GHANAIAN INDIGENOUS HEALTH PRACTICES: THE USE OF HERBS
Master of Arts 2009
Isaac Nortey Darko
Graduate Department of Sociology and Equity Studies
University of Toronto

Abstract

Herbal medicines remain integral part of indigenous health care system in Ghana. Most conventional health medicines are directly or indirectly derived from plants or herbs. Despite its significant role in modern medicine indigenous herbal practices has been on the low light for some time due to perceived antagonistic relationship that exists between practitioners of herbal medicine and their counterpart in the conventional system.

Using an indigenous knowledge discursive framework, the thesis examined the relevance of herbal medicine to the contemporary Ghanaian society. The thesis also examined the tension between the indigenous herbal practitioners and their orthodox counterparts. The thesis noted that for health care system in Ghana to be effective, there is a need for collaborate relations between these two practitioners. Also, it was noted that for health care system to be effective in Ghana, spirituality has to be central in the works of the herbal practitioners.
Dedication

This work is first dedicated to God almighty for His mercies and favor. Secondly to my entire family especially my parents Mr. Dickson Darko & Mrs. Emma Ntow. This work is for you. I will never forget all the efforts put into my life. If I am to come back to this world again, I pray you still remain my parents. Thank you once again.
Acknowledgement

My greatest appreciation and thanks go to God Almighty for making it possible for me to complete this journey successfully. The Akans of Ghanaian have a saying that goes like this: “se nnipa ye adea ose ayeyi,” which literally means “when a person does well, she or he deserves a praise.” It is within this context that I like to express my profound gratitude to a number of individuals who have been inspirational to this work.

My deep appreciation goes to my supervisor and academic mother, Professor Njoki Nathani Wane of Ontario Institute of Education of the University of Toronto (OISE/UT). Professor Wane undoubtedly has been a strong pillar in my academic pursuit at OISE. Professor Wane moved from being been my supervisor to a mother who cared for every other needs of a lonely boy in Canada. Professor Wane, May God Almighty make all your ways straight and successful.

Professor George Dei, also a Professor of OISE/UT and my second reader, deserves a very big applause. Professor Dei has also been an unmovable pillar in my academic and personal life. He always made sure my writings turn out to be the best and only the best. Prof, you are and will remain an important part of my life. To you I say may God Almighty bless you abundantly.

If I forget to mention Mr. Paul Adjei Banahene then I will be ungrateful. From my application to U of T, visa application, all the way through my arrival at Pearson airport, Paul has never given-up on me. Besides the big brotherly role Paul has played in my life in Canada, he also took keen interest in this thesis always there to guide me when the need arises. Paul, I don’t even want to think of how my stay in Canada will be like without you. To your lovely wife, Sister Martha who always welcomed me
with a smile no matter my troubles, I say may God grant all your heart desires and continue to bless more people through you. Thank you, thank you, and thank you.

In my first encounter with Margaret Brenan of the Students Services of OISE, I knew I have met a wonderful persona. Margaret is always ready to offer assistance in any form possible. Margaret, your advices and supports have made a huge difference in my personal and academic work, and I would like to say a special thank you. To the Ghanaian Toronto Seventh-day Adventist church, I say another big thank you. Elder Oteng, Antie Esther, Uncle Ebo and family, Marcelle, Tracy, Noah, Uncle Ernest Dei, the Ansong family to mention but a few, the elders, and the entire members of the congregation, I say thank you for making me part of your Christian family. To all “my kids” and friends at Sabbath school, thanks for all the laugh we have shared.

Last but not the least, my dear friends, Francis Boateng who I affectionately call Fransoa, Ernest Agyeman, Emmanuel Adu Poku, Michael Oduro, Michael Nwalutu, Jennifer, Ronel, Larrisaa Burr, and Yumiko; guys, I really appreciate all the diverse ways you have affected my life. May God continue to bless you. There is no doubt that these aforementioned names deserve every praise reserve for this work; however, if there is any mistake, I am afraid, I have caused and should be rightly directed to me.
## Table of Contents

- **ABSTRACT** ........................................................................................................................ ii
- **DEDICATION** ..................................................................................................................... iii
- **ACKNOWLEDGEMENT** ....................................................................................................... iv
- **TABLE OF CONTENT** ......................................................................................................... vi
- **LIST OF TABLES & FIGURES** ............................................................................................. ix
- **ABBREVIATIONS** ................................................................................................................ ix

### CHAPTER ONE

- 1.1. Introduction ........................................................................................................................ 1
- 1.2. Problem Statement ............................................................................................................. 3
- 1.3. Aims and Objective ............................................................................................................ 5
- 1.4. Methodology ...................................................................................................................... 5
- 1.5. Personal Location ............................................................................................................. 5
- 1.6. Definition and operationalization of key terms .................................................................. 8
  - 1.6.1. Indigenous/ Traditional .................................................................................................. 8
  - 1.6.2 Alternative medicine ....................................................................................................... 11
  - 1.6.3. Herbal Medicine .......................................................................................................... 13
  - 1.6.4. Spirituality .................................................................................................................... 14
- 1.7. Outline of thesis .................................................................................................................. 17

### CHAPTER TWO

- Literature Review ..................................................................................................................... 19
  - The Global Distribution and Use of Herbal Medicine .......................................................... 19
  - 2.3. Types of Health Care Practises ...................................................................................... 20
  - 2.4. The Use of Herbal Medicine and Associated Challenges In Ghana .............................. 21

### CHAPTER THREE

- Indigenous Knowledge: A viable way of Knowing the world .................................................. 30
CHAPTER FOUR
Mampong Centre for Scientific Research into Plant Medicine; Bridging the Gap between Scientific and Indigenous healing practices
4.1. Introduction
4.2. History of the Centre
4.2. Departments, Sections and Works of the Centre
4.2.2. Pharmacology and Toxicology department
4.2.3. Activities:
4.2.4. Plant Development Department
4.2.5. Activities:
4.2.6. Microbiology Department
4.2.7. Activities:
4.2.8. Production Department
4.2.9. Clinical Department
4.2.10. Scientific Information Department
4.2.11. Other Departments
4.3. Achievements
4.4. Future Plans
4.5. Examination of some common Medicinal Herbs or Plants

CHAPTER 5
5.3. The work of the herbal practitioner
5.4. Who Is Who In Healing: A Tale Of The Challenge Between Conventional And Herbal Medicine
5.5. Challenges Of Herbal Medicine In Ghana

CHAPTER 6
Spiritual Embodiment Of Herbal Medicine To The Indigenous Ghanaian Culture And Ways Of Life
6.2. Reasons for diseases
6.3. The Healing Process
6.4. Categories of healers
6.5. Challenges to spiritual healing in Ghana
CHAPTER SEVEN ........................................................................................................................................ 91
Current Trends In Traditional Healing In Ghana: Conclusions And Recommendations ........ 91

7.1. Pedagogic and Instructional relevance of dissertation for classroom practitioner of Indigenous Science Education ................................................................................. 93

7.2. Recommendations ................................................................................................................................ 94

Reference .......................................................................................................................................................... 98
List of Tables

Table 1: Commonly used TM/CAM therapies and therapeutic techniques
Table 2: African countries that have established structures, budget and training in Traditional Medicine
Table 3: Categories of challenges confronting TM/CAM

List of Figures

<table>
<thead>
<tr>
<th>Scientific Name</th>
<th>Common Name</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1: Barassus Aethiopum Mart</td>
<td>Fan Palm</td>
<td>52</td>
</tr>
<tr>
<td>Figure 2: Elaeis guineensis Jacq:</td>
<td>Palm tree</td>
<td>53</td>
</tr>
<tr>
<td>Figure 3: Dissotis rotundifolia</td>
<td>-</td>
<td>53</td>
</tr>
<tr>
<td>Figure 4: Leea guineensis</td>
<td>-</td>
<td>54</td>
</tr>
<tr>
<td>Figure 5: Gardenia ternifolia</td>
<td>-</td>
<td>54</td>
</tr>
<tr>
<td>Figure 6: Morinda lucida</td>
<td>-</td>
<td>55</td>
</tr>
<tr>
<td>Figure 7: Azadirachta indica</td>
<td>Neem Tree</td>
<td>55</td>
</tr>
<tr>
<td>Figure 8: Khaya Senegalensis</td>
<td>Mahogany</td>
<td>56</td>
</tr>
<tr>
<td>Figure 9: Ficus asperifolia</td>
<td>Sand paper tree</td>
<td>56</td>
</tr>
<tr>
<td>Figure 10: Musa paradisiacal</td>
<td>-</td>
<td>57</td>
</tr>
<tr>
<td>Figure 11: Psidium guajava</td>
<td>Guava</td>
<td>57</td>
</tr>
<tr>
<td>Figure 12: Balanites aegyptica</td>
<td>-</td>
<td>58</td>
</tr>
<tr>
<td>Figure 13: Cleistopholis patens</td>
<td>Salt and oil tree</td>
<td>58</td>
</tr>
<tr>
<td>Figure 14: Mitracarpus villosus</td>
<td>-</td>
<td>59</td>
</tr>
<tr>
<td>Figure 15: Mitragyana inermis</td>
<td>-</td>
<td>59</td>
</tr>
</tbody>
</table>

Abbreviations

CAM           Complementary and Alternative Medicine
CSRPM         Center for Scientific Research Into Plant Medicine
GMS           Ghana Medical School
TM            Traditional Medicine
W.H.O         World Health Organization
Chapter 1:

1.1. Introduction

Herbalism or herbal medicine is seen as the use of herbs to treat sickness (Weiss, 2000) or the use of herbs for their therapeutic and medicinal values (Helpfulherbalist, 2009). Herbal medicine falls within the group termed “unproven healing practices” (Bratman, 1997). It includes Naturopathy, Chiropractic, Traditional Chinese medicine, Unani, Ayurveda, Meditation, Yoga, Biofeedback, Hypnosis, Homeopathy and Acupuncture (Bratman, 1997). Historically, many herbs have been used to provide human remedies for diseases that confront men and women. Although Western medical practices seem to have questioned or even denied the efficacy of many traditional herbal remedies, traditional plants undoubtedly continue to play a key role in the well-being of indigenous communities. It is estimated that one quarter of all medical prescriptions are based on plant derivatives or plant-derived synthetic derivatives and approximately 80 percent of the world’s population (primarily those in developing countries) continue to rely on medicines derived from herbs (WHO, 2002). Thus, despite the dramatic advances of conventional medicine, it is clear that herbal medicine continues to possess a high level of significance in many social settings.

The overarching theme of the research is to investigate the traditional herbal medicine and its practices among the indigenous people of Ghana. The study investigates the relevance of herbal medicine in contemporary health care provision in Ghana. The research also explores the attitude of Ghanaians towards herbal medicine and more importantly, how the traditional and the orthodox medical practitioners cooperate in Ghana to promote effective herbal care system. The research also explores the activities of the Centre for Scientific Research into Plant Medicine.
and how the institution functions to promote an effective interaction between the practitioners of traditional and orthodox medicines. The research further examines the challenges facing the Ghana health service as they attempt to integrate the two health approaches. Finally, the research explores the roles of indigenous spirituality in traditional health practices in Ghana.

1.2. Problem statement

The research is guided by these questions:

1. How relevant is herbal medicine to the contemporary health care needs of Ghanaians?

2. What are the various forms of challenges that beset indigenous herbal medicine practices in Ghana?

3. What are the roles of spirituality in the traditional healing process in Ghana?

Herbal medicine in Ghana, as in most African countries, is a very popular health care system. It is usually practised by traditional or spiritual healers. It is perceived that most households in Ghana have at least an individual or collective knowledge in herbal medicine. Though some herbalists are systematically trained, knowledge of the use of herbs is mostly inherited or informally carried from generation to generation through orality. Herbal medicine is practiced in line with the socio-cultural background of the people; thus making it an intimate part of their culture. In addition to herbal medicine, massage, therapeutic dieting, fasting, hydrotherapy, and radiant healing therapy are often among the other components of traditional medicine practices in many parts of Africa. However, given the great diversity of cultures, ethnicities, and geographical regions within Africa, it is extremely difficult to make generalizations about African herbal medicine (Helpfulherbalists, 2009).
Notwithstanding the challenges and competition herbal medicine faced vis-à-vis Western Medicine, many Africans; especially, those in the rural areas rely on herbs not only for their medicinal value and promotion of good health and fortune but also for their spiritual well-being.

The history of herbal medicine in Africa predates the ancient Mesopotamia and Egyptian civilisations. It is believed that in Mesopotamia, the Sumerian civilization in particular was extraordinarily advanced in many ways and possessed remarkable knowledge of growing and using plants. Assyria could also boast of an impressive knowledge of medicinal herbs. When the Greek civilization was built it also gave rise to a number of important schools of medicine and healers including Hippocrates who is often referred to as the “Father of Medicine” (Helpfulherbalist, 2009). According to Helpherbalists (2009), as trade among Europe, the Middle East, India, and Asia flourished in the second and third centuries so did interest in herbal medicines and spices. Most scholars began documenting plants and their medicinal properties during this time period. Both China and India were able to develop extensive medical systems with herbal medicine. Although these systems varied significantly, they focused on the idea that illness is the result of bodily imbalances. Thus, healing can take place by using herbs to create the bodily balance and harmony. Through the word of mouth, apprenticeship, and constant use of herbs as natural remedy, ancient healers were able to develop a high level of practical knowledge of herbal medicine.

In Ghana, both Western and traditional herbal practitioners work to meet the health needs of the people. Although Western medicine appears to dominate the health practices in Ghana, the indigenous herbal practice remains a viable option to the majority of Ghanaians. According to Professor Laud K.N.A. Okine, the director of
the Centre for Scientific Research into Plant Medicine of Mampong, about 65 percent
of the country’s population; especially the rural folk depend on herbal medicine for
their well-being (Spectator, 2007). Usually, at least in most cases, herbal medicine is
the first approach one resorts to in case of a sickness. However, when the condition of
the sickness does not improve for the better, the sick person may be sent to the
hospital. The government of Ghana upon realising the important roles played by
traditional medicine established the Center for Scientific Research into Herbal
Medicine at Mampong in the Eastern region of Ghana. The Center is established to
harness the works of the orthodox and traditional medical practices to ensure an
improve health practices in Ghana. Unfortunately, available research, as far as I know,
appears to focus primarily on the efficacy, strength, and scope of traditional medical
system in modern-day society (see Foote 1999; Anfom 1990 on the practice,
problems, and prospects of Traditional Medicine in Ghana; Twumasi 1988 on the
interplay between Traditional and Modern Medical Systems; Chao & Wade 2008 on
the complementary and alternative medicine among racial/ethnic groups; and Barimah
& Teijlingen, 2008 on traditional medicine among Ghanaians in North America);
however, not much has been written specifically on co-existence of the two health
care systems in Ghana especially as it relates to the synergies and the conflicts that
exist between them. This study therefore attempts to fill in the knowledge gap by
exploring the relevance of herbal medicine in contemporary health care provision in
Ghana; the attitude of Ghanaians towards herbal medicine, and finally how traditional
and orthodox medical practitioners cooperate with each other to promote a common
understanding and effective health care practices. The study further examines the
challenges facing the Ghanaian health service as they attempt to integrate the two
health approaches.
1.3. Aims and Objectives

Using the Mampong Centre for Scientific Research into Plant Medicine as the case study, the study assesses the extent to which Traditional and Western health care systems complement or conflict each other in Ghana. Specifically, the study aims to:

1. Examine the use of herbal medicines or products in Ghana;
2. Examine challenges facing the indigenous herbal practitioners in Ghana.
3. Examine the role of spirituality in the traditional healing process in Ghana.

1.4. Methodology

Data for this project was collected through secondary sources in the academic and other professional sources. I utilize textual analysis as my data analysis tool, I explore health documents from government and non governmental groups, health policies, health studies, health research, informal conversations with people, newspaper articles, periodicals, reports from world health organization (WHO), and other international bodies concerned with world health issues.

1.5. Personal Location

I write this essay from a subjective position as a Ghanaian male student currently pursuing my graduate education in Canada. Although I was born and raised in post-independence era in Ghana, I was trained to think and act more as an European than as a Ghanaian. As similarly argued by Dei (1996; 2004) and Adjei (2007; 2008), I was trained in an educational system that exposed me to a world that was 18000 miles away from my local community. Thus it was not surprising that I grew up with an understanding that sickness can only be cured by a professionally trained medical doctor. I was trained to believe that the best form of health care is offered in the hospital, where all forms of diseases could be cured. Even though I do
occasionally take locally prepared herbs, I was made to believe that these were just complementary medicine; they were not an end in itself but a means to an end. And that the end is the hospital, where one will be examined by a professionally certified doctor. Through this colonial perception, a great difference was created between Westernised medical system and the indigenous ways by which Ghanaian cured their infirmities. Whilst the later was painted barbaric, evil, and unchristian; the former was seen as the ultimate to a good and happy life. Appiah (2006, p.7) citing Abdou Moumini contends that “colonial education did more than just to corrupt the thinking and sensibilities of Africans; it also fills Africans with abnormal complexes which de-Africanized and alienated them from the needs of their environment. Colonial education, thus, disposed and put out the control of the African intellectual and necessary forces for directing the life and development of their society.

I contend that the overhyping of Western health practices in Ghana can be attributed to the colonial education system in Ghana. Thus, it is not surprising that a high number of students turn up every year to pursue training in Western medical health practices at the universities in and outside Ghana. Until recently, no room was made available for the training of herbal medicine practitioners in Ghana. However, traditional medicine has a systematic methodology of its own and a body of knowledge preserved through many centuries and passed on orally from generation to generation. So instead of being an alternative to conventional health practices most people would rather prefer to call it complementary medicine (Yeboah, 2009). Thus, the intent of my research is to explore further the tensions that exist between indigenous herbal practitioners and their colleagues in the westernised medical system. This, I describe as the “fight for medicinal supremacy.” This “cold war” is fought at the expense of patients.
In spite of all the attempts to demonize and totally eradicate traditional herbal practices through colonial education in Ghana, the interest in indigenous health practices has seen increased in recent times. This upsurge of interest in traditional herbal practices can be attributed to the influential roles play by the Centre for Scientific Research into plant Medicine, Mampong. Through their effort, many Ghanaians living in Ghana and abroad have renewed their interest in herbal medicine. Osei (1993) noted that right after Ghana’s independence in 1957, various activities, research programmes, and health projects were launched to intensify the popularity of traditional medicine. In fact, there was the nationalists' campaign to promote African cultural identity which called for indigenization of medicine. In the years following independence, this ideology shaped the policy of extending health and welfare services to rural areas and encouraged research into indigenous medicine. The idea was to develop traditional medicine to the same level as Western medical practice, and also integrate it into the Ministry of Health and the cultural beliefs of the people. Commissions such as Brachott Committee and others were set up to advice government on various projects and activities aimed at bringing indigenous health knowledge into limelight (Brachott Committee Report, MOH, 1961; Easmon Report, MOH, 1966). Notably, the Ghana Psychic and Traditional Healing Association was formed in 1963 with an overall goal to promote and encourage the establishment of training and research programmes (Mensah-Dapaah, 1968). The Mampong Centre for Scientific Research into Plant Medicine was established in 1975 as a statutory corporation with a ruling council. It had a clinic attached and given the power to research into herbs as well as systemising the efforts of traditional healers. In 1991, the Directorate for Herbal Medicine was set up within the Ministry of Health with a
related goal. Other similar projects were established throughout the country, with two prominent ones at Danfa and Kintampo (Yeboah, 2009).

