the end of the decade of the 1980's, the successes of these programs, combined with the relative failure of development initiatives aimed at the expansion of modern medical infrastructure, were beginning to gain the attention of the policymaking community. They had, in effect, successfully elevated indigenous medicine to the institutional policy agenda.

Establishing Legitimacy through Government Consolidation

Though much of this analysis has focused on the efforts of outside initiators and individual actors, much of the progress of the past fifteen years has been primarily due to intentional government consolidation of a diverse group of political advocates into a cohesive political lobby capable of moving forward a formal policy agenda. The most striking example of this government leadership in consolidating the opposing factions within the traditional medicine movement was the role of the Ministry of Health in confederating the six separate traditional healers into the now unified Ghana Federation of Traditional Healers Associations. A former official from the Directorate for Herbal Medicine had this to say regarding the role of the Ministry of Health and, in particular, the Minister of Health himself:

> The Minister of Health realized that having these six splinter groups wasn't going to help the association [Ghana Psychic and Traditional Healers Association]. The Minister thought that all these groups should come together, so he called for a conference in which they nominated their executives and decided to form the Ghana Federation of Traditional

Healers Associations in 1999. Now, there are no splinter groups. Every year they meet and elect their officers… At that time the orthodox medicine people would not have wanted them to be recognized anyway so if they went their own separate way they would not have been able to achieve their objectives. It didn't take a day or two it took months.[5]

It is essential to note that the major accomplishments of the past fifteen years were all preceded by the creation of the Directorate of Herbal Medicine within the Ministry of Health in 1991. In the early 1990's, the first priority of the Directorate was the creation of a branch within the national Food and Drugs Board that would focus on investigating and licensing traditional herbal products for manufacture and distribution. In 1995, the Food and Drugs Board was formed and, within the board, a special branch was created which would oversee the licensing of over the counter medical products, including herbal medicines. In collaboration with the Centre for Scientific Research into Plant Medicine, traditional herbal practitioners were for the first time provided with an opportunity to have their products formally recognized, evaluated, and licensed.

Secondly, the Directorate began to work with the various traditional healers associations by urging them to form a federation that would be unified in its lobbying activities. In 1999, the Ghana Federation of Traditional Healers Associations was formed. Shortly thereafter, the GHAFTRAM produced its formal code of ethics and a draft policy for including traditional medicine into the national healthcare system. These actions, combined with significant lobbying efforts by the newly formed federation of healers associations and the Centre for Scientific Research into Plant Medicine, resulted in the passage of the Traditional Medicine Practice Act in 2000.

Since the passage of the Traditional Medicine Practice Act, the Directorate has continued to be active in consulting with the Centre for Scientific Research into Plant

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Medicine, GHAFTRAM, Kwame Nkrumah Universtity for Science and Technology, and a variety of non-governmental organizations who offer training programs for traditional healers. The centralization of knowledge and information under the leadership of the Ministry of Health has resulted in a quickening pace in the professionalization process in the current decade. At present, the aim is to have traditional healers practicing alongside modern physicians in all government hospitals and clinics by the end of the decade. In a personal interview, an official from the Centre for Scientific Research into Plant Medicine stated that the goal for the future should include:

> We should be in a situation where people can have choices. I want to go in for Western Medicine, or I want to go in for Herbal Medicine. We should be able to provide them with the best products whose quality has been guaranteed because they have gone through screening and have been analyzed. We want to make sure that we have products out their with the right dosages so we can vouch for the efficacy and we can treat the ailment that they have been prepared for. Also [we want] to have, perhaps not in the hospitals themselves but alongside them, clinics with highly trained herbal medicine practitioners. Lastly, that we have established plantations which are capable of meeting the needs of supplying the manufacturers.[6]

Conclusion

In summary, the socio-political factors found to have most significantly impacted the development of a synergetic policy model in the Ghanaian national healthcare system are government mobilization paired with the presence of a larger cultural nationalist movement. The emergence of the Ghanaian medical revivalist movement was framed by the larger cultural revival of the post-colonial decade of the 1960's. Under the leadership of Kwame Nkrumah, the empowerment of important stakeholders in the role of

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traditional Ghanaian medicine began the movement that would develop over the next four decades and which continues to progress in the modern Ghanaian healthcare system.

