Interest groups, issue definition and the politics of traditional medicine in Ghana: emphasis on Asante (1902–2013)

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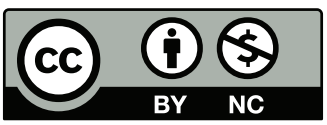
Abstract

In some African societies, the highly accessible means of healthcare that has stood the test of time is traditional medicine. Though several actors have different views pertaining to its practice, traditional medicine continues to survive even in the age where biomedicine has become very reputable among African communities. Statistics have indicated that, 80% of Africans make use of traditional medicine before consulting any health practitioner in biomedicine. In the Ghanaian setting, traditional medicine users range from 75% to 90%. Using colonial Asante as a case study, which includes Ahafo, this article draws insight from a wide range of archival sources to highlight the various transformations underlying traditional medical practices in Asante and its environs. It argues this in the context of definitions and meanings attached to traditional medicine by actors such as the Ghana Psychic and Traditional Healers Association (GPTHA), the British Colonial Government in Asante, immediate post-colonial governments and Native Authorities who are at the centre of cultural norms in which traditional medicine features greatly. The findings suggest that the perspective of emerging healers who have modernised their practices, continue to have significant implications on healthcare in Ghana. It fur-



ther postulates that their engagement has increased the functional scope of traditional medicine in Ghana.

Key Words: Health practices, traditional medicine, Ghana, Asante

Introduction

Traditional medicine (TM) is seen as a belief system based on a people's culture, which structures their behaviours and actions (Meincke 2016). In pre-colonial Ghana, traditional healers who were vested with traditional authority defined traditional medicine with support from chiefs. These chiefs deemed it a responsibility to ensure the development of their citizens be it social or economic. Health also occupied the essential services chiefs offered their communities; so they handed over this health responsibility to traditional healers known as Indigenous Priest Healers (IPHs) (Odotei and Awedoba 2006). These healers defined diseases from the religious point of view and partly focused on knowledge concerning traditional pharmacopeia. Individual misconduct and sometimes disease demons among others were believed to be the causes of diseases. The activities of witchcraft and malevolent demons as disease causative agents in the traditional cosmology saturate the literature on traditional medical practices in Ghana (Adu-Gyamfi 2015). Also, customs required individuals within the traditional community to strictly adhere to traditional laws or taboos. When individuals within the local community flouted these rules, disease demons had the opportunity to attack and inflict them with diseases. These practices and belief systems have subsisted and evolved over time in the face of diverse interests, especially with the presence of Europeans and colonial policies. In this article, we discuss the various transformations underlying traditional medical practices in Ghana and Asante in particular. It is essential to note that in Asante, traditional medicine was defined as a practice to check behaviours that directly affected the individual's health and general wellbeing.[1]

Bierlich (2007: 79) has argued that major socio-economic, epidemiological and medical changes have affected Ghana (formerly the Gold Coast) since its encounter with the Europeans, who introduced many new infectious diseases such as smallpox and syphilis. This introduced new forms of medical practices in the country, a concept which Twumasi (2005) described as 'medical pluralism'. With the influx of such practices, orthodox medicine or biomedicine became a constituent of the healthcare system in the Ghanaian medically pluralistic space. However, by 1957 when Ghana gained independence, traditional leaders, the new emerging political leaders and other interest groups continued to maintain their interest in what was more appropriate as a tool or vehicles for the provision of healthcare. The influence of interest groups in defining issues in healthcare as well as the politics of healthcare was therefore central.

Comparatively, Meincke (2018) has emphasised that the connections of traditional and western medicine in sub-Saharan African countries are far from unified. In her study on Namibia, she argued that African countries have not successfully established and implemented sufficient regulatory frameworks, which would allow for control and recognition of traditional healers and their practices. Im-

[1] In Asante, traditional beliefs played an important role in the healthcare of the people. Traditional practices include; especially spiritual cures, some using religion and appeals to ancestors. Thus, the use of traditional medicine played an essential role in people's understanding of life and their wellbeing.

portantly, traditional medicine's attachment of spiritual traits to restorative plant-based practices has complicated the situation. This has provided an alternate disease etiology, which has made it difficult to test and recognise traditional medicine as scientific (Meincke 2018).

Countries such as Tanzania expressly preclude any spiritual practices by alluding to these in respect of 'Witchcraft Act' (Meincke 2018). Several scholars maintain that the 'Witchcraft Act' has survived from colonial times in several African countries due to the relevance of the phenomenon in these countries (Thomas 2007; Ashforth 2005; Bond and Ciekawy 2001). During and after the colonial era, witchcraft in Africa has been studied as a traditional belief system though many societies considered the existence of Witchcraft Act as a proof of Africa's backwardness and primitiveness (Meincke 2016). This narrative is consistent with the case of Ghana and Asante in particular where fear of witchcraft and witchcraft perceptions have been found to be a major reason for opting for treatment or support from spiritual healers (Adu-Gyamfi 2010). In contrast to witchcraft, the power to healing lies with the deities and the Supreme Being/God (Adu-Gyamfi and Adjei 2017).