1.6. DEFINITION AND OPERATIONALIZATION OF KEY TERMS

1.6.1. Indigenous/ Traditional

According to Semali and Kincheloe (1999) the concept “indigenous knowledge” has often been associated with primitive, the wild, and the natural within the education system in the West. Such misrepresentation, as they further argued, has not only evoked condescension among Western observers, but more troublingly has generated little appreciation for what indigenous knowledge is and its relevance to schooling and education in contemporary time. Indigenous knowledge, in its basic sense, reflects the dynamic ways the residents of a given locality come to understand themselves in relationship to their natural environment and Cosmo world. According to Dei et al. (2000, p.6), indigenous knowledge is accumulated by individual and social groups through historical and current experience. Thus, through the process of learning from old experiences, new knowledge is also discovered. This understanding of indigenous knowledge is very important because in this era of globalization and Diasporic relations, it is easier for one to assume that indigenous knowledge has lost its relevance and even existence due to modernity. Such misunderstanding only tends to misrepresent Indigenous knowledge as something that sits in ‘pristine fashion’ outside the effects of other knowledges (Dei 2000a). But, like all other knowledges, Indigenous knowledge also borrows from other knowledges. In fact, when Barman, Herbert, and McCaskill (1987) argue that the Aboriginal people should return to their past, they were not referring to the very ancient lives of their ancestors; but rather was asking Aboriginal people to affirm their identity by selecting aspects of old ways and
blending them with the new ways. Thus, the argument that “hybridization” only lead to a third space (See Bhabha 1995) raises many concerns for scholars like myself who is interested in Indigenous knowledge. Understandably, the current education system in the global south still carries elements of colonialism (see Wane 2006; Dei 2004; Adjei 2007; Adjei and Dei 2008), but that notwithstanding, indigenous knowledge still remains rooted within the fabric of indigenous society. The very fact that English language is 70 percent of Latin language does not make it any less English. Thus, indigenous knowledge should not be less indigenous because it has borrowed from Western knowledge system. Besides, there are evidential supports that Western knowledge system has also in the past borrowed and appropriated from indigenous African knowledge (see Asante 2007; Karenga 2006).

I personally believe that the issue at stake in the academy is not the logics of knowledge production, but rather the politics of knowledge production. The very fact that Eurocentrism continue to be the tacit norm by which all other knowledges are judged, clearly confirms the politics at play in the Western academy. So, not surprisingly, indigenous knowledge has been rendered invisible in the Western academy. As Nyamnjoh (2004) rightly observes, Eurocentric thoughts have engendered theories and practices that justify without explanation almost everything from colonialism, racism, imperialism, to delegitimization of Indigenous people and their knowledge system (p. 164). However, decolonisation cannot be attained unless this so-called progressive construct of Eurocentric knowledge as against the supposedly backwardness of indigenous knowledge is challenged in the academy. By writing a dissertation on Indigenous knowledges in a Western academy, I am invariably reaffirming indigenous knowledge as a legitimate form of knowing.
According to Maurial (1999), indigenous knowledge is the people’s cognitive and wise legacy. Maurial further categorizes indigenous knowledge into three bases: First, indigenous knowledge is a result of the quotidian interactions among indigenous families and communities. This knowledge is immersed in the whole culture and it is recreated through generations in the daily oral stories, symbols, songs, riddles, myths, and idioms constructed in local languages to reflect their daily agrarian work in the land, the curative powers of their local plants as well as the celebration of special events. The most important thing about indigenous knowledge is that it is alive in indigenous peoples’ culture, but the distinction between indigenous and western knowledge is that indigenous knowledge is neither archived nor stored in the laboratories and is not separated from political and everyday life of the indigenous people. The implication of this is that it makes indigenous people the actors of their own knowledge and not passive repositories of a knowledge that is separated from their everyday life.

Secondly, indigenous knowledge is holistic in the sense that ideas and practices are one. There is no division among “disciplines of knowledge.” What Western knowledge may call Religion, Law, Economics, and Arts are united within a whole entity of worldview. This is expressed through oral and written tradition especially through indigenous peoples’ mythical narrations and symbolic works. Such exposition presents local people as theorists of their lived experience. Unlike Western classroom, where theorizing of live experience remains the privilege of those in the academia, the indigenous knowledge is rooted and grounded in the local people’s everyday practices. The local people theorize through their daily interaction with one another. This is why Indigenous knowledge is experientially based and relies on the
subjective experience and the inner workings of the self to make sense and meanings to social interactions. Thus, indigenous knowledge is holistic and relational.

Finally, indigenous knowledge, according to Maurial (1999), is transmitted through oral tradition in societies that are agragha. By definition, agrapga is a word used in Hispanic Anthropology to refer to societies that did not invent or incorporate originally written expressions in their culture. These societies maintained a complex oral tradition repeated daily from parents to children and elders to youngsters. Through oral tradition, indigenous people transmit their holistic culture through proverbs, songs, riddles, storytelling, fables, myths and health practices to foster a relationship among themselves, and between themselves and nature.

Even though some scholars have tried to differentiate between indigenous and traditional, I discuss the two concepts with the same operational and definitional understanding. As explained by (WHO, 2002) indigenous/traditional medicine is the sum total knowledge, skills, and practices based on the theories, beliefs, and experiences use by indigenous or different cultures to maintain health as well as to prevent, diagnose, improve or treat physical and mental illnesses. To this end, a Ghanaian traditional medicine can be considered as a solid amalgamation of dynamic medical know-how and ancestral experience (Erah, 2008).

1.6.2 Alternative medicine

The term alternative medicine has been discussed by various authors in the medical world. In the Western world, alternative medicine covers any healing practice "that does not fall within the realm of conventional medicine" (Brat Man, 1997, p.3). Alternative medicine may include Meditation, Herbalism, Naturopathy, Chiropractic, Traditional Chinese Medicine, Unani, Ayurveda, Yoga, Biofeedback, Hypnosis,
Homeopathy, Acupuncture, and Diet-based therapies (Medicine Net.com, 2009).

Alternative medicine practices differ in their fundamental principles and methodologies. Practices may incorporate or base themselves on traditional medicine, folk knowledge, spiritual beliefs, and newly envisioned approaches to healing (Acharya & Anshu, 2008). Many scholars have challenged the grouping of alternative medicines with complementary medicines. Complementary medicine is commonly used in reference to medical interventions used in conjunction with mainstream conventional system (White House Commission on Complementary and Alternative Medicine Policy, 2002; Ernst 1995; Joyce, 1994). Scholars have argued against the same meaning given to alternative and complementary medicine, emphasizing that there are differences in approach; nevertheless, the term Complementary and Alternatives Medicines (CAM) is used as a standard for all medicines outside western medical system (Classiest & Deng, 2004).

Most claims made by alternative medicine practitioners are generally not accepted because they do not meet the standard evidence-based assessment of safety and efficacy requirement by the western medical system. If scientific investigation establishes the safety and effectiveness of an alternative medical practice, it may be adopted by conventional practitioners (Kassirer 1998 & National Center for Complementary and Alternative Medicine at the National Institutes of Health, 2006). Because alternative techniques tend to lack evidence, some have advocated against defining alternative medicine as non-evidence based medicine, or not medicine at all. However, establishing the efficacy of medicine by only scientific methods completely misses indigenous traditions of healing. This is because scientific approaches do not make way for the spirits which constitute the main element in using indigenous medicines. Some researchers state that the evidence-based approach to defining
Complementary Alternative Medicine is problematic because some Complementary Alternative Medicine is tested, and research suggests that many conventional medical techniques lack solid evidence (Kopelman, 2004).

In using the term alternative medicine, I am aligning myself to the group of scholars that call for differences between alternative and complementary medicine. By using the term alternative medicine, indigenous practices gain a form of independence from the conventional medical system. This means that they can replace the western medical system not just complementing its efforts. However since most literature examined were written by western medical professionals who see no difference between the two, the words may be used interchangeably especially in reviewing literature.

1.6.3. Herbal Medicine

Herbal medicine, also called, botanical medicine or phytomedicine is defined by the University of Maryland Medical Centre as the use of a plant's seeds, berries, roots, leaves, bark, or flowers for medicinal purposes. Plants have been used for medicinal purposes since time immemorial. Egyptian civilisation, for example, used papyrus writings to describe medicinal plant uses. Indigenous cultures (such as African and Native American) used herbs in their healing rituals, while others developed traditional medical systems (such as Ayurveda and Traditional Chinese Medicine) in which herbal therapies were used systematically. Scientists over the years have realized that people in different parts of the globe tend to use the same or similar plants for the same purposes. Ghanaians until colonization totally depended on herbs for treating illness. These plants are believed to contain essential ingredients for both the physical and spiritual well being of the body. Most herbalists had
supernatural revelations on the type of plants and their therapeutic components. Due to the growing demands by the conventional medicine, herbal medicine has taken a new level where scientific analysis is introduced to improve the healing capacities of these plant medicines. Though there is a raging debate on the scientific research into these indigenous plant medicines in the medical world, Herbal Medicine as used in this dissertation, simply refers to medicines that are purely derived from plants either scientifically analysed or not analysed but in contrast with conventional medicine.

1.6.4. Spirituality

One of the difficult tasks in academia is defining spirituality. There are so many different answers to what constitutes spirituality. According to Wane (2002) spirituality is something so personal, unique, and individualistic that it cannot be captured in one clear definition (p. 144). In the views of Dei et al (2000) and Shahjahan (2005,p.70), “defining spirituality in contrast to beliefs and practices, religion or religious theories, is likely to be more varied because in many cases the latter are observable and articulated in sacred texts or scripture.” Today, the concept spirituality is treated as a cardinal sin in the education system in Euro-American/Canadian society. This is because our minds, to a large extent, have been shaped to accommodate the self as concealed in the Western fashion, fitness, and career (Helminski, 1999). Thus, any new concept which suggests otherwise is looked upon with suspicion. O’Sullivan equally echoes this concern: “higher education has become so accommodating to Western economic consequences that there is no spirits in these institutions” (1999). Elsewhere, Griffiths in Fernandes (2003) has argued:

If mankind is to survive- and it is his survival, which is now threatened –it can only be through a change of heart, a metanoia, which will make science subordinate to wisdom. The discursive reason which seeks to dominate the world and imprisons man in the narrow world of the conscious mind must be dethroned
and must acknowledged its dependence on the transcendent mystery, which is beyond rational consciousness (p.98).

Hindman (2002, p.175) in a matriculation ceremony in Wofford College in the United States of America (USA), the President of the college welcomed them with these words:

You are among the best students ever to matriculate at Wofford College. You have the best high school records of any class before you. We are proud to have you as our students. Yet because most of you come from South Carolina, that means that most of you happen also to be racist. Your racial attitudes are mostly a matter of our history, your culture, the notions handed down to you by your parents. This college hopes to change that about you through your studies here. We hope to make you into the sort of people who will be able to know, from your education here, the errors of such opinions as racial superiority. It will take us four years to do this. And though we may not succeed in changing all of you, we hope to change enough of you to make a difference in our state in the future.

Personally, spirituality has become an important issue for me because it appears the academy is centred on science and all that is considered non-science is labelled irrational. With this set up how we as educators can introduce matters of the spirit or soul into the classroom. One thing that I have come to learn through the spirituality and schooling class for which I was part is that for one to be successful in any venture there must be a spiritual connection. For a medical officer to be successful in treating patient, he or she must be connected to that patient. If institutions of higher education do not bond itself to the larger life forces, the community life, to social movements, it loses its soul (O’Sullivan, 1999). Without spirituality in our academy, there is a price to pay. This is illustrated by Parker Palmer who puts it this way:

I have seen the price we pay for a system of education so fearful of soulful things that is fails to address the real issues of our lives, dispensing data at the expense of meaning, facts at the expense of wisdom. The price is a schooling that alienates and dulls us that graduates people who have had no mentoring in the questions that both vex and enliven the human spirit people who are spiritually empty at best and spiritually toxic at worst” (2003, pp. 379-380)

Holistic education engages the whole person—teaching students to think critically and creatively, local spirituality and indigenous practices were silenced or severely
amputated in Africa. For instance, we know that Christian missionaries have been credited of bringing schools in many areas of Sub-Saharan Africa. However, little is mentioned that Christianity was (and is still is in many areas) a driving force behind denying African ancestral values and practices.

Although not all herbal practitioners believe in the spirituality of healing, majority of them believe in the concept of the supernatural involvement in healing. For the purpose of this study, spirituality is used in a specific context. According to Bruce (2000), spirituality in the traditional Ghanaian setup can be conceptualized as having vertical and horizontal dimension. The vertical dimension reflects the relationship to God or a supreme being. God is believed to be the initiator of all existence. The earth is sustained by His mercies; and is the giver of life. Many names and titles are therefore used for the Supreme Being. The horizontal dimension reflects both the relationship and connectedness to the ancestors, lesser gods, nature, and to our personal identity. These lesser gods are believed to live in rivers, forests, stones, mountains and plants. The ancestors are departed relatives who still live in the spirit and therefore are not seen physically but are active participants in the daily activities of the living. The concept of the sacred is essential in defining spirituality in the Ghanaian context (Bruce, 2005). Spirituality in the Ghanaian milieu therefore refers to the relationship between the Supreme Being, ancestors, lesser gods and deities and man. With the introduction of Christianity, Islam and other organised religions, spirituality has had a broader meaning and understanding. Spirituality is an indispensible aspect of Herbal medicine because of the pivotal role played by the spirit in the life of Ghanaian.
1.7. Outline of thesis

This work is divided into seven chapters. Chapter one begins with an overview of the topic being discussed. It gives a brief historical overview of herbal medicine. The chapter further discusses the aims and objectives of the research and as a follow up, raises a number of research questions. My personal location as a researcher and a Ghanaian traditional medicine believer is also discussed in the chapter. Important terms or key terms in the study are defined and explained. The key terms defined includes spirituality, herbal medicine, alternative medicine, and indigenous knowledge. Chapter two examines literature on the use of herbal medicine among Ghanaians. Chapter three provides a theoretical framework for the study. For my discursive frame work I employ “Indigenous Knowledge” as a tool that opposes Eurocentric ways of producing knowledge and draws attention to the use of indigenous knowledge as an alternative method to knowledge production that is viable and potent like the Eurocentric method. Chapter four explores the work that is currently been done at the Mampong Centre for Scientific Research into Plant Medicine; bridging the gap between scientific and indigenous healing systems. Additionally, the chapter examines some common medicinal plants, outlying its therapeutic properties, where they are grown in the country, its local or vernacular and scientific names, diseases that it cures or remedy’s as well as a pictures of these plants. In Chapter five, I discuss the role of herbal medicine in the lives of Ghanaians. I examine the perception of section of the Ghanaian population on the use of herbal medicines. The chapter also examines the tensions between practitioners of the conventional health system and the indigenous herbal system. Additionally, I examine categories of herbal medicine practitioners, noting their various roles played in promoting the use of herbal medicines in Ghana, procedures, similarities and
differences among herbal medicine practitioners as they work. The last part of the chapter discusses some major challenges herbal medicine practitioners face. Chapter six examines the spiritual embodiment of herbal medicine by the indigenous Ghanaian community; the role it plays in their culture and their daily lives. I further examine the role of spirituality in the healing process. Chapter seven provides the synthesis of my findings, recommendations and conclusion.
Chapter 2:

Literature Review

The Global Distribution and Use of Herbal Medicine

Herbal medicines have contributed immensely to man's effort against diseases and sustenance of health. In recent years, interest in the use of herbal preparations has increased and it's estimated that 2.3 billion people representing 56% of the world’s population continue to rely upon traditional practitioners and healing techniques for treatment of a wide variety of physical and mental illnesses (Good, 1977).

Again, the WHO (2003) estimates that the global market for herbal medicines currently stands at over US $60 billion annually and is growing steadily. In Western Europe, 50% of the population in the United Kingdom have used a natural remedy at some point in their life. In Germany, the figure is around 90%. Again, in the United Kingdom, annual expenditure on alternative medicine is estimated at US$ 230 million.

In North America, an estimated over 50% of the population have used complementary or alternative medicine at least once. In Canada for instance, the figure –70% exceeds the regional average stated above. Between 1995 and 2000, the number of doctors who had undergone special training in natural remedy medicine had almost doubled to 10,800 (ibid). In the United States, 158 million of the adult population use complementary medicines (ibid). According to the USA Commission for Alternative and Complementary medicines, US $17 billion was spent on traditional remedies in 2000 (WHO, 2003).

In Asia especially China, traditional herbal preparations account for 30%-50% of the total medicinal consumption.
On the African continent, the first line of treatment for 60% of children with high fever due to malaria for countries such as Ghana, Mali, Nigeria and Zambia is the use of herbal medicines at home (WHO, 2003).

2.3. Types of Health Care Practises.

Anfom, 1989, identified the four main forms of health policies practice over the world. The first is the exclusive or monopolistic model which is practiced in countries like Cuba and socialist countries of Eastern Europe. It is also practiced in various forms in countries like France, Algeria, Yemen, and Mongolia. This system bans all except modern scientific health care in the country. The second is the tolerant model practised in the UK especially where practitioners who are not in the mainstream Western medical system are not prohibited but may not be allowed to undertake certain specified medical procedures. The third is the inclusive model where two or more systems of health practise co-exist and are protected by statutory law. This model is found in countries like Pakistan, Bangladesh, Sri Lanka, Burma, Thailand and parts of South Asia. Lastly the integrated model has two systems which incorporate both modern and traditional systems. This is practiced in China and Nepal. This last model as practised in China forms the focus of my study.

Further, Anfom recounts that after the establishment of the People’s Republic of China in post Second World War era, the official government policy regarding health care was to unite the modern and the traditional. It was important to the new government to ensure that everyone had access to health care. This meant that traditional doctors with their herbals, acupuncture and moxibustion must be used to serve the people. By uniting with Western Medicine, the strategy has been to cull out those elements of ancient Chinese healing which are effective and discard what is not.
Every Western style medical school in China contains a department of traditional medicine. Similarly the smaller number of traditional medicine schools each contains a department of Western Medicine. Western style and traditional Chinese doctors work together at the (Commune Health) Centre according to the policy of integrating the two systems. “Patients may see either type of doctor. Brigade-based services carry out preventive public health measures, although some curative services provided by traditional doctor (are) also available” (ibid, p. 44-45).

2.4. The Use of Herbal Medicine and Associated Challenges In Ghana

One of the earliest materials on the use of herbal medicine among Ghanaians—*Traditional Medicine in Ghana: Practice, Problems and Prospects* which was published in 1990 by Dr. E. Evans—provides detailed information as to the widespread use of herbal medicine among the populace and how the practice has survived throughout generations. According to a review done by Foote (1999), Dr. Evans begins his work by identifying the several types of traditional healers and goes further to examine the differences in the training procedures and practices for both traditional and orthodox medical practitioners. Again, his studies indicate that for a majority of Ghanaians; especially the rural folks where traditional medicine serves as alternative to orthodox medicine, the significance of the traditional medical system cannot be overemphasised. Traditional medicine takes into consideration the beliefs and practices of indigenous people. In spite of the important roles played by the traditional health system in attending to the health needs of the people, he identified a host of setbacks by providing some case studies of patients treated by traditional healers. These setbacks include attaching superstition to every health occurrence which may have being caused by environmental factors like dirty surroundings as well as over emphasized efficacy of herbal medicine. Extreme individualism and
element of secrecy on the part of practitioners also serves as a drawback. Beyond this, the laudable efforts being made by the government of Ghana to use orthodox medical facilities to improve and regulate the use of herbal medicine and to integrate traditional medicine into mainstream society are discussed. The effort includes the establishment of the Ghana Psychic and Traditional Healers’ Association which is given the power to certify trained herbalist for practice. Significantly, he recognizes the importance of including traditional healers into the general health care system.

