International Institute of Social Studies

Erasmus

The Integration of Traditional and Alternative Medicine: What Lies Behind?

A Research Paper presented by:

Roberta Aku Bleboo

(Ghana)

in partial fulfilment of the requirements for obtaining the degree of
MASTER OF ARTS IN DEVELOPMENT STUDIES

Major:

Governance and Development Policy
(GDP)

Specialization:

Local Development Strategies (LDS)

Members of the Examining Committee:

Dr. Farhad Mukhtarov
Dr. Mathias Rieger

The Hague, The Netherlands
December 2020

Disclaimer:

This document represents part of the author's study programme while at the International Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

Inquiries:

International Institute of Social Studies
P.O. Box 29776
2502 LT The Hague
The Netherlands

t: +31 70 426 0460
e: info@iss.nl
w: www.iss.nl
fb: http://www.facebook.com/iss.nl
twitter: @issnl

Location:

Kortenaerkade 12
2518 AX The Hague
The Netherlands

Contents

List of Tables *v*
List of Figures *v*
List of Maps *v*
List of Appendices *v*
List of Acronyms *vi*
Acknowledgement *vii*
Abstract *viii*

Chapter 1: Introduction **1**
1.1 Background of the study 1
1.2 Problem statement 2
1.3 Research aim 2
1.4 Research objective 2
1.5 Research questions 3
1.6 Justification of the study 3

Chapter 2: Literature and Conceptual Framework **4**
2.1 Introduction 4
2.2 Literature review 4
2.3 Conceptual framework 6
2.3.1 Healthcare Governance 7
2.3.2 Institutionalisation of TAM 8
2.4 Theoretical Framework 10

Chapter 3: Methodology **13**
3.1 Introduction 13
3.2 Research Design 13
3.3 Study Area 13
3.4 Sampling technique and sample size 14
3.5 Methods 15
3.5.1 Interview 15
3.5.2 Focus Group Discussion 16
3.6 Analysis Techniques 16
3.7 Coding of Themes 17
3.8 Limitations 18
3.9 Ethical Consideration 18
3.10 Reliability 18

Chapter 4: Analysis and Findings **20**
4.1 Introduction 20

4.2 Summary of Key Findings 20
4.3 Main actors and their respective roles 22
4.4 TAM implementation and policy enforcement 24
4.5 Challenges of TAM integration into public healthcare 26
4.6 Opportunities for TAM integration and Implementation 29
4.7 Increasing use of TAM 30
4.8 Discussion of findings 31
4.8.1 Stakeholder participation 31
4.8.2 TAM implementation and policy enforcement 32
4.8.3 Challenges of TAM integration into public healthcare 32
4.8.5 Opportunities for TAM integration and implementation 33
4.8.6 Increasing use of TAM 34
Chapter 5: Conclusion and Recommendation 35
5.1 Introduction 35
5.2 Conclusion 36
5.3 Recommendation 36
Appendices 38
References 40

List of Tables

Table 1.1 Summary of Themes 17
Table 1.1.2 Actors and their respective roles 22

List of Figures

Figure 1.1 Adopted Policy Cycle 9

List of Maps

Map 1.1 Map of Ghana 14

List of Appendices

Appendix 1 Semi-Structured FDG and Interview Questionnaire 38

List of Acronyms

AM	Alternative Medicine
CMPR	Centre for Plant Medicine Research
FDA	Food and Drugs Authority
FDG	Focus Group Discussion
FAO	Food and Agriculture Organisation
GHAFTRAM	Ghana Federation of Traditional Medicine Practitioners Associations
GHS	Ghana Health Service
GoG	Government of Ghana
HM	Herbal Medicine
ISS	International Institute of Social Studies
ITAM	Institute of Traditional and Alternative Medicine
KNUST	Kwame Nkrumah University of Science and Technology
MoH	Ministry of Health
NGO	Non-Governmental Organisations
NHIS	National Health Insurance Scheme
SDG	Sustainable Development Goals
TAM	Traditional and Alternative Medicine
TAMD	Traditional and Alternative Medicine Directorate
TLST	Teaching and Learning Support Team
TMPC	Traditional Medicine Practice Council
UHC	Universal Health Care
WHO	World Health Organization

Acknowledgement

I would like to say a big thank you to Daniel Doe of Western Sydney University for taking time off his busy schedule to review the paper, Isaac Gyamfi for his continuous assistance and encouragement throughout my study, Bithiah and Tony Singh for all the discussions over dinner and being interested in this study and my life in general.