In Asante, the value placed on childbirth signifies the importance and prestige attributed to Traditional Birth Attendants (TBAs) in the traditional Ghanaian community. Childbirth is seen as a perpetuation of an individual's lineage, clan or family at the basic unit. In addition, the delivery process is seen as warfare between life and death. In respect of the above, TBAs combine a wide range of knowledge in herbs and a long period of experience to protect the pregnant woman from witchcraft. The Indigenous Priest Healers (IPHs) were another important constituent of the traditional medical institutions in Ghana. Referred to as traditional priests, several authors have postulated how potent and influential their medical practices have been in Ghana - and Africa in a broader context (Homsy *et al*. 2004; Gyasi 2014; Gyasi *et al.* 2016). Twumasi describes how the IPHs employed herbal knowledge to add to their broader knowledge in spiritual healing (Twumasi 2005: 26).

The Asante herbalist, known as *Odunsini* combines both spiritual medications and herbs to effect healing. In the local Ghanaian and Asante communities in particular, the essential duties of herbalists rest in the indigenous understanding of Judeo-Christian concept that man should eat the fruit and use herbs of plants to heal. Herbs in the traditional sense are small non-woody plants treasured for their medicinal, sharp or musky potency (Falodun 2010). Herbalists in Ghana are grouped into two, those with spiritual orientation or connotation associated with their practice and those who apply medicinal plants without any spiritual consultations.

In this article, we highlight the roles of interest groups in defining issues that relate to healthcare and traditional medicine in Ghana with emphasis on Asante, spanning from 1902 to 2013. Within the past decade, several research works have emphasised the question of integration of traditional medicine with orthodox medicine. There are several others that have also focused on related dangers associated with traditional medicine and what is largely referred to in the literature as the Alternative and Complementary Medicines. It is clear that apart from the work of Brenya and Adu-Gyamfi (2014) that emphasises the roles of interest groups in healthcare in Ghana, no other work has paid attention to same especially in the area of traditional medicine.

The authors used 'interest group' to explain how activities of individual entities or organizations have shaped traditional medicine in Ghana. Asare (2009) defined interest groups as "associations or movements that exist in a political system with an aim of influencing policies towards their interest". Though these groups may use means such as demonstrations and petitions, they may also

resort to 'venue shopping' to air their grievances to the government[2]. The most striking means through which these groups push their protest has been definition or redefinition of issues. For example, in Ghana and Malawi in the 1990s, interest groups redefined tobacco as an avenue to secondary smoking with its associated dangers. (Brenya and Adu-Gyamfi 2014: 91-92).

This study explores historically, how the colonial administrators, traditional authorities, indigenous healers, the Ghana Medical Association (GMA) as well as The Ghana Psychic and Traditional Healers who are interest groups have defined traditional medicine in Ghana and particularly among the Asante in terms of practice and efficacy from 1902 to 2013. To emphasise, we argue that traditional medicine in terms of practice and effectiveness has been defined in diverse ways from pre-colonial, colonial and post-colonial perspectives. The study is further guided by what influences were made by the major stakeholders; the British Colonial administration, traditional leaders and healers among others. We answer the question; how did such influences in terms of interactions shaped traditional medicine within the colonial and post-colonial periods in Ghana and Asante in particular? It is intended that this paper will open up a space for further intellectual dialogue concerning interest groups, definition of issues and the politics of traditional medicine in Ghana and Asante in particular.

Method of the study

The study employed the qualitative research approach, using archival and literature studies. Data was obtained from both primary and secondary sources. The primary data was gleaned from the Public Records and Archives Administration in Kumase-Asante Region of Ghana (PRAAD). The authors paid attention to colonial acts that influenced both the practice and consumption of traditional medicine in Asante. The qualitative data obtained from these sources were analysed thematically to focus on the objectives of the study.

Again, we retrieved nuggets of information from existing literature: books, articles and relevant internet sources. The use of secondary data provided a better understanding of the state and practice of traditional medicine in Ghana especially in the Akan communities. The data from both primary and secondary sources were collated, synthesised and analysed thematically to produce this narrative.

Ghana and the indigenous medical system: philosophy and practice

According to Madimbe (1988), the inception of Africanism brought about Africans' own motives as well as objects, and fundamentally commenting upon their own being, while systematically promoting a *gnosis* (knowledge). This indicates that, due to the knowledge and investigation of their own culture and practices, Africans have become conscious of their own being and existence including the practice of traditional medicine. Konadu (2008) argues that by the twentieth century, traditional medicine had become the dominant healing system in countries such as Ethiopia, Tanzania, South Africa, Zambia, Cameroon, Nigeria and Ghana. Meincke (2018) argues that, although some of these African countries including Tanzania, Zimbabwe and Namibia do not officially recognise supporting capacity of traditional healers, their citizens continue to benefit from traditional medicine. In Namibia, traditional medicine is acknowledged in public policy documents, yet the practices of traditional healers remain legally unrecognised. This is because of the traditional healers' unwilling-

[2] Venue shopping as a political strategy is used by these groups who have an intention of influencing a policy problem. Here, they shop around for a favorable venue, whether a court or a parliamentary committee which is receptive to their claims about the nature of a policy problem and its solution.

ness to cooperate due to their understanding of their practice as divine and hence not requiring any regulations. The others include failure of the state to consult traditional healers on policies concerning their practices due to earlier failed attempts concerning the philosophies underpinning traditional medicine. Truter (2007) has defined traditional medicine in relation to its health practice as "the performance of a function, activity or service based on a traditional philosophy that includes the utilization of traditional medicine or practice". The philosophy concerning traditional medicine encapsulates physical cures and spiritualism as the broad base of the practice (Konadu 2007; Foster 1976). This has drawn several controversial debates among scholars interested in traditional medicine in Africa.