Expressing his view at the famous Danquah Memorial Lectures in Accra, Ghana on the topic “Traditional medicine in Ghana – Practice and Problems,” Anfom (1986) uses a number of case studies of a four year old boy suffering from acute glomerulo-nephritis, a young man suffering from anaemia and toxicity as well as a thirty five year old senior civil servant suffering from a mental illness to illustrate both the harm and the good which can be done by the traditional healer. He re-established the fact that traditional medicine practice in Ghana is closely linked or bound to the culture of Ghanaians. He therefore concludes that “Traditional Ghanaian society has from time immemorial subscribed to certain set of beliefs and engaged in certain practices which taken together, may be said to make up traditional religion of the Ghanaian” (ibid, p.25). Although Ghana is a heterogeneous society with various beliefs, yet the traditional beliefs in God (Creator), ancestral spirits (representing the souls of departed kinsfolk), the lesser gods (deities-usually found in trees, stones etc) and the belief that certain plants and animal formed special relationship with communities for historical reasons are common among all the ethnic groups in Ghana.

Additionally, there are spirits of mystical powers such as agents of witchcraft, magic, and sorcery with power to help or harm human. Lastly, there are charms, amulets, and talisman which may also be used for protection or harmful purposes. The
traditional healer had the prerogative rights in diagnosing and treating any form of illness. The methods and tools used by the traditional healer are accepted without question and “his or her success was greatly appreciated and applauded and his and her failures were understood and condoned as acts of God” (Anfom, 1986, p.26).

Anfom further notes that the negative effects of colonialism that came in the form of formal education and Christianity have greatly affected the Ghanaian culture and role of the traditional healer. As the economic status of sections of the community changed due to formal education and rural-urban migration, and the missionaries scathing criticisms of individuals traditional practices which was previously left unchallenged, most people were not bound to their traditional clans and therefore lost interest in the traditional practices over the time. As Anfom puts it:

Amongst the casualties of this cultural onslaught was the practice of traditional medicine which, although not banned by any official legislation, could be described as a system which was merely tolerated and whose practitioners were not given any protection whatsoever in the event of their activities resulting in the death of a patient. (1986, p.27)

Probably the acts of deculturalization were further exacerbated due to the presence of expatriate doctors and staff from the colonial administration. After overcoming initial resistance from the local communities, scientific medicine became established especially as it was able to cure major diseases at the time. These diseases, according to Anfom (1986), were mainly environmental due to the insanitary conditions and malnutrition. This gave rise to diseases such as malaria, yellow fever, yaws and sleeping sickness. The particular success of scientific medicine in curing especially the yaws epidemic gave it the full support and acceptance in the Ghanaian community. Many scientific medicines proved to be more efficient in meeting the health needs at the time. In view of these developments, Anfom (1986) concludes that scientific medicine gained grounds long before Ghana gained her independence.
Though independence sparked more efforts in expanding modern health care, it also brought “agitation for the restoration and reactivation of these cultural practices which under pressure from the colonial authorities had become submerged” (ibid, p.28).

Before concluding, the author identifies a host of challenges which adversely affect the practice of herbal medicine in Ghana. First, some of the traditional practitioners have apparent lackadaisical attitudes towards their practice and therefore have other jobs as farmers, artisans, fishermen, and civil servants. They therefore see no reason to be registered and officially recognized by any authority. Second, the high illiteracy rate among practitioners is seen as another setback. As Anfom (1986) notes, even the most experienced is handicapped because they lack a better knowledge in the area of diagnosis, anatomy, physiology, pathology, proper body examination, and conducting laboratory test to support their diagnosis. Third, majority of the traditional medical practitioners in Ghana are extremely individualistic. Thus, it is not surprising that most of the practices are shrouded in secrecy.

Through the suggestion of Dr. Kwame Nkrumah the first president of Ghana, the “Ghana Psychic and Traditional Healing Association” was established in 1960. Due to internal power struggles among members, the association never survived that long. This resulted in many factions emerging with each group claiming to be the mouthpiece for the traditional practitioners in the country. The effect is that lack of co-operation among the traditional healers making it difficult for them to unite under one body to promote a better co-existence with the orthodox system. As noted by Anfom (1989);

It seems to me that the major problem facing the traditional healers is not opposition to them by modern medical practitioners, who they overwhelmingly out-number, but their own internal factional splits over questions of secrecy, experimentation, organization, and leadership. It is clear that as far as a “clientele” is concerned, there is no shortage of patients for the traditional indigenous physicians. Therefore, the problem is not co-operation with modern
physicians but competition among themselves. The dispute here cannot be dignified as searches for the best or affirmation of cultural identity; it is simply a struggle for power. The disputants are not colonalist and anti-colonialist. They are all traditionalist (p.47)

As an indigenous scholar working with an anti-colonialist thought, I disagree with the assertion that the colonialists have nothing to do with the scrambling among the traditional practitioners. The colonial masters established a system of rule based on power, reward and punishment. No wonder these traditional practitioners are fighting among themselves just to gain power because colonialism introduced a system where power comes with good reward.

Anfom, (1986) argues that because of the difficulty in diagnosing correctly, most practitioners tend to abuse the spiritual component of the traditional system and ascribe supernatural causes to diseases which may cause troubles.

In her article *Traditional Medicine in Contemporary Ghanaian Society: Practices, Problems, and Future Outlook*, Foote (1999) explores the strengths of the traditional medical system in Ghana. Foote (1999) identifies the challenges facing orthodox medical system and compares them with the challenges facing the traditional medical system. Foote (1999) argues that the major challenge facing traditional medicine system is the secrecy involved in the transmission of knowledge. Foote (1999) argues that the suspicious attitudes of some traditional practitioners to the orthodox medical system contribute to the lack of cooperation between the former and the latter. Herbal practitioners believe that the knowledge acquired by orthodox system may be used for selfish purposes but not for the service of the whole community. Furthermore, the orthodox medicine practitioners believe that the traditional herbal medicine is primitive and unscientific. This perception of the orthodox medical practitioners has further exacerbated the rift between these two groups. Foote (1999) concludes that the tension between the orthodox and the
traditional practitioners compelled the government of Ghana to establish the Centre for Scientific Research into Plant Medicine in Ghana to arouse the interest of Ghanaians and medical students in herbal medicine.

In his inaugural lecture delivered at the University of Ghana in 1981, Professor Archeampong (1989) of the University of Ghana Medical School examines the conventional medical practices and indigenous herbal medicine. In his introductory lines, he identified suspicion and sometimes clumsy attitudes of traditional healers as hampering research into herbal medicines. Citing Addae-Mensah (1975), he identifies three categories of herbal or traditional healers. The first is the properly-trained and competent herbalists who often run clinics and often emphasize the efficacy of herbs. The Second is the herbalist who place particular reliance on supernatural causes and cures for diseases. In the opinion of these individuals, herbs are not the ends but a means to an end. The last group are the itinerant herbalists who often roam about with herbs usually claiming cures for a wide range of ailments. Although Archeampong supports the first group of herbalist, he distrust the second and third group which he accuses of speaking more on spiritual issues that cannot be substantiated scientifically. As Archeampong (1989) argues:

Like every scientific research, it has to be undertaken by properly-prepared personnel—scientists, medical practitioners, and the first category of traditional healers. The need to avoid undue sensationalism should be recognized and instead strict scientific criteria for clinical assessment of claims attributed to plants should be laid down and that without these provisions nothing in progress can be regarded with any degree of seriousness. (P.29-30)

Although I share the concerns of Archeampong, I still think it is quite premature for anybody to discard the spiritual component of traditional healing. As an indigenous scholar, I believe issues of spirituality must be given some level of acknowledgement in the traditional healing. The fact that spirituality cannot be scientifically proven does not justify any effort to discredit its efficacy and potential. In fact, the ontological
foundation of indigenous knowledge asserts that the nature of reality goes beyond what can be proven in the Cartesian or Behaviourist classroom. For local people the ontology of knowledge production include what is not known and cannot be proven to exist. Of course, the intent is not to encourage quack herbalists who indeed have no knowledge of their practice but rather hide behind issues of rituals and spirituality to exploit their clients. However, while we can seriously discuss the criminal elements in the traditional practitioners, we do not have to use the exceptional cases to make the general rule. Indeed, every profession including the Orthodox practitioners constantly have to deal with criminal elements in their profession. There are legitimate cases of illness that require spiritual response. Thus, the idea of making spirituality an important component of traditional healing is not without justification.

Archeampong further addressed the enormous amount of work, time and money that must be invested in researching into the efficacy of plant and traditional medicine. According to him “not only must the agent be isolated and tested for physiological and pharmacological activity, which usually lasted between 3-20 years (Addae Mensah, 1975) but the active principle must undergo toxicity, teratology, carcinogenicity, and metabolic tests before release for test on volunteers and finally clinical trials” (1989, p.13). He then commented on the great deal of duplication and hardly co-ordination among institutes and research centres at the national, regional and continental levels. To him, the lack of proper central organization and co-ordination has been the bane of traditional herbal medicine practice in Ghana and in most African states.

Addae-Mensah (1989) examines indigenous medicine and the myths surrounding it. Addae-Mensah (1989) pays attention to some of the hard realities that Ghanaians must face if they are to pay serious attention to herbal medicine. He further
traces the history of herbal medicine from the oldest repository of human knowledge written between 4500 and 1600 BC. These histories show that before the origin of western medicine, Africans and Asians relied on herbs for their health care.

According to him, the multiple spiritual churches springing up in Ghana is a major threat to herbal medicine in Ghana. Using the curative powers of local herbs to cure certain diseases such as mumps and Herpes zoster (locally referred to as Ananse), which conventional medicine cannot cure, Addae-Mensah (1989) contends that herbal medicine sometimes defies conventional medical practitioners. Given some examples of plants with medicinal values, the author warns patients not to let the success stories of herbal medicine blind them to some of the harmful and dangerous side effects which might arise due to the lack of toxicology and teratology of herbal medicines. Making reference to the case in India, the author notes that it was not until the early nineteenth century that organic chemists took up systematic study of many plants principles in order to know their therapeutic properties. As he argues:

The indiscriminate use of plants by herbalist was dangerous and wasteful, since in most cases, the actual dosage, and even the correct identification of the plant was left to individual herbalists to determine (p. 8).

I have taken a particular interest in India’s story because it resonates to similar situation happening in Ghana. It was for this very same reason—the misuse and over claims of some herbal practitioners in Ghana—that informed the government of Ghana’s decision to establish the Centre for Scientific Research into Plant Medicine at Mampong. This Centre was to regulate, investigate, and coordinate the activities of herbal practitioners so as to avoid the dangerous and wasteful use of plants.

Addae-Mensah spends the rest of his discussion on some common plant medicine that have many healing properties. He concludes that a more scientific approach in examining herbal medicine needs to be adopted, but further warns that this must be
done without destroying the psychotherapeutic aspect, which he believes is the most important component in the Ghanaian community.
Chapter 3:

Indigenous Knowledge: A Viable Way of knowing the World

Ladislaus and Kincheloe define indigenous knowledge as:

Knowledge that reflects the dynamic ways in which the residents of an area have come to understand themselves in relationship to their natural environment and how they organize that folk knowledge of flora and fauna, cultural beliefs, and history to enhance their lives. (1999, p.3)

Indigenous knowledge therefore makes a group of people unique in their cultural, social, and everyday life. It represents the natural knowledge shared between a group of people, in terms of language, respect for the environment, as well as a respect and honour for the past. Dei (2000) also defines indigenous knowledge as:

Knowledge associated with long term occupancy of a place. It refers to the traditional norms and social values, as well as mental constructs, which guide, organize and regulate a people’s way of living and making sense of their world. It is the sum experience and knowledge of a given social group that forms the basis of decision making in the face of familiar and unfamiliar problems and challenges (p. 6)

Indigenous knowledge therefore becomes a unique way by which a group of people with distinctive history and ways of existence make meaning to their live realities. This knowledge is part of the cultural heritage and histories of the peoples (see Fals Borda, 1980; Fals Borda & Rahman1991; Warren, et al 1995). Indigenous knowledge therefore originates from the land; it is dynamic, experiential, and holistic and has physical and metaphysical connection. It recognizes the sacredness of activities and acknowledges the communication that exists with the living, the dead, and even the unborn. It accepts the limitations of human sense to comprehend everything. Such belief is embedded on the notion that there exist mysterious forces beyond human capacity and sense, which have direct control over humankind.
Using indigenous knowledge as a discursive framework, Dei (2004, p.5) notes that indigenous knowledge:

Specifically refers to the epistemic saliency of cultural traditions, values, belief systems, and worldviews that in any indigenous society are imparted to the younger generation by community elders. Such knowledge constitutes an ‘indigenous informed epistemology’. It is a worldview that shapes the community’s relationships with surrounding environments. It is the product of the direct experience of nature and its relationship with the social world. It is knowledge that is crucial for the survival of society. It is knowledge that is based on cognitive understandings and interpretations of the social, physical, and spiritual worlds. It includes concepts, beliefs, and perceptions and experiences of local peoples and their natural and human-built environments.

The Centre for Indigenous Knowledge System therefore thinks “Indigenous Knowledge refers to the complex set of knowledge, skills, and technologies existing and developed around specific conditions of populations and communities indigenous to a particular geographic area. Indigenous knowledge therefore represents the knowledge that people in a given community have developed over time and continue to develop. It forms the bases of livelihood which encompasses every aspect of life from agriculture, food preparation, health care, education and training, environmental conservation, and a host of other activities. Indigenous knowledge is entrenched in community practices, institutions, relationships, rituals and ceremonies (CFIKS, 2009). Indigenous knowledge materialises in the immediate context of the livelihoods of local peoples as a product of a sustained process of creative thought and action within communities when local people struggle to deal with an “ever changing set of conditions and problems” (Dei, 2008, p.7). Dei (2008) further argues that Indigenous Knowledge like other forms of knowledge are not static and undergoes changes and are in constant motion as peoples and communities confer their complex relations with nature, land, culture, and society.

The term Indigenous Knowledge however according to Kincheole & Steinberg (2008) could be defined as a multidimensional body of understanding that
have since the beginning of the European scientific revolution of the 17th and 18th centuries been viewed by Euroculture as inferior, primitive, and without much experience for humanity. But to Kincheoloe & Steinberg (2008, p.136), the term has an important meaning for indigenous communities around the world. “It is a lived-world form of reason that informs and sustains people who make their homes in a local area.” This form of knowledge challenges the Eurocentric ways and contrasts the international system developed by educational and research institutions that esteem science as having the explanatory power over all knowledge and experience. In other words, science becomes the explainer of every phenomenon that humankind has experienced. Anything that science cannot explain is seen as unreal, inhuman, and non acceptable to humanity. Unfortunately most indigenous knowledge holds exactly the opposite view, emphasizing the need of finding meanings in life beyond science.

In recent discussion on Indigenous Knowledge in the academia, scholars use indigenous knowledge to counter Western’s science destruction of the Earth and its resources (Kincheoloe & Steinberg, 2008). This is not surprising in view of on-going contestation and validation of some form of knowledge over the other in the academia. It is argued that Indigenous knowledge in the academia must affirm the collaborative dimension of knowledge and at the same time be in a position to address the emerging call for academic knowledge to speak to the diversity of histories, events, experiences and ideas that have shaped human growth and development (Dei, 2005). In reiterating the subjugation of indigenous knowledge within the academy, Kincheoloe & Steinberg, (2008) describes the epistemological tyranny in the academy:

It subverts multilogicality. The power issues here are naked and visible to all who want to look through the epistemological hole: The power struggle involves who is
allowed to proclaim the truth and to establish the procedures by which truth is to be established; it also involves who hold the power to determine what knowledge is of most worth and should be included in academic curricula. In this context, the notion of indigenous knowledge as a “subjugated knowledge” emerges to describe its marginalized relationship to Western epistemological and curricular power (p.144).

Commenting on the consequences for the contemporary learner, Gelsa Knijnik (1999) warns of “the complexity and the need for students of indigenous knowledge to explore the many ways power operate in the interactions of indigeneity, science, and epistemology” (Kincheoloe & Steinberg, 2008, p.145). Dei (2005) therefore argues that ‘Indigenous knowledge’ can be fundamentally an experientially-based, non-universal, holistic, and relational knowledge of ‘resistance’ when located in the Euro-American educational context.

Dei (2008, p.9) contends that though no one openly says that indigenous knowledge is “beneath the dignity of western academy,” there exist scepticism of and on people who claim to indigenous knowledge experience. Agrawal (2004) argues that Indigenous knowledge is closed, non-systematic, holistic rather than analytical, without an overall conceptual framework, and advances on the basis of new experiences, not on the basis of a deductive logic (Banuri & Apffel-Marglin, 1993; Howes & Chambers, 1980), as against Eurocentric scientific ways that advances open, systematic, objective, and analytical by building rigorously on prior achievements. Agrawal further brings to mind distinctive characteristics as advanced by indigenous knowledge that separate the two ways of knowing. These are argued in substantive, methodological and epistemological as well as contextual grounds. Substantively, it is argued on the grounds that differences exist in the subject matter and characteristics of indigenous and Western knowledge. On methodological and epistemological grounds, because the two forms of knowledge employ different methods to investigate reality, there is the need to have a distinction. Contextually, it
is argued on the grounds that traditional/indigenous knowledge is more deeply rooted in its environment (Banuri and Apffel-Marglin, 1993; Chambers, 1980.2; Dei, 1993; Howes and Chambers, 1980.330; Warren, 1989 and 1990.1). To Kincheoloe & Steinberg (2008), “the last half of the first decade of the 21st century, in an era of an expanding U.S. empire replete with mutating forms of political, economic, military, educational and epistemological colonialism, indigenous knowledge comes to be viewed by the agents of empire as threat to Euro/Amercicentrism and/or as a commodity to be exploited” (p.135).

An African indigenous discursive framework although not totally peculiar to Africa will offer the best platform to discuss herbal medicine. An indigenous African discussion as noted by Dei (2008) takes into consideration African values and concepts such as community, collective responsibility, mutual interdependence and responsible governance. He further argues that for an indigenous way of knowing and experience especially healing to be conceptualised, many important issue must be mentioned:

We must challenge binarisms and dualistic modes of thought. For example, we ought to seek to destabilise any conceptions of indigenous or Western knowledge as ‘good’ or ‘bad’ knowledge. We must evoke indigenous knowledge to challenge the linearity of Western paradigms privileged in the academy. In this regard, the power to thinking in circles can release us from linear modes of thought and the culture of knowledge hierarchies. Our conceptions of indigeneity must also challenge static, fixed conceptions of “indigenous.”(ibid, p.8)

An African indigenous framework therefore has its foundation in a history and experience outside Euro-American construction of the identities of others (Dei, 2008). It therefore understands and appreciates the African ways of life through the African’s own lenses. It offers an anti-colonial discussion that seeks to resist oppression, domination, self determination, political, and intellectual sovereignty from Eurocentric ways of life.
As explained by Adjei (2005), Indigenous Knowledge accepts humans’ limitation in comprehending all that is around us. Indigenous ways of knowing explains this predicament of humanity by recognizing the power and role of the unseen world, of the spirits and of the unknown. What holds in the seen world is believed to be as the result of what is happening in the unseen world. Based on this philosophy, indigenous health system is always called upon especially in circumstances where the conventional methods of healing seem not to offer any help. Indigenous healers are believed to have the power and “eyes” to comprehend the unseen aspects of human life.