Finally, I would like to thank all the respondents who agreed to participate in this study. I am grateful to all the authors whose works I used as part of the literature review for the study. I am most grateful to my supervisors – Dr. Farhad Mukhtarov and Dr. Mathias Rieger for their guidance and patience that lifted my spirit to ensure the hard work to produce this piece of literature as my contribution to the body of knowledge on traditional and alternative medicine.

Abstract

The use of traditional herbal medicine in Ghana is not new, but it has never been fully integrated into the public healthcare system. In 2011, the government of Ghana started the integration of Traditional and Alternative Medicine (TAM) into the mainstream public healthcare system as a pilot project. The integration was mandated by the Alma-Ata Declaration in 1978 and the Ouagadougou Resolution by WHO.

The integration of TAM into public healthcare is the government's effort to recognize traditional medicine and its practitioners as part of the national healthcare system, to promote universal healthcare for all, and grant service users their fundamental human rights. Even though the integration has been largely successful, there are still some key challenges hindering service delivery.. My research documents how the integrations of TAM into the public healthcare system was done and identify barriers and/or opportunities the integration of TAM have brought into the Ghanaian healthcare system.

Relevance to Development Studies

Better health is fundamental to human development and happiness and contributes significantly to economic growth (who.int.com). Even though the evolution of healthcare from traditional to science-based in some developing countries has attracted high research interest, existing works have mainly focused on efficacy and production of traditional medicines, whereas research on integration of traditional medicines into mainstream health delivery have fallen by the empirical wayside.

My study adds to existing literature to guide and assist policy-makers to make decisions on investment and job creation.

Keywords

Traditional, Alternative, Herbal, Healthcare, Biomedicine, Integration.

Chapter 1: Introduction

1.1 Background of the study

Ghana's health care system, like in many other developing countries was faced with competing interest in traditional medicine and mainstream healthcare. As part of the country's effort towards universal healthcare for all, the government decided to integrate TAM into the public healthcare system in 2012 under the framework of the Declaration of Alma-Ata in 1978 and the Ouagadougou Resolution in 2000. Under the declaration and the resolution, The World Health Organization (WHO) and the African Union (AU) and member states recognized traditional medicine and its practitioners as part of a national health system. The Declaration further mandated member states to govern and enact laws and policies to adequately improve traditional medicine (WHO, 2000:1).

Complementary and Alternative Medicine broadly refers to collection of healthcare procedures that are not part of the culture of a nation and are not completely incorporated into the framework of public healthcare. Traditional medicine is the sum of complete information, skills and procedures focused on theories, values and experiences of various societies used in the preservation of health as well as in prevention, diagnosis and improvements, whether explainable or not (WHO, 2019: 8). Generally, the traditional system of healing in Ghana consists of faith-based healing, traditional birth attendants, bonesetters, spiritual herbalist or mallams, and Muslim circumcision surgeons (locally known as wanzam) (Ember and Ember, 2004:109). Herbal Medicine (HM) forms a subset of Traditional Medicine (Appiah et al., 2018:2), which is an essential component in the personal healthcare for most people in Ghana. Herbal Medicine includes herbs, parts of plants materials, herbal and finished herbal products contain active ingredients. It is almost impossible to provide background information on how HM started in Ghana because it is regarded as part of a heritage which is passed on to future generations. In Ghana, malaria, infertility, sexually transmitted diseases (STDs), headaches, stomach-aches, and fever are few of the common diseases and ailments herbal medicine practitioners cure (Addo-Fordjour et. al., 2012: 240). Examples of plant medicine sold are; nimiba for malaria treatment which cost ₵6.50 (€ 0.94), aphrodisia powder for low sperm count sold for ₵20.00 (€ 2.89) and URO 500 for treating prostate and urine flow which is sold for ₵25.00 (€ 3.60) (https://www.cpmr.org.gh/).