Traditional medical practitioners attribute diseases in the traditional African society to misdemeanour on the part of the inflicted person. This is to argue that supernatural causes explain the African understanding of diseases.[3] Arising from the sociological view, Twumasi (2005) explains the whole mechanism in which the African indigenous medicines work. He highlights on the social causative theory of medicine where deities inflict illness on an individual when he/she commits a misdemeanour (Twumasi 2005). More importantly, Abdullahi (2011) describes traditional medicine as a holistic approach to healthcare in which healers attempt to locate both emotional and social balance of the sick based on community rules and relationships. In contrast, Abel and Busia (2005) see traditional medicine as a departure from natural equilibrium where traditional healers are spiritually and non-spiritually based. They refer to healers who grounded their healing methods in herbal applications as non-spiritual healers and those who serve as the mouthpiece of said deities and apply limited sense of herbs as spiritual healers (Abel and Busia 2005). In contrast, Warren cited in Wyllie (1983) argued that spiritual causes of disease were relatively unimportant in the traditional etiological theory until the introduction of western based medicine which caused indigenous healers to find same to be important in their quest to hold on to their previously revered position within a medically pluralistic space (Wyllie 1983, 47). This orientation as reported by Wyllie is problematic. In a broader context, the specialties of traditional practitioners are tied to the type of sicknesses in which they combat. These largely arise from the Akan and for that matter Asante traditional categorization of infirmities under spiritual sickness. These include sicknesses resulting from curses; home sickness and sickness from the blood. Spiritual sicknesses are believed to be caused by demons, witchcraft and destructive powers acquired from medicine makers; literally it is referred to as *Sunsum Yadee* (Adu-Gyamfi and Adjei 2017). Home sicknesses also results from bad sentiment in inflicted person's home, and can also relate to curses.

Similarly, Foster (1976) largely places the African's etiology of diseases into two groups; personalistic and naturalistic. Those associated with personalistic factors interpret all misfortunes, including diseases, the same way. Adu-Gyamfi (2010) has indicated that the African traditional healing system is categorised into specialties including indigenous priest healers, traditional birth attendants, herbalists and traditional bone setters among others.

In Asante, the *Nsumankwaahene* authorised and supervised the activities of the indigenous healers during the colonial and post-colonial eras.[4] However, the British colonial administration supervised this practice to check and report quackery in the indigenous

[3] Stretching from Ethiopia, Tanzania, South Africa, and Zambia to Cameroon, Nigeria and Ghana, indigenous African healing system remained highly utilised by large segments of the rural population.

[4] The *Nsumankwaahene* is the chief physician of Asantehene, the King of Asante.

medical milieu.[5] Largely, it can be inferred that it is from Asante that this idea of an indigenous chief physician emanated in Ghana (Adu-Gyamfi 2010).

Colonial rule and traditional medicine in Ghana

There are several debates that suggest that colonial rule is responsible for Africa's underdevelopment. Several scholars argue that colonialism was a medium through which imperialism spread in Asante and other states in the Gold Coast (Adu-Gyamfi and Oware 2019; Olsen 2003; Sender and Smith 2013). This, in the long run affected Africa's social institutions; hence the African people had to battle to choose between western and indigenous oriented philosophies and practices bequeathed to them through colonization (Rodney 1972; Feierman 1985). In the social terrain of medicine, the line of tension between colonisers and Africans was drawn along source and efficacy of traditional healing. The coloniser's disease theory, germ theory, contrasted the social causative theory of diseases known to Africans. The germ theory attributed diseases to germs and environmental conditions rather than disease demons (Addae 1996). The introduction of western medicine led to a cultural-ideological clash which underscored the African indigenous medical systems in the twentieth century (Abdullahi 2011: 116).

In Ghana, colonial policies regarding traditional medicine took the form of banning and later licensing in the attempts to modernise aspects of traditional medical practices (Adu-Gyamfi 2010). Essentially, this was to curtail the practice's close relations with witchcraft as major cause of maladies in Africa. Abdullahi (2011: 116) has stressed that, "the ban of TM was partially based on the belief that the conception of disease and illness in Africa was historically embedded in 'witchcraft' whereas in western knowledge, witchcraft reinforces 'backwardness', 'superstition' and 'dark continent'." This was essentially seen in the suppression of several witch finding shrines in the Gold Coast from the 1930s onward (Adu-Gyamfi 2010).

