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Evaluating the Integration of Traditional and Western Medicine in Rural Ghana: The Role of Healers and the Government

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Evaluating the Integration of Traditional and Western Medicine in Rural Ghana:

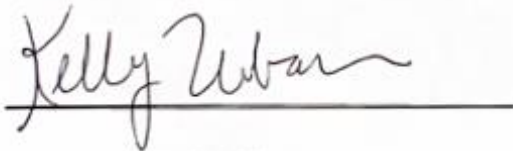The Role of Healers and the Government

By

Nicole Lemon

A thesis submitted in partial fulfillment of the requirements of the Honors College at the

University of South Alabama and the Bachelor of Arts in the Anthropology Department.

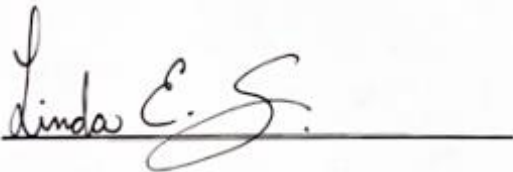University of South Alabama

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<u>DEDICATION</u>

I would like to dedicate my thesis to my family, who were not exactly sure what a thesis was at the start but were supportive, nonetheless. I would not be creating this thesis without them because I would not be in college without their support. I am so thankful for their constant acknowledgment of my hard work and how willing they are to uplift me when I need it. I would not be able to pursue medicine if they had not pushed me so hard and always picked me up when I was down. I love medicine and culture because they have exposed me to both of these and allowed me to develop my interests in them.

ABSTRACT

A question of pressing importance for the healthcare system in Ghana is the integration between biomedical physicians, who are unreachable for many rural citizens, and traditional healers, who fill in the gaps in access for rural and non-rural citizens seeking care, and are oftentimes the preferred choice. The care offered by each system is derived from differing paradigms, with the biomedical related to Westernized practices and the healing related to holistic, traditional approaches. Integration of these systems would allow for more acknowledgment and communication between these two different kinds of providers, which in turn would improve the quality of care provided to all patients.

The Ghanaian government did create policies to aid in integration, but the integration attempts were unsuccessful. The private practice attempts began in the 1940s while public service attempts began in the 1980s. The most notable integration efforts began in 2011 with the creation of traditional medicine herbal units within hospitals. This, along with other factors, has led some scholars to consider the government's efforts as "tokenistic." The issue, however, is that the authors do not fully explain why this is the case. Through an investigation that relied on scholarly literature, Ghanaian government policy documents, World Health Organization (WHO) strategies, and news articles, I found the following:

- the Ghanaian government likely did use the WHO strategies when developing their policies
- most healers are in favor of an integrated healthcare system
- the government did not appear to fully consider the needs of healers and their viewpoints when creating their policies

This lack of consideration relates to why the efforts of the government appear only tokenistic and do not address the needs of all demographics. Auyero's "patient model" and Menjívar and

Abrego's "legal violence" frameworks can be used to hypothesize why the government may

have allowed these barriers to remain during implementation.

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LIST OF ABBREVIATIONS

ATR: African Traditional Religion

GHAFTRAM: Ghana Federation of Traditional Medicine Practitioners Associations

MOH: Ministry of Health

NDC: National Democratic Congress

NHIS: National Health Insurance Scheme

NHIA: National Health Insurance Authority

NPP: New Patriotic Party

OMP: Orthodox Medicine Practitioner

TM: Traditional Medicine

TAM: Traditional African Medicine

TMD: Traditional Medicine Development

TMP: Traditional Medicine Practitioner

UHC: Universal Health Coverage

WHO: World Health Organization

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INTRODUCTION

The healthcare systems in Ghana, biomedical and traditional, remain separate from one

another in spite of the benefits that integration would provide Ghanaian citizens. There have

been attempts by Ghana's healers, physicians, and citizens to integrate the systems, but none

prevailed, seemingly due to a lack of structural change prior to and as the policies were being

created by the Ghanaian government (Kpobi & Swartz, 2019). The policies left barriers in place

that determined the implementation experience for each group, with some at a greater

disadvantage than others. The World Health Organization (WHO) created strategies to aid

nation-states in integrating their health systems, resulting in several successful integrations.

Ghana does not share the level of success witnessed in other countries, which creates a puzzling

situation for scholars to analyze.

This situation begs the question, did the Ghanaian government use the WHO's 2002–

2005 strategy for integration during their 2011 attempt to incorporate traditional medicine into

the biomedical healthcare system? (There were previous attempts at integration, including a

private effort in the 1940s and a public effort in the 1980s, but this thesis is concerned with the

2011 implementation.) The healers were one of many groups who would be substantially

affected by integration, so what were their viewpoints on the implementation of an integrated

healthcare system? Were these viewpoints and their needs considered by the government during

policy creation? Why/why not?

To answer these questions, I will use scholarly literature to establish the context of

healthcare in rural and urban Ghana and the differences between the two. I also plan to analyze a

number of primary sources including articles from Ghanaian news outlets, as well as the official

reports and policy documents from both the Ghana Health Service and the Ghanaian Ministry of

Health. By comparing the policies created by the government to the WHO's Strategy for

Integration in 2002–2005 and in 2014–2023, I can identify whether or not one of the WHO's

strategies was used and if the government's efforts appear inclusive and equitable. An inclusive

and equitable effort to integrate healthcare systems goes beyond tolerance of differing systems

and instead means communication, education, and acknowledgment (Ampomah et al., 2022). It

also means removing the barriers certain socioeconomic groups face so that integration will be

useful and beneficial for all.

Health experts within the WHO insist upon the benefits of integrating traditional

medicine and biomedical healthcare systems. According to the WHO, integrated health systems

tend to be more "people-centered," and people-centered systems are shown to be "more

effective, cost less, improve health literacy and patient engagement, and are better prepared to

respond to health crises" (WHO, "Services organization and integration: Integrated people-

centred health services"). In the WHO's Technical Series on Primary Health Care, they continue

to share the benefits of integration in their "Integrating Health Services" brief (2018). WHO

states that integrated health services enhance health-outcomes and quality of life while also

improving access to services, yielding "fewer unnecessary hospitalizations and readmissions,"

and show greater adherence to treatment (2018). WHO continues to state the public health

benefits of integrating primary care by stating, "this integration helps respond to unhealthy

lifestyles and environmental risk factors and to tackle other risk factors and determinants of

health" (2018). Public health is also benefited through integrated health services' ability to

enhance equity by providing patients with a choice of services "based on the holistic needs of a

given population" and by delivering "many different types of care across the life course" (WHO,

2018).

Traditional medicine and biomedicine are two paradigms utilized in two different healthcare systems. To better understand the methodologies behind each type of healthcare system, one must first understand how a healthcare system is theorized. The healthcare system is the cumulation of "socially organized responses to disease that constitute a special cultural system" (Kleinman, 1980). The responses differ among paradigms, but all can be related to disease and illness (Kleinman, 1980). Disease is more individualized, while illness is associated with more than one person in familial, social, and community situations (Kleinman, 1980). Disease also remains relatively constant regardless of the setting, while illnesses and the experience of having an illness can differ based on cultural influences (Kleinman, 1980). Traditional medicine and biomedicine both rely on science in order to practice evidence-based medicine, but they differ in their orientations toward disease and illness (Kleinman, 1980). James Lett defines science as "a systematic and self-correcting method for acquiring reliable factual knowledge" that seeks objective evidence free from bias (1997). The knowledge found must be publicly verifiable and rational in that the beliefs are "both falsifiable and unfalsified" (Lett, 1997).

Traditional medicine is used by indigenous practitioners who carry the knowledge and practices of their ancestors, and this system is more associated with cultural practices passed down through familial linkages (Lock and Nguyen, 2010). Traditional medicine practitioners are disease-oriented, but "their explanatory frames take into account illness issues to a greater degree than does the biomedical perspective" (Kleinman, 1980). Biomedicine shares the disease orientation of traditional medicine, as shown by its reliance on biologically oriented methods of diagnosis and cure, but it does not always take illness factors into account during the treatment

process (Lock and Nguyen, 2010; Kleinman, 1980). Biomedicine is also referred to as orthodox or Westernized healthcare.

Traditional medicine in rural Ghana is characterized by cultural nuances and community efforts to care for a variety of ailments. Their methods can be spiritual or non-spiritual, with the non-spiritual aspects often relying on medicinal native plants (Barimah & Akotia, 2015). Some Ghanaian healers specialize in a particular practice, such as bone setting or midwifery (Isola, 2013). The choice to involve spirituality in these practices is based on the healer's preference; others perform their specialty under a biological orientation only. Biological refers to the anatomical body and its natural physiological functions. The spiritual aspects rely on divination to diagnose as well as knowledge provided to them through supernatural consultations. The most common religions in Ghana are Christianity, Islam, and African Traditional Religion (ATR) (Barimah & Bonna, 2018). West ATR is a collection of the "various cultural beliefs and practices of West Africans that have not been diluted by their contacts with religions such as Christianity, Islam or Hinduism" (Barimah & Bonna, 2018). The cultural beliefs and practices associated with ATR explain how health and illness are viewed. Health is less individualized, and instead, it is treated like it is "for the whole community" (Barimah & Bonna, 2018).

In rural Ghana, there is neither a hospital system nor a biomedical clinic, so it seems as though traditional healing is the only choice and is chosen out of necessity (ITA, 2022). While it is possible for rural inhabitants to travel to urban areas, it is difficult and costly. A majority of rural individuals do not own vehicles, and the road network is poor in rural areas (Afukaar et al., 2019; Imoikor, 2023). However, even in urban Ghana traditional healers are relied on for their specific skill set and knowledge, therefore suggesting that rural Ghanaians draw on traditional medicine for reasons beyond a lack of access to biomedical care. This is not an uncommon

phenomenon, however, as many societies seek out healers regardless of their relationship to biomedicine (Lock & Nguyen, 2010).