There has been an improvement over the past decade in the use of TAM in Ghana. The increasing use of TAM over the past few decades has been linked to users seeking readily available medication produced from natural plant products (Tilburt and Kaptchuk, 2008:594). Aside from user choice and preference for "natural products", the increasing use of TAM has been attributed to challenges such as the uneven distribution of healthcare facilities, high cost of biomedicine, lack of trust and belief in biomedicine, and poor doctor to patient ratio in developing countries. For instance, the doctor to patient ratio in Ghana is about 1: 8000 (healthanddietblog.com) whiles the WHO recommended ratio is 1: 1000 (WHO.int.com).

Ghana is among the countries in West African sub-region with high prices for medicine. The prices of some medicine are also above the original baseline. The supply of essential drugs in public health facilities is also limited (56.79%) compared to private health facilities which record 86.55% (World Health Organization, 2018:42). Healthcare delivery system is

managed by the Ghana Health Service (GHS), an agency within the Ministry of Health (MoH) which works in five levels namely; health post, health centres and clinics, district hospitals, regional hospitals and tertiary hospitals. The total number of healthcare delivery facilities in Ghana is 4,000 across the country (Pharm Access, 2016).The government of Ghana since 1961 recognised the importance of Traditional Medicine, which led to the formations of The Ghana Psychic and Traditional Healers Association. In 1991, the Traditional and Alternative Medicine Directorate was established, followed by the development of the Traditional Medicine Policy in 2005 . However, Until 2012, government has given less attention to integration of traditional and alternative Medicine into the mainstream public healthcare systems (MoH-Ghana, 2005). My research reports the findings from a comprehensive analysis of the extent to which the implementation of TAM integration into the public healthcare system (PHS) in Ghana has been successful and the apparent challenges.

1.2 Problem statement

In 2011, the Government of Ghana (GoG) started a pilot project to integrate TAM into 19 public healthcare facilities (Appiah, 2012: 831). However, there has been little information on the extent to which the integration has been effective and the challenges of implementation (Boateng et al., 2016:2). For instance, Yevutsey et al., (2012:3) notes that despite the extensive use of TAM over the years, its formal acceptance into the public healthcare system in Ghana has been a great challenge . Yevutsey and colleagues mention that the massive demand for traditional medicine for a large proportion of the populace raises issues as to the extent to which the two-health delivery systems are integrated and coordinated. Appiah et al. (2018:2) notes that the efficacy of the integration of TAM into the public health care system in Ghana depends on factors such as efficacy, safety, quality, economical, prestige and competition.

However, the integration of Traditional and Alternative Medicine) into the health system is vital to improving the delivery of health services in the country (World Health Organization [WHO], 1978:VI). My research, therefore, seeks to document Ghana's TAM integration lessons and related challenges. For this study, traditional medicine in the context of Ghana refers only to herbal medicine, even though there are other forms of traditional medicine and healing.

1.3 Research aim

The integration of traditional herbal medicine has been ongoing for nine years. However, less is known about the implementation focus and the extent integration has met the program focus. I investigate what policies and regulatory measures are in place to enhance an effective integration using the WHO framework as a benchmark and WHO definition of regulation, defined as a set of rules explicitly governing the conduct of TAM (World Health Organization [WHO], 2019:17).

1.4 Research objective

I examine how the implementation of TAM integration is ongoing, focusing on stakeholder efforts and public policies on health. I also study the perception of medical professionals, TAM practitioners, religious leaders, NGO's, academics, government officials and managers on the integration and the extent of the integration process, and the challenges.

1.5 Research questions

1. Can the implementation of TAM integration be considered as "good enough governance"?
2. Who are the main actors of TAM, and what are their respective roles in the TAM implementation process?
3. How are national policies on TAM enforced in the implementation process?
4. What are the challenging factors hindering the implementation of TAM integration into public healthcare system (PHS)?

1.6 Justification of the study

Since the beginning of the new millennium, the quest to understand health care services in countries with low and middle-income has increased. My research paper, therefore, will provide additional knowledge and insights to the existing literature about the integration process in Ghana. I will also analyse the extent to which Traditional, Alternative Medicine (TAM) and biomedicine are well integrated in Ghana's Public Healthcare System with the view to inform policy decisions for the health sector.