The colonial government empowered chiefs to issue licenses to practitioners including herbalists and circumcision surgeons. Referring to applications in Asante, these healers were to present in writing to the office of the *Asantehene* stating their location, area of specialty and the number of years of practice. This was accompanied with a fee of two pounds. Licensing of healers did not only define the role of colonial administrators as key stakeholders in determining the quality of healthcare in the Gold Coast but also to check and report quackery. Though the Kumase Division Native Authority issued the former, a formal approval came from the office of the Governor.[6] The idea of modelling the indigenous health system of Gold Coast along the western medical system was the prime motive of the British colonial administration. Hence, it could be inferred from the archival records that, the colonial administration employed the idea of licensing to model traditional medicine along the lines of orthodox medicine. There were no attempts to integrate the indigenous medical practices of Gold Coast into western medicine; leaving the former to thrive on its own (PRAAD, ARG1/14/26, License Application Letter, 27th January, 1943). However, the indigenes made efforts to enhance the status of Native Medicine in the Gold Coast. Notable amongst them was Joseph Ankonam Kwesi Aaba, a native of Sekondi Takoradi.

[5] The colonial administration defined quackery to mean those whose claims to cure were proven not to be so and those whose medicines were harmful to the individual's health and wellbeing.

[6] From the period 1934 to 1955, the Kumase Division Native Authority began to issue licenses to honest and capable indigenous medical practitioners. This was so because of the belief that the references upon which such registration could be granted to persons who applied would come from chiefs and people well respected in the respective communities in Asante where such practitioners engaged in their healing practices.

In an earlier study, Last (1981) reported that traditional healers accidentally failed in their quest to administer care to sick persons and in extreme cases, this led to the death of their patients.[7] The idea of trial and error goes a long way to account for unforeseen challenges on the individual's health. Murray (1981) argues that patients had a role to play, since the typical patient was not interested in knowing the cures or the ideas, which were being used to cure his/her ailment. Rather he/she recognised only a single, wide-ranging corpus of illnesses for which all the different healers should possess the cures. In instances where a patient died while receiving treatment, the practitioner would first have their license stripped and in extreme cases of severe abuse, the police were empowered to take charge of such cases.[8] In other instances, the healer paid a fine. Chiefs were consulted on decisions to curb such offences, especially in instances where the Native Authority issued such licenses. In addition, the colonial government and the local chiefs jointly checked quackery. The case of Mr. Agbojan is a useful example:

> Convictions were recently obtained in Accra against a quack doctor, T.S Prince Agbojan, for practicing medicine, receiving payments for practicing medicine, importing dangerous drugs and poisons and for dealing in poisons. Fines to the total of £50 were imposed by the District Magistrate Accra. Agbojan first came to the notice of the police following the death of one of his patients and, when searched, a vast quantity of dangerous drugs, hypodermic syringes, ampules and surgical instruments were found in his possession. There is no doubt that apart from endangering lives, Agbojan had a very lucrative practice…. (PRAAD, ARG1/14/26, License Application Letter, 27th January, 1943).

The archival record further stated that:

> He (Agbojan) produced a medical herbalist license purporting to have been signed by a chief but who is in fact an individual unconnected with a Native Authority… Although this case is no reflection on the Native Authorities, it has occurred to me that there should be some check on holders of genuine herbalist licenses issued by the Native Authorities as, you will agree, these individuals, unless they are of good character are in position to do considerable physical harm in addition to extorting money… (PRAAD, ARG1/14/26, License Application Letter, 27th January, 1943)

In a suggestion to curb such menace, the Chief Commissioner of the Gold Coast proposed that:

> I should like to suggest that, before herbalist licenses are issued by the Native Authorities, the applicants be referred to the nearest police officer who, after enquiries would be able to advice whether or not the license be issued or not…Please let me have your views (PRAAD, ARG1/14/26, Letter of Correspondence between the District Commissioner, Wenchi/Sunyani District and the Governor, 15th October 1948).

[7] In Asante, herbalist and other medical practitioners used trial and error to discover plants which were more effective than others and some ailments responded to one herb and some to another. The existence of such forms of healing power is what was frowned upon in the twentieth century by the colonial administration. (See Manhyia Archives of Ghana, Kumase, MAG 1/1/102A, 3rd August, 1963).

[8] Essentially, the Colonial Administration employed the Commissioner of Police who was responsible for advising after making enquiries whether licenses should be issued to a medical practitioner or not. The Kumase Division Native Authority granted permission that information about applicants of herbalist licenses be seen by the police before such licenses were issued. Such efforts did not only lessen the burden on the Colonial Administration and Native Authorities but rather improved quality and efficiency in the indigenous healing.

Due to the increasing rate of quackery, the Commissioner of the Gold Coast entrusted the police service with the responsibility to determine which practitioners were practicing genuine medicine and those who were quacks. In Asante, the case was different, the office of the *Nsumankwaahene* dealt directly with the issue of licensing.[9] According to Adu-Gyamfi (2010), the *Nsumankwaahene* determined quackery in traditional medical practice and reported the outcome directly to the office of the *Asantehene*.[10] Following the precedence of the police referral instituted by the colonial administration, Asante adopted such method in addition to the work of the *Nsumankwahene.* From this time onward*,* the *Nsumankwaahene's* office continued to issue the licenses. However, the police undertook strict investigation and background checks to identify genuine practitioners from quacks. Here, quackery referred to those whose claims to cure were harmful to the individual's health and wellbeing (Adu-Gyamfi 2010).