For many families, traditional healing is their first choice. Healers provide care at a lower cost and remain the most accessible option for rural Ghanaian individuals. Exposure to traditional medicine during childhood is also a significant factor in individuals' choice to use this method of care. Those who have trusted healing since their childhood continue to prefer this system as adults (Ampopah et al., 2022). The role healing plays during childhood is apparent not only in healthcare service users but also in healers. Many traditional healers gained their knowledge from their parents and ancestors throughout the duration of their childhood (Adu-Gyamfi et al., 2019; Gyasi et al., 2017; Isola, 2013). Their accessibility is partially location-based but is also due to the shortage of biomedical physicians who are employed by the Ministry of Health (Krah et al., 2017). This shortage leaves many physicians stretched beyond their limits and many citizens lacking orthodox healthcare.

Those citizens lacking orthodox healthcare (i.e., biomedical care) must find care through other channels, such as healing. Traditional healers fill these gaps in access through their intricate framework in which they refer patients to one another (Krah et al., 2017). This referral system spreads into the biomedical healthcare system as physicians and healers refer patients to one another, both aware of their own limits. While this is true for many Westernized healthcare professionals, some do retain a bias against healers and choose to neither refer patients to healers nor support healers' practices (Gyasi et al., 2017). The biomedical physicians are aware of their lack of knowledge regarding the traditional practices many of their patients use. Because of their lack of knowledge, they are unable to provide treatment that complements healers' practices rather than supplants them. They also struggle to find the time to learn these practices that could

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complement their current care methods due to their intense workload (Gyasi et al., 2017). This workload is mainly due to a shortage of physicians, especially in rural areas. The healers also feel they lack valuable knowledge, but this knowledge is related to biomedical practices and the current technologies biomedical physicians are employing.

There have been attempts to integrate these systems by the Ghanaian government, many of which ended in failure (Kpobi & Swartz, 2019). The earliest attempt was led by one medical doctor who set up a private practice to work alongside herbalists in the 1940s (Kpobi & Swartz, 2019). This was successful, and it was followed in the 1980s by a "Primary Health Training for Indigenous Healers programme" (Kpobi & Swartz, 2019). This, however, was considered unsuccessful in its purpose to improve healers' methods likely due to differing specialties and practices just among healers (Kpobi & Swartz, 2019). The efforts continued after this, and in 2011 the Ministry of Health in collaboration with the Ghana Health Service established small herbal medicine units within 17 hospitals throughout Ghana (Kpobi & Swartz, 2019; Barimah & Bonna, 2018). Unfortunately, an evaluation five years later showed that the herbal unit and biomedical facility were perceived to be running parallel to one another instead of being integrated, and many patients were not even aware that the herbal units existed (Kpobi & Swartz, 2019). This evaluation was performed by Boateng, a public health researcher separate from the Ghanaian government, and his study attributed this disconnect as possibly caused by a lack of policy to directly regulate integration (Boateng et al., 2016). However, it is relevant to add that these herbal units "throughout the country" were mainly in the most densely populated regions of Ghana with the most urbanization, suggesting that no serious effort was made to address urban-rural disparities in healthcare access (Barimah & Bonna, 2018).

Regardless of these failures, it must be said that the government's strides to recognize healers and incorporate them are laudable compared to countries that are not trying. It is also significant given healers' previous loss of their ability to openly practice traditional medicine during colonialism, and it could be said this is another strong step toward reinstatement and appreciation of pre-colonial beliefs (Kpobi & Swartz, 2019). The World Health Organization created strategies to assist in the integration of these systems through policy recommendations and implementation examples. The Ghanaian government's choice to not use these strategies or not tailor them to fit their specific needs may have contributed to the failure of their previous integration attempts.

Rural families in Ghana can benefit from a change in policy that takes the contemporary strengths and weaknesses of rural health into account. This means an acknowledgment by the government of differing socioeconomic statuses and abilities to seek out care, and an incorporation of this knowledge into the policies would make them more inclusive and equitable. This information is the backing for the main questions this thesis seeks to answer. First, to understand how the policy created by the Ghanaian government plays into this, I investigate the following question: did the Ghanaian government use the WHO's 2002–2005 strategy for integration during their attempt to incorporate traditional medicine into the biomedical healthcare system? To answer this question, I compared the WHO Traditional Medicine Strategy 2002–2005 to Ghana government policies (National Medicines Policy, National Health Policy, Policy Guidelines on Traditional Medicine Development, Referral Policy and Guidelines).

To build off the policies and strategies and understand the other factors at play, I utilized the following question: what were the viewpoints of the healers on the implementation of an integrated healthcare system? To answer this question, I relied on the viewpoints and attitudes of

healers which I identified through their publicly shared opinions on the healthcare system and the government's attempts at integration. To survey healers' perspectives, I analyzed their comments and posts on the Facebook accounts of the Ministry of Health and the Ghana Federation of Traditional Medicine Practitioners Association and in oral interviews published by other scholars.

A follow-up question that makes clear the significance of these viewpoints on the policies is the following: were these viewpoints and healers' needs considered by the government during policy creation? To answer this question, I relied on both previously identified source bases: the Ghanaian government policies and the opinions of healers after all policies were implemented. This allowed me to see where the shortcomings were and if they were preventable prior to implementation. Preventable barriers incorporated within the policies would indicate a lack of consideration for healers' needs during policy creation and implementation. To understand this further, I asked why or why not? I hoped to find direct commentary from Ghana's citizens regarding this question, but the data on social media was limited, possibly due to a lack of internet access among those who use TM most. I incorporated scholarly literature regarding legal violence to understand the reasoning behind the government's behaviors. The content and application of the integration policies also provided insight into this question.

These questions and Ghanaian integration in general can be better understood through a framework that includes broader contextual factors: environmental, demographic, social, political, economic, and ideological. I will be using this framework to consider how each of the contextual factors play a role in how the Ghanaian government designed their integration attempt. The environment encompasses the division between the rural and urban and includes the areas in which integration attempts took place. In this case, much of the integration occurred in

urban areas. This is problematic because that would indicate integration is only benefiting those who already somewhat have access and may have more resources. The demography breaks down the actual population distribution in both the rural and urban areas. Rural areas originally were more populated, but beginning around 2010 this began to shift as urban areas gained higher population densities (Statista, 2023). As shown on the map below, the southern coast has the highest population densities indicative of the most urbanized areas.

Text alternative for map below:

The most densely populated region in Ghana is the "Greater Accra Region," with 1,493.5 persons by km^2. The bottom half of the map is the coastal side of Ghana, and it is more populated than the Northern half of Ghana. Darker shades of green indicate higher population density, and the green is darker from the coast to the Bono East region in central Ghana.

Map 1: "Population Densities in Ghana from Geo-Ref.net," created in 2021:
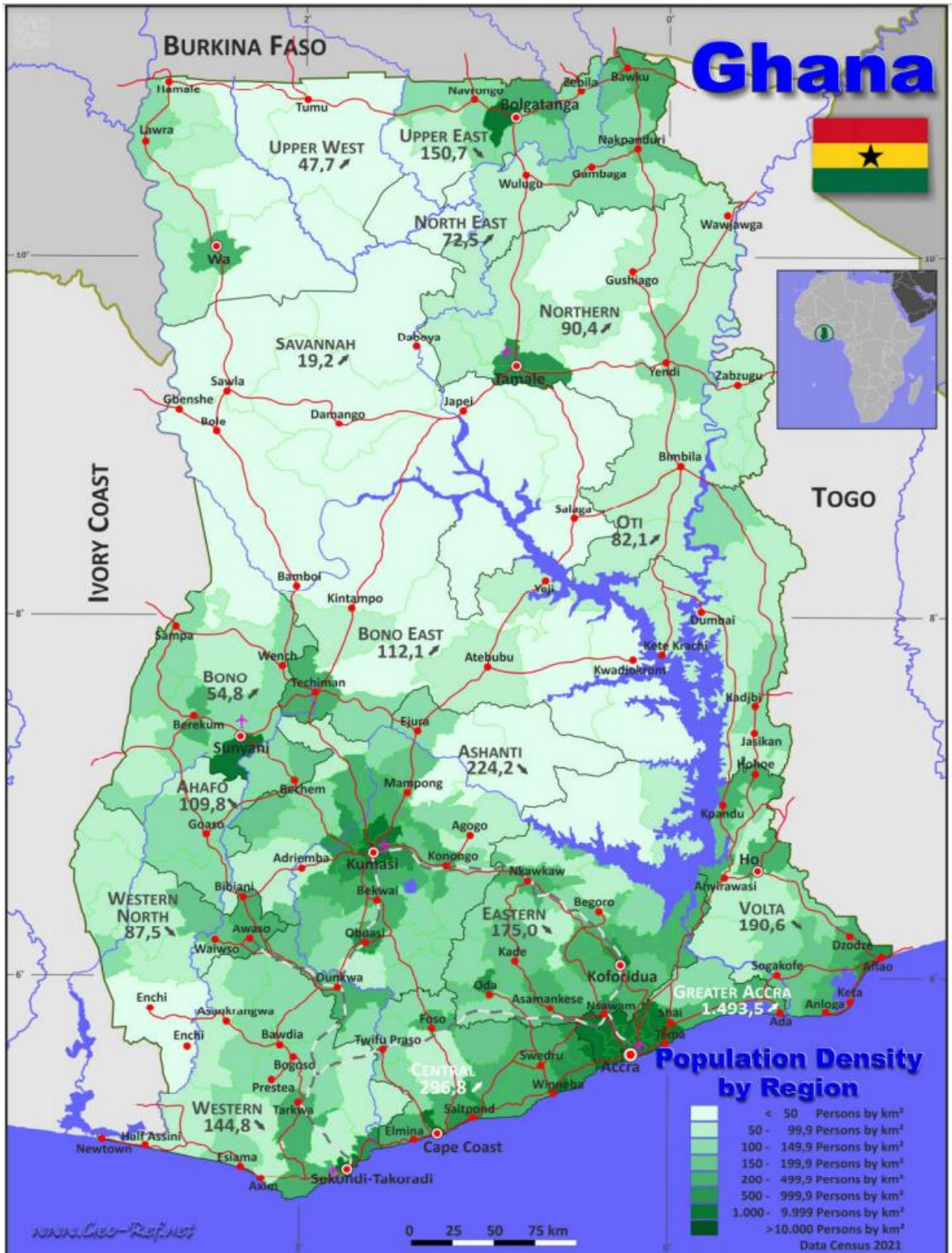
Both the environment and demography shape, and are shaped by, social, political, and economic actions. The social groups vary, but generally, they are divided here into healthcare service users, biomedical providers, and traditional medicine providers. This can be broken down further into rural and urban healthcare users and rural and urban healers. There is also another social distinction among healers between spiritual and non-spiritual. This affects politics, as these distinctions and growing gaps make fighting for representation difficult (Barimah & Bonna, 2018). Ghana is a democratic country with two dominating political parties, the New Patriotic Party (NPP) and the National Democratic Congress (NDC) (Mills, 2018). The NPP is considered the more liberal party and is more so composed of individuals in the Ashanti Region, which is more densely populated than the Northern and Volta regions that commonly support the NDC party (Mills, 2018). Neither party is dominated by support from a particular socioeconomic group (Mills, 2018).