Chapter 2: Literature and Conceptual Framework

2.1 Introduction

The literature review discusses the demand, acceptance and use of Traditional and Alternative Medicine in developing countries and a few outlines of challenges associated with the integration process. However, to the best of the researcher's knowledge not much is written on the implementation of the integration process in the public healthcare system in Ghana. I am thankful to authors such as (Bodeker 2001, Adams, 2013, WHO 2019, Appiah et al. 2018, Boateng et al. 2016) whose work identified some of the challenges hindering the integration in Ghana. The discussions of these authors describe the lack of health insurance coverage of herbal medicine as a major challenge hindering the integration process. Whiles this assessment is accurate, the lack of financial investment and government focus including other factors contribute to this challenge. Another challenge is if the government is working towards the issue of why service users access private herbal health centres and pay out of pocket but yet find it difficult to pay in public hospitals. By reviewing the related literature, it has helped me to understand thoroughly how other variables and concepts play significant roles in Traditional and Alternative Medicine integration in other developing countries.

2.2 Literature review

The debate on the integration of TAM into the public healthcare system is an ongoing issue in developing countries, but before medicine, healing existed since the prehistoric era; its beginnings are lost in the darkness of time from when no documents remain (UNSCHULD & Reimers, 2009:7). Medicine, however, is a relatively young cultural construct that endeavours to understand the normal and abnormal states of the body to prevent the strange or sick state or even to reverse them completely (UNSCHULD & Reimers, 2009:6). Traditional and Alternative Medicine (TAM) have coexisted with biomedicine for centuries now. In the past two decades, especially, there has been a significant reinvigoration and expansion of TAM around the world. As we near the threshold of the twenty-first century, there are an enormous number and variety of health belief systems active, in addition to biomedicine (O'Connor, 2014: 1). The need for integrated care became an urgent focus for the world at the Alma-Ata conference in 1978 in order encourage and protect people's health, there was a need to bridge the gap in the existing inequality in health status in developed and developing countries (World Health Organization [WHO], 1978:I).

A framework was developed by WHO to hold healthcare service providers accountable. Accountability means providing care that is universally accessible to all, equitable, financially sustainable and of good quality. In doing this, an integrated people-centred care system was needed (World Health Organization (WHO), 2016:1). Integrated healthcare is identified as health service management and delivery for individuals to access a continuum of health promotion so they can prevent, treat and manage within different levels of a collaborated system that is either within or out of the healthcare system depending on their need (World Health Organization (WHO), 2016:2). Since the focus of integration is people-centred care, an approach where families', communities', individuals and professionals' are considered to be the participants and beneficiaries in a trusted system (World Health Organization (WHO), 2016:2).

According to WHO (2000:1), to promote, protect and provide healthcare for all, there was the need to bring together biomedicine and TAM by developing comprehensive strategies that will promote the use of traditional and alternative medicines (TAM) within each country. The strategy encourages the introduction of traditional medicine procedures into health systems for which there is proof of safety, efficacy and quality and the production of such proof where there is a lack of evidence. O'Connor (2014:162) elaborates on this fact by saying, the need for evidence-based efficacy, safety and quality for TAM is needed since TAM is mostly aligned with culture, ethnicity, belief, religion, ancestry and social class. Whether ethnically identified or not it cuts across lines of the educated, middle-class, and "mainstream" groups. People who have recourse to TAM practices are most likely to do so instead of resorting to the biomedical system, and this impression has given rise to a good deal of frustration and concern in the health professions.

The frustration within the two healing systems has led to TAM being viewed with a medical centric bias lens. However, what remains less sure says Bodeker et. al., (2007:29) is that if there will be demand, acceptance, and tolerance for TAM practice within the ranks of biomedicine, then public healthcare managers, and policy-makers must help to fight these issues. Regardless of the frustration in the medical arena, health and healing consist of the healer and the patient. To prevent these two healthcare systems from competing, the state government, which serves primarily the interests of its citizens, must periodically make concessions to subordinate social groups in the benefits of maintaining social order (Ember and Ember, 2004:115), hence the integration of TAM and biomedicine into healthcare.