The archival record suggests that, in the 1940s the people of Asante demonstrated a high sense of commitment to find antidote to their health challenges. They agreed to refer matters concerning traditional medicine application to the police commissioner for investigations before issuing license. In one of such reports, the District Commissioner of Kumase reported the situation in Obuase in the 1940s through a correspondence that:

> Reference to your letter No. 041/33 of 31st July, 1948 all Native Authorities in Obuase Districts have been informed and have agreed to co-operate by first referring the applications to the assistant Superintendent of Police or the District Commissioner (PRAAD, ARG1/14/26, Letter of Correspondence between Asantehene Prempeh I and the District Commissioner of Kumase, 29th October 1948).

In addition to Obuase, the *Offinsohene*, *Edwesohene*, *Kokofuhene*[11] and traditional areas like Bekwai and Adanse among others agreed to this practice. The quest of the colonial government to ensure a safe dispensation of traditional medical care including that of orthodox medicine necessitated a combination of the efforts of both traditional authorities and the police or law enforcers as agency of the British colonial administration to ensure the process was followed through. Here, power served as a productive network which ran through the whole social body (Foucault 1980: 119). The major interest groups we identified include; the British colonial administration, the native Authorities (chiefs), the police as well as the traditional or indigenous healers themselves. It is important to emphasise that at this stage the British colonial administration defined the issues. This notwithstanding, as argued by Knights and Vurdubakis (1994), power is always opened to possibilities of resistance and opposition as actors struggle to maintain or promote their preferred meanings. In Asante, local practitioners dictated new levels of discourse to allow for new inclusions into the traditional medical practice. They also purported to consolidate the traditional medical practice in the face of some contrary European views. In this case, resistance and opposition did not function against power but rather sought to harness power, especially in the production of a different outcome (Hardy and Thomas 2014).

The licensing strategy introduced by the British colonial administration met resistance in some traditional communities. For ex-

[9] The *Nsumankwaahene,* served as the chief physician of the *Asantehene* (The traditional leader of the Asante Kingdom)

[10] 'Hene' in Asante is a title that is used to refer to a chief or King. The 'Nsumankwaahene' as used in this paper is not referring to a particular individual but rather the title of the office that dispense such duties. This also implies to 'Asantehene' which does not refer to a particular King but rather 'King of Asante'

[11] The *Offinsohene*, *Edwesohene*, *Kokofuhene* denote "Chief of Offinso, "Chief of Edweso" "Chief of Kokofu". Offinso, Edweso and Kokofu are towns in Asante.

ample, in the Southern district of Asante, the *Omanhene* of Bekwai opposed the colonial administration's licensing strategy (PRAAD, ARG1/14/26, License Application Letter, 27th January, 1943). Though it was an initiative to check attitudes like that of Agbojan, the opposition resulted from fear that referring all license application to the colonial authorities will restrict the chief from undertaking his responsibilities of ensuring the perpetuity of traditional values. Again, it had the tendency to ignite a sense of doubt among the people in relation to the efficacy of the medicine of the traditional healers that they have been accustomed to most of their lives. In the indent below, the District Chief Commissioner stated:

> In the light of improvement of Native Authorities, it is considered essential to adopt the past and usual practice without referring the applicants to the Government Police to merely investigate the conduct of the native applicants who is best known by the community he lives. The new procedure when accepted, will weaken the activities of our N.A (Native Authority) Police from who we expert useful service (PRAAD, ARG1/14/26, Letter of Correspondence between Chief Commissioner of Police Gold Coast and District Commissioner of Police Kumase, 17th June 1948).

On this note, the chief Commissioner of Kumase reported that, "While sympathizing with Brekum's view, I think the precaution of consulting Government Police should nevertheless be universally adopted; it should be possible to put this arrangement into practice without encroaching upon the Native Authority's sense of independence…" (PRAAD, ARG1/14/26, Letter of Correspondence between District Commissioner of Police, Kumase and Chief Commissioner of Police Ashante, 20th September 1948).

Though, there were objections, the *Asantehene* in a response letter to the Chief Commissioner of Police in the Gold Coast dated 29th of October 1948, R.G Cooper suggested that the District Commissioner of Kumase prepared a register to ensure that all licensed practitioners will have their names entered in order to have in record all practitioners in the province. Agyemang Prempeh further suggested that, the police could use the prepared register to identify quacks in the system. The register was to be used by all confederacy members of Asante. A section of the letter stated that:

> Most Native Authorities have offered no objection and I suggest that the Confederacy Council approves of a register suitable for adoption by all Native Authorities in Ashanti who issue 'Herbalist Licenses'; if you so wish I will ask the Commissioner of Police to prepare a specimen page for your consideration… It should then be possible for Police Officers or Police Patrols to inspect these registers and advise whether in their opinion any licenses are undesirable characters. The responsibility of issuing or refusing to issue/not issue would of course remain with the Native Authority concerned (PRAAD, ARG1/14/26, Letter of Correspondence between Asantehene Prempeh I and the District Commissioner Kumase, 29th October 1948).