One group that attempts to close gaps among the many healer organizations and types is the Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM), a major organization conjoined with and led by the main healthcare political organization, the Ministry of Health. Furthermore, these factors affect each individual's economic status, but their economic status can also affect their political and social status. The economic factors associated with integration are important, as there are underlying issues surrounding poverty and a lack of affordability that need to be addressed and resolved before integration can ever be a success. While the economy in Ghana has been growing, there are many areas that require political reformation (Mills, 2018). According to Mills, social programs remain underfunded, the "income

distribution is grotesquely skewed," and many individuals remain impoverished, which adds to rising social tensions (2018).

In regards to the economic factors associated with healthcare, the Ghana 2021 census reported that "68.6% of the population is covered by either the National Health Insurance Scheme (NHIS) or private health insurance schemes" (ITA, 2022). The NHIS covers formal sector employees (anyone employed by an establishment that is regulated by the government and receives benefits through the government), self-employed individuals who contribute to Social Security, children, pregnant women, disabled individuals, and the elderly (NHIS, site copyright 2024; scheme instated in 2003). The scheme has grown since its instatement in 2003, and now also includes coverage for various childhood cancers and for future family planning (ITA, 2022). Nonetheless, as of 2021, 31.4% of Ghanaians are not covered by health insurance.

All of this plays a conjoining and significant role in how the government designed integration. In this case, it appears integration was not designed with all groups in mind. It only caters to certain subsets of the population: urban healers who can afford registration of their practice and medicines and urban citizens who are not solely reliant on TM. The subsets of the population can be defined as healers in rural areas, healers in urban areas, biomedical physicians (typically only in urban areas), and rural and urban citizens. This is why a tokenistic effort has been repeatedly associated with the Ghanaian government's attempts to integrate. Finally, all of the aspects from environment to design attempt to align with the ideology of the WHO towards integration. Each has a role in the other, and each has the potential to be an area of failure during any of the stages within the integration and implementation process.

The stages of integration may be best understood as pre-implementation, implementation, and post-implementation. Pre-implementation involves observing the current systems,

incorporating viewpoints of all involved parties, and creating policies and plans for implementation. Once the data from this stage is ready to be put into action, the implementation stage is reached. This stage involves action and on-the-ground work. Finally, after implementation is complete, one can reflect to see where improvements can be made. This stage would be best for analyzing any barriers that became apparent during implementation and correcting them. Failure can occur at any of the stages or at a combination of the stages.

Chart 1: "Contextual Framework for Ghanaian Healthcare Integration"

Environment: Ghana can be divided into rural and urban environments.

Demography: The population distribution in Ghana has changed but explains the rural/urban separation.

Social: There are many separate groups involved in the healthcare systems and within Ghana as a whole.

Design: The policies don't appear to be designed inclusively and were affected by the contextual elements and the WHO's ideology.

Political: Ghana's government is a democracy and there are political groupings among healers.

Economic: 70% of Ghana's population relies on TM, but it is not fully incorporated the NHIS.

Ideology: The WHO's ideology is that integration is beneficial and improves health services.

Further Explanation of Each Chart Element:

- Design: It does not appear as though the policies and the other regulations that were designed to aid and facilitate integration were created with all groups in mind. The policies meet some of the requests of healers, but in most regards healers cannot actually follow them for various reasons. The regulations are also weakly enforced. The design appears to be lacking a genuine understanding of the needs of healers, healthcare users, and biomedical physicians. Each of the Ghanaian contextual factors (environmental, demographic, social, political, economic) and the ideology of the WHO contributed to how integration was designed.

- Ideology: The ideology of the WHO that set forth integration efforts within Ghana is that integration is beneficial to the country's health system as a whole and promotes patient-centered care. The WHO posits that integrated health services improve quality of life, health-outcomes, and access to services among other benefits. Their backing of TM integration stems from their mission to "help save lives and improve health by closing the huge gap between the potential that essential drugs have to offer and the reality that for millions of people – particularly the poor and disadvantaged – medicines are unavailable, unaffordable, unsafe or improperly used" (WHO, 2002).

- Social: The separate groups are traditional medicine practitioners, orthodox medicine practitioners, and healthcare service users. There also seems to be a separation between rural and urban healers as indicated by their different perceptions on registration, education, and methods (Ampomah et al., 2022). Ghana's population is 71% Christians and 17% Muslim (World Pop, 2023). Furthermore, there is a separation between spiritual and non-spiritual healers.

- Political: Ghana's government is a democracy similar to the American government (USAID). Political org's related to TM include the Ministry of Health which is over the

teaching hospitals where integration attempts have occurred and works in conjunction with and over GHAFTRAM. There are also a variety of TMP groups under GHAFTRAM, each with their own unique identities. There is a significant political power struggle between spiritual and non-spiritual healers that affects TMPs' representation and their ability to fight as one team (Barimah & Bonna, 2018).

- Economic: Although over 70% of the population relies on it, traditional medicine is only partially covered by the NHIS and that coverage only applies to integrated government facilities (such as the teaching hospitals with herbal med. units) (Ampomah et al., 2022; Barimah & Bonna, 2018). The lack of coverage makes seeking care difficult as it is unaffordable for many Ghanaians, especially the 27% who live in poverty (The World Bank, 2023).

- Demography: The population distribution has changed greatly over the years as more individuals used to live in rural areas than urban, but the urban population has overtaken the rural. Their urban population reached about 19 million people in 2021, which is 58% of the country's total population. The rural population reached 13.8 million, or 42% (Statista, 2023).The population grows at a rate of 2.2% (World Pop, 2023).

- Environment: Ghana can be divided into rural and urban, and hospital integration typically occurs in urban environments since there are few, if any, hospitals within rural regions. There were 15 pilot hospitals with herbal medicine centers, with only two appearing to be in less populated areas (Barimah & Bonna, 2018). There are two hospitals in the most populated region, Greater Accra, four hospitals in the second most populated region, Ashanti, and one hospital in the third most populated region.

LITERATURE REVIEW

Medicine is a key player in any society, and medical knowledge is informed by the cultural practices and geographic location of each group (Lock & Nguyen, 2010). This knowledge differs based on certain aspects of the culture, such as whether they are literate or not (Lock & Nguyen, 2010). Non-literate groups appear to associate disease and death with many causes rather than one individual ailment, and they attribute these causes more commonly to their external environment and chance (Lock & Nguyen, 2010). Literate groups may also incorporate multiple causes, but when compared to non-literate groups, literate non-biomedical practitioners more commonly focus on bodily signs, such as observable changes on the skin's surface, one's pulse, and any abnormalities found during palpitations after other signs are investigated (Lock & Nguyen, 2010). Biomedicine differs in that it attributes no luck or chance to the causes of illness and focuses on internal rather than external causes and signs (Lock & Nguyen, 2010).

Indigenous medicine, also known as traditional medicine, incorporates much of the previously mentioned ideas regarding illness and remains a top choice for many. The WHO (2013) defines traditional medicine as "the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness." During the rise of biomedicine, which began in the 18th century as the state started supporting the medical profession but further developed into the now-utilized biomedicine by the late 19th century, many believed traditional medicine would either die out or be incorporated and then fade away (Lock & Nguyen, 2010). This is not the case for a variety of reasons related to the cultural competencies of healers, the ability of healing to fill the gaps biomedicine cannot meet, and the social and economic status of the patients seeking

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care (Lock & Nguyen, 2010). Instead, indigenous medicine has only grown more innovative as practitioners of biomedicine and TM share information back and forth and TMPs adapt to a modern world (Lock & Nguyen, 2010). There are many examples of this in countries where traditional medicine is prominent, such as China, Ghana, and India, as healers modernize their practices while maintaining their inclusion of folk beliefs (Lock & Nguyen, 2010).