Ontologically, Indigenous Knowledge is argued on a prior proof approach that seeks to interpret the universe through the spirit. Indigenous Knowledge tends to give a spiritual understanding to all that exist in life. For this experiential knowledge, indigenous knowledge stands as the cross road with western ways of knowing. According to Dei (2000), indigenous knowledge recognizes the efficacy of inter-generational knowledge and communication. In African systems of thought, the ontological viewpoint stresses that to understand reality is to have a complete or holistic view of the society. This view emphasises the necessity for a harmonious co-existence between nature, culture and society (Dei 2000). It acknowledges the interdependency among all peoples, to extend; such existence of individual/subject is only meaningful in relation to the community that he or she is part of (Dei 2000). Spirituality in indigenous knowledge then becomes asset for knowing. My argument is not necessarily on the best practice but the fact that there are two ontological ways of knowing and for that matter healing, informed by individuals’ worldview. Hence, articulating indigenous knowledge of knowing and healing is not to pit it against conventional methods but to suggest that the two need be recognised. To the
indigenous Ghanaian, the environment, flora, fauna and the supernatural is the most important part of knowing and healing that cannot be ignored. The question is why are certain forms of healing knowledge seen as inappropriate and branded fetish or even evil, while others are seen as the absolute best? Indigenous ways of knowing especially in healing is ignored by many dominant healing practitioners. Many institutions, especially of higher learning as well as professionals have historically avoided indigenous ways of knowing and healing including spirituality. Perhaps, this could be due not only to the difficulty of defining aspects of indigenous knowledge such as spirituality, but also to the ambivalence of many who work in an academic world that has emphasized rationality and the scientific methods for most of the twentieth century (Tisdell, 2003). I strongly believe it’s time the academia and health professionals recognized the value of other forms of knowing; especially those that deal with the unseen or the spirit; for whether it’s accepted or not, it serves as a major source of knowing for indigenous communities around the world.

Epistemologically, Indigenous Knowledge stimulates the varied ways of knowing reality. In other words, it talks about multiple domains and types of knowledge with differing logics and epistemologies and forms the ontology on which scholars argue for indigenous knowledge”. It therefore, validates the use of emotions, dreams, intuition, and visions as authentic media of gaining knowledge and understanding of our world. It recognizes practice and experience as the contextual basis of knowledge production (Dei 2000). In other words, knowledge and survival go hand in hand. Knowledge must therefore be understood in the context of a society or a group. To understand a people therefore means to experience their ways of life and to appreciate it. Indigenous Knowledge hence does not separate experience from stories, rather these experiences forms the stories of the lives of indigenous people.
Explaining the epistemology of indigenous knowledge, Battiste & Henderson explains that Indigenous knowledge is a complete knowledge system with its own epistemology, philosophy, and “scientific” and logical validity... which can only be understood by means of pedagogy traditionally employed by the people themselves” (Battiste & Henderson, 2000,p. 41). This means that Eurocentric approach to life will not be a good idea in studying indigenous people. To learn indigenous ways of life is to apply indigenous ways of knowing and living. It is not an extension of the European- based knowledge system, but a distinct knowledge system in its own right. While there are connections that exist across and within the indigenous system, variations exist between the methods, concepts, experiences, and values used by various Indigenous peoples to gain their knowledge. Thus, there are differences in interpretations and applications of Indigenous knowledge in every situation. Indigenous knowledge therefore has its own principles and rules which are distinct from other forms of knowing (Battiste & Henderson, 2000; Cajete, 2000).

As noted further in Hart (2007), several authors have identified significant aspects to understanding what Indigenous knowledge is. One of the dominating features is its holistic base (Battiste & Henderson, 2000; Cajete, 2000, 1999). Unlike the positivistic empiricism paradigm that dominates Americo-European knowledge, Indigenous knowledge does not separate realities into disciplines, such as religion, philosophy, art, physical sciences, and social sciences. Instead, these systems are often looked at and addressed together. Realities in indigenous knowledge are the experience between man, the supernatural and the environment. An understanding that stems from the various sources is seen as being mutually dependent upon one another, thus making it unreasonable to divide them. These various constructs in indigenous knowledge connect and depend on each other for survival. (Hart, 2007)
Hart (2007) further argues that as a holistically-based approach, Indigenous knowledge is reliant upon the relationships within personal and social contexts. Personally, Indigenous knowledge relies upon subjective interpretations and experiences of indigenous people. The principal end is self-knowledge (Cajete, 1999). Explaining further and referring to Henderson (2000), Harts (2007) opines that the goal of Indigenous knowledge is to understand and attempt to contain the energies that encourage everything in order to create a lifestyle that is harmonious with the local ecosystem. Knowledge therefore is developed on a personal level through subjective reflection and participating in ceremonial and stage-based process that inculcate into the individual the fundamental principles of life. (Cajete, 1999; Ermine, 1995) Thus, it is gained through experience and all the senses and instincts (Henderson, 2000). On a social level, Hart (2007) espouses the idea that Indigenous knowledge is highly localized in that knowledge is based upon the environment and situations encountered by learners. In other words, each experience becomes a form of knowledge that is shared and esteemed by the society (Cajete, 1999 & 2000). It has a focus on “the web of relationships between humans, animals, plants, natural forces, spirits, and land forms in particular localities, as opposed to discovering particular ‘laws’” (Battiste & Henderson, 2000,p. 44).

The distinctive nature of indigenous knowledge is common to most indigenous people all over the world. In most African societal contexts for example, people do not conceive of themselves as separated from the cosmos or the universe but as being completely integrated into the universe that is much larger than any of them yet it is centred around them” (Mazama, 2002). Citing Henderson (2000), Hart argues, Indigenous knowledge is dependent upon people’s experiences with their local ecosystems (Hart, 2007) and a holistic base will therefore include the physical and
spiritual realms since there is no division between science (what is visible) and spirituality (what is invisible). There is therefore the recognition of Indigenous ways of learning through the physical world which includes such methodologies and practices as observation, experiential learning, and apprenticeship (Cajete, 1999, 2000). This means that, the closer one is to nature, the closer he/she gets to the spirit world.

An indigenous discursive framework is appropriate in examining indigenous healing since it seeks to draw energy from the interconnectivity that exists in the indigenous communities. The indigenous healing system believes that the healing practices and traditions operate in the context of relationship to constructs, (Portman & Garrett 2006), namely the supreme God, who is omnipotent and omnipresent. One could not communicate with the Supreme Being directly hence the importance of the second group, i.e. the deities. These are found in tress, plants, stones, and many forms, and points to man’s relations with the environment. The next construct is the ancestral world. These are deceased relatives who are believed to be part of the daily lives of the living. Only relatives who led exemplary lives are qualified to be called ancestors. An indigenous perspective to me will therefore provide the platform to articulate the interconnectivity that exists in indigenous communities and their spiritual activities.

Perhaps conducting a research in indigenous knowledge may be a very difficult task. I might say at this point that in spite of the ambivalence towards indigenous ways of knowing especially its spirituality component, many in the academia and in health care have indeed begun to explore the role of indigenous ways of healing and thought. According to Tisdell (2003), in the areas of health care, Sloan, et al (1999) noted that in a recent study of family practice physicians in USA, 99 percent reported they believed in the importance of spirituality in the healing process,
and 79 percent of a thousand non-physicians adults’ surveyed believed spirituality could help people recover from disease.

In the next section of the thesis, I discuss the Mampong centre for scientific research into plant medicine and what it has been doing to bridge the gap between scientific and indigenous healing practices.
Chapter 4:
Mampong Centre for Scientific Research into Plant Medicine; Bridging the gap between Scientific and Indigenous Healing Practices

4.1. Introduction

Using herbs for its therapeutic properties has been part of the Ghanaian livelihood since time immemorial. It is an accepted and unquestioned way of life perceived to be practiced in almost every Ghanaian home. The use of herbs links the living and the dead, the spirit and physical, the seen and the unseen and the natural and the supernatural. In view of this many rituals surrounded the use of herbal medicine. These rituals were meant to seek the favour of the ancestors, who are believed to have the ability to diagnose and heal. It is the belief among most indigenous Ghanaians that illnesses were the results of disobedience to the ancestral spirits. So for one to be fully healed, there must be forgiveness from the ancestors. Until the establishment of the centre for scientific research, herbalists and spiritualists exercised the sole prerogative on diagnosis and treatment of illness. They served as a link between the patient and the ancestors or spirits who may offer cure for a disease. Later developments among herbal practitioners however may have coerced the government into establishing the centre. The exaggerated potency of herbal medicines by some practitioners; the unethical and inappropriate application of healing practices such as bathing married women naked in the night; and the increased number of self acclaimed practitioners are just but a few of the reason that got the government to establish the centre. The Centre was established to coordinate and oversee the preparing of herbal medicines as well as regulate the work of practitioners. The Centre works alongside other prominent conventional medical centres like Korle-Bu teaching hospital and the
Komfo Anokye teaching hospital. The centre offers alternative health care to the conventional system as well exemplifying the fact that both approaches could exist as alternative and complementing each other.

4.2. History of the Centre

From the foundation laid by Dr. Oku Ampofo, who is considered as the pioneer of herbal medicine in Ghana, a renowned allopathic medical practitioner, in the early sixties, the Government of Ghana established the Centre for Scientific Research into plant medicine (CSRPM) in November 1975; with the main aim to “conduct and promote scientific research relating to the improvement of plant medicine; ensure the purity of drugs extracted from plants; co-operate and liaise with the Ghana Psychic and Traditional Healers’ Association, research institutions and commercial organizations in any part of the world in matters of plants medicine; undertake or collaborate in the collation, publication and the dissemination of the results of research and other useful technical information; establish, where necessary, botanical gardens for medicinal plants; and perform such other functions as the government may assign to it from time to time” (CSRPM, 2000, p.7).

Upon its establishment, the government established a governing council. Members of the council were selected from areas directly involved in or concerned with the performance of the functions of the Centre (Medicine) or in the application of its research results. As a functional body, the Council was charged with the following responsibilities: “custody, control and use of the common seal of the Centre; “encouragement of the use of medically proven reparations as effective substitute for conventional drugs; advising the government on the preservation and restrictions of the exportation and importation of certain medicinal plants; proper management and administration of the revenue and property of the Centre and maintain general control
over the conduct of the affairs of the Centre” (ibid). An advisory Committee was set up at the Centre’s inception to help the Director of the Centre, until 1976 when the first Council was inaugurated. Members of the Council constituted the following; Chairman who is appointed by the Government of the Republic of Ghana and must be a person with recognised qualification or experience in plant medicine or related subjects. Other members of the council included a representative of the National Council for Higher Education; the Dean of the University of Ghana Medical School or his representative; the Dean of the Faculty of Pharmacy, the University of Science and Technology or his representative; the Director General of the Council for Scientific and Industrial Research or his representative; the Director General of the Ghana Health Services or is representatives; a representative of the Ghana Pharmaceutical Council; two persons with special interest in plants medicine nominated by the Government, consideration to be given to traditional rulers; a representative of the Ghana Medical Association; a member of the Ghana Federation of Traditional Medical Practitioners Association (GHAFTRAM); the Director of the Centre for Scientific Research into Plant Medicine.(ibid)

It was then the responsibility of the Council to establish other committees; hence it established a permanent Research Committee for the Centre. Members of the Committee were; the Dean of the Ghana Medical School, Korle-Bu; immediate past Dean of the Ghana Medical School; the Dean of the Faculty of Pharmacy, UST, Kumasi; the Deputy- Director General of the CSIR in charge of health; the Deputy Director of the Noguchi Memorial Institute of medical research; the Head of the Department of Biochemistry, University of Ghana; the Head of the Department Pharmacology, UST, Kumasi; the Head of the Department of Chemistry of University
of Cape-Coast; a representative of the Ministry of Health, the Director of CSRPM and the Deputy Director of CSRPM as secretary (CSRPM, 2000).

4.2. Departments, Sections and Works of the Centre

To ensure that the Centre achieved it purpose for which it was established, the government put a number of important departments and sections in place. These are distinctive departments but mutually work for the success of the Centre.

4.2.2. Pharmacology and Toxicology Department

This was one of the earliest departments established in 1989 to engage in Clinical pharmacology, Toxicology, Pharmaceutics; (a) kinetics (b) dynamics, Animal house, Quality control and services; (a) analyses of herbal products of the Centre, (b) analyses of products brought by Herbalist and manufacturers and (c) customize herbal medicines for industry (CSRPM, 2000).

4.2.3. Activities:

The Department carries out toxicological (acute, sub-acute and chronic) screening using laboratory animals produced and maintained in an animal house. The department further determines dosage levels after toxicological studies and conducts efficacy assessment of herbal medicinal preparations using Hippocratic screening and in-vitro-vivo techniques. In addition to the scientific work done on the Centre’s herbal products, the Department also carries out safety and efficacy assessment of herbal medicinal products presented to the Centre by herbalists and manufacturers. The Department also trains both local and foreign students and visitors who come to the Centre on attachment. The Department is collaborating with the Faculty of Pharmacy, KNUST, Kumasi in a joint effort to establish toxicological and pharmacological
activities of some of the Centre’s herbal products. This, the Department hopes to facilitate collaboration of Ghanaian students in Ghanaian universities to herbal medicine development and application (CSRPM, 2000).

4.2.4. Plant Development Department

In September 1998, this department was detached from the Plant Production and Development Unit and given the new name. Functions of this department included; Establishment of arboreta; Nursing, (a) sale (b) arboreta; Herbarium (updates of records); Grounds and Gardens (landscaping and customize); plant search and sourcing (CSRPM, 2000).

4.2.5. Activities:

Arboreta: The centre established four (4) medicinal plants gardens. These are located at Mampong-Akuapem (5 acres), Mamfe-Akuapem (10 acres), Begoro (50 acres) all in the Eastern Region and Ayikuma (640 acres) in the Greater Accra Region. (ibid)

Nursery: The Department obtains needed medicinal plants through germplasm collection and establishes nurseries that cater for the Centre’s medicinal plants farms, gardens and for sale to interested persons involved in medicinal plants out-grower programmes (ibid, p10).

Herbarium: The Centre’s herbarium is involved in the documentation of ethno-botanical and ethno-pharmacological data on medicinal plants that are claimed by herbalists for the management or cure of various diseases; The documentation of finished herbal medicinal products brought to the Centre by herbalists and manufacturers for analyses; Identification of plants specimens used by the Centre by patrons; Preparation of voucher specimens of medicinal plants to serve as
confirmatory guide to the identification of new plants samples; Training of herbalists in herbarium techniques and sustainable harvest of medicinal plants (CSRPM, 2000).

**Plants search and sourcing**: The Department employs data obtained on the localities of plants to plan out collection areas for the Centre. To achieve this, the centre gathers information from the it’s herbarium and other herbaria like Ghana Herbarium at the Botany Department, University of Ghana, Legon (Ibid).

**4.2.6. Microbiology Department**

The Microbiology Department was established in August 1998 with the following responsibility; Bacteriology; Mycology; Protozoology; Virology; Quality Control; Standardization and Services; (a) Analysis of specimens (b) Analysis of herbalists’ drugs (CSRPM, 2000).

**4.2.7. Activities:**

The Department undertakes Aetiology and control of plant-infecting fungi; Clinical monitoring of the anti-microbial effect of Mist Nibima on Plasmodium falciparum; Aetiology and drug susceptibility profiles of pathogens causing sores on rabbits at the Department and provides clinical microbiological services to patients of the Centre. Additionally, the Department also provides consultancy services to traditional herbal practitioners by conducting microbiological analysis of their herbal products. The Department has a working link with the Microbiology Department and Public Health Reference Laboratory of Korle-Bu Teaching Hospital for the acquisition and identification of microorganisms, as well as provide teaching services to both national and foreign students who come to the Centre on attachment (CSRPM, 2000).
4.2.8. Photochemistry Department

The phytochemistry Department started in 1986 as a general laboratory referred to simply as the “Research Laboratory” to differentiate it from the clinical laboratory. However, in 1991, a new research laboratory was established to cater for the pharmacological aspects of plants medicine research. It was then that the premier Research Laboratory was renamed Phytochemistry Laboratory to reflect the nature of its activities. The department has since then expanded and comprises a laboratory section and a commercial section (CSRPM, 2000).

The Department was established to undertake functions such as; medicine formulation, standardisation, quality control, Phytochemical analysis of medicinal plants, macro- and-micromorphology, services; (a) Phytochemical analysis of herbal products, (b) others. Activities they the Department undertake include encapsulation; tableting; determination of concentration of active ingredients; determining quality control of the Centre’s medicinal products. The department also undertakes qualitative determination of classes of compounds present in medicinal plants and herbal medicinal preparations. The department also carry out Chromatographic isolation and identification of active constituents from medicinal plants. Other activities included analysis of herbal medicines on the request of herbalist, manufacturers and government agencies such as the Police, Food and Drugs Board and the Ghana standard Board, as well as establishing collaborative links with industrial concerns (ibid).
4.2.8. Production Department

The Centre since its inception in 1973 has performed the preparation of herbal drugs. This was however done in little quantities. From its humble beginning and through support from government the activities grew bigger and bigger till it acquired departmental status in 1991 (CSRPM, 2000).

Functions of this department include raw materials purchase. The department sources and purchases various parts including roots, stem barks, leaves, fruits and seeds of over 70 medicinal species of local plants which are used for preparing various herbal drugs. Additionally, the department is responsible for raw material treatment. The department living up to the purpose for its establishment has products range comprising capsules, tablets, decoctions, powders and ointments which are useful in treating a broad range of diseases that are common in the tropics. The Department also standardises production processes in order to improve and maintain the quality of the products, and to improve the efficiency of the processes. The department in collaboration with Microbiology, Phytochemistry, Pharmacology and Clinic Department carry out Quality control programs. Furthermore the department is responsible for pilot plant production and packaging (CSRPM, 2000).

4.2.9. Clinical Department

This Department was personally set up by the late Dr. Oku-Ampofo in 1973 to conduct clinical trials on the Center’s herbal medicines; offer out-patients clinical care using (a) nurses, (b) medical doctors and provides routine consultation for patients; clinical records provides statistical data of patients; helps in the compilation of names, method of administration, efficacy, potency, side effects, indications, contradictions of all herbal drugs prepared at the Centre; offering medical laboratory
services that makes analyses on various types of specimens such as blood, urine, stool and skin snip (CSRPM, 2000).

4.2.10. Scientific Information Department

The Department started running in September of 1998 to link the Centre to the rest of the scientific community the world over. The major function and activity of the department is to link the Centre to the scientific community of the world through modern information technology; including internet, e-mails, electronic searches and information exchange etc; acquiring the Centre’s literature with focus on plant medicine. Aside its library functions; indexing and obstructing, preservation of materials, the department is responsible for publications like annual reports, brochures, newsletters, scientific publications etc from or about the Centre (CSRPM, 2000).

4.2.11. Other Departments

The Administrative department is responsible for the day to day programs and coordination of the various departmental activities. The three (3) additional departments that exist include the Accounts, Public Services Workers Union of TUC and the Welfare Association of the Centre.

4.3. Achievements

Through its various departments, the Centre has chalked a number of successes. These include; Provision of pharmaco-toxicological data on some of the Centre’s herbal products. This has led to the determination of dosage levels and the provision of more scientific information for the preparation of monographs towards the protection of the intellectual property of the Centre. Among the numerous herbal products worked on include Mist Nibima, Mist Tonica, Mist Asena, Mist Diodia,
Garibe ointment, Kenken capsules, Lippia tea and Sirrappac powder. Great improvement in converting some of the Centre’s products into more consumer acceptable forms e.g. capsules and tablets. Additionally it provides scientific data on herbalists’ products which include safety and efficacy tests. The Centre’s Herbarium has a store of more than 1,000 voucher specimens of the medicinal plants in Ghana (CSRPM, 2000).