While local chiefs had shared their sentiments with regard to the colonial administration's attempt to control traditional medicine and its operation, elsewhere in Sekondi Takoradi – individuals like Kwesi Aaba among others – championed the cause for the recognition of traditional medicine by both the colonial and the indigenous people. At this point, literacy was used as the major weapon to define the place of traditional medicine in the Gold Coast. This quest led Aaba to play leading roles in the formation of the Society for African Herbalists in 1931. According to Osseo-Asare (2016), Aaba advocated for a

more formal way of keeping records as well as extending such knowledge to the general public as opposed to the traditional system of communicating practices of traditional medicine verbally. This corroborates Bonsi's (1980) argument that a person who has procured reading and writing aptitude can augment his horizon of experience through correspondence (Bonsi 1980). This attitude led to Aaba publishing his *African Herbalism: A Mine of Health* in 1934. The photographic piece detailed herbal medicinal plants and their healing prowess. It should be noted that from 1902 onwards, especially when Asante power had been toppled by the British, the colonial administration placed emphasis on European medicine. Thus, education was the major tool used to perpetuate that course.

Patterson (1981) has argued that the colonial administration used education in changing old beliefs and making people more receptive to western medical ideas. The demand of the colonial administration during this period was to raise the local practice of what was termed as "Medical Herbalism," to a higher standard and to seek for a free and unhindered practice for its members. This transcended into every aspect of the lives of indigenes including health, thereby influencing an individual's choice for western medicine. The spread of literacy augmented the spread of nationalist activities within the Gold Coast. To be placed at par with their counterparts, traditional healers mobilised and formed societal groups which highlighted their efficacy in terms of healing by employing their literacy. Notable among them was the Society for African Herbalist (Osseo-Asare 2016: 69-75). They also sought to undermine all sort of religious underpinnings of traditional medicine which seemed to weaken their chances of being at par with western medicine (Adu-Gyamfi 2015: 59).

Twumasi and Bonsi (1975) also highlighted significant factors that impacted the health systems of the Gold Coast during this era. Factors like rural-urban drift, education, the search for white collar jobs and the shift of family systems influenced the status of traditional medicine in the Gold Coast during the 1940s. These factors exposed the Gold Coasters to the efficacy of western medicine, thereby placing traditional medicine at a lesser position (Twumasi and Bonsi 1975: 42-58). At this stage, traditional medicine was seemingly in decline due to the struggle for dominance between it and the more sophisticated British colonial machinery. As argued by Anyinam, the idea of traditional medicine as fetishism has its roots in this era, when the colonial government consciously undermined its progress by tagging it as fetish (Anyinam 1987: 316). This, coupled with the transforming society of Gold Coast gave rise to the competition for medical authority by the colonial government and indigenous healers.

Gold Coast Nationalism by the latter part of the 1950s did not assume only a sense of radicalism but also highlighted the key features of African cultural values and practices including traditional medicine. This was a reaction to the idea that Africa had no history and was incapable of developing her own institutions. In response to this, various philosophical movements evolved on the continent. Notable among these included The Negritude Movement and the Concept of African Personality (Nkrumah 1971). It was in quest of these among other things that post-colonial governments, especially Nkrumah and the Convention People's Party (CPP) sought to develop the indigenous medical system of Ghana alongside the colonial orthodox system.

Traditional medicine under the Nkrumah and Post-Nkrumah governments

Traditional medicine under the Nkrumah era was rekindled along the concept of African Personality. Here, the major interest groups were Africans. Nkrumah saw the need to promote the cultural values of Africans. In this regard, Nkrumah welcomed any effort that sought to highlight the Ghanaian cultural val-

ues and promote indigenous knowledge. It is on this note that Nkrumah welcomed the efforts by earlier perpetuators of traditional healing. This interest led to the establishment of the Ghana Psychic and Traditional Healers Association (GPTHA) in 1961 (Warren *et al*. 1982; Adu-Gyamfi 2010). Though this association was the first of its kind in terms of a collaborative effort by the national government and the local people, Nkrumah realised the need to heed to the advice of men like Aaba to give a formal recognition for traditional medicine in the Ghanaian society.

Upon its establishment, the GPTHA tasked itself with ensuring a safe practice of traditional medicine in Ghana. It encouraged the licensing strategy used during the colonial period. Though its pioneers had no formal education, it had the presidential directive to uphold and preserve all manner of traditions and practices passed on by their ancestors. In view of this, membership was opened to priests, priestesses and herbalists who sought to promote indigenous medical knowledge and tradition (Adu-Gyamfi 2015). By inference, the practitioners were to ensure both the religious and physiological wellbeing of the local people.