While there is a share of information in many cases involving biomedical practitioners and TMPs, there is also a certain level of distrust and devaluing in certain situations. This can occur when biomedical physicians treat a healer's knowledge as less than theirs due to the different practices through which the healer gained the knowledge (Lock & Nguyen, 2010). For some healers, there is no formal, in-school training. Instead, there are hands-on apprenticeships and all is learned through observation and experience. This means there is less regulation and standardization, which causes some professionals to devalue TM. This does not only occur in research. It has been witnessed in biomedical doctors who treat patients differently once they learn their patient used TM or even doctors who display bias against healers by not referring patients under the reason of not being able to "guarantee the quality of care they will provide" (Ampomah et al., 2022; Gyasi et al., 2017). This harms integration because it undermines the current efforts and discourages healers who want to learn more (Kwame, 2021).

This attitude has been witnessed in Ghana, which is especially shocking since traditional medicine is a common method of care for many individuals, with 70% of the population using some form of traditional healing (Ampomah et al., 2022). This is due not only to the healers' utilization of holistic, patient-first care but also due to the affordability and accessibility of traditional healing (Krah et al., 2017; Isola, 2013; Rasmussen, 1998). The remedies provided by healers are more easily available to the communities they serve, which usually consist of

individuals of lower socioeconomic status (Rasmussen, 1998; Ampomah et al., 2022). In rural

Ghana, there are no biomedical healthcare services, so if an individual is of a lower

socioeconomic status, they cannot travel to said services (International Trade Administration,

2022). Because much of the population uses some form of traditional medicine, there have been

calls from traditional healers, biomedical physicians, and Ghanaian citizens to integrate this

healthcare system with the state-run biomedical system.

These calls to integrate can also be tied with nationalistic views, as TM was being

practiced in Ghana prior to European colonialism (Adu-Gyamfi et al., 2019). During the colonial

period, Ghanaians were not able to practice traditional medicine as they once did. At the peak of

colonization, there was no chance for traditional medicine or healers to develop (Barimah &

Bonna, 2018). Even as colonists were instating a healthcare system, it was one with no

incorporation of healing whatsoever due to their stigma that it was "primitive" (Barimah &

Bonna, 2018). Because of this, the resurgence of TM can be associated with nationalism that

plans to uplift the nation and the innovations that were originally created within it (Lock &

Nguyen, 2010). One of these innovations is the traditional healthcare system that not only cares

for all patients but also highlights the usefulness of the natural African fauna.

The medical systems in Ghana currently remain pluralistic instead of integrated, relying

on tolerance instead of acknowledgment and communication (Gyasi et al., 2017; Ampomah et

al., 2022). The following are the different types of medical systems relationships: intolerant

medical orthodoxy, tolerant medical orthodoxy, parallel development of multiple health systems,

policy of integration, and active collaboration between fully recognized health systems (Barimah

& Bonna, 2018). These terms are used to describe the relationships between TM and

biomedicine in any society, and they were initially utilized at a workshop of Traditional Health

Systems and Public Policy organized through a collaboration between the following divisions of

Canada's International Development Research Center with the Canadian Society for

International Health and the Pan-American Health Organization: the Health Sciences Division,

the Gender and Sustainable Development Unit of the Corporate Affairs, and the Initiatives

Division (Barimah & Bonna, 2018). Intolerant medical orthodoxy refers to an intolerance of TM

by the government and competing healthcare systems to the point of making it "illegal or

institutionally repressed" and only providing biomedical practitioners the right to practice

medicine (Barimah & Bonna, 2018). Tolerant medical orthodoxy means TM is tolerated by the

governing powers and systems, but there is neither official recognition for healers nor are they

allowed to present themselves as registered medical doctors (Barimah & Bonna, 2018). Parallel

development of multiple health systems provides TM and biomedicine practitioners with official

recognition in equal, regulated systems while maintaining their separation (Barimah & Bonna,

2018). Integration policy seeks a merged system where the teachings of TM and biomedicine are

combined to create a new practice, but this type is considered incredibly difficult and other

options, such as establishing equality of the separate systems instead, may be more appropriate

(Barimah & Bonna, 2018). Finally, active collaboration between fully recognized health systems

means there are still two separate paradigms, but they both achieve equality, respect one another,

and understand each other (Barimah & Bonna, 2018).

Barimah and Bonna (2018) note that the healthcare systems in Ghana are currently closer

to parallel development, but if efforts are made to promote the growing trend of respect and

equity, then there is a possibility of reaching active collaboration. This system would mean a

"true medical pluralism in Ghana capable of addressing the health needs of all its citizens"

(Barimah & Bonna, 2018). Regardless of this lack of complete, collaborative integration, a

referral framework still exists between healers and biomedical professionals (Isola, 2013; Krah et al., 2017; Gyasi et al., 2017). Many Western-trained physicians accept healers, displaying an attitude of understanding and acknowledgment, but in order to properly integrate their practices, biomedical physicians believe that there must be a higher form of government regulation and accreditation of traditional healers (Adu-Gyamfi et al., 2019; Kwame, 2021).

Healthcare professionals are concerned about the healers' lack of regulation as they prescribe a variety of herbal remedies with no quality standards (Gyasi et al., 2017; Kahumba et al., 2015). Another obstacle to regulation is the healers' attitudes towards sharing their methods and receiving restrictions. Many spiritual healers view their practice as divine, unwilling to cooperate with the views of the natural world (Barimah & Akotia, 2015). Herbal medicines are distributed freely, leaving many individuals at risk (Kahumba et al., 2015). Some of these remedies also remain unregistered, further adding to the challenge of regulation (WHO, 2019). There are laws attempting to handle this challenge, but their weak enforcement only adds to the problem (WHO, 2019). These laws are outlined in the Public Health Act 851 passed in 2012, and the following are a few examples of what these laws address in relation to drug registration and regulation: "118. A person shall not manufacture, prepare, import, distribute, sell, supply or exhibit for a drug, herbal medicinal product…unless the article has been registered by the Authority," "121. A person who, without permission from the Authority, distributes a drug or herbal medicinal product as samples commits an offence," and "122. A person who has not been issued with a license or permit under this Part, shall not import a drug, herbal medicinal product…" (Ghana Ministry of Health, 2012).

The integration of these healthcare systems requires formalization and standardization of traditional healers' practices (Kpobi & Swartz, 2019). This would call for effort from healthcare

professionals, healers, and government officials. For healers, this effort refers to standardizing their practices and increasing their knowledge of modern healthcare practices. For healthcare professionals, this effort refers to gaining knowledge on the cultural side of healing while maintaining an attitude of cultural relativism. For the government, this could look like many things, but it would mainly require support, financial or otherwise. There has been no successful standardization yet, which is necessary for further steps such as public insurance policies and knowledge sharing between systems (Barimah & Akotia, 2015; Adu-Gyamfi et al., 2019; WHO, 2019). Lack of government support is evident as Ghana lacks government and public research funding for traditional medicine, as well as no reimbursement for traditional medicine services by public health insurance (WHO, 2019). The general consensus from healers, healthcare workers, and healthcare users is that integration would require more effort from the government than they are currently receiving (Gyasi et al., 2017).

While efforts from government officials regarding insurance and regulation enforcement have been minimal, the officials did put forth effort when creating associations to band together indigenous medicine practitioners. Many organizations have been formed, most under the Ghana Federation of Traditional Medicine Practitioners' Associations (Kpobi & Swartz, 2019). The federation works underneath Ghana's Ministry of Health, intending to recognize and organize the many specialties of traditional healing while maintaining their practices. The unification of healers under this federation was an attempt by the government to promote intercultural healthcare, but it is viewed more as a token than a genuine and useful effort (Gyasi et al., 2017).

Overall, the secondary literature provides a useful perspective either of healthcare users' experiences or the experiences of the providers, both traditional healers and biomedical professionals. After analyzing the perspectives, I deduced that the government plays a unique

role in each perspectives' obstacles to integration and is one of many connections among them. Tolerance of these systems by one another is not enough to improve the quality of patient care in the way that integrated health care would. There is already an existing framework of individuals who understand the importance of this challenge, as well as its many benefits. They have witnessed the failed attempts, the lack of government support, the need for regulation, the advantages of standardization, and the number of Ghanaian families that could greatly benefit from a systematic change. While the authors have each provided useful information regarding Ghanaian healthcare, there are many questions left unanswered.

One book, in particular, can be used to conceptualize the data provided by the other scholarly literature that is related specifically to Ghanaian healthcare. *Patients of the State: An Ethnographic Account of Poor People's Waiting* by Javier Auyero highlights how the government can create structures that technically are meant to aid citizens but instead place them in emotional and mental turmoil (2011). Public service systems exercise power over individuals through the excessive use and manipulation of their time (Auyero, 2011). This waiting is also in an area of discomfort; in this study, Auyero investigated a welfare office with uncomfortable plastic chairs that only a few patrons can use as there are not enough for everyone, no cleaning throughout the day by any staff, no air-conditioning, and little natural light (2011). One individual considered the process unfair due to the fact that they wait so long and oftentimes do not even receive what they originally came for (Auyero, 2011). While there is discomfort within the waiting area, there is also the formation of relationships and networking. The "patient model" encompasses the factors described above and highlights how groups who are already in difficult situations related to finances, geographic location, etc. are further abused by a system that is created to "reproduce… political subordination" (Page 2; Auyero, 2011).