The Microbiology Department specifically has chalked a number of successes in many research areas. Five species of fungi, which infect paints and ruin painted walls and houses, have been isolated. They include Botryodiplodia theobromae and four other species. Additionally, 80% of the malarial patients (with parasiteamia +2 and +3) studied over 28 days; Mist Nibima was effective in clearing Plasmodium falciparum from the blood in three days after drug administration. Researchers in the department were able to isolate pathogens Clostridium tetani and C. perfringers from the sores on the body and around the mouth region of the Centre’s rabbits. Parasiticidal ointment, a herbal base ointment prepared and dispensed at the Centre was sole used to heal the sores. The pathogens however were also sensitive to penicillin. Mist Enterica, a herbal drug used against typhoid fever at the Centre’s clinic was observed to shoe activity against the pathogen and its minimum inhibitory concentration (MIC) was found to be 100mg/ml (CSRPM, 2000).

Through the activities of the clinical Department, the Centre has more than thirty six (36) plant preparations that has shown clinical successes in the treatment of a number of disease conditions. The Centre achieved a 98% rate of guinea worn eradication in parts of the country with locally prepared herbs. The Centre is seriously looking into recent collation of clinical trail results which indicate that diseases such as prostate cancer, cervical cancer, renal calculus (kidney stones) , bleary Calculus
(gall bladder stones), hepatitis B, heart palpitations and acute bronchial spastic attacks can successfully be treated or managed with herbal medicinal preparations. In collaboration with the University of Ghana Medical School, the Centre in March 1997 successfully carried out clinical trials on sirrapac powder a herbal product used at the Centre in the management of osteo-arthritis. Through the efforts of the clinical department, the treatment period of malaria using Nibima, a herbal product of the Centre has been reduced from one week (7 days) to three (3) days (CSRPM, 2000).

4.4. Future Plans

The Centre in order to maintain its role in the medical science and encourage the use of herbal medicine in Ghana has outlined future plans and activities to ensure this objective is achieved. These included conducting research into the possible mechanism of actions of the Centre’s herbal medicinal products. To carry out special studies and other toxic effects such as metabolism, absorption, excretion, teratogenicity and carcinogenicity and to have an efficient liaising policy with the Food and drugs Board and the Ghana Standards Board towards approval for herbal drugs prepared by herbalists and industrialists.

Through its production department, the centre hopes to list its herbarium in the index Herbarium (a reference book of recognised herbaria of the world) and on the internet. It also plans to mount consultancy services for the use of medicinal plants for landscaping and other home gardens to enhance easy availability of nature’s pharmacy to all and intends to use more advanced Geographical Imaging system (GIS) and other modern identification mapping technology to locate and document medicinal plants in Ghana. The Centre hopes to continue providing interested Ghanaians with the scientific knowledge and understanding of herbal products so as to meet the competition from the conventional system.
4.5. Examination of Some Common Medicinal Herbs Or Plants

To the Ghanaian and most African peoples, life is lived daily with plants that are meant to heal their frailties. Herbal plants are therefore located in almost every inch of a distance in tropical Africa and particularly Ghana. The main aim of this chapter is to pictorially show some common plants that holds medicinal values for the Ghanaian. If possible, their vernacular names will be cited, its medicinal properties, description and its region popularly located. Due to different language names used in reference to these plants, I will begin with the “scientific” name, followed by the others. By outlining the plants medicinal properties I am no way asserting self medication since most of these plants are combined and specially prepared before they are administered.

**Scientific name: Barassus Aethiopum Mart**

**Common Name:** Fan Palm

**Local Names:**
- **Fante:** Mbaakube
- **Nzema:** Mmaalekuwe
- **Ga:** Weidzo
- **Dagbani:** Kukpalaga
- **Dagaari:** Kong konga
- **Ewe:** Agoda
- **Mole:** Voaka

**Description**

Its tree could grow to 24 m high and 1.8m in girth; bark grey, with the remains of the leaf – stalks persisting in young trees; leaves broadly fan-shaped, leaf stalks very large, split at base; flowers greenish; fruits very persistent and ripening shortly before the new flowers appear, orange, sweetly scented.

**Areas mostly found**

It’s widespread in all ten regions, especially found in marshy areas and by stream side in Savannah country; and also coastal areas

**Medical use**

The flowers are used to treat impetigo; and the roots for asthma and some other lungs related diseases

*Figure 1: Mbaakube: (Floristic Studies in Ghana, 2000) & http://upload.wikimedia.org/wikipedia*
**Scientific name:** Elaeis guineensis Jacq  
**Common Name:** Palm tree  
**Local names:** Akan: Abe; Ewe: Deti; Fante Abe; Ga: Nme; Nzema Arele

**Description:**  
A tree of secondary forest; has more leaves in a terminal crown, commonly spiny at margins; segments in 4 ranks, acuminate, glabrous, the lowest spinescent; spadices interfoliaceous; male flowers densely crowded, minute with linear sepals, petals linear – oblong, stems 6; female spadix with short peduncle and branches congested into a globose capitulum; female flowers much longer than the male; with ovoid vary and relatively large resolute stigmas, fruits ovoid of somewhat angular, often bright red and shining black when ripe

**Areas mostly found:**  
It’s is cultivated and occurs spontaneously in much of the forest zone in the country. From Brong Ahafo to the eastern; It’s almost in all the region in Ghana

**Medicinal use:**  
The fruits are used to treat dracontiasis, the kernel for filariasis; the oil is used to treat baldness and certain types of bodily rashes while the young petiole is used to treat wound and otalgia.

**Figure 2:** Abe (Floristic Studies in Ghana, 2000)  
[http://images.google.ca/imgres](http://images.google.ca/imgres)

---

**Scientific name:** Dissotis rotundifolia  
**Local names:** Nzema: Adoalee, Ndowa-alee; Twi: Boreadaso, Borekete, Obommofoawaw; Ewe:Adongo Gbe

**Description:**  
This is a decumbent herb; stem pilose rooting at the nodes, leaves opposite, shortly ovate, up to 2-4cm.long and 10-25mm. broad, shortly cuneate at base, petiole 5-25mm. long, hairy: flowers in 2 or 3 at the apex of the auxiliary branch lets, calyx tube more or less densely covered with simple and/or plumose bristles; seeds with concentric ridges, pitted in centre

**Areas mostly found:**  
In Ghana it can also be found in the forest regions of eastern, western, Brong Ahafo and Ashanti regions.

**Medical uses:**  
The whole plant is used to treat abdominal plants, diarrhoea, poisoning, gonorrhoea, rheumatism and for prenatal care; the leaves are used to treat cough; the leafy stems for asthma, while the roots are used to treat oliguria. The leaves (or aerial parts) are used to treat orthitis.

**Figure 3:** Boreadaso (Floristic Studies in Ghana, 2000)  
[www.zimbabweflora.co.zw/speciesdata/imagedisplay.php?species_id=142590&image_id=2](http://www.zimbabweflora.co.zw/speciesdata/imagedisplay.php?species_id=142590&image_id=2)
**Scientific name:** Leea guineensis

**Local names:** Twi: Agyaben, Okatanini, Okatakyi

**Description**
Erect or subject soft-wooded shrub; leaflets opposite, oblong-elliptic, rounded or slightly narrowed at base, acuminate, petals 5, glabrous, short, bright yellow or red; fruits brilliant red then turning black

**Areas mostly found**
In Ghana its common in all tropical regions like eastern, Brong Ahafo, Western.

**Medical uses:**
The leaves are used to treat skin ulcer and general skin rashes, cut wound and convulsion in children. Together with certain plants its used to treat typhoid fever.

*Figure 4: Agyaben (Floristic Studies in Ghana, 2000).47-48 & http://www.plantoftheweek.org/image/leea.jpg*

**Scientific name:** Gardenia ternifolia

**Local name:** Ga: Akpetekplebii; Ewe: Flige; Mole: Subudgaaga; Twi; Peterprebi

**Description**
This is a savanna plant, globrous; leaves obovate, prominently reticulate with more or less parallel venation on both surfaces, flowers fragrant, white opening at night; turning yellow next day, fruits more or less ellipsoid, grey green, long-persistent

**Areas mostly found**
It grows in the Eastern, Central and Western regions and some part of the Northern regions of Ghana

**Medical uses:**
The whole plant is used for constipation; the roots for female infertility, rheumatism, leprosy, black water fever, skin ulcers; the leaves doe syphilis; and the fruits for myalgia and sty.

*Figure 5: Peterprebi (Floristic Studies in Ghana, 2000) & www.zimbabweflora.co.zw/speciesdata/image display.*
Scientific name: *Azadirachta indica*

Local names: Fante: Nim, Aboode, Abodua, Ewe: Liliti; Ga-Dangbwe: Kintso; Asante: Gyedua; Twi: Nimsi, Dua gyane.

**Description:**
This tree can grow up to 15m. high, always green leaves compound, imparipinnate; leaflets 5-8 lanceolated pairs, falcate, asymmetric at the base, Longley acuminate, glabrous; inflorescence in axillary panicle, small flowers, white fruit berry-like, yellow at maturity, fragrant.

**Areas mostly found**
In forest, particularly secondary regrowth forest in the Western, Eastern, Brong Ahafo and Ashanti regions.

**Medicinal uses:**
The leaves are used to treat ringworm, boils, fever, hepatitis, jaundice, lumbago and malaria; the seeds are used to treat intestinal helminthiasis, wounds, pruritis and dermatitis; the stem-bark is used for helminthiasis, malaria and pharyngitis; while the root-bark is used for helminthiasis. The bark is used to treat pharyngitis. The wood could be made into chewing stick for strong and bright teeth.

*Figure 7: Gyedua (Floristic Studies in Ghana, 2000)*
[www.ncnhdistrict.org/aom/neem.html](http://www.ncnhdistrict.org/aom/neem.html) [www.plantoftheweek.org/week310.s](http://www.plantoftheweek.org/week310.s)

---

Scientific name: *Morinda lucida*

Local names: Asante: Okonkroma; Ewe: Dadaklan, Dzadzaklenu, Ake; Ga: Kpoti; Nzema: Sima; Twi: Opeasiakwa.

**Description:**
The tree usually has the bole and branches markedly crooked; bark grey, rough flaking off in irregular patches; slash yellow leaves elliptic to broadly elliptic, broadly cuneate or occasionally rounded at the base; flowers white; fruits persisting for a long eventually becoming black and soft. Wood yellow.

**Areas mostly found**
In forest, particularly secondary regrowth forest in the Western, Eastern, Brong Ahafo and Ashanti regions.

**Medicinal uses:**
The leaves are used to treat stroke (paralysis), constipation, fever, malaria; the stem or root, for dysentery, Typhoid fever, haemorrhoids, constipation; the stem and root together are used for chest pains; the roots alone are used for sickle cell anaemia, malaria; and the root-bark, for threatened abortion; the roots are used to treat oligomenorrhea.

*Figure 6: Okonkroma (Floristic Studies in Ghana, 2000)*
Scientific name: *Khaya Senegalensis*
Common names: Mahogany
Local names: Hausa: Madwachi, Madwachi; Ewe: Logo; Fante: Okum; Ga-Dangbe: Kug; Twi: Kuntunkuri; Mole: Kuka; Brong: Korobaa; Nzema: Anane

Description
This tree could grow up to 20m. high. Leaves imparipinnate; leaflets 3-7 pairs, oblong or elliptic, 6-12 cm. long and 2-5 cm broad, rounded or shortly acuminate at apex, glabrous; lateral nerves, 8-16 pairs, flowers blackish; fruits capsular, dehiscent, with 4-5 valves, 4-6 cm diameter; winged seeds orbicular.

Areas mostly found
Very common in forest regions of Ghana such as Eastern, Brong Ahafo, Western, Ashanti and Central regions

Medicinal uses:
The stem-bark is used for convulsion, arthritis, hemorrhoids, malaria, boils, anaemia, helminthiasis and heat rash; the leaves are used to treat headache. The plant is used to treat loss of appetite.

Figure 8: Kuntunkuri (Floristic studies in Ghana)
http://commons.wikimedia.org/wiki/khaya_senegalensis

Scientific name: *Ficus asperifolia*
Common name: Sandpaper Tree
Local names: Twi: Onyannkyeren; Ga: Nyankese; Nzema: Nyangele; Akan: Onyankyeren; Ewe: Tataputala, Tataflala

Description
A scrambling shrub or small tree up to 3.5m high; with brownish-purplish branchlets; leaves scabrid; often lobed, variable, nearly entire, oblong-elliptic, or pinnately 3-5 lobed, 5-17 cm long, 2-8 cm broad.

Areas mostly found
Common in secondary closed forest in regions like the Brong Ahafo, Eastern, Western and Ashanti regions

Medicinal uses:
The leaves are used to treat a form of cancer and headache; the seeds, for fever; and the stem-bark for treating haemorrhoids and wound. The leaves are used to treat tumour. The plant is used to treat hemorrhage.

Figure 9: Onyankyeren (Floristic Studies in Ghana, 2000)
www.figweb.org/Ficus/images/asperifolia/Ficus_asperifolia_ENC2064_400.jpg
**Scientific name:** *Musa paradisiaca*

**Local name:** Twi: Brode; Fante: Borodze; Nzema: Banna; Ga: Amadaa

Common name: Plantain

**Description**
This is a herbaceous food plant, looking like a shrub, with thick rhizome sending out shoots up to 4-5m. High leaves 1.6 – n2.6. Long and 0.6 1 m broad, Midrib thick, prominent beneath and canaliculated above; petiole thick; canaliculated and broadly sheathing; inflorescence elongated first enveloped in a large mauvish spathe; flowers numerous, clustered along a common thick axis fruits in bunches of 2 or 5; yellow at maturity

**Areas mostly found**
It’s widely cultivated in the entire tropical region, especially in Eastern, Ashanti, Brong Ahafo, Western, Central, Volta and parts of Northern Ghana

**Medical uses:**
The root is used for placental retention; the leaves and stem are used for treating goitre while the leaves alone are used for treating wound and palpitation. Stack of fruits is used form tooth whitening.

*Figure 10: Brode (Floristic Studies in Ghana, 2000)*

---

**Scientific name:** *Psidium guajava*

**Common name:** Guava

**Local names:** Esa: Agua, Ewe: Goa; Fante: Eguabe; Ga: Gowa; Nzema: Aduoba; Twi: Oguawa; Ga-Damgbwe: Aguwa; Hausa: Goba

**Description**
This is a Shrub plant, 5-8 m. high, leaves simple, opposite, entire, ovate, 3-5 cm long and 2.5-4 cm broad, glabrous; 8-15 prominent lateral nerves beneath; inflorescence in axillary cyme or solitary flowers; flowers white. Pedunculate, 1.5-2 cm. diameter; fruits spherical berry with persistent sepals on top pulp white or pink, seed small and numerous

**Areas mostly found**
Grows in all tropical regions in Ghana

**Medical uses:**
The leaves, stem-bark and roots are used to treat diarrhoea; the leaves are also used to treat chronic diarrhoea, painful urination, measles, toothache and Herpes zoster; the fruits are used for pharyngeal abscess and constipation; the stem-bark for boils. Fruits prevent constipation.

*Figure 11: Oguawa (Floristic Studies in Ghana, 2000) www.raintree.com/Plant-Images/guava-pic.htm*
**Scientific name: Balanites aegyptica**

**Local names:**
- **Brong:** Kobowoo
- **Twi:** Kobowoo
- **Hausa:** Adua, Aduwa
- **Dagbani:** Gongogu, Gungo
- **Mole:** Kye gelga
- **Mossi:** Chiala
- **Wala:** Gongo
- **Dagaare:** Gongogua
- **Mossie:** Chiola

**Common name:** Desert Date

**Description**
A tree plant 4-10m high; bark grey with vertical fissures in which the yellow of the new bark can be seen; slash pale yellow; branchlets dark green; leaves with 2 leaflet on a common stalk; leaflet slightly obovate, blunt or round at the apex; flowers in short clusters borne above the leaf axils; fruits broadly oblong ellipsoid, green and shortly velvety when young, yellow and glabrous when ripe

**Areas mostly found**
In drier savanna region; preserved as a fruit tree hence found mostly in the three Northern regions of Ghana

**Medical uses**
The root-bark is used to treat circumcision sores whiles the roots and fruits are used for herpes zoster and abdominal pain. The fruit is used to treat keratoderma, malaria, schistosomiasis and helminthiasis

*Figure 12: Kobowoo (Floristic Studies in Ghana, 2000) & http://images.google.ca/imgres*

---

**Scientific name: Cleistopholis patens**

**Common names:** Salt and Oil tree

**Local names:**
- **Twi:** Nykene ne ngo
- **Wassa:** Wisa ne kyene
- **Asante:** Wisa ne kyene
- **Ayem:** Fifiriwa

**Description**
A tree with horizontal branches; leaves ovate-elliptic to lanceolate, coriaceous, shining above, glabrous young leaves very long; outer petals obovate to oblong; flowers greenish-yellow. Wood light, floats easily.

**Areas mostly found**
Mostly found in the Eastern, Brong Ahafo, Ashanti and Western regions

**Medical uses:**
The bark is used to treat jaundice and infective hepatitis

*Figure 13: Nkyene ne ngo (Floristic Studies in Ghana, 2000) & http://users.telenet.be/sf16063/pauwels/CanaOdor2.jpg*
**Scientific name:** Mitragyna inermis

**Local names:** Asante: Subaha; Ewe: Afafali, Anyimo; Brong: Kukyafie; Ga: Tsina, Kpaakpong; Wass: Subaha; Mole: Yiliga

**Description**
This is a Shrub or low branching tree with scaly bark; leaves obovate-elliptic, acute to shortly acuminate, rounded to subcordate at base, ciliate on nerves beneath; flowers white

**Areas mostly found**
Grows in swaps and besides streams hence could be found in almost all ten regions.

**Medical uses:**
The leaves are used to treat fever, rheumatism, boils and wounds; the bark, for oliguria, xerostomia and abdominal pains; the roots for malaria; and the roots and bark for gonorrhoea

*Figure 15: Subaha (Floristic Studies in Ghana, 2000) & http://www.metafo.be/prelude/prelude_pic/Mitragyna_inermis1*

---

**Scientific name:** Mitracarpus villosus

**Local names:** Twi: Susubiribi; Ga: Gbeshiabaa; Ewe: Nyagabe, digbe

**Description**
This is an annual herb, half woody at the base, erect, with terete branches; stem puberulous; leaves lanceolate, glabrous below, scabrous above or nearly smooth; flowers white

**Areas mostly found**
Its common in all tropical regions like Eastern, Brong Ahafo, Ashanti and Western.

**Medical uses:**
The leaves and stems are used to treat female infertility. The whole plant is used to treat dermatitis, wound and leprosy

*Figure 14: Susubiribi (Floristic Studies in Ghana, 2000) & http://homepage.univie.ac.at/Christian.Puff/images/Mitracarpus_3_web.jpg*
Chapter 5:
Herbal Medicine in Modern Ghana

As conventional medicine makes a domineering path in the health care system in many Ghanaians homes, questions have been raised on the role of herbal medicine in the health setup. Many have wondered if that will mean the end to herbal medicine or indigenous ways of healing. This chapter examines some important issues in Ghana’s traditional ways of healing. Ghana obviously has a high stake in the 80 percent worldwide use of herbal medicine. According to the World Health Organization (WHO, 1993), herbal medicine, undoubtedly, is the most common traditional medicine therapy used for many therapeutic techniques (See Table 1). It constitutes a major aspect of the most therapeutic techniques all over the world.