Following the declaration of the 1964 referendum and the overthrow of Nkrumah in 1966, Ghana became a one-party state. This meant that all political parties were banned from contesting elections. However, this was resolved in May 1969 when the ban was lifted. Busia's Progress Party (PP) achieved a tremendous victory over the strongest opposition party, the National Alliance of Liberals led by Gbedemah (Boahen 1975). In pursuing his anti-Nkrumah agenda, Busia resorted to banning the sale of any photograph of Kwame Nkrumah and made it an offense to mention his name.

This idea also dwarfed some policies initiated by the first president of Ghana. Though he achieved remarkable results in rural health development, Busia did not perpetuate Nkrumah's vision of developing the Traditional Medical System of Ghana. Oriented by western philosophies of democracy, Busia embarked on rural development focusing largely on western models. The development of the traditional medical institution was not emphasised in the same manner that the Nkrumah government did. Eventually, Busia was ousted from office in 1972 by a coup led by I.K Acheampong.

In 1975, the National Redemption Council (NRC) led by Ignatius Kutu Acheampong saw the establishment of the Centre for Scientific Research into Plant Medicine (CSRPM). This was through the efforts of Dr. Oku Ampofo, a native of Obikyere in Akuapem Mampong who benefited from the group sent by Nkrumah to study the Traditional Medical System of China and its process of integration into orthodox medicine (Addy n.d.). Upon his return, Dr. Ampofo, together with a team from the Ghana Academy of Art and Science and the Ghana Psychic and Traditional Healers Association presented a proposal to the NRC government, which through a decree established the research centre to coordinate and facilitate all research work into Ghana Medicinal Plants.[12] This placed Ghana on the global scene as the first sub-Saharan country to make traditional medicine part of its Ministry of Health. This also made the research centre an agency of the World Health Organization to research into Traditional Plant Medicine (Addy, n.d.).

According to Ampofo (1994), the late 1970s witnessed an international revolution in healthcare. The World Health Organization's quest to extend healthcare to every individual in developing countries ignited the Alma-Ata conference in September 1978. The conference proposed that countries made Primary Health Care a top priority in ensuring good standards in public health. This raised several challenges which African governments had to tackle. To respond to these effectively, they met in 1989 at Bamako in Mali and came up with health strategies known as the Bamako initiative.

[12] 1975 (NRCD 344)

Among the top decisions taken were active community participation in the management and delivery of services; sustainable financial resources, including community financing and consistent supply of essential drugs (Ampofo 1994: 16-18).

To ensure that Primary Healthcare met both equitable and accessible demands of African States, the conference held by the World Health Organization (WHO) required that member countries integrated traditional medicine into their health systems. Contextually, Konadu (2008) argues that global health challenges in Africa were conditioned by the failed structural adjustment policies and highly indebted poor countries initiatives of the 1980s and 1990s, which collapsed health structures. Significantly, the global confrontation between pharmaceutical companies and African governments, and the lawsuits brought by pharmaceutical multinationals against these governments for seeking less expensive drug alternatives meant that efforts had to be made to seek alternatives from the use of indigenous knowledge (Konadu 2008).

In the Ghanaian context, efforts to ensure the safety of TM and efforts to integrate it into the formal health system dates back to 1979 when the Ministry of Health in collaboration with the Catholic Holy Family Hospital organised a Primary Health Care training for Indigenous Healers. However, this materialised when in 1991 the unit that looked into the promotion and development of traditional medicine was set up within the Ministry of Health. This became the Traditional and Alternative Medicine Directorate (Ministry of Health 1999).

In 1992, several laws and acts were passed to certify the sale of traditional herbal medicine products to Ghanaians and to regulate the practices of traditional medicine.[13] The new millennium also saw the passing of the Traditional Medicine Practice Act (Act 575) in 2000, which set up the Traditional Medicine Council for the registration of all Traditional Medical Practitioners in the country (Ministry of Health 2005).

Traditional medicine in the 21st century Ghana: an integrative process or a fallacy?

The integration of traditional medicine into western/orthodox medicine in developing countries has been ongoing. To ensure the "Health for All" vision adopted in 1978, the Regional Committee for the World Health Organization in Africa adopted a resolution in 2000 to promote traditional medicine in health systems of Africa. Among the current objectives of the WHO is to encourage countries in Africa to develop and integrate traditional medicine into their health systems. The resolution adopted by the WHO again encouraged countries to embark on implementing realistic traditional medicine policies (WHO 2001: 39).

In the sub-continent, Nigeria is said to have made some successful attempts to integrate indigenous medicine into orthodox healing (WHO 2001: 39). In the field of psychiatric healthcare, traditional medicine practitioners worked under the supervision of clinical staff. However, their success did not last long as the trained physicians discouraged the idea of indigenous practitioners working along with them in the same institution. Consequently, this collaborative medicine faded in Nigeria. Even though Feierman's argument (1985) of struggle for control of healing holds in most African settings, Ghana has seen progress in its quest for integration since the establishment of the Centre for Scientific Research into Plant Medicine (CSRPM) in 1970s. However, the challenges that Nigeria has encountered persist in the Ghanaian context.

In the Ghanaian context, recent research has pointed out that response from nurses in Kumase, the capital of Asante, showed skepticism towards the integration of traditional medicine into the health system of Ghana.