In-text caption and text alternative for Chart 2 below:

Chart 2: A comparison of Auyero's "Patients in Waiting" to the situation healers are facing within Ghana. The chart compares the who, where, and how of both situations. In "Patients in Waiting," the 'who' are the powerless individuals seeking welfare assistance, and in Ghana, the 'who' are the rural individuals of lower socioeconomic status. For both, their respective governments represent power in their scenarios. The location for "Patients in Waiting" is Buenos Aires in welfare assistance offices, and the comparable location for Ghana is Ghanaian bureaucratic offices. The how in both is related to the government's ability to place individuals in difficult situations when they are seeking assistance or attempting to abide by the law, thereby reinforcing their powerlessness in the face of powerful societal structures.

"Patients in Waiting" Compared to Ghanaian Traditional Medicine Policies and Healers

WHO:

- Both the groups who are powerless in Buenos Aires and Ghana are rural individuals who are of a lower socioeconomic status. They therefore have difficult with affordability and transportation.

- Both the groups who are in power are governments. In Buenos Aires, the main issue is with the welfare offices. In Ghana, the policies that are creating issues were formed by the Ministry of Health, an agency of the government that is overseen by the main Ghanaian government but also oversees other agencies below it related to health.

WHERE:

- The offices that individuals seeking welfare assistance must go to are all in urban areas. This means many in need of help must travel long distances, which is not always affordable. In one example presented by Auyero, a woman walked 1.5 miles to the office because she could not afford a bus ticket.

- The bureaucratic offices that healers who are seeking registration and FDA approval must go to are also all in urban areas. Rural healers do not have the transportation to get there. Also, since healers are often not paid in money in rural areas they cannot afford the travel cost.

HOW:

- In Buenos Aires, the patient model is applied to individuals who are made to wait in welfare offices for hours and sometimes even days as they return after closing repeatedly. The powerful government is exploiting and robbing them of their time while placing them in a difficult situation. They need to receive welfare in order to live.

- In Ghana, the patient model is applied to healers who are made to register by government created policies but without any assistance to overcome the many obstacles. They need to register in order to align with the policies and continue their practice.
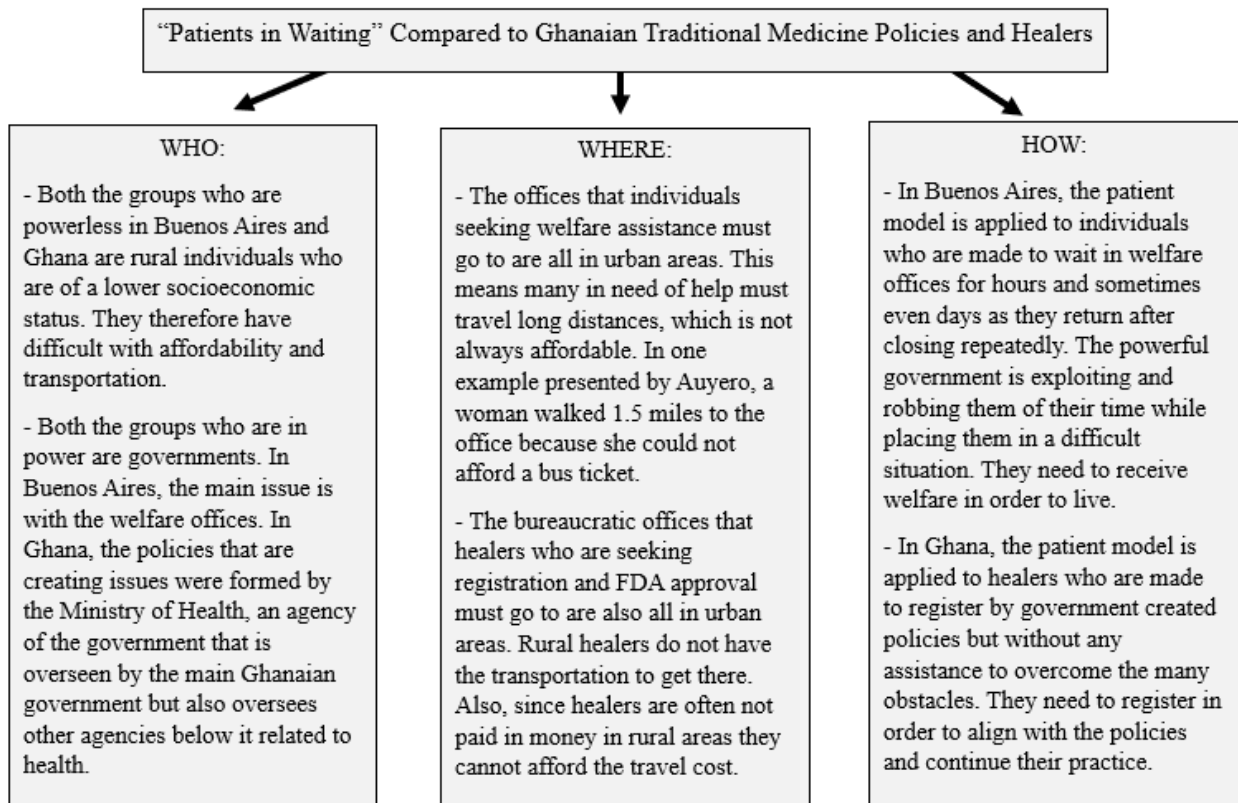
Chart 2: A comparison of Auyero's "Patients in Waiting" to the situation healers are facing within Ghana (Auyero, 2011; Ampomah et al., 2022; MOH, 2005).

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Another article that is useful as a conceptual framework is "Legal Violence: Immigration Law and the Lives of Central American Immigrants" by Cecilia Menjívar and Leisy Abrego. The legal violence framework can be used to explain how laws punish certain groups for their arbitrary circumstances and only worsen the situation (Menjívar & Abrego, 2012). The authors use this framework to conceptualize immigration law and the difficulty immigrants face in attempting to migrate and become citizens. In a more general sense, the legal violence framework can be used to evaluate the harmful consequences that develop "through the implementation of laws that delimit and shape individuals' lives on a routine basis." When this framework is applied to Ghanaian integration policies, it can explain why healers are being required by the policies to do things that are not necessarily possible, especially not with the many barriers in the way that the policies do not address. Rural healers are being made to register and receive FDA approval, and for those who cannot, it shapes their lives in a negative way. Those unable to register are unable to properly practice under the new rules, which affects how their practice is viewed and their consumer base (Ampomah et al., 2022). These processes are expensive, which means the medicine and treatments performed by healers must also become more expensive because they must find a way to make profits (Ampomah et al., 2022). Since they are not included in the NHIS, this is a less-than-ideal situation for healers and patients.

I argue that the patient model and legal violence framework can be applied to Ghanaian healthcare, specifically to traditional healers and rural citizens, to highlight how the government may have knowingly created policies that did not aid in removing barriers from certain individuals. Since they left up these barriers, which harm the practices of rural healers, this could be considered legal violence. This affects patients and healers, as patients are left in discomfort

waiting to receive care and attempting to find it wherever they can. The policies were partially

meant to improve accessibility of care, especially in a society with a biomedical physician

shortage. However, increased costs and the inability to practice "properly" may only worsen

accessibility (Ampomah et al., 2022). Healers mention the challenges they face in meeting

regulatory requirements outlined in the TM and National Medicines policies related to the

registration of both healers and their medications (Ampomah et al., 2022). The policies entail the

formalization of healers' practices, providing healers with training, including healers in the

insurance scheme, and more (MOH, 2005; MOH, 2017; MOH, 2020). The catch, however, is

that there are many obstacles that the policies do not take into account or purposely left there to

hinder healers and their patients. Registration of one's practices and medicines is expensive and

FDA approval requires repeated travel (Ampomah et al., 2022). The cost of these processes and

their travel requirements make them less obtainable for rural healers who have no funds and no

means for such travel (Ampomah et al., 2022). Those who cannot meet the requirements are

pushed further "outside the law" (Menjívar & Abrego, 2012).

     While the scholarly literature previously discussed provides much useful information,

there are limits to what one can learn about Ghanaian integration from said scholarship. Each of

the authors mainly relied on quantitative and qualitative data stemming from surveys and

government policies, respectively. There is also a general usage of the WHO's strategy and

report on traditional medicine integration, but I believe the authors' choice to not compare that

strategy to the actual Ghanaian Ministry of Health policies is a shortcoming in the existing

literature. My thesis will add a comparison to the literature useful in identifying any areas in the

government policies requiring improvement. By also incorporating the perceived strengths and

weaknesses of traditional healing, I can further evaluate the adjustments necessary to benefit this particular population.

The qualitative data I utilized to create comparisons consists heavily of WHO statements as well as Ghana's traditional medicine policy. The authors of the pre-existing scholarship relayed the information stated by the WHO regarding their support of an integrated healthcare system but did not compare this to the policies actually created in Ghana. Many authors referred to the policies as tokenistic without displaying an analysis of the actual policies. Gyasi (2017) in particular noted the government's disregard for practicality when forming the integrative policies, but they did not cite specific policies nor their implications. The qualitative data also focuses on the opinions and feelings of traditional healers, biomedical professionals, and healthcare users. The choice to incorporate the thoughts of individuals most affected by integration relays the importance of this decision, as well as its many repercussions. However, I believe more of a focus should be put on how these individuals believe the integration efforts can be improved rather than just their opinion on the current state of affairs.