Table 1
Commonly used TM/CAM therapies and therapeutic techniques

<table>
<thead>
<tr>
<th></th>
<th>Chinese Medicine</th>
<th>Ayurveda</th>
<th>Unani</th>
<th>Naturopathy</th>
<th>Osteopathy</th>
<th>Homeopathy</th>
<th>Chiropractic</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herbal Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Acupuncture/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>acupressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual therapies</td>
<td>Tuina(^a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Spiritual therapies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□</td>
</tr>
<tr>
<td>Exercises</td>
<td>Qigong(^c)</td>
<td>Yoga</td>
<td></td>
<td>Relaxation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) For example many informal TM systems in Africa and Latin America use Herbal medicines
\(^b\) For example in Thailand, some commonly used TM therapies incorporate acupuncture and acupressure
\(^c\) Type of manual therapy used in Traditional Chinese Medicine
\(^d\) Refers to manual therapy of Japanese origin in which pressure is applied with thumbs, palms, etc to certain point of the body
\(^e\) Component of traditional Chinese medicine that combines movement, meditation and regulation of breathing to enhance the flow of vital energy in the body to improve circulation and enhance immune function


- • Commonly uses this therapy/therapeutic
- □ Sometimes uses this therapy/therapeutic technique
- □ Uses /therapeutic touch
Against the presumption that the 21st century Ghanaian care less and know less about herbal medicine and its role in the general wellbeing of Ghanaians, studies done by corporate bodies and individuals prove otherwise. According to Boateng & Darko (2008), in a survey within the business district of Accra, it came out clear that the average Ghanaian on the street had at least an idea on what is herbal medicine. When asked what herbal medicine is, respondents defined the term as follows

(a) Medicine that is derived from leaves and wood backs;
(b) medicine that is made from roots of some trees, leaves and tress combines in a state which can be consumed;
(c) Medicines that is obtained usually from the combination of herbs which is often in the form of liquids, syrups or powder – mainly obtained from tree backs, roots and leaves;
(d) Any health natural product prepared without chemicals;
(e) It is the use of herbs in making medicine to cure all sorts of diseases;
(f) these are medicines that are naturally prepared from backs of leaves, roots;
(g) it is the combination of raw leaves which is made by people who have no professional western medical training but have little knowledge about it;
(h) Medicines made from natural plants mostly prepared by believers of African Traditional religion;
(i) Medicines made of natural substances without any addictives

From these responses, it is obvious that many Ghanaians have in one way or another used herbal medicine as a curative or preventive remedy and is perhaps the most popular form of disease remedy. According to WHO (2003) 60 percent of children

---

The Term “traditional Medicine” TM is used through most of this paper. But in some developed countries, the term complementary and alternative medicine (CAM) is used where the dominant health care system is based on conventional medicine or where TM has not been incorporated into the national health care system.
fever resulting from malaria are treated with herbal medicines at home. In Africa as a whole, 80 percent of its population depend on herbal medicine (Okigbo & Mmeka, 2006). As noted by Inamul Hag, (2004), and reiterated by David Ofori-Adjei (Senior lecturers-GMS) 70 percent of Ghanaians depend on herbal medicine. The doctor-patient ratio is 1:400 as against 1:1200 in the conventional system.

Botwe (2002) also notes that, between 60 and 70 percent of Ghanaians rely on traditional herbal medicine for their health care. In another recent survey by Boateng & Darko (2008) it came out clear that almost eight (8) out of every ten (10) respondents randomly selected had reasons to believe herbal medicine is of great importance in contemporary Ghanaian health system. Most reasons were given in contrast to conventional health care system. These reasons include less side effects comparing to conventional medicine; a holistic approach to health care; proven efficacy over conventional system; readily available; relatively cheaper; more preventive than curative; works faster on eliminating illness; comes with less complications; pure because they are less or free from chemicals contamination; it usually has permanent solutions to ailments and prevent surgery; its usage is part of the history and ways of life, beliefs, and practices; and offers diagnostic options for diagnosing illness (Haq, 2004; Boateng & Darko, 2008; Okigbo & Mmeka, 2006; Botwe 2002 ). David Ofori-Adjei (Senior lecturers-GMS) argues that the decision by a person to use traditional medicine may depend on the type and progression of illness as well as the patient’s perception of the illness. He further argues that “there are circumstances where a belief in traditional medicine is so strong that it is the first option and only when it is not working will the patient go to the hospital. Patient will revert to traditional medicine when they have gone to hospital and not had any improvement in their condition” (Royall, 2003, p.254).
In view of the important role herbal medicine plays in developing a better health system, the Ghanaian government, like other African countries have put in place structures, allocated money, and instituted training for traditional medicine practitioners. As shown in table 2, Ghana has a legal framework, a national management or coordinating body, an association of traditional practitioners, and a national budget allocated to traditional medicines.

**Table 2**

<table>
<thead>
<tr>
<th>Country</th>
<th>A legal framework</th>
<th>A national management or coordination body</th>
<th>Association(s) of traditional practitioners</th>
<th>Directory of traditional practitioners</th>
<th>National budget allocation for TM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botswana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burkina Faso</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cameroon</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dem. Rep of the Congo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equatorial Guinea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eritrea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gambia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ghana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesotho</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madagascar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mali</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mauritania</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Namibia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Niger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soa Tome &amp; Principe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senegal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: World Health Organisation, 2000*
5.3. The Work of the Herbal Practitioner

For many years, Ghanaians have customarily sought health advice from a mixture of traditional healers, including herbalists, cult healers, fetish priests, church leaders, imams, and other religious healers (Twumasi, 1979; Mills, 2001). Many authors (Fosu, 1981; Warren, 1979; Green, 1999) have investigated theories of health, disease causation, and healing associated with the traditional and indigenous healing system in postcolonial Ghana and among some indigenous groups. Illness or sickness is usually believed to be caused by natural or spiritual means. Therefore the search for healing usually falls between the two causative agents (Fosu, 1981; Senah, 1997; Warren, 1979; Mill, 2001). Although the majority of illnesses are perceived to be natural, some illnesses such as gonorrhoea may be caused by natural or spiritual agents (Warren, 1979) or by a combination of the two (Fosu, 1981). Mills note that illnesses categorised as natural tend to be minor and respond to drug therapy and have a known etiology. Spiritual illnesses, on the other hand, are typically more serious and less responsive to drug therapy, and believed to be caused by ghosts, witches, sorcery, curses, or the gods. Determining the etiology of illnesses, whether due to natural or spiritual causes, is an essential aspect of the healing process (Fosu, 1981; Senah, 1997). Frequently, illness is seen to represent punishment for antisocial behaviour on the part of the patient, his relative, or an ancestor and serves as a method to reinforce the moral and social order of society (Senah, 1997).

There are basically five main categories of indigenous or traditional healing practitioners in Ghana. First, the properly trained and very competent herbalists who have had their skills handed over to them through oral traditions or a long ancestral line. They usually have their own “hospitals” or “clinics,” and are consulted by clients in a manner similar to what normally happens in a conventional hospital or clinic.
This class of herbal medical practitioners usually believe more in the actual efficacy of the herbs, and attribute their cause to the particular herbs administered. Supernatural considerations are secondary, (although quite important) factor in their practice (Addae-Mensah, 1989).

The set up of the second class of herbal practitioners is similar to those in the first category, but those in this group believe more in the supernatural causes and cures of diseases. Usually, the herbal preparations they administer are employed not as the actual curative agent, but as a means of either driving away evil spirits, destroying the supernatural powers responsible for any particular ailments, or involving the help of “good spirits” who will then administer the cure required. Traditional priests and priestesses, cult healers, pastors, imams, and others are identified with this group. The supernatural plays a very important role in the life of the herbalist in this category. From the diagnosis to the treatment of illness, the supernatural or spirits are made integral part of the healing. They usually undertake rituals before giving herbs. This is believed to evoke the blessings of the spirits to heal the sick (ibid).

The third group includes the itinerant herbalists, who conduct their trade either at street corners or from house to house; His practice is usually an ill-defined hybrid of categories one and two above. He goes from house to house advertising cures for a wide spectrum of ailments from piles and boils, through ability to make a 35 year old barren woman a prospective mother of triplets (ibid).

The next major group are those termed scientific herbalists. These are herbalists who combine herbalism and scientific methods in treating disease. Practitioners in this group usually allow patients to visit scientific laboratories for diagnosis before herbal medicines are used to treat diseases. Efforts are been made by
the government and individual corporations and entities to encourage this category of practitioners. Since 2003, for example, the pharmacy department of Kwame Nkrumah University of Science and Technology have officially being training herbal medical doctors (Boateng & Darko, 2008).

The last group which holds most members is the amateur practitioners made up mostly of people who have had a bit of skill, or a few remedies transmitted to them from friends or relatives who usually give their services to friends or relatives free of charge, or for a token fee.


The battle range between Eurocentric and other forms of knowing such as indigenous ways has gradually made its way into the Ghanaian health system. Hardly will a day pass without a comment or incident that shows an unhealthy relationship between conventional system of health care and the traditional herbal practice. As noted by Hevi (1989) people’s approach to health care is based on their understanding of human being, life, and consequently health. Ghanaians as well as other indigenous peoples or non-western nations have always had a challenge on the interplay of traditional health care systems and imported or conventional western health care. This interplay creates tensions for the allocation and utilization of health care resources (Hevi, 1989). Each system points accusing fingers at the other in many aspects. To the conventional medical system, indigenous herbal medicine are archaic, less hygienic, never comes with a dosage, not scientifically tested, demonic, unchristian, not well packaged, less effective in curing diseases, works too slowly, unrecognised internationally, few and restrictive forms of medications, practitioner not “formally trained” in “Westernised” institutions, over exaggerated healing properties, and
complicated in its use (Boateng & Darko, 2008). The herbal practitioner also argue against conventional health system as being a colonial agent for exploitation, foreign, complicated, higher or worse side effects, expensive to use, unnatural, cures less diseases, alien to our cultures and ways of life, unfriendly practitioners, always experimenting with lives and denying traditional medicine practitioners of their role as spiritual leaders as well as their source of employment in the community (Boateng & Darko, 2008). These tensions between the two systems sterns from the conception of health and illness. As noted by Erah (2008) concepts on health and illness in Africa are more comprehensive than those of the conventional system.

In contrast with western medicine, which is technically and analytically based, traditional Ghanaian medicine takes a holistic approach, recognizing the fact that good health, diseases, success or misfortune are not seen as chance occurrences but are believed to arise from the actions of individuals and ancestral spirits according to the balance and imbalance between the individual and the environment (Erah, 2008).

As noted in my discursive framework, the purpose of this work is not to identify the best among the two approaches to health care, but to call into question the wholly acceptance of orthodox healing practises and the subsequent rejection of indigenous healing practises and to call for the effective cooperation among the two approaches. In other words, in the current situation, knowledge expansion, decolonization, cultural transition and the increasingly advocacy for plant medicines, how could these unnecessary tensions be resolved (Erah, 2008). How can indigenous and western medical system complement each other? A survey by Boateng & Darko (2008) in Accra suggests that eight out of ten Ghanaian randomly asked on the possibility of the two approaches working together answered in the affirmative.
The world health organization commenting on this tension between the Traditional medicine and the conventional or allopathic medicine calls for the need to recognize the effective role Traditional medicine is playing especially in the health of AIDS patients despite uninformed scepticism arising from questions of safety and efficacy:

Many TM/CAM providers seek continued or increased –recognition and support for their field. At the same time many allopathic medicine professionals, even those in countries with a strong history of TM, express strong reservations and often frank disbelief about the purported benefits of TM/CAM. Regulators wrestle with questions on safety and efficacy of traditional herbal medicine, whiles many industries groups and consumers resist any health policy development that could limit access to TM/CAM therapies. Reports of powerful immunostimulant effect for some traditional medicines raise hope among HIV-infected individuals, but others worry that the use of such “cures” will mislead people living with HIV/AIDS and delay treatment with “proven” therapies. So together with growing use of TM/CAM, demand has grown for evidence on safety and quality of TM/CAM products and practices. Interestingly, much of the scientific literatures for TM/CAM uses methodologies comparable to those used to support many modern surgical procedures… Nevertheless, scientific evidence from randomized clinical trials is strong for many uses of acupuncture, for some herbal medicines, and for some of the manual therapies. In general, however, increased use of TM/CAM has not been accompanied by an increase in the quantity, quality and accessibility of clinical evidence to support TM/CAM claims (WHO, 2000, p.2)

The daily battle between traditional and orthodox practitioners is not peculiar to Ghana but to most Africans States. According to Anfom (1986) few years ago, Dr. Ofodile described what traditional medicine is in the Daily Times of Nigeria:

It’s a collection of individually evolved practices developed in different families over generations and transferred to a limited number of people by apprenticeship. The practices are as varied and divergent as there are practitioners, and also as different in form as there are ethnic groups in the country. It is difficult to talk in such as circumstances to talk of traditional medicine as if it were one entity. (, p.28)

Dr. Ofodile in his article condemned the harmful practices of some traditional healers and recommended some form of control over these practitioners. In his rejoinder to the article, Chief J.O. Lambo, President of the Nigerian Association of Medical Herbalist, condemned Dr. Ofodile for displaying colonial attitude:
... Death will come when it will. It is sheer hypocrisy to assign the cause of death to a particular art. The life span in Nigeria was longer before the white man came than at present. The traditional doctors have a sure way of preserving the life of a patient in order to give room for treatment. This was done in the form of a long ring or belt. When all hope of survival was gone this material was removed and the soul would escape through the head. Dr. Ofodile must have been nursed by traditional medicine when he was young because all African mothers are used to it. Spiritual atonement is part of traditional therapy and is effective. (ibid, p.28-29)

In a similar instance Addae-Mensah (1989) challenges the a well know school of thought among herbalist that nature has its own checks and balances and that if a particular plant being used to effect a cure for some diseases, contains poisonous components, nature always makes sure there is another component present which neutralises the effect of the poison. To Addae-Mensah though herbal practitioners may know some plants which are poisonous not all plants immediately shows toxic effects until they have cause enough harm already. He therefore thinks this assertion by herbal practitioners could not be substantiated hence not valid.

As a scholar advocating indigenous ways of knowing the world, I do not agree with Addae-Mensah assertion. Even in the so called well research orthodox medicines, studies have showed that long usage of a drug results in side effects. And most often these side effects are not known for a long until many patients have suffered. This implies that the traditional practitioners view is not different from that of the orthodox practitioner. In both cases, the effectiveness and the subsequent consequences of a drug may not be known for a long time until many patients have suffered those side effects.

5.5. Challenges of Herbal Medicine in Ghana

The use of herbal medicine just like others indigenous systems is faced with numerous challenges in the wake of western imperialism especially in “developing” countries like Ghana. One major challenge facing herbal practitioners and the industry
is how to de-demonize the use of herbal products by Ghanaians. Due to imperialist structures, most indigenous knowledge and ways of life is seen as inhuman or demonic. It is therefore necessary that most Ghanaians especially the semi educated be de-Europeanized on their ideas on herbal medicine. Herbal medicine must regain its image as a traditional powerful social set up inherited and transmitted from generation to generation. It needs to be saved from the hypocrisy of some religions especially found among Christians and Muslims that seeks to demonize herbal medicines and their practitioners. In addition, there is the need to raise the moral and interest of Ghanaians in using locally produced Ghanaian herbs and knowledge. This will help build our cultural and social heritage and will also provide employment and reaffirm our stands as an independent nation.

One major challenge facing herbal medicine practices in Ghana has to do with the appropriation and patent rights of herbal practitioners. There is the fear of government regulation thereby denying healers their inherited rights. For example, in April 2000 there was a legislation establishing a council to regulate the practice of traditional medicine. Though the aim of the government was to integrate the herbal medicine into the mainstream line; thereby, putting it on the prescriptive drug schedule for the ministry of health, it denies indigenous traditions practitioners their patent right handed over to them from generation to generation. The subjectivity associated with some form of herbal medications has come under various attacked. Due to its subjective nature, it becomes difficult to track down false herbal practitioner especially those who claim to have inherited the knowledge from the ancestors. In other words, it is easier to have a quack herbalist than a fake westernised medical practitioner.
Unlike the conventional health care system, herbal medicine has suffered in the sense of advertisement, hence not popular. Until recently, most images on herbal medicine found in the Ghanaian media portrayed the practice in the negative sense. This has therefore affected the marketing strategies of most traditional medicines. As noted in a survey, most Ghanaians blamed the bad packaging, lack of dosages, and unclear instructions on the use of drugs as some of the issues that deter them from using herbal medicine (Boateng & Darko, 2008).

One major challenge to herbal medicine in Ghana is the unhealthy relationships that exist between most herbal practitioners and their colleagues in the western system. The antagonistic relationships that exist among practitioners of the two systems affect the attitudes of most Ghanaians. Patients seeking better health care are caught in the war of not knowing which approach to seek. Most often, practitioners within the conventional system warn or advise their patients not to visit or use herbal medicine especially together with their prescription. It is argued that as result of chemical imbalances that may arise from using both conventional and indigenous approaches one is safe in using the conventional system alone, but studies have shown that it’s more than that. Its ripple effect is the not so good relationship between the two systems. This is explicitly shown in an answer given by Dr. David Ofori-Adjei, a renowned lecturer at the University of Ghana medical school on how his colleagues view traditional medicine: “I think the expectation is that traditional medicine should be evaluated with the same rigour as conventional medicine … if this is done I think western trained doctors will gradually accept it” (Royall, 2003, p.2). While indigenous practitioners expect to be evaluated by their own standard such as spirituality, intuition, dreams etc. their counterpart want a purely scientific evaluation.
De-forestation and the gross lack of respect for the environment especially the forest is another challenge facing herbal medicine in Ghana. Since herbal medicines are fundamentally derived from plants and most plants are grown in the forest, a destruction of these plants invariably means the destruction of the sources of healing. Improper Agricultural practices, natural disasters, bush fires, and the effects modernization are gradually eliminating these species of medicinal plants.

The government’s response, actions, and inactions are a major obstacle to the work of herbal medicine practitioners. Until 2003, indigenous herbal practitioners were not legally recognised as a body that offered alternative health care to Ghanaians. Government support and assistance to the health sector excluded herbalists and other indigenous healers. The World Health Organization has categorised challenges of traditional medicine into four main groups. This is shown in table 3 below:
<table>
<thead>
<tr>
<th>Categories of challenges confronting TM/CAM</th>
<th></th>
</tr>
</thead>
</table>
| National Policy and regulatory frameworks | • Lack of official recognition of TM/CAM providers  
• TM/CAM not integrated into national health care systems  
• Lack of regulatory and legal mechanisms  
• Equitable distribution of benefits of indigenous TM knowledge and products  
• Inadequate allocation of resources for TM/CAM development and capacity building |
| Safety, efficacy and quality | • Lack of research methodology  
• Inadequate evidence-base for TM/CAM therapies and products  
• Lack of international and national standards for ensuring safety, efficacy and quality control of TM/CAM therapies and products  
• Lack of adequate regulation and registration of herbal medicines  
• Lack of registration of TM/CAM providers  
• Inadequate support for research |
| Access | • Lack of data measuring access levels and affordability  
• Need to identify safe and effective therapies and products  
• Lack of official recognition of role of TM/CAM providers  
• Lack of cooperation between TM/CAM providers and allopathic practitioners  
• Unsustainable use of medicinal plant resources |
| Rational use | • Lack of training for TM/CAM providers and on TM/CAM for allopathic practitioners  
• Lack of communication between TM/CAM and allopathic practitioners, and between allopathic practitioners and consumers  
• Lack of information for public on rationale use of TM/CAM |

*Sources*: *World Health Organization*, 2000
Chapter 6:

*Spiritual Embodiment of Herbal Medicine to the Indigenous Ghanaian Culture and Ways of Life*

Ghanaian health care approaches like many other African and indigenous peoples are based on the understanding of the human being. The Being is understood in the Indigenous Ghanaian society as a force. Consequently the human being is the immediate manifestation of spiritual power or force. According to Hevi (1989) most indigenous Ghanaians see life as a total, integrated, contemporaneous experience of existence in all dimensions that is, the spirit and physical, social and personal. The physical being is thus the manifestation of the spiritual force that essentially constitutes the human being. Since the physical is the manifestation of the spirit, any physical infirmities point an in-depth spiritual concern. To the Ghanaian, sickness does not only mean the pains in the physical body or the malfunctioning of cells in the body. The concept, though complex, it indicates an imbalance within the human being and the community that must be healed or reconnected. This view on health further reflects an understanding of the individual as truly human only as an integral member of the community. Good health, then, is well being resulting from personal and communal integrity (Hevi 1989).