There are different dimensions of traditional and alternative healing systems. Traditional healing systems within African societies include herbalists, diviners and faith-based healing. Herbalist use natural things, including plants, animals and minerals. The unique healing agents form a piece of dynamic information set within the biomes of the ecosystem (Hewson, 2015:79). Diviners are generally expert in oracles or rituals; they use enchantments and incantations and have the power of foresight or prophecy. Diviners are typically the last resort for all cases of illness (Amzat and Razum, 2014:212). Faith-based healing, this ritual of healing is based on a divine bond with the Almighty God whom believers believe has solutions for all human problems. This form of healing is prevalent among Christians and Muslims. Alternative Medicine includes chiropractic science, homoeopathic science, psychic science, and even occult science (the heraldghana.com).

In developing countries the increase in TAM is attributed to factors such as high cost of prescription drugs, patient overcrowding in clinics and hospitals. There is no daily access to quality modern facilities for certain minority groups (Bodeker, 2001:164). The difficulty in the accessing of biomedicine and the lack of cultural fit also means that practitioners in developing countries do not enjoy the monopoly on medical pluralism. TAM practitioners continue to serve the vast clientele. Drawing heavenly on the problem, Bodeker continues to argue that since the 1990s, there has been a strong political controversy between TAM and biomedicine over fee concerns, the right to sell and prescribe herbal medicines and the licensing of professionals in developing countries. Expectedly, two -thirds of TAM practitioners do not want TAM solutions to be included in national health insurance. This array of problems in developing countries as indicated by Bodeker (p.165), is highlighted by the Korean experience where the absence of a robust central control mechanism is underpinned by professional conflict.

It is now well established that interest in TAM is rising rapidly throughout the world (Adams, 2013:162). Policy-makers, consumers and professional organisations have been calling variously for more significant evidence of integration of TAM and biomedical services (Adams, 2013:165). The public sector support for TAM services and comprehensive national policy for what has been a consumer-led trend in most countries is yet to receive funding, policy recognition and research attention. Some countries, notably China, India and several other Asian nations, have been working actively to build the TAM sector for the combined motives of perpetuating the tradition and promoting cost-effectiveness in health services (Bodeker et. al., 2007:18). As a result, individual practitioners, with the backing of clients and particularly influential patrons, have been able to obtain legitimation in the form of full practice right or limited practice rights (Ember and Ember, 2004:104).

Ghana currently has a dual system of medical practice that recognises both traditional and biomedical practices in law and promotes their coexistence (Bodeker, 2001:166). Interestingly, the use of TAM is very high among people with long-term conditions, and most of it is "self-care" in as much as it is not provided by the National Health Insurance Scheme (NHIS), patients choose and pay for it themselves. Encouraging parallel use will improve self-care and will be cost-saving since the National Health Insurance is struggling with underfunding. (Adams, 2013:159). Adam continues to say that for integration to be successful, TAM must marry the science with the art of medicine and, in various ways, as highlighted, challenges can result in possible solutions. According to the (Bruchhausen, 2018:34), national and international bodies, such as the European Union and the World Health Organisation aim to control the growth, distribution and application of TAM. Through this initiative, however, no African international organisation and only one African state, Ghana, has joined the organisation of the WHO.

2.3 Conceptual framework

For patients to have easy access to healthcare and also have the freedom to choose how they want to be cared for, healthcare integration is needed. Integration, according to Garcés-mascareñas and Penninx (2016:14), is defined as the process of becoming an accepted part of society. Integration is designed to build coherence and cohesion between various parts of the healthcare system in order to increase system performance, quality of care, life and customer satisfaction particularly for patients with complex and multi-problems (Suter et al., 2009:7). The culture embeddedness, the exclusion of competition, boundaries and bias in integrated care on behalf of the patient brings collaboration and positive outcomes. Governments have no choice but to restructure the healthcare system in ways that increase efficiency. The integration will reduce fragmentation in order to continue providing affordable quality healthcare.