I plan to investigate the viewpoints of the healers on the implementation of an integrated healthcare system to understand how that could have affected integration. The scholarly literature highlights some of these viewpoints, but whether or not the government took their suggestions into consideration is unclear in current scholarly sources. By incorporating the opinions of healers on the implementation of an integrated healthcare system, as well as the government's usage or lack thereof, I can further analyze whether or not the government's policy efforts were genuine.

METHODS

       The initial research process began with a generalized search through the abstracts of the *Annual Review of Anthropology* and the *Medical Anthropology Quarterly* journals to identify potential sources. I then mined the notes and bibliographies of the articles for additional secondary sources. I analyzed these secondary sources (mainly written by scholars) that explained the healthcare system in Ghana as well as in other countries to gain a more detailed understanding of traditional medicine and alternative medicine systems. Through analysis of these sources, I was able to identify questions I believed were unclear and repeatedly unanswered.

       Once I identified a gap in knowledge, I used the references of the scholarly literature to identify primary sources that I could utilize to close this gap. These primary sources are the World Health Organization's Traditional Medicine Strategy 2002–2005, WHO's Traditional Medicine Strategy 2014–2023, WHO's Global Report on Traditional and Complementary Medicine 2019, and the following Ghanaian Ministry of Health policy documents: the Policy Guidelines on Traditional Medicine Development 2005, the National Health Policy 2020, and the National Medicines Policy 2017. News articles that express the viewpoints of healers as well as the current state of integration also serve as primary sources.

       I compared the Ghanaian MOH policies to the WHO strategy by outlining key elements of both in order to make the information more digestible. Identifying the key elements and how they compare allowed me to identify whether the Ghanaian government considered the WHO strategy when creating their policies regarding traditional medicine. The alignment of multiple policies and expected outcomes between both documents is likely indicative of a consideration of WHO guidance by Ghanaian stakeholders during policy creation.

In order to investigate the viewpoints of healers on an integrated healthcare system, I

used scholarly literature from authors who interviewed TMPs in Ghana from urban and rural

areas to gain an inclusive understanding of healers' wants and needs. Investigation of whether or

not the Ghanaian government considered healers' viewpoints and needs as well as the needs of

their communities during policy creation is evident in the scholarly literature that discusses

current barriers placed on healers regardless of the policies meant to aid them. This could be an

intentional act of legal violence by the government or an unintentional act of disregard when

creating the policies that left the needs of healers unconsidered. Scholars who interviewed TMPs

highlight the challenges they feel they are currently facing that are not aided by the original

government policies. These same challenges are noted in the news where individuals provide

their suggestions on where integration can be improved.

An attempt was made to use the Ghana Ministry of Health Facebook to find commentary

from healers and/or citizens regarding healing, but a majority of the comments were not

regarding healing or anything related to TM. The few comments that were from citizens

discussing TM or TM practitioners were positive, praising TM and expressing excitement for

future TM advances. There were a total of three posts with nine comments total regarding TM,

and their contents are documented below:[1]

- Under a post highlighting GHAFTRAM's visit to the MOH Chief Director, citizens

  commented "Well done Our great leaders," "Blessings from the most high upon us ALL.

  GHAFTRAM!!! GHAFTRAM!! GHAFTRAM! UNITY," "Well done GHAFTRAM,"

  and "Fantastic soon Ministry of Health will accept herbal medicine at the public hospital

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[1] The small amount of comments regarding TM is likely correlated to how few TM posts there are, and may be
correlated to a lack of internet access among populations who use TM most commonly. Rural areas do not typically
have internet access and more consistently rely on traditional healing.

just like Madagascar and the rest." All comments are from April 2023 when the post was made.

- Under a post of the newest medical herbalists inductees in the MOH, citizens commented "Congratulations to the doctors, let's practice evidence based medicine," "Very good. It's time we resort to our traditional medicine," and "Congrats doctors, let's change the narrative." All comments are from October 2022 when the post was made.

- Under a post commemorating the 13th African Traditional Medicine Day and 16th Traditional Medicine Week in Ghana, citizens commented, "I think the ministry should employ more health educators to embark on nationwide education on traditional medicine" and "Great benefits yet to be tapped from traditional medicine. Until we accept and appreciate who we are and what we have, we will not develop as a people." All comments are from September 2015 when the post was made.

Table 1: "Comparative Analysis of Primary Source Documents"

Document		
Traditional Medicine Development 2005	6.0 "E and C on Rational Use of Traditional Medicine" Policy 6.2: "(i) Public education shall be intensified on the values, benefits, and dangers associated with both practices." (iii) The media shall be trained and supported to promote TM."	(2002-2005) Component 9: Proper use of TM/CAM by consumers Expected Outcome 9.1: "Reliable information for consumers on proper use of TM/CAM therapies" (Page 45)
National Medicines Policy 2017	1.5.3 Traditional Medicinal Products Activity 3: "Include TMs in the NHIA Minimum Benefit Package" Sub Activity 3: "Develop & implement generic coding for TMs for reimbursement" (Page 95)	(2014-2023) 3.4 Universal health coverage and the integration of T&CM: "Universal health coverage is the best way to cement the gains made during the previous decade. It is the ultimate expression of fairness." (Page 35)
National Medicines Policy 2017	1.5.3 Traditional Medicine Products Activity 6: "Support manufacturers of TM" Sub Activity 6: "Ensure manufacturers and their products are registered"	(2002-2005) Objective: Safety, Efficacy and Quality Expected Outcome 4.1: "National regulation of herbal medicines, including registration, established and implemented"
National Medicines Policy 2017	Policy Objective 6.3.3: "The Herbal Medicine Industry shall promote sustainable cultivation of medicinal plant resources including plant tissue culture." (Page 46) 1.5.3 Traditional Medicine Products Activity 7: "Strengthen collaboration for sustainable cultivation of medicinal herbs" (Page 97)	(2002-2005) Objective: Protection of Medicinal Plants: "Promote sustainable use and cultivation of medicinal plants" Expected Outcome 7.2: "Sustainable use of medicinal plant resources" (Page 45)
National Health Policy 2020	3.1 Policy Objective 1: To strengthen the healthcare delivery system to be resilient: "Ghana is committed to achieving Universal Health Coverage (UHC). UHC in Ghana mean that all people in Ghana have timely access to high quality health services irrespective of ability to pay at the point of use." (Page 5)	(2014-2023) 3.4 Universal health coverage and the integration of T&CM: "Universal health coverage is the best way to cement the gains made during the previous decade. It is the ultimate expression of fairness." (Page 35)

Table 1	Ghanaian Government	World Health Organization Strategies
Traditional Medicine Development 2005	3.0: "Intellectual Property Rights Protection" 3.1 and 3.2: "TM practitioners shall be educated on all aspects of patent, copyright, and trademark laws." "IPR system in respect of indigenous knowledge of TM practitioners and other scientists shall be protected and harnessed." (Page 5)	(2002-2005) Component 2: "Protection and preservation of indigenous TM knowledge relating to health" Expected Outcome 2.1: "Increased recording and preservation of indigenous knowledge of TM, including development of TM libraries" (Page 45)
Traditional Medicine Development 2005	5.0: "Research and Product Development" 5.2: " (i) TM practitioners shall be trained in research methods to enable them to carry out research and documentation of results of their practices. (ii) Guidelines shall be provided for efficacy and safety studies in relation to TM medicine products to ensure relevance. (iii) Guidelines shall be provided for clinical trials of Traditional Medicine products. (iv) TM practitioners shall be required to document and report all adverse effects of plant medicine products and all reported cases shall be investigated." (Page 6)	(2002-2005) Objective: Safety, Efficacy and Quality Expected Outcome 3.2: "Technical reviews of research on use of TM/CAM for prevention, treatment and management of common diseases and conditions" Expected Outcome 3.3: "Selective support for clinical research into use of TM/CAM for priority health problems…" Expected Outcome 5.1: "Technical guidelines and methodology for evaluating safety, efficacy and quality of TM" Expected Outcome 5.2: "Criteria for evidence-based data on safety, efficacy and quality of TM/CAM therapies"
Traditional Medicine Development 2005	7.0: "Standardization, Quality Assurance and Large-scale Production" 7.2: " (iii) TM practitioners shall be assisted to standardize their medicinal product to ensure uniformity in the batches that are offered for sale. (iv) Manufacturing premises shall be regularly inspected to ensure good manufacturing practices (GMP)."	(2002-2005) Objective: Safety, Efficacy and Quality Expected Outcome 4.1: "National regulation of herbal medicines, including registration, established and implemented" Expected Outcome 4.2: "Safety monitoring of herbal medicines and other TM/CAM products and therapies"
Traditional Medicine Development 2005	Policies: 4.1: " (iii) Allopathic health practitioners shall be encouraged to study and practice TM and vice versa" 12.2: " (i) The Traditional Medicine Practice Council (TMPC) shall encourage training and education of TMPs to upgrade their knowledge and skills with the view to strengthening the co-operation between TMPs and OMPs. (iv) The Ministry shall encourage collaboration between TM and OM practitioners through education on all sides to arrive at cooperation."	(2002-2005) Component 6: Recognition of role of TM/CAM practitioners in health care: "Promote recognition of role of TM/CAM practitioners in health care by encouraging interaction and dialogue between TM/CAM and allopathic practitioners" Expected Outcome 8.1: "Basic training in commonly used TM/CAM therapies for allopathic practitioners" Expected Outcome 8.2: "Basic training in primary health care for TM practitioners" (Page 45)

RESULTS

Policy Documents (This section provides a text alternative for Table 1 regarding primary document similarities.):

The Ghanaian policy documents and WHO strategies appear to align in the following areas: protection of property rights, research and product development, registration and standardization, professionalization of healers through formal training, protection of consumers, medicinal product creation and plant conservation, and insurance coverage. The 2002–2005 WHO strategy listed the following as one objective related to traditional medicine (TM): "increased recording and preservation of indigenous knowledge of TM, including the development of digital TM libraries" under the overall goal of "protection and preservation of indigenous TM knowledge relating to health" (Page 45). This relates to the 2005 Traditional Medicine Development (TMD) policy that insisted "TM practitioners shall be educated on all aspects of patent, copyright and trademark laws" and that the "IPR system in respect of indigenous knowledge of TM practitioners and other scientists shall be protected and harnessed" (Page 5). If harnessed by the practitioners through trademarks or patents, they would be able to develop "long-term business interests" (Essegbey & Awuni, 2015). However, it is important to note that according to Essegbey and Awuni's 2015 article, there was still a lack of awareness among healers on how to perform this process. These similar policies represent a shared interest in the collection and protection of healers' intellectual property, but further investigation highlights their actual practicality and implementation.