Secondary factors also significant in the development of medical syncretism in the Ghanaian example include individual leadership, personified by the personage of Dr. Oku Ampofo, and the presence of organized and influential outside initiators. Influential outside initiation took multiple forms in the Ghanaian case study. Firstly, the UCLA sponsored Danfa project exemplifies the role that international research institutions can play, as an outside initiator, in highlighting potentially valuable policy alternatives. Secondly, the Centre for Scientific Research into Plant Medicine and the Ghana Federation of Traditional Healers Associations demonstrate the role how an organized and cooperative network of interest groups can affect policy agenda setting and, eventually, policy transformation.

IV. Policy Implications

Introduction

The initial part of this thesis examined the historical development of so-called traditional medicine within the world system. In doing so, traditional medicine was defined as a complex variety of medical beliefs and practices, developed within the evolutionary context of individual cultural systems, which have perhaps shared little more than their common experience of subjugation to so-called modern medicine since the beginning of the colonial period. Sections two and three presented a case study of the reemergence of traditional medicine within the Ghanaian national health system as a public policy initiative seeking to integrate traditional medicine into a national primary healthcare strategy. In following this course of discussion, the focus has been primarily

on the social and political factors influencing the public policy agenda in the Ghanaian traditional medicine revivalist movement. In this final section, the focus will turn towards a brief analysis of traditional medicine policy in Ghana at present. This section will focus on the strengths of current traditional medicine policy in Ghana and also point out some other areas, which have been less comprehensively developed in the Ghanaian context. Secondly, this chapter will present policy recommendations for the future development of traditional medicine policy in Ghana. Lastly, the limitations of this study and potential areas for future research will be discussed.

Policy Analysis and Areas of Concern

Clinically Oriented vs. Community Based Traditional Medicine Policy

In examining the historical development of policies focusing on integrating traditional medicine into the Ghanaian national healthcare system, it is clear that the crucial area of concern for Ghanaian policymakers has been the development of traditional herbal medicine. This may not be surprising when one considers the fact that within the multiplicity of traditional healing practices, including traditional birth attendants, bonesetters, and psychic practitioners, 65.5% of traditional medicine practitioners in Ghana have been classified as indigenous herbal medicine practitioners. (Bodecker et al, 2005) Further, the central role played by the Centre for Scientific Research into Plant Medicine in this development process has guided the development of a policy strategy primarily concerned with scientific evaluation and clinical distribution of traditional herbal products in the national and international medical marketplace. While the Ministry of Health, along with various other non-governmental organizations including the Ghana Federation of Traditional Healers Associations, has worked to

educate and regulate traditional medical practice, the impact of these activities in both rural and urban areas of the nation is less pronounced than is the emergence of a variety of indigenous herbal products within the national medical marketplace. Speaking about the evolution of traditional medicine practice in the urban and rural areas of Ghana, an official from the Ministry of Health stated:

> In the rural areas it's the practitioner and his client. That is the key relationship. So you go to a traditional healer, they give you herbs, teach you how to use it, and that's it. In the past ten years the situation is changing. We have pre-packed products coming into the rural areas, products that are well bottled, well packaged, and sold. And so, we have a situation where people can get the products without seeing the healer. So previously you go and see the healer, he examines you, and gives you a product. But, people are becoming more Westernized, and so you have shops even in the rural areas and you have vans coming with herbal medicines into the rural areas and advertising the products and people are buying. That's the situation currently in the rural areas. So we are moving gradually from visiting the healer to just buying off the shelf. In the urban areas its becoming more sophisticated. We are having herbal medicines being sold in pharmacies side by side with Western clinics…. So we have people who are not directly seeing the practitioner, they are just buying from ships. Alongside, we also have clinics that are much stronger in the urban areas. I must say there has been a lot of progress in this respect. If you visit a typical clinic, we have a traditional healer who is wearing a stethoscope and has examination beds, but the meds being prescribed are just herbal. You also have clinics where they have laboratories attached to the clinic. I think that this is a big improvement really.[7]

In a comparative analysis of the usage of herbal medicine in primary healthcare, LeGrand and Wondergem (1990) point out that policy focused on the development of herbal medicine may be clinically oriented, community-based, or a combination of both. In a clinically oriented herbal medicine strategy, policy focuses on manufacturing traditional medical products and integrating these products into the modern healthcare marketplace. Clinically oriented herbal medicine strategies are therefore less concerned

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with the role that the indigenous medical practitioner may play in the delivery of the product itself. This style of policy development adequately represents the policies that have been most comprehensively developed in the Ghanaian case study presented in previous sections and described in the above quotation.