The growing need for TAM integration into public healthcare means optimisation and sustainability of patience-centred health systems for better performance. Public healthcare integration is needed to meet the changing needs of patients and the expectations of communities (Suter et al., 2009:12). The growing interest of corporate and governmental elites in alternative medicine is related to the cost of high- technology. There is little and in some cases no financial and legal support for TAM, yet governments choose to focus, expand and accept biomedicine (Ember and Ember, 2004:115). Governance provides the framework and the support system and leadership required to achieve integration.

The conceptual framework of TAM Integration demonstrates the interaction of two characteristics: Healthcare Governance and Institutionalisation. Each of these features of TAM integration has been explained subsequently.

2.3.1 Healthcare Governance

The overlapping of health reform has been prompted not only by perceived failure in health systems but also by the quest for greater efficiency, fairness and responsiveness to the expectations of service users (WHO report 2000:13). Healthcare providers are often unaccountable to the users they serve and therefore, have limited incentive to provide the responsive care that matches the needs of their users (World Health Organization (WHO), 2016:1). Healthcare governance is needed to shape health system capacity and cope with challenges within the system in order to help the providers become more patient-centred. Some of the challenges faced by health systems are inadequate human resource, change in political government, emerging new technologies, implementation of laws to adhere to universal healthcare and financial constraints (Greer et al., 2016:4).

Healthcare governance applies to a wide variety of government/decision maker's steering and rule-making roles as they aim to achieve national health policy targets that are conducive to universal coverage (WHO.int.com). To achieve a sustainable, universally, integrated care system and for different subsystem within the health sector to work together depends on the quality of health governance. According to the Savedoff (2011:2), governance can be analysed at a secondary level in the forms of specific policies, that result in rules, institutional laws and enforcement mechanisms. The implementation of TAM integration can be successfully achieved if the principles of quality governance, which are accountability, transparency and collaboration (participation) are incorporated into the system.

Accountability

Accountability reduces vulnerability to corruption and uses the tools available to produce the best possible outcomes. Accountability means the answerability of decision-makers by providing performance results (World Health Organization (WHO), 2016:6). In developing countries, the lack of accountability in healthcare can be attributed to factors such as lack of access, user dissatisfaction, cost, abuse of power, lack of responsiveness, corruption and inequitable distribution of health facilities (Brinkerhoff, 2003:1).

An accountable system fortifies the responsibility of wellbeing frameworks and requires joint activity at all levels to move forward system administration and delivery of wellbeing arrangements in health. It also drives the public and private sector and individuals towards a common objective. To increase user/public in accountability means creating the platform for users/the pubic to turn from passive recipients to active recipients of service (Brinkerhoff, 2003:11). This can be done through participation in policymaking and involving communities in service delivery functions. Users can also be encouraged to give feedbacks on services received.

Transparency

Another quality of governance that achieves an integrated patient-centred health system is transparency. It brings consistency and facilitates collaboration among healthcare professionals. Healthcare integration involves, to an extent professionalisation and attitude. Involving stakeholders in various level of the integration process will give them a sense of belongingness, and this will help in the improvement of the system. A well-developed governance

system achieves transparent, integrated healthcare, increases collaboration and reduces hierarchical fragmentation. If people, actors, investors know how, when and why decisions are made they will contribute towards the knowledge (Greer et al., 2016:33)

Collaboration/Participation

Governance also means working together with other industries, such as the private sector and civil society, to encourage and sustain participatory and inclusive population health (WHO.int.com). For the integration of TAM and biomedicine to be effective and successful; both systems need to come together and engage in a consensus-oriented manner, this strategy of governing is known as collaborative governance. Collaborative governance is considered to be a govenance structure where one or more public entities specifically participate in a joint decision-making process with non-stakeholders (Ansell and Gash, 2008:544). This method of governance is systematic, consensus-based and deliberative and aims at creating, executing public polices or controlling public programmes. Collaborative governance arose as a reaction to the failure of downstream implementation and high regulatory cost and politicisation. It is an antidote to the pluralism of adversarial interest groups and managerialism's transparency failures (Ansell and Gash, 2008:544). TAM integration into public healthcare cannot happen in isolation. Therefore government needs to work together with TAM practitioners, biomedical practitioners and other stakeholders to develop necessary policies and laws to enhance the restructuring effectively. Collaborative governance is required as an impetus and resource to provide the accountability, foundation and leadership to accomplish integration (Suter et al., 2009: 44).