WHO and Ghanaian government officials both cite research development within their respective documents. The 2005–2005 WHO strategy listed the following objectives related to

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improving research into TM: "technical reviews of research on use of TM/CAM for prevention, treatment and management of common diseases and conditions," "selective support for clinical research into use of TM/CAM for priority health problems," "technical guidelines and methodology for evaluating safety, efficacy and quality of TM," and "criteria for evidence-based data on safety, efficacy and quality of TM/CAM therapies" (Page 45). The 2005 TMD policy shares this interest in bolstering TM research efforts as shown in the following: "(i) TM practitioners shall be trained in research methods to enable them to carry out research and documentation of results of their practices. (ii) Guidelines shall be provided for efficacy and safety studies in relation to TM medicine products to ensure relevance. (iii) Guidelines shall be provided for clinical trials of TM products. (iv) TM practitioners shall be required to document and report all adverse effects of plant medicine products and all reported cases shall be investigated" (Page 6).

The organizations also both recognize the importance of standardizing products for public consumption, as the 2002–2005 WHO strategy promotes "national regulation of herbal medicines, including registration, established and implemented" and "safety monitoring of herbal medicines and other TM/CAM products and therapies" (Page 45). The 2005 TMD policy states, "(iii) TM practitioners shall be assisted to standardize their medicinal product to ensure uniformity in the batches that are offered for sale" and "(iv) Manufacturing premises shall be regularly inspected to ensure good manufacturing practices (GMP)" (Page 8). This goal to register all TM products is not only present in the TMD policy but also within the National Medicines Policy from 2017 as shown in the following: "support manufacturers of TM" and "ensure manufacturers and their products are registered" (Page 97).

The professional development of healers through formal training as well as biomedical physicians through cultural competency training is highlighted in the following objectives from both the 2002–2005 WHO strategy and the 2005 TMD policy respectively: "basic training in commonly used TM/CAM therapies for allopathic practitioners, basic training in primary health care for TM practitioners" and "training and education of TMPs to upgrade their knowledge and skills with the view to [sic] strengthening the co-operation [sic] between TMPs and OMPs" (Page 45, Page 14). Both organizations also promote communication between TMPs and OMPs as the WHO lists "promot[ing] recognition of role of [sic] TM/CAM practitioners in health care by encouraging interaction and dialogue between TM/CAM and allopathic practitioners" as an objective, and the Ghanaian government states, "[T]he Ministry shall encourage collaboration between TM and OM practitioners through education on all sides to arrive at cooperation" (Page 45, Page 14).

The 2002–2005 WHO strategy and TMD 2005 policy both mention a common desire to protect consumers through education. WHO officials believe this can be done through the distribution of "reliable information for consumers on proper use of TM/CAM therapies" (Page 45). This belief is shared by Ghanaian officials who created the following policies: "(i) public education shall be intensified on the values, benefits, and dangers associated with both practices" and "(iii) the media shall be trained and supported to promote TM" (Page 7).

While there is clearly an emphasis on the protection of consumers, there is also an emphasis on the protection of the medicinal plants. The 2002–2005 WHO strategy and National Medicines 2017 policy both mention a common desire to protect the African fauna through sustainable practices. The WHO strategy records "promot[ing] sustainable use and cultivation of medicine plants" as an objective and "sustainable use of medicinal plant resources" as an

outcome (Page 45). Moreover, the National Medicines policy states, "[T]he Herbal Medicine Industry shall promote sustainable cultivation of medicinal plant resources including plant tissue culture" and lists "strength collaboration for sustainable cultivation of medicinal herbs" as an objective.

Finally, many of these changes that aim to improve integration between orthodox medicine and traditional medicine cannot be solidified without further changes. To the WHO, this final solidifying change is the implementation of universal health coverage (UHC): "Universal health coverage is the best way to cement the gains made during the previous decade. It is the ultimate expression of fairness" (WHO Strategy 2014–2023, Page 35). This appears to have been taken into account in multiple Ghanaian policy documents. The National Medicines 2017 policy lists "include TMs in the NHIA Minimum Benefit Package" and "develop and implement generic coding for TMs for reimbursement" as objectives to complete. The National Health 2020 policy also cites UHC as important to their growing healthcare system in the following passage: "Ghana is committed to achieving UHC. UHC in Ghana mean [sic] that all people in Ghana have timely access to high quality health services irrespective of ability to pay at the point of use" (Page 5).

Viewpoints of Healers on the Implementation of an Integrated Healthcare System:

Based on scholarly literature, most healers are very supportive of the implementation of an integrated healthcare system, but they feel there are still many concerns that the policies did not take into account. Some healers, specifically certain spiritually based healers, do not want to share their knowledge nor receive this form of training as they view their abilities as divine or worry about having to accept money for their healing, which "weakens medicine" (Kwame,

2021). Many healers and scholars also believe there is much more work to be done before implementation can truly be considered successful.

Traditional medicine practitioners have discussed their belief that it is a good thing to be able to offer patients an alternative/choice between healthcare options and to provide to those without a choice at all (Ampomah et al., 2022). For example, the president of the Ghana Federation of Traditional Medicine Practitioners Associations, Prof. Samuel Ato Duncan, explained during the GHAFTRAM 2023 annual award ceremony, "Through the use of traditional medicines, we can improve access to health care services, especially in rural areas where access to modern medicine may be limited" (Abbey, 2023). Healers, scholars, and stakeholders all appear aware of the biomedical professional shortage and know they can provide help in this area (Barimah & Bonna, 2018).

Healers are hopeful about being able to offer more options to their patients but also about the knowledge they could gain. Many TMPs are trained through oral instruction and observation, and rural TMPs commonly lack any other types of formal training. This leaves many individuals wanting to learn more that they could incorporate into their practices, therefore modernizing certain aspects of the care they provide (Gyasi et al., 2017). They are "eager to improve their knowledge and skills, welcome opportunities for communication and education, and appreciate interaction with biomedical healthcare providers" (Krah et al., 2017). This would also help with the stigma against healers by biomedical professionals that causes patients to fear telling their physicians they also use traditional healing (Kwame, 2021).

Consideration of Viewpoints and Needs During Policy Creation:

While it is clear the policies benefit healers in certain areas and align with their wishes, there are many aspects of the policies that did not appear to consider healers once they were

implemented. The alignment of the TMPs' desires to be formally trained, to be able to provide

patients with choices, and to continue a collaborative conversation with biomedical practitioners

with the policies is evidence that there were at least a few surface-level considerations of the

wants and needs of healers.

The evidence of a consideration of healers' wants and needs is evident in the TMD 2005

policy as its goals include but are not limited to: "intellectual property rights protection" (Page

5), encouragement of "education and training" of TMPs (Page 14), and encouragement of

"collaboration between TM and OM practitioners" (Page 14). Each of these goals would improve

the lives of healers and their patients through the improvement of their overall practice. In

Gyasi's (2017) interviews of traditional healers, they repeatedly shared their interest in

improving their practices, serving their clients better, and one healer specifically mentioned the

secrets of their "gift" that they are unable to share, which means intellectual property protection

is useful and necessary.

However, there is also quite a bit of evidence that can be used to prove the Ghanaian

government did not genuinely take healers' wants and needs into account. The struggles of

healers after the policies were created highlight that many of them were not met where they

were. This means instead of the government making specific alterations to the policies that can

aid certain demographics who are not at the same baseline as others, they created blanket policies

that aid some but leave many without any assistance. This is displayed in Ampomah's (2022)

interviews of healers in rural and urban areas.

Ampomah (2022) describes the following barriers to healthcare integration: registration is

a multi-faceted, expensive process that is not accessible for rural TMPs, FDA approval is also

multi-faceted and expensive, and both of these processes are even less accessible due to their

location in the city. Each of these barriers could be corrected through financial assistance from the government, but that does not exist and was not mentioned during the creation of the policies. This indicates that, whether intentionally or unintentionally, the government did not take these obstacles into account. They left these barriers in place, which is why their policies are viewed as tokenistic.

Why/Why not?

It appears the government did not take the needs and viewpoints of healers into account, which leaves one wondering why they may have done this. It could be unintentional, meaning the creators did not purposely want to create issues but also did not want to put in the effort required to eradicate said barriers and problems. However, if treated like an intentional act by the government, it could also be interpreted through theories of the patient model and legal violence. There is little direct evidence for this question, so it must instead be conceptualized using theoretical frameworks and answered through educated assumptions.