In contrast, community based herbal medicine strategies focus on raising community awareness of traditional medicine usage. By educating traditional medicine practitioners, community leaders, and the general population as a whole, community oriented strategies seek to elevate awareness of issues such as safe consumption of herbal medicines, proper usage, and the role that traditional herbal medicines serve as complementary forms of medical treatment. Realizing that the usage of indigenous herbal medicines is not limited to interactions with indigenous medical practitioners, the strength of the community-based approach is that it serves to educate the widespread usage of herbal products in self-medicating behaviors. Community-based strategies are particularly essential in rural areas of the country where, despite the availability of clinically tested herbal products in urban regions, the issue of accessibility in rural regions continues to be problematic. Importantly, the authors note that community-based and clinically oriented policy strategies are not mutually exclusive. In fact, the two strategies are highly complementary.

Developing the Next Generation of Ghanaian Traditional Medicine Practitioners

As the nation of Ghana moves its traditional medicine strategy forward, there is growing concern over the dwindling number of traditional medicine practitioners, particularly in the rural regions of the nation. The development of a clinically oriented herbal medicine strategy has significantly impacted the number of traditional herbal

medicine practitioners in the rural regions of the nation. Traditional herbalists, eager to have their products placed into the international market, are moving in greater numbers to urban centers where they can more easily consult with institutions such as the Centre for Scientific Research into Plant Medicine and the Directorate for Herbal Medicine. Those practitioners whose products are found to be safe and effective find that there is a larger market in the urban areas, and they choose not to return to their rural villages where market potentials are significantly smaller.

Further, in recent decades a growing number of young persons interested in careers in medicine have chosen to pursue education in modern medical practice due to the greater economic remuneration and social legitimacy attached to modern medical practice. Though the development of Bachelor of Science Degree in Traditional Medicine and Kwame Nkrumah University of Science and Technology (KNUST) is a positive sign for the future, it is necessary to examine the historical experience of other nations who have created similar academic programs. In doing so, the case of Ayurvedic medicine in India is particularly revealing.

Similar to the history of medical revivalism in Ghana, the first step in the revitalization of Ayurvedic knowledge in India was the formation of regional Ayurvedic medicine associations. These associations, composed of traditional Ayurvedic practitioners, worked to raise public awareness of Ayurveda's claims for legitimacy within the Indian healthcare system and lobbied for government support of Ayurvedic schools, hospitals, pharmacies, and research funding. Also similar to the Ghanaian case study, the primary mechanism in Ayurvedic medicine's revivalist strategy was to link

itself with the growing nationalist sentiments of the Independence Movement. Charles

Leslie (1973) states:

> Though Gandhi and Nehru were cool to medical revivalism, it gained
> support from other leaders of the Independence Movement and, linked
> with this powerful force, continued to inspire a proliferating literature, the
> founding of colleges, and sporadically successful attempts in various states
> to gain governmental support. (p.363)

However, unlike the case of Ghana, the strategy linking Ayurvedic revivalism

with growing nationalist sentiments of the Independence Movement was largely

successful in establishing Ayurvedic universities and medical journals. The successful

creation of Ayurvedic universities in India then lead to a second phase of political activity

in the middle decades of the twentieth century. As graduates of the newly formed

Ayurvedic Universities became more and more frustrated by their marginalized status

within the national healthcare system and the inequality of pay scales for modern versus

Ayurvedic physicians, student advocacy groups were formed to pressure for heightened

government support for Ayurvedic medicine in India. Paul Brass (1972) states:

> The students in Ayurvedic colleges throughout India have engaged in
> strikes, agitation, and demonstrations during the last decade [1950's-
> 60's]…. In the period 1958 through 1964, there were at least fifty-five
> strikes or other demonstrations in the indigenous medical institutions of
> India…Forty-one of the fifty-five strikes were focused upon issues
> relating to the student demands for equality with modern medical
> graduates, for employment, and for modernization and improvement of
> college facilities and curricula. (p.354-355)

This tumultuous period in the history of Ayurvedic revivalism lead to an internal

fragmentation within the movement that hindered its ability to effectively make claims of

legitimacy to state and national governing bodies. Despite the strength of the student

protests of the 1950's and 60's, the strength of the Ayurvedic movement was not able to

immediately obtain its demands for legitimacy over the protestations of powerful interest groups representing the modern medical establishment in India.