[13] The food and drugs laws 1992, PNDCL 305 B and the Traditional Medicine Act 2000

Though the nurses were concerned about some unresolved issues or questions pertaining to dosage and medical complications, Gyasi *et al*. (2016) reported that there is the need to advocate for traditional medical training for nurses in Ghana and Kumase in particular. It is expected that this shall enhance nurses' knowledge in both cultural and social aspect of medicine in relation to the populace in Ghana and Asante in particular. Essentially, it will enhance efforts to reach the WHO's aim of total integration.

In the twenty first century, one of the foremost efforts to integrate traditional medicine into the formal health system was the establishment of the Department of Herbal Medicine at the Kwame Nkrumah University of Science and Technology, which welcomed its first students in 2001. The four-year program trains the students in basic pharmaceutical, medicinal and social sciences, which is aimed at producing medical herbalists in the country. Currently, a number of herbal health centres have emerged in the country. These include government health centres and private herbal institutions. The government health centres include departments that treat diseases using herbal medicine.[14] In this sense, we can ask if the Ghanaian medical system is fully integrating both traditional and orthodox/ western medical practices or is it stripping the cultural element off traditional medicine in order for it to fall in line with orthodox or western medicine?

Conclusion

Traditional Medicine in the Ghanaian context has undergone several transformations. As a result, it is envisaged that it would be a safe delivery tool for healthcare and can become widely acceptable for orthodox administration and policy makers who manage health facilities. Previously, health care rested in the hands of indigenous healers whom the traditional authorities found worthy to entrust the lives of their subjects to cure their maladies. This position was challenged with the advent of colonialism, which introduced orthodox medicine into Ghana. Medicine in this era was defined from biomedical perspectives which undermined religion and largely the worldview of the indigenous people as the underlying factors in determining causes of diseases in the Gold Coast. The earliest part of the twentieth century saw nationalist drives giving traditional medicine a new footing and recognition. In perpetuating this vision, the governments immediately following Nkrumah, created a space for traditional medicine by establishing the Centre for Scientific Research into Plant Medicine.

In contemporary times, value is placed on the aspects of the traditional medicine that oscillate between science and culture. In promoting a local culture as well as ensuring priorities of International Organisations, Ghana among other developing countries has begun to prioritise research into traditional medicine as a means to ensuring universal health coverage for its citizens. However, the recent emergence of herbal centres - especially in the private sector - leaves the question of affordability to be discussed. Gradually, the cost of using herbal medicine is increasing due to the emergence of trained professionals from the Kwame Nkrumah University of Science and Technology (KNUST) and the University of Ghana, among other related institutions. Recent studies have shown that the absence of integration of traditional medicine with the modern setting as well as the lack of organization on the part of traditional healers has made it impossible to fully contemplate the extension of health insurance facility to traditional healers. Referring to Van der Geest (1997), Barimah (2013) argued that ironically, since

[14] These include the Koforidua Regional Hospital, Ho Municipal Hospital, Salaga Government Hospital, Suntreso Government Hospital and Cape Coast Metropolitan Hospital. The private health centres into herbal medical applications include; Agbeve Herbal Clinic and Amen Scientific Herbal Hospital among others.

1978, the WHO has consistently been calling for the integration of TM and biomedicine in African health care services, only to be sabotaged by national governments and their ministries of health, which are controlled by biomedical practitioners who are not interested in attaining this goal. Again, a further call for the Ghana Health Service and the Ministry of Health to work with the World Health Organization and other stakeholders to support the work of Traditional Medicine Practice Council (TMPC) to regulate and supervise the activities of herbal practitioners in Ghana, cannot be gainsaid (Barimah 2013).

The above notwithstanding, a growing utilisation of various modalities of traditional medicine is subject to its efficacy and potency and it is not surprising to find no differences in the utilisation of TM regardless of the status of health insurance in a society where traditional medical therapies have been a part of the culture (Gyasi 2014). The perspective of emerging healers who have modernised their practices continues to have significant implications on healthcare in Ghana. The aforementioned arguments are also consistent with contemporary studies like that of Simmons (2012); Meincke (2018) among others, who generally argue that traditional healers are constant developing numerous strategies to modernise and improve upon their services in order not to become extinct but rather maintain their reputation as healthcare providers amidst challenges regarding integration. Their engagement has increased the functional scope of traditional medicine.

Again, research has shown that a majority of western-trained physicians readily accepts traditional healers and sometimes works hand-in-hand with them. This is based on the fact that basic clinical and scientific research have revealed the pharmacopeia content of various herbs, which has helped to improve the understanding of the various benefits that can be gained from traditional therapies. Significantly, this enhances the debate for interest groups to engage governments and policy makers in particular to continuously support policies that would enhance and advance traditional medicine. This study has wider implications; it has drawn the attention of the critical reader to the need to continuously engage interest groups and policy makers to define pertinent issues that would facilitate the development of healthcare, and traditional medicine in particular. In this paper we have opened up a space for further intellectual dialogue concerning interest groups, issue definitions and the politics of healthcare in Ghana especially regarding that which concerns the grand politics of traditional medicine since the 1990s up to the new millennium.

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