DISCUSSION

Based on comparisons between the WHO's strategies and Ghanaian policy documents, I believe the Ghanaian government took the WHO's advice into account during the creation of its traditional medicine-related policies. This is evident through the various commonalities found between WHO strategies (2002–2005 and 2014–2023) and the TMD 2005 policy, the National Medicines 2017 policy, and the National Health 2020 policy. This can be interpreted as some form of effort regarding what to cover within the TM policies and how to formulate the policies in a way that is understandable even outside of Ghana. The incorporation of healers' desires

within the previously mentioned policies also indicates some level of consideration of their needs and viewpoints by the Ghanaian government.

On the other hand, there are a variety of other issues that are neither addressed within the policies nor corrected during implementation that should have been prevented and could be fixed. The struggles healers are facing as they try to register their practice and their medicines and try to receive FDA approval are strong evidence that the policies are not inclusive of everyone, and therefore, do not indicate a considerate, maximum effort on behalf of the Ghanaian government. A maximum effort would be full consideration of healers' viewpoints, wants, and needs. Only certain viewpoints and needs are considered, and they are the ones that do not involve support, financial or otherwise, on behalf of the government. Even the viewpoints that do not necessarily require financial support would be greatly improved by government involvement through actions such as organizing workshops for rural training and organizing collaboration opportunities between orthodox physicians and traditional healers.

Why this may be this case is more unclear and indirect compared to the other questions and arguments put forth, as there are a variety of interpretations from the scholars and the reasons could be plentiful and in any combination with one another. This could be financial, as scholars assert the central government does not give "adequate support particularly in the areas of infrastructure and financing" to the TM system (Ampomah et al., 2022). It could also be discussed under the umbrella of two theoretical frameworks, the patient model and legal violence, and utilizing indirect educated assumptions.

The patient model highlights how the government emphasizes the gap between the powerful and the powerless through societal structures that leave individuals in positions of powerlessness, distress, and in a state of constant waiting for help and change (Auyero, 2011).

Auyero developed the patient model to explain how citizens seeking welfare assistance in Buenos Aires were placed in situations that left them powerless and changed their status from citizens to "patients of the state" (2011). When this model was applied, it allowed Auyero to identify the power dynamic and how subordination was repeatedly recreated in citizens seeking help (2011).

The patient model has been utilized to describe other situations involving inequitable power dynamics that leave one group waiting, which only worsens their situation. Specifically, the framework was used by Reid (2013) to discuss the periods of waiting for FEMA assistance experienced by Katrina survivors. After Hurricane Katrina, many individuals were left homeless and in need of housing assistance (Reid, 2013). FEMA is the Federal Emergency Management Agency and was meant to aid survivors in finding and affording new housing, but the FEMA policies treated certain demographics as "more deserving" of welfare assistance than others (Reid, 2013). Reid placed this scenario under the patient model to conceptualize how certain citizens who experienced a natural disaster became "patients of the state" who were trapped in a state of struggle and uncertainty (2013). Other citizens, however, who were not considered marginalized groups were not affected by the same societal barriers ingrained in the FEMA policies (Reid, 2013).

When the patient model is applied to Ghanaian integration, it can be used to explain why the government may leave societal and economic structures in place that do not serve certain healers, rendering the policies insignificant and unhelpful for a rural majority. The Ministry of Health's TMD policy requires healers to become registered in order to practice and requires the registration of their medicines for FDA approval and sale (MOH, page 3). However, registration is expensive and sometimes requires them to travel back and forth from rural to urban areas

repeatedly, increasing the cost (Ampomah et al., 2022). They also must go through many bureaucracies, which may mean their own type of waiting game as they receive one approval and must continuously seek out the next. They are repeatedly left in a state of reliance on a system that does not serve them as it should, which renders them powerless.

While the patient model is an informative framework with which to view Ghanaian integration, the legal violence framework could also be utilized to conceptualize how the traditional medicine laws inflict far-reaching consequences on healers and patients. Legal violence highlights how laws can have violent outcomes when exerting control over specific, marginalized groups (Menjívar & Abrego, 2012). In Menjívar and Abrego's study (2012), they use the legal violence lens to consider the "complex and often overlooked effects of the law on immigrants' paths of incorporation." Many of these effects are harmful and leave this group sectioned out and isolated from the rest.

The legal violence framework has been implemented in a variety of studies since its identification by Menjivar and Abrego but is most commonly associated with undocumented immigrants. Jimenez utilizes the framework to highlight the experiences of undocumented immigrants who are attempting to receive healthcare and instead suffer and remain trapped in a cycle that perpetuates vulnerability and exclusion (2021). The author investigated the Harris Health System in Houston, Texas, by interviewing migrant patients to understand the challenges they faced and the interactions they underwent at the hospital (Jimenez, 2021). He found that the system placed these individuals into two categories, one capable of receiving care and the other left suffering, based on their migrant status (Jimenez, 2021). The lack of treatment they received only worsened their conditions (Jimenez, 2021). This example encapsulates the medical-legal violence framework well by addressing how the entire system, healthcare and broader social

structures, must be altered to combat these daily acts of violence that leave certain groups burdened and suffering.

This is comparable to integration where the Ministry of Health created laws to aid in the integration and incorporation of healers into the mainstream healthcare system, but at the same time, this incorporation leaves many rural communities further burdened. The heightened standard to register likely worsens the stigma surrounding healing and leaves the unregistered facing an even greater stigma than before (Gyasi et al., 2017). While not a physical act of violence, it is violent in that the business prospects and practices of TM practitioners are harmed. Also, the act of saying healers can protect and harness their treatments through IPR in policies, but then not making healers aware of this keeps them in the same positions, unable to move up within their practice. The harmful effects of legal violence do not only harm healers, but they also harm patients who would benefit from more FDA-approved medicines that are entirely consumer-safe.

While both theoretical models are useful in conceptualizing certain aspects of Ghanaian integration, returning to the initially mentioned framework allows for a clearer understanding of where exactly integration is going wrong. Problems begin at the environmental level as only urban areas are included in the integration efforts, which would therefore most benefit those who already have the most resources. This in itself is increasing an already present gap where certain groups have far less than others and therefore could be considered structural violence. There are also issues at the economic level, as there must be some type of financial support in order for integration to ever be successful. The most significant barrier is financial need. The government's lack of financial assistance could be related to a lack of political lobbying power among healers. Internal disputes within the overall group of TM practitioners take away their

ability to appear as a "united front of the Government of Ghana in their fight for formal official recognition" (Barimah & Bonna, 2018). A significant factor that also must be mentioned and is related to political power regards which party was in power at the time of integration. The "Traditional Medicine Development" policy was published in 2005, which is when the NPP was in power (UCA, 2021). The NPP is the more urban, liberal party. In 2011, when the NDC was in power, the herbal units were placed inside hospitals (Kpobi & Swartz, 2019; UCA, 2021). However, five years later in 2016, the NPP was in power again and an evaluation of the herbal units displayed a lack of integrative policy and parallel practices (Kpobi & Swartz, 2019; UCA, 2021). There appears to be a correlation between the party in power and the perceived efforts and success of integration, which may be a contributing factor to its failure in Ghana.

An integration designed to be implemented for everyone and to overcome the obstacles that were well known even before these attempts would have not led to the types of failures seen in Ghana. Based on my overall findings throughout this investigation, I believe the government neglected to fund this effort adequately and only provided minimal integration regulation because minimal effort is perceived as alignment with the WHO's suggestions without the costs of actual integration, the needs and wants of the party in power during the initial integration effort were not aligned with the needs of healers and rural citizens, and there may be an inability to take a stance against these minimal efforts due to the many differing groups and ideologies surrounding TM, which dissipates their power as a political lobbying group.

CONCLUSION

Ghanaian healthcare integration is incredibly complex and important. While it does appear the Ministry of Health used the WHO strategies as an aid when creating their integrative

policies, it also appears there is much more that should have been done. Only certain viewpoints of healers were taken into consideration, and the viewpoints of healers after implementation still seem to be disregarded. There is no doubt that a successful integration could benefit all parties involved, as seen in other countries that the WHO assisted. However, the evidence here and in the scholarly literature proves that this would first require a greater investment from the government. This is not only a financial investment, but also an investment of time and support that can be aimed at creating collaboration among healers and biomedical practitioners. According to Barimah and Bonna (2018), this collaboration under the integrative policy system would look like a joint practice that merges the two medical paradigms, and under the active collaborative system, it would look like mutual respect and understanding. While this is ideal, it may still be difficult to convince both parties in Ghana to find common ground among their practices and rid themselves of the "us versus them" mentality. This may be best achieved through genuine, open communication so that both groups can find commonalities in their paradigms, treatment plans, and patient care protocols.

A majority of the scholars who discuss Ghanaian healthcare integration agree with the sentiment that the government must invest more resources. More specifically, an enhanced financial investment could be made in the institutionalization of TMPs within and near biomedical institutions – including primary care instead of just hospitals – in urban areas with advertisement of this to patients. The open communication platforms between TMPs and biomedical physicians would also require financial investment to be created and maintained. Another suggestion for a way to utilize financial investments to improve integration would be to create a unit or group of employees focused on inspecting the success of integration within different settings and among different groups.

With these investments, the integration in Ghana could go a long way in improving orthodox practitioners, traditional medicine practitioners, and patients' lives. A system that overcomes these socioeconomic and societal barriers may look like a more respectful system that allows healers to be the first contact point without the patient facing the later stigma of using TM. This system would also incorporate TM better into the NHIS while also combatting the barriers of registration affordability that create higher prices for healers' products. Many obstacles must be overcome before the integrative system in Ghana is ideal, but the Ghanaian government's efforts thus far prove the significance of healing to their country and are important to take into consideration.

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