As was stated in the previous chapter, the Bachelor of Science degree at Kwame Nkrumah University in Ghana is still in its infancy. As the initial graduating classes move into the professional workforce, policymakers will need to pay particular attention to graduates' ability to find employment and demand adequate economic remuneration. Attractive employment opportunities and adequate economic remuneration are imperative if the Ghanaian traditional medicine movement is to prevent the fragmentation that was experienced by the Ayurvedic revivalist movement in India. The creation of a professionalized traditional medicine workforce will also create a competitive atmosphere in which young persons will once again recognize traditional medical practice as a socially legitimate, as well as an economically viable career opportunity.

Environmental Concerns

Yet another concern for the future of Ghanaian traditional medicine policy focuses on maintaining an adequate supply of herbal products that are experiencing rapidly increasing demands due to their popularity in the herbal drugs marketplace. One former official from the Ghanaian Directorate for Herbal Medicine claimed:

> It used to be that you could walk only a short distance and find herbal medicines. Now, in some cases, you have to travel long distances to find them. There are a few individuals who have land who are offering the land for the cultivation of medicinal plants, knowing that in a few years they can sell them to manufacturers…. Otherwise, the business is rich today, but tomorrow there will be nothing.[8]

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[8] Personal Communication

Although a central mandate of the Centre for Scientific Research into Plant Medicine is the maintenance of herbal gardens, the danger that some plant species may not survive rapidly increasing consumption rates poses a serious threat to be addressed. This issue is particularly relevant in rural regions where herbal medicines are not being systematically replenished and consumption rates are extremely difficult to monitor. While large-scale farming may continue to supply the growing demand for specific plant species, policymakers must also consider the potentially damaging affects that plant removal will have in the rural Ghanaian ecosystem.

Policy Recommendations

Continuing the Development of Clinical Research within Traditional Medicine Policy

As has been discussed in previous chapters, the current traditional medicine policy strategy in Ghana is centrally focused on the development of traditional herbal medicines. The primary policy outputs of this strategy have included the creation and development of the Centre for Scientific Research into Plant Medicine and the development of branch within the National Food and Drugs Board that is specifically concerned with the regulation of traditional herbal products within the medical marketplace.

As the nation moves its strategy forward it is necessary to continue to provide the opportunity for traditional practitioners to have their products subjected to clinical trials to test both safety and efficacy. Trials must not focus solely on herbal products in isolation, but must also consider and test their efficacy as complimentary medicines to be used in combination with modern medical treatments.

Developing a Community-Based Strategy

While the development of the clinical sector of traditional medicine is providing new, cost-effective and profit generating medical resources within the Ghanaian healthcare sector, the development of a community based strategy to complement the clinical focus has been largely a secondary priority. Ghanaian policymakers must begin to focus on developing a community-based strategy for promoting the safe and appropriate usage of herbal medicines in the rural regions and villages of the nation. In doing so, policy planners should look to the experiences of the Danfa and the Primary Health Training for Indigenous Healers (PRHETIH) Projects for guidance in creating health education and development strategies that encourage community participation and the creation of local stakeholders.

The advancement of a community-based strategy will compliment the clinical sector of traditional medicine in a variety of ways. Firstly, by educating rural populations about the proper usage of newly available herbal products, community-based activities will increase demand for products that are now only available in urban areas. A community-based strategy can also encourage the development of small herbal farms in towns and villages throughout the nation so as to safeguard against the threat of over consumption of certain plant species. Lastly, the development of a community-based strategy will serve to increase the social legitimacy and treatment efficacy of rural practitioners. This would have the dual effect of slowing the movement of traditional practitioners to urban areas and increasing the attractiveness of traditional medical practice for the next generation.

Although the majority of traditional medical practitioners in Ghana are primarily herbalists, the potential contributions of other traditional practices must be addressed. While much research has also focused on traditional birth attendants and bonesetters, the particular role that spiritual and psychic healers play in primary healthcare has been largely ignored outside of the interest of medical anthropologists and other academicians. While spiritual and psychic healing practices cannot be investigated in regular clinical trials, their role in providing psychosocial support and palliative care to persons with chronic illness should not be underemphasized. Policy planners and other stakeholders must collaborate with spiritual and psychic healers in the creation of an African model of social work that will incorporate traditional Ghanaian psychic and spiritual healing for those citizens ailments remain outside of the bounds of effective treatment.

Limitations and Areas for Future Research

The collection of data for this research project had several limitations. Firstly, the research was limited to the examination of data available in secondary sources and telephone interviews. The researcher was not involved in any form of field research. The incorporation of data collected in the field would have contributed greatly to this research effort. As such, the research was limited to the collection of data from sources that may not reflect an adequate cross-section of stakeholders in Ghanaian traditional medicine policy. While the researcher attempted to use secondary sources from investigators who had participated in significant field research in Ghana, this limitation has certainly impacted the scope of this analysis. Future research should incorporate the collection of field data from a larger sample of traditional practitioners and community

stakeholders. Future research should also consider the views of rural communities.