Healing, in the Ghanaian’s sense, is the harmonious restoration and wholeness in humanity and its relationships to the physical, psychological, social, moral, economic, political, and spiritual. When disharmony occurs, it is experienced as illness in the family, clan, and community. The causes are multiple: they could be related to ancestral wrath, evil spirits, and natural circumstances. In order to restore harmony, ancestors are either directly or through the healers consulted in order to
establish the true cause and the healing rituals to be performed. Many forms of rituals and practices are often performed. Through these rituals, unity and healing are achieved.

Spirituality informs Ghanaian of the past, present, and the future. All happenings in the physical are a manifestation of what is happening in the spirit world. This, therefore, establishes the indigenous traditional healer as a very important and respected personality in the community. The whole process of healing engages the spirit and seeks to reconstruct ones wholeness. Sacrifices are normally made, which are special rituals of offerings made to the ancestors to ask for favour for healing the land, the body, broken relationships, and offer protection.

The role of Spirituality in the work of the traditional healer and the whole creed surrounding healing is explicitly stated in the Akan proverb, “se Nyame ma wo yaree, osan ma wo hahama a esa yaree no,” which translates to mean “When God gives you a disease, He also gives a local plant to heal it.” With the view that diseases are more than an abnormality in the physical body, it is believed that two forces, the physical which is seen and the spiritual which is unseen contends in the world. Although unseen, the spiritual or supernatural exerts a powerful influence over the natural or visible world, and it is responsible for all that goes on in the physical world. So, to the indigenous Ghanaian, a disease is caused by any detachment in the spirit world which is then reflected or translated into a physical infirmity. Therefore, to experience healing, one must consult the spirit world. The traditional healer, therefore, bears the responsibility of assisting the sick to reconnect to the supernatural or the spirit world that gives complete healing. Spirituality, therefore, is seen as an embedded ontology in the healing process. Healing is thus characterised by the supernatural cause of illness, and therefore the need for consultation and divination to
diagnose and establish healing. It is the belief of a spiritual healer that one cannot treat illness without adequately dealing with the “spiritual” factors which ultimately account for all illness and other human misfortunes (Geest, 1991; Ngokwey, 1994; Bierlich, 1995).

6.1. Ontology of spiritual healing

It is a well established fact among scholars and the academia that more than one ontological methods of knowledge exists in the medical or healing field. However, the most popular and usually acclaimed as the best is the scientific and chronological medical practice. An important aspect of healing that has to do with the spirit is most often ignored. In the Ghanaian context, spirituality constitutes the most important aspects of human being. Speaking of spirituality as a major component of human existence is part of the decolonization process and the establishment of indigenous knowledge as a viable way of knowing. The process of decolonization involves two parts; first to resurrect one’s own history and to find out how it has contributed to the history of the world and second, to rewrite colonial history to show how it has led to poverty rather than progress (Graveline 1998). An ontology on spiritual healing stems from the inherent role played by spirituality in the daily life of the Ghanaian community. Spirituality is established as the major force behind existence. Hence, ignoring such phenomenon mean ignoring ones existence. The living practices of indigenous Ghanaians hover around maintaining a healthy relationship between oneself, the Supreme Being, ancestors, deities which are in natural phenomena such as trees, stones, rivers, stars etc and other gods. A break in connection with the spirit world results in physical sickness that could only be cured or healed in the spirit before it can manifest in the flesh. Since spiritual ways of knowing has come to establish itself as a major source of knowing especially among
indigenous communities, I believe an ontological approach to its study is in the right direction.

6.2. Reasons for diseases

Sickness is traditionally seen as a metaphysical happening; hence, it takes more than the physical to heal. Spirituality is therefore not an after-thought; it is an embedded ontology of healing. Whenever one is sick, there is the call to examine the relationship that exist between the known and unknown, the spirit and the body, visible and invisible, natural and the supernatural. Against this background, traditional or indigenous healing systems have its bases on the supernatural causes of illness or diseases. Hence, healers concentrate more on the “why” of illness than the “how” of illness. In other words, the magico-religious aspect of disease is reckoned to be more important than the pathological effects (Acheampong, 1989). As noted (ibid, 1989), Seek ye first the supernatural cause, remove it, and all pathological afflictions of the body will be put right.

According to Foster (1988) the following can be seen as causes of illness as conceived by the traditional medical practitioner:

(i) “Angry deities who punish wrongdoers, e.g. Those who violate taboos
(ii) “Ancestors and other gods which feel they have been too soon forgotten or otherwise not recognised.
(iii) “Sorcerers and witches, working for hire for personal reasons
(iv) “Loss of the soul following a bad fright that jars it loose from the body or as the consequence of the work of a sorcerer or supernatural spirit.
(v) “Spirit possession, or the intrusion of an object into the body
(vi) “Loss of the basic body equilibrium usually because of the entry of excessive heat or cold into the body
Foster (1988) further subdivides these causes into two broad categories: first, “the personalistic which are characterized by the purposeful intervention of sensate agents (deities, evil spirits, sorceress) who, whatever their reasons, seek out a victim who fall ill … aggression or punishment is directed against a single person as a consequence of the will power of a human or supernatural agent being or” (p.15). The second is the Naturalistic, which looks at illness from impersonal systemic terms. The intrusion of heat or cold into the body upsets its basic equilibrium. In this case, the balance of humours (liquids) of the dosha of Ayuverda or the “Yui” and “Yung” of Chinese medicine must be restored if the patient is to recover.”

The work of the traditional healer is explicitly described in a popular Akan proverb: “odunsini dea ne se ote aduro, nso ayaresa fri Nyame.” This is literally translated to mean the work of the traditional healer is to get the herbs, but the actual healing comes from God. This proverb undoubtedly explains the philosophy that lay at the base of healing in the traditional setup. Sickness, in the first place, is seen as a punishment from the ancestors or the supernatural power. Given the fact that sickness is caused by the ancestors for various reasons, if a traditional healer does not cooperate with the gods to identify the actual truth behind the sickness, the healer will not be able to properly diagnose the illness and therefore cannot recommend the right herb to cure it. Thus, it is possible for a healer to misdiagnose a disease if the supernatural world is not consulted. Since the spirit world is seen as the most significant element in the healing process, it is important at this point to take a look at the hierarchy in the spirit world.
The most powerful deity in the spirit world, according to the indigenous Ghanaian belief system is the Supreme Being. The Supreme Being is regarded as the greatest of all deities and has diverse names. These include “Onyame” among the Akans, “Mawu” among the Ewe, “Ataa Nyumo” among the Gas. Knowledge about the Supreme Being is seen as innate to almost all traditions in Ghana (Sarpong 1974). Expressions such as “Obi nkyere akwadaa Nyame” (Nobody shows God to a child). God or the Supreme Being is seen as the originator and the one who sustains the universe. Not only is the Supreme Deity a giver and helper, but also He has personal qualities such as all wise, eternal, terrifying, invisible, omnipotent, omniscient, and omnipresent. The Akans of Ghana believe that the Supreme Deity prayers in the form of libation and worship are offered to the Supreme Deity through the lesser gods. When the lesser gods that deal with human suffering fails and the ancestors slumber or turn away in times of trouble, then the Great God can be appealed to. He is the final resort in times of trouble (ibid). A Traditional healer will therefore never begin any healing process without acknowledging the power and wisdom from the Supreme Being. From the diagnosis to the treatment, power is sought from the Supreme Being by the traditional healer.

Since the Supreme Being is all powerful, it is believed by the traditional Ghanaian that one cannot worship Him directly. Therefore, He has provided deities through which one can worship Him. These deities are often identified as being present in rivers, trees, sacred groves, reserved forests, and stones. The deities range from great tribal gods to little deities. Sarpong (1974, pp. 1-2) groups them into four main categories. The ones generally worshiped by one tribe like river Tano; those worshiped by inhabitants of certain town, localities or traditional area; those worshiped by the smaller sections of the community such as the special lineages or
village companies; and lastly those worshiped each day by individuals or their households, these may be in the form of ornament or charms hanged on the body or in the house of the individual. Since sickness or diseases are mostly seen as a punishment from the gods, the traditional healer needs to do a spiritual cleansing of the individual to seek for forgiveness from the deities and ask for deliverance in the form of healing. Deities could at times possess a healer leading him or her to the forest to get a particular plant that could cure a disease. The important role of the deities is evident in a proverb that read “he who is not granted health by the gods will not get heal.” As indicated earlier, diseases are punishment from the gods or deities, and only the gods or deities have the power to allow healing. The deities are therefore believed to be the cause as well as the answer to all forms of diseases in the community.

The next in chain of command is the ancestors. Ancestors are relatives or relations that are deceased but are believed to live in the spirit and serve as a guard to the living. Ancestors play a very important role in the whole process of healing because of the interconnectedness and unity that exists between the livings, dead, supernatural, and the divine and the environment. As stated earlier, ancestors are “departed” members of a family or a clan who maintain a relationship and care for the living. They have special capabilities because they no longer experience the limitations of human beings. Ancestors perform many roles: unifying families and people, caring for each other, empowering, blessing, rewarding, inspiring, protecting families and clans from diseases, evil, enemies, and even in war. They also mediate between people and the Divinity; enforcing discipline in case of breaking social values and facilitating holistic healing (Maryknoll: Orbis, 2000). Ghanaians use of ancestors in daily life points to some fundamental beliefs and principles. First, death
meant a transfer of life from a physical to a spiritual condition. So the dead are not
dead, they are within and around the household as parents who are still maintaining
their parental role. Hence, they are believed to be involved in family affairs.

Secondly, the communion between the living and the ancestors never ends. It
goes on forever. Ancestors are also believed to be clothed with supernatural power
from the Creator. Therefore, they are capable of protecting the members of their
family, clan, and community wherever these members are. Additionally, ancestors are
believed to have needs just like their surviving descendants. It is therefore the
responsibility of the livings to meet the ancestors’ needs. Failure to meet these needs
can result in retribution, which can be in a form of sickness or misfortune. These
ancestors make their presence and manifestation felt with the living through dreams,
appearances, visions, sounds, and incarnations through animals such as: birds,
butterflies, bees, snakes, lions, and sometimes through diviners, mediums, and
traditional healers. It is however important to note that not all deceased relations
qualify to be considered ancestors. Individual who had lived exemplary lives may
qualify to be considered ancestor. This ancestral status is believed to be given by early
or old deceased relations. Relations who may qualify to be named ancestors may have
their names given to newly born babies so as to keep the good name of the family.
The traditional healer is firmly aware of the fact that if these ancestors are not
consulted in times of sickness, they can be prevented from knowing the cause and
treatment of illness. This is so because some diseases are believed to be the result of a
curse from an ancestral spirit who might have been offended or disobeyed. In this
regard, the healer pleads for forgiveness on behalf of the sick so that the ancestral
spirits may provide or show the cure for such illness.
6.3. The Healing Process

The whole process of diagnosis goes with a ritual for mercy and forgiveness that seeks to reconnect the spirit world with the physical, which is believed to be broken when one is sick. Indigenous traditions uphold the interconnections that exist between the Supreme Being, the environment, the deities, and ancestors. The whole process of healing must therefore appeal to the Supreme Being, Deities, and ancestors. In getting the herbs, herbalists need the guidance and direction of the spirit. It is believed that plants in themselves don’t have the sole ability to heal. It is the powers invested in them by the spirit world that gives its potency to heal any form of disease or sickness. Most spiritual and indigenous healers in Ghana believe the ancestors and the spirit world relate to them through dreams and visions in which specific plants are described or given with instructions on how to cure particular disease. Patients who had offended the ancestors or gods through disobedience need forgiveness from the ancestor before their sickness can be healed.

Training as a spiritual healer recognizes and upholds holistic education that espouses the importance of spirituality and recognizes this complexity by speaking to the idea of wholeness (see Miller, 1989; 1997; 1999). Training healers in Ghana takes into recognition the physical training as well as the metaphysical and their interconnection and effects on each other. It is a fundamental believe among most traditional healers in Ghana that for one to be a spiritual healer one needs to be called. Most spiritual herbalists will recount their stories of how they got themselves into the profession. For example, one healer recounts his experience:

... Healing is in the family… but mine is spirit possession. In the beginning it was like “adava” (madness) … I saw things and I was violent when people tried to talk to me. One day I had a visitor, a strange person, I cannot give you any more description about how this person looks …. It will be like showing our nakedness in public. The visitor gave me a calabash and some cowry shells and said they (the deities) had selected me….. They gave me detailed directions about how to
communicate with them and they gave me the names of people in the village who will supply me with the items to start my work; … is one of those people you can ask me. After that they came for me and took me into the forest several times, sometimes I stayed for three to seven days without food and they showed me all the plants that I can use to treat people … even now as soon as the person comes with a problem the first thing I do is to call them (the deities) to find out what is wrong before we can do anything … The music makes them respond quicker (Tsey, 1997, p.1065)

Music forms a very important component of training and healing. Music used during such periods has these benefits: first, to invoke the spirits of the deities and ancestors. Second, it prepares the heart of the healer to receive guidance from the spirits. The deities are believed to appear to these healers at specific times in the day, most often in the night. These healers are then drawn into the bushes where spiritual direction is given of a plant and its significance in curing diseases. Healers are shown medicinal plants based on their obedience to the wishes of the gods or deities (Tsey, 1997).

Twumasi in his book *Medical systems in Ghana* outlines some systematic training for traditional healers in some parts of Ghana. He refers to “training school” and gives an outline of the course content year by year for the three-year period of the student practitioner’s training until he graduates to the status of a fully trained traditional medical practitioner. He then follows with a description of the ceremony at the shrine and the routine shrine procedure. The training starts with a ritual bath in the cemetery to enable the candidate to get in touch with the spirits of his ancestors. The training includes the observance of certain taboos, chief among them is taking a vow of celibacy, learning the names of herbs and their medical and spiritual properties, learning how to dance to call the god (deity) whom the candidate is training to serve, learning how to construct charms and perform propitiation by laying the fetish on the ground and kneeling in front of it and holding a live fowl. He or she is then told to cut off its head and allow the blood to drop upon the fetish, repeating certain words he or she has learnt from his or her trainer. During the third year he or she learns the
techniques of water gazing and the art of divination. When he or she has attained proficiency, she or he will be able to see the faces of spirits or ancestors in the water and communicate with them. Other rituals followed until the graduation day and thereafter. Learning and training is done all through seeing and imitation. In other words, all instructions are given orally; there is no written literature to refer to. The period of training may last for three years in normal cases but may go on for ten years or more or even until the master dies.

Traditional medicine is closely linked to the culture of the Ghanaian and as the case may be among most African societies. Culture as most of us know may be defined as the way of life of a given society. It depends on the beliefs, customs, and traditions handed down from one generation to another. The Traditional Ghanaian society has for a long time subscribed to a certain set of beliefs and engaged in practices, which when taken together, may be said to make up the traditional religion of the Ghanaian. Being a heterogeneous society there are variations but the underlying theme of all these practices and beliefs are the same. There is the overall belief in God as the Creator of the universe, almighty powerful, just, beneficent and omniscient; the belief in ancestral spirits who represent the soul of the departed kinsfolk; the belief in lesser gods (deities) of the supernatural world who derive their powers from God. Such powers include those for rewarding and punishing. These deities are often associated with trees, river, mountains, rocks, etc. using them as their habitation. As spirits, the deities could come and go at will (Acheampong, 1989). There is also the belief that certain plants and animals (dogs, Cats) form sacred relationship with certain communities for historical reasons and are therefore untouchable for the special powers they are deemed to possess (ibid). Then, there are the spirits of mystical powers e.g. agents of “witchcraft,” magic and sorcery with powers to aid or
harm man. Lastly, there are the “charms, amulets and talismans (suman) used for protection or for offensive purposes.” Ones health is dependent on the good relation or connection that is established between an individual and the chain of authority; from the supernatural being, ancestors, deities to the other smaller gods.

6.4. Categories of healers

The elders, both men and women, play a major role in healing process in an indigenous Ghanaian setup. Owing to their wisdom and life experience, they are able to see when harmony is disturbed and also if ancestors are displeased. The elderly are the advisors of the community. There is no general trend of gender differentiation as that depends on the roles played in that particular ritual. The paternal or maternal aunts depending on the type of that particular society (patrilineal or matrilineal) have also special roles in the ritual performances in their clans (Acheampong, 1989). The paternal aunt plays a crucial role in the health of the brother’s children in her clan, and the first-born male plays a major role in the healing of his clan members. A curse might be placed on someone by their parents or ancestors. Then the person confesses and discloses what the problem was. The elders will speak on behalf of the person and try to arrange reconciliation. Some healing activities are performed by first-born males or females in a clan. These people, because of their birthright, play key roles in some family rituals.

The spiritual role of indigenous healers as assigned by the gods in the Indigenous Ghanaian communities is genderless. Therefore, a diviner or spiritual healer could either be male or female who has been called and ordained by the ancestors. She or he uses divination to communicate with the ancestors and also to understand causes of sickness and healing rituals or processes required to address the problem. Divination includes acts such as the reading of palms, dancing, falling into a
trance, throwing bones or shells, prayers, reading of water, reading of a mirror, and reading the stars (Maryknoll, Orbis, 2000). According to Acheampong (1989) when it comes to the physical examination, the traditional practitioners are limited in the interpretation of the signs they observe or able to elicit: “The average traditional healer him/herself is therefore not very accurate in his or her methods of diagnosis and most often leans heavily on a method of oracle or omens or from contact with the supernatural or divine forces. This may mean calling a specialist in divination if the practitioner himself or herself is not trained in, or endowed with powers of divination.

At the core of the healing practice among indigenous healers is the concept of “holistic healing.” The concept has at its pedestal the idea that a sick person is the one whose system is deranged and therefore lacks a unity of personality. So, unlike the orthodox doctor who will give patient aspirin to cure headache and tries to locate other reasons for the persistent headache, the traditional healer believes there is a specific underlying cause of headache which the healer tries to identify before treatment is made. Hence, most healers will begin by calling the “spirit” to infer from the cause of the illness. Consultation with the gods is the major method used in the diagnosis of a patient’s illness. Some are done with or without the effort of the sick person. Methods used in diagnosis include the interpretation of gestures and utterances which usually composed of “unintelligible” language from the priest and usually interpreted by the linguist of the priest known locally as Komfo Kyeame. The priest can also gaze into a pot or a bowl of water, or a mirror to communicate with the spirits or the divine world. Another method mostly used in diagnosis is the use of cowries shell. This is thrown randomly on the floor or specially laid mat. The healer then interprets the formation of the cowries which is believed to contain a message from the spirit world. Additionally, the spiritual healer aside from the diagnosis must
consult divination to make possible for the practitioner to know which remedy to apply after the cause of the illness has been established. Hence in the words of Acheampong (1989), divination is at the same time a diagnostic, therapeutic, and prognostic tool. A session with a herbalist typically lasts one hour or more depending on the condition of the patient.