A well-developed governance system combined with accountability, transparency and actors collaboration/participation is needed to enhance the integration of TAM.

2.3.2 Institutionalisation of TAM

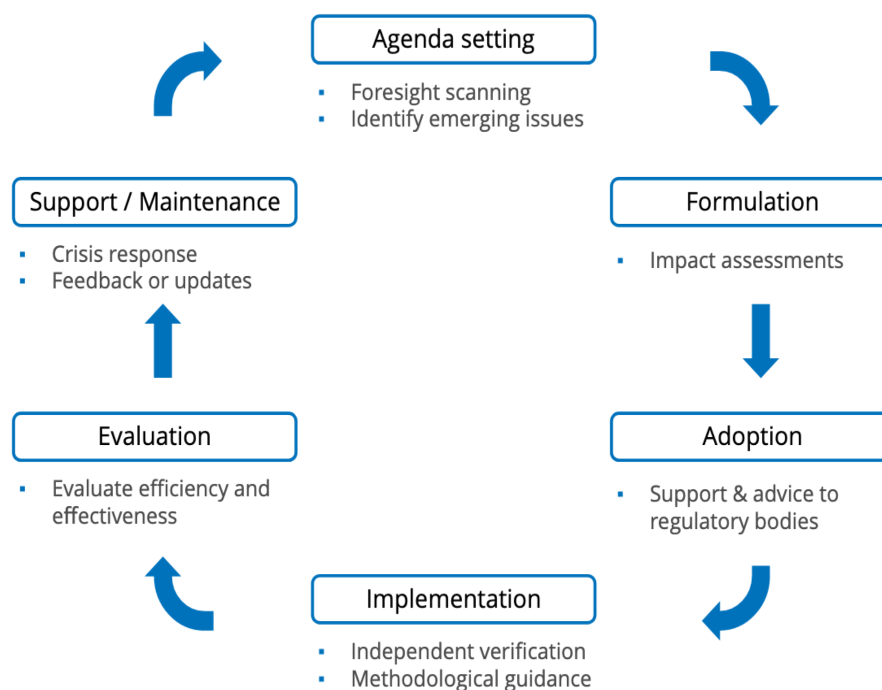
The institutionalisation of TAM integration into healthcare delivery differs from country to country. Some countries have the integration policies and strategies well implemented; there are other countries that are in the process of implementing policies; whiles others have separated the TAM healthcare delivery system from biomedical healthcare delivery system (Park and Canaway, 2019:25). Countries such as Japan and Vietnam have been able to integrate and implement TAM successfully through education and emphasis on research whiles India and South Korea have also done so but have separate systems within the healthcare (Bodeker, 2001:165). Although these countries have successfully implemented, the institutionalisation of TAM was through politicising of the health sector (Bodeker, 2001:165).

The importance of promoting the use of TAM into healthcare was a comprehensive strategy developed by WHO for African member states in order to optimise and institutionalise TAM by formulating legal policy frameworks, allocate adequate resources, improve regulations and the protection of property rights (World Health Organization [WHO], 2000:3). To promote TAM and assist member states to carry out this strategic institutionalisation, WHO developed guidelines for implementation, monitoring and evaluation of TAM. Some of these guidelines are; (i) traditional medicine implementation framework, (ii) code of conduct and ethics framework (iii) norms and standardisation models and (iv) regulatory framework for identification, registration and accreditation.

Proper integration can lead to the achievement of Universal Health Coverage (UHC), which is a sustainable development goal 3 (World Health Organization (WHO), 2016:2). Universal health coverage (UHC) means that, without being subjected to financial distress, all individual receive the quality, basic healthcare they need (WHO, 2015:IV). For UHC to be achieved, an integrated approach to medical pluralism must be the way forward, a robust program of health financing would guarantee sustainability and attract sufficient support by budgeting and risk pooling (Amzat and