While this analysis has advocated the development and integration of indigenous medical

modalities into primary healthcare strategies, what are the desires of the actual members

of the communities, both urban and rural, who will be affected by such policy

implementations?

Secondly, as was addressed in the chapter one, the need for comparative study in

the area of traditional medicine policy development is significant. While several African

nations have begun to pursue policy strategies to develop and integrate traditional

medicine into their primary healthcare strategies, how have these policy strategies

differed? What has been the policy outcome of these various strategies? Certainly, the

investigation of traditional medicine from a public policy perspective could be very

fruitful for future research.

Lastly, there is a great need for future research in the area of the role of spiritual

and psychic healing in providing psychosocial support and palliative care for persons

with chronic illness. As the HIV/AIDS pandemic continues to have a devastating impact

on the African continent, policy planners must utilize all the resources available to

provide care which moves beyond the simple treatment of physical illness. As was stated

in the previous section, the development of an African model of social work could and

should be influenced by the indigenous practices of psychic and spiritual healing.

Conclusion

The global health campaign, now greatly focused on developing healthcare

strategies in southern Africa, must work to incorporate indigenous physician/healers as a

primary partner and stakeholder in public health policy development. The difficult health

challenges in southern Africa demand that all potential resources be utilized. In the first chapter it was demonstrated that the neglect of the indigenous physician/healer in this campaign is based primarily on a racialized discrimination against traditional healing methods and materials, which do not readily adhere to the cultural European definition of correct medical practice. The third chapter presented a case study of the West African nation of Ghana. Ghanaian traditional medicine policy was chosen for this research due to the fact that, within the context of the African continent, Ghana has consistently worked to institutionalize indigenous medical practice within its national healthcare strategy. Particular attention was given to understanding the social and political factors responsible for this policy development. Significant factors discussed in chapter four included the role of cultural nationalism, individual leadership, and government consolidation.

In the fifth chapter it was shown that the nation of Ghana has focused primarily on the development of a clinically oriented herbal medicine development strategy. The goal of this strategy is the development of high quality, cost-effective, culturally accepted, and readily available herbal medicines that will serve to create revenue within the nation's healthcare sector while providing inexpensive alternatives to costly Western pharmaceuticals. Secondarily, the Ghanaian strategy is continuing to work to educate and incorporate a new generation of traditional medical practitioners into its primary care hospitals and community health clinics as equal counterparts to cosmopolitan medical physicians. As such, the desired policy outcome is a healthcare system bridging the traditional and the modern. While this policy strategy is seen to be highly desirable, the

analysis concluded with a series of policy recommendations as well as a discussion of some areas for future research.

Throughout the thesis comparison has been made between the Ghanaian case study presented here and similar research previously conducted concerning the development of syncretic healthcare policies in both China and India. While the herbal medicine strategy in Ghana still lags significantly far behind the accomplishments of these two nations, it should be noted that Ghana's rapid policy development has been due in part to Ghana's willingness to seriously examine the strengths and weaknesses of these two nation's medical systems and create a model of its own without borrowing wholesale from either the Chinese or the Indian models. Speaking of the relationship of the Ghanaian strategy with the Chinese and Indian policy models, one former Ministry of Health official stated:

> I wouldn't say in that particular form, but some form of it could come across. I know that the Ministry has sent delegates to India to understudy them. I also know that they have gone to China, but as to whether or not it will come in that form I am not sure…In Ghana, you are going to find it difficult to accept the non-quantifiable practices, the Psychic practices. For now, the approach should be herbal. Things you can quantify and observe. Once you create excitement and acceptance of this you can veer into other things.[9]

The hesitancy of the Ghanaian policy strategy to reach out to non-herbal traditional practices in the manner in which both India and China pursued nearly a century ago may speak to the further advancement and globalization of orthodox, Western medical philosophy within the world system in the twentieth century. Or, it may simply represent the fact that Ghanaian traditional medical practice is more uniquely based on a foundation of herbal medical practice than either traditional Chinese medicine or

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Ayurvedic and Unani medicine in India. In any case, the example of medical syncretism

in the Ghanaian national healthcare system is a positive example for other nations

wishing to pursue an alternative to policy strategies that continue to ignore the significant

impact that their own societies' traditional medical knowledge can add to improving

public health outcomes.

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