One important feature of indigenous spiritual healing has to do with what Tsey (1997) refers to as a residential care. This normally involves patients moving in to live as part of the practitioners’ extended family. Most cases involving residential care patients are often related to patients with mental and other psychological cases. If spirituality is to have a continuous significance in the Ghanaian community and its ways of life, especially in herbal medicine, its teaching must be inculcated into the school curricular. Teacher and student must build a mutual relationship that seeks to promote and defend the rights of the herbal practitioners and indigenous knowledge in general. Students must not only be thought the chemical and therapeutic properties of plants, but also thought the ancestral, traditional, customs, and ritual that goes with them. If students are trained in the importance of respecting and honouring indigenous ways of life they will serve as a major instrument of change in the society. As Jones (2005) notes:

Spirituality in education refers to no more—and no less—than a deep connection between student, teacher, and subject—a connection so honest, vital, and vibrant that it cannot help but be intensely relevant. Nourishment of this spark in the classroom allows it to flourish in the world, in the arenas of politics, medicine, and engineering—wherever our students go after graduation. (p.3)

6.5. Challenges to spiritual healing in Ghana

The first challenge of spiritual healing in Ghana is the subject of authenticity. This can be attributed to the commoditisation of spiritual healing in Ghana. Spiritual traditions are now public property and no longer the private preserve of the parochial
groups (York 2001). The holistic and sacred nature of indigenous healing has been
given up. Time is not given to establish the broken link between the ancestors and
ones physical sickness. Previously, indigenous healers never demanded any reward
for establishing a link between a sick individual and the spirit which results in
healing. It used to be a token of appreciation and usual “thank you” after recovery.
But, today, things have changed. With the increase in the cost of living coupled with
the new policy that herbal practitioners have to register and pay for the license fees,
the herbal practitioners are now increasingly demanding monetary payments for their
services. This has ultimately affected the spiritual component of traditional healing
because spiritual things cannot be bought or swayed with money.

Second, the introduction of Christianity, Islam, and other organised religious
organizations has exacerbate the challenges facing indigenous spiritual healers. With
the introduction of these organized religious institutions in Ghana, the focus had
sharply shifted from spiritual traditional healers to “spiritual men and women” in
these religious groups. The work of traditional spiritualists has now unfortunately
been termed by this organized religion as something negative and destructive. Thus, it
came as not surprising that many Ghanaians viewed the work of indigenous spiritual
healers as unpopular and negative.

Third, modernity has also had its toll on the work and role of the spiritual
healers in Ghana. With the introduction of ultra-modern and highly-equipped hospital
and centres all around the country, there appears to be visible or physical explanations
to causes of diseases. In addition, modernity also tends to give a logical explanation to
every occurrence in society. Thus, the logical manner the traditional spiritual healers
follow to diagnose diseases and prescribe medicine has become more unpopular.
Thus, it is not surprising that majority of Ghanaians are shifting their attention away from the traditional spiritual healers to the hospitals for answers to their illness.

Fourth, the rise of herbatologist in Ghana has made the work of the spiritual healer even more difficult. Herbatologists are scientifically trained medical practitioners who use basically tree plants, roots, and barks to treat various forms of diseases. Since these practitioners basically use the same elements used by traditional spiritualist in a more “hygienic” condition, most people are comfortable receiving treatment for their illness from these new groups of practitioner rather than the native spiritual herbalist who is often termed dirty and unkempt.

Five, the lack or inadequate support for herbal spiritual healers from government and state-owned institutions is another big challenge facing spiritual traditional healers in Ghana. Unlike their counterparts in the orthodox hospitals and clinics, traditional spiritual healers have no legal backing. Hence in the period of death, damage, or deformity of patients, the herbal spiritual healers are made to face the full vigour of the law (CSIR, 1990).

Six, the commoditisation of traditional African medicinal knowledge is another move hindering the work of spiritual healers. Views on this topic range from categorical rejection of the process of commoditisation to views that the process could be an act aimed at liberating indigenous communities and making them part of the “proper civilization”. It is argues that knowledge from indigenous communities are acquired through the exchange of ideas, hence product from these exchanges could be used by both sides without guilt. This debate is often characterised by generalisations and a lack of empirical engagement (Vermeylen, 2008). As a requirement to be recognised and given needed assistance, most healers are asked to formally document their practices and procedures. These are intend sold out or published for public use
without permission or reference from the originators of such knowledge. This also becomes a requirement for recognition to the effect that healers who are not recognised by such standard are termed quack or inefficient. Since spiritual issues are not easily documented, many healers are left out in the race.

Seven, One other issue worth noting is the failure of the academia and the scholarly world to recognise the existence of other methods of knowing aside the Eurocentric model. Most people who have received western education have lingering doubts of the effectiveness of indigenous spiritual healing in Africa. The belief rests on the erroneous assumption that because indigenous spiritual healing is not empirically proven, its existence and practices should not be encouraged.

Archeampong (1989) argues that the effects of colonialism on the Ghanaian culture needs to be looked at. Part of the imperial ideology is to always portray the colonised knowledge and practices as the inferior “other.”
Chapter 7:

Current Trends in Traditional Healing in Ghana: Conclusions and Recommendations

For a long time, Ghanaians have lived with the impression that traditional medicines were not good; it is time we consider such viewpoints once more. Despite the decline in herbal use with the coming of Europeans and the subsequent introduction of conventional health care practices in Ghana, studies have shown that herbal medicine still holds a vibrant role in the dispensation of good health practices in Ghana. Most Ghanaians are realizing the potency and prospects of using herbal medicine despite the opposition from conventional medicine. In spite of the legitimate concerns such as packaging, over emphasized healing properties of herbs, non-hygienic preparation, and the absence of dosage to mention but a few, herbal products have survived comparing it to other indigenous setups such as African Traditional Religion and some socio-cultural practice which have been acculturated. Many Ghanaian are quick to point out the differences between herbal medicine and other forms of alternative cares. It is evident that Ghanaians regard Herbal medicine as an alternative not just complementing conventional medicine. The history of herbal medicine in Ghana can be traced to the very beginning of Ghanaian homes and livelihoods. Herbal medicine has been an integral part of the daily lives of many Ghanaian homes. It was with indigenous Ghanaians since time immemorial and I can positively predict that herbal medicine will continue to be with Ghanaians. Most Ghanaians irrespective of their age, educational level, socioeconomic status, and religious affiliation have one way or the other used herbal medicine in a life’s time.

The increasing number of patients who turn up at the Mampong Centre for Scientific
Research in Plant Medicine for treatment goes a long way to show how Ghanaians are embracing the concept of good health care provided by both the orthodox and traditional practice. Today, approximately 300 patients visit the centre each day (Boateng & Darko, 2008). Usually, patients turn to either orthodox or herbal medicine depending on the extent of illness. Either approaches treat simple and complicated illness. Ghanaians use herbal medicine for diverse reasons. Most importantly, it offers an alternative to the dominant conventional approach in diagnosis and treatment. Herbal medicine is easily accessible and affordable for majority of Ghanaians especially in Africa. The doctor patient ratio is much better with herbal practitioners than the orthodox medicine practitioners. Also, traditional herbal medicine has fewer side effects, and it is more holistic than the orthodox medicine. As a spiritual pluralistic society, Ghanaians have a strong spiritual attachment to the use of herbal medicine.

From the study it is clear that if herbal medicine will reach a 100 percent usage among Ghanaians, both traditional and orthodox trained practitioners must come together and fashion ways of enhancing the potency of herbal medicine. Engaging science in herbal medicine preparation is not to replace the role of traditional healers but to enhance their knowledge by introducing facilities like laboratories to test the efficacy of the herbal medicine. Again, since spirituality plays central role in the general life of Ghanaians, it is important for the health system not to ignore questions of spirituality in its practices even if there is no empirical evidence to support its existence and relevance to indigenous healing. Therefore, if there would be a comprehensive medical system for Ghana, spirituality must find its way into the practices.
Furthermore, the study shows that though traditional healers and orthodox practitioners need to work together in order to have a comprehensive health care system for Ghanaians, the elements of suspicion, secrecy, ineffective communication, and creating of hierarchies of knowledge hinder their common cause. Thus, it will serve a better purpose if efforts are made to bridge the growing gap between orthodox medical practitioners and the indigenous medical practitioners. Furthermore, the study shows that most Ghanaians are developing more trust and interest in herbal medicine because of the scientific approach given to it, especially with the emergence and progressive work of the CSRPM.

The study has also shown that though all successive Ghanaian governments beginning from its first president, Dr. Nkrumah, through many initiatives showed some interest in developing traditional herbal medicine research, these efforts are often meet with quarrel and power struggles among practitioners making it ineffective. Additionally, examining the current collaboration between practitioners of both orthodox and herbal medicine, vis-a-vis the culture of the people, Ghanaians would rather benefit from a concurrent development plan that would improve both traditional and orthodox practice that collaborate and complement each other.

7.1. Pedagogic and Instructional relevance of dissertation for classroom practitioner of Indigenous Science Education

Pedagogically, this work re-echoes and incites the reader and class room practitioner to consider alternative ways of knowing and understanding the world. If indigenous science education is to be taught and learnt in its rightful context, through the lens of the indigenous tradition, the educator must recognize and validate indigenous ways of knowing. Accessing and understanding indigenous healing practices strictly through Eurocentric approach may be problematic for educator and
medical practitioners. According to Battiste (2003, p.2) “the problem with this approach is that indigenous knowledge does not mirror classic Eurocentric orders of life. It is a knowledge system in its own right with its own internal consistency and ways of knowing, and there are limits to how far it can be comprehended from a Eurocentric point of view”. It is very relevant for educators in medicine to recognize the fact that there cannot be a single perfect system that would ensure total health for Ghanaians. However if both alternative and conventional system are rightly harnessed and encouraged to co-habit, it will go in the long way achieve a better health care for Ghanaians It also befalls on educator and policy makers to develop and support indigenous knowledge innovations in Educational institutions. There is also the need to develop new certification and assessment of knowledges originating from indigenous communities and to recognize and encourage indigenous research and ideas in the class room works.

7.2. Recommendations

First, all stakeholders both in government and individuals must put in more effort to tap herbal medicinal knowledge from indigenous practitioners. This I believe could be done by educating practitioners and teaching them how to document plants and their therapeutic properties for future generations. As an advocate for indigenous ways of knowing, I am not asking documentation in English language or any colonised language but the local languages of herbal practitioners. Since almost all local languages in Ghana can be written and studied just like English language I suggest an intensive education for herbalist in the local dialect like Twi, Ewe, Nzema, Dagari and the rest. As Bonsu (1989, p.ii) rightly notes:

Ayaresa mu no, esƐ sƐ, yen man, yi mu Nnusinfo, Nuoroyofo neyen nuanom ‘Adoctxfo’ bƐmm,den twer’ anaasƐ yeda nea yƐnƐm na yasua, adi de kyere afofor. EnsƐ sƐ yƐgyina se ebia, Borofɔ kasa nkooa so tumi kyere adwene wɔ
This literally translated means: “healing in the Ghanaian context must bring together herbalists, medicine men, and western trained doctors to teach or practice what they have learnt not only in the English language but in our local dialects so as to preserve herbal knowledge of roots, leaves, and plants”

Secondly, it is important that all medical practitioners in orthodox and herbal medicine have a standard health care that cut across all board. Amo (2008) noted that the practice is like treating different bodies and contradicting each other all the time. The body of patients who are in desperate need of help then become mechanical object played about by doctors from both sections (ibid). This I believe is not necessary but a crime against responsibilities as medical practitioners to their patients. It is worth noting that the difference between herbalists and orthodox practitioners is not necessarily the way they think but the way they use therapies. It is therefore suggested that for the health delivery system in Ghana to function well with less or no squabbles, there must be a standards of care that hold all practitioners equally responsible “for working with a problem solving algorithm based upon how the human body works: structural integrity, mechanical integrity, balanced muscular integrity, neuro-regulatory function, pscho-spiritual integrity, energetic integrity, metabolic, genetic and occupational factors (Amo, 2008, pp1-2).

Third, herbal medicine considering its historical and cultural settings must not be left to the scientific paradigm with the coming of CSRPM. This is because of the metaphysical component of herbal healing. In recognizing the scientific aspects of herbal medicine, one needs to be cautious of not relegating spiritual and ritual aspects of the practice. This will ensure that herbal medicine meets both physical and spiritual components of its embodiment.
Fourth, just as various measure have been put in place by the government of Ghana to enhance the services of conventional medicine, attention must also be given to traditional herbal medicine. Budgetary allowances must match that of conventional system. Government must enhance efforts by the Centre for Scientific Research into Plant Medicine (CSRPM) and other private herbal health post such as Top Herbal Clinic, Amen Herbal Scientific clinic, and many others that are springing up in the country. In so doing, the government must put in effective regulatory bodies to periodically check the works of these health posts.

Fifth, although I am not absolutely in support of advocacy for the separation between spirituality and religion, I think such idea will not be bad at all considering the fact that many people use religion to disregard the potency and usefulness of herbal medicine. Most Ghanaians refuse to use herbal medicine because it is regarded as fetish, unchristian, and “traditional”. It is imperative for Ghanaian to realize that herbal medicine is a different field of knowing though has a link to African Traditional Religions and some of its practices. Therefore it is crucial for one to separate herbal medicine from African Traditional Religion since over 70 percent of Ghanaians either profess to be Christians or Muslims.

Sixth, integrating herbal medicine into the national health care policy of Ghana would be an action in the right direction. There must therefore be a much stronger national policy and regulatory framework on issues pertaining to safety, efficacy, quality, access and rational use of traditional herbal medicine. Furthermore, there must be a clear policy on intellectual property rights and equitable benefit sharing relating to herbal medicine, Indigenous Knowledge, and products made complex by biopiracy, and unsustainable use of medicinal plants (Mwangi, 2004).
Seventh, it will be of much benefit if both traditional and orthodox medical practitioners recognize and work on their similarities instead of differences that exist between the two medical systems to provide a comprehensive medical care for Ghanaians. Efforts must be made to make the real intentions of researchers known to traditional healers (Foote, 1999). Scientist doing research into plant medicine must take into account “that though anyone can learn the use of herbal medicine, in environments where people still have a strong connection with their religion and culture, an outsider may not be socially acceptable to practice as a healer” (ibid, p.37).

As Foote (1999, p.37) rightly notes:

Ghana sits on top of a gold mine of thousands of different plants, roots and herbs that may contain chemicals to treat and cure diseases that are currently leading to humans’ potential extinction. If actions are not taken soon to study, preserve and protect these medicines, these medicines may find themselves along with every other African product that foreigners have deemed profitable and thus exploitable in the hands of foreign control.

An effective health delivery system for Ghana must be one that inculcate and tolerate both orthodox and traditional practitioners. Standards, measuring up to principles, theories, and beliefs pertaining to each system must be systematically adhered to so as to produce only the best. Conventional health approach must not be seen as the paramount or better health system. Instead of establishing a pecking order or hierarchy, both approaches must be encouraged to complement each other. In other words each must be an end in its self as well as a means to an end.
Adjei P.B. & Dei, G. S. (2008). Decolonizing Schooling and Education in Ghana. In A. A. Abdi & S. Guo (Eds.), *Education and social development: Global issues and analyses* (pp. 139-154). Rotterdam: Sense publishers


Centre for Indigenous Knowledge Systems (CEFIKS), 2009


UBC Press.


Report on Pharmaceutical sector study with emphasis on traditional medicine (Technology Transfer centre {CSIR}) Accra, Ghana 1990


of the Bono in Ghana. In Z.A. Ademuwagun, J.A.A. Ayoade, I.E. Harrison & D.M. Warren (Eds.), *African Therapeutic systems*. (pp. 36-42). Waltham, M.A:


**Note:** Sources for figures

<table>
<thead>
<tr>
<th>Scientific Name</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1: Barassus Aethiopum Mart</td>
<td><a href="http://upload.wikimedia.org/wikipedia/commons/thumb/0/01/Borassus_flabellifer.jpg/250px-Borassus_flabellifer.jpg">http://upload.wikimedia.org/wikipedia/commons/thumb/0/01/Borassus_flabellifer.jpg/250px-Borassus_flabellifer.jpg</a></td>
</tr>
<tr>
<td>Figure 2: Elaeis guineensis Jacq:</td>
<td><a href="http://images.google.ca/imgres?imgurl=http://upload.wikimedia.org/wikipedia/commons/9/9f/Elaeis_guineensis_fruits_on_tree.jpg">http://images.google.ca/imgres?imgurl=http://upload.wikimedia.org/wikipedia/commons/9/9f/Elaeis_guineensis_fruits_on_tree.jpg</a></td>
</tr>
<tr>
<td>Figure 3: Dissotis rotundifolia</td>
<td><a href="http://www.zimbawweflora.co.zw/speciesdata/imagedisplay.php?species_id=142590&amp;image_id=2">www.zimbawweflora.co.zw/speciesdata/imagedisplay.php?species_id=142590&amp;image_id=2</a></td>
</tr>
<tr>
<td>Figure 4: Leea guineensis</td>
<td><a href="http://homepage.univie.ac.at/Christian.Puff/images/Mitracarpus">http://homepage.univie.ac.at/Christian.Puff/images/Mitracarpus</a></td>
</tr>
<tr>
<td>Figure 5: Gardenia ternifolia</td>
<td><a href="http://www.zimbawweflora.co.zw/speciesdata/image">www.zimbawweflora.co.zw/speciesdata/image</a> display.php?species_id=155370&amp;image_id=1</td>
</tr>
<tr>
<td>Figure 6: Morinda lucida</td>
<td><a href="http://www.ncnhdistrict.org/aom/neem.html/www.plantoftheweek.org/week310.shtml">www.ncnhdistrict.org/aom/neem.html/www.plantoftheweek.org/week310.shtml</a></td>
</tr>
<tr>
<td>Figure 7: Azadirachta</td>
<td>indicawww.ncnhdistrict.org/aom/neem.html/www.plantoftheweek.org/week310.shtml</td>
</tr>
<tr>
<td>Figure 8: Khaya Senegalensis</td>
<td><a href="http://commons.wikimedia.org/wiki/khaya_senegalensis">http://commons.wikimedia.org/wiki/khaya_senegalensis</a></td>
</tr>
<tr>
<td>Figure 9: Ficus asperifolia</td>
<td><a href="http://www.figweb.org/Ficus/images/asperifolia/Ficus">www.figweb.org/Ficus/images/asperifolia/Ficus</a>_</td>
</tr>
</tbody>
</table>
Figure 10: Musa paradisiaca
asperifolia_ENC2064_400.jpg

Figure 11: Psidium guajava
www.rain-tree.com/Plant-Images/guava-pic.htm

Figure 12: Balanites aegyptica

Figure 13: Cleistopholis patens
http://users.telenet.be/sf16063/pauwels/CanaOdor2.jpg

Figure 14: Mitracarpus villosus
http://homepage.univie.ac.at/Christian.Puff/images/Mitracarpus_

Figure 15: Mitragyna inermis
http://www.metafro.be/prelude/prelude_pic/Mitragyna_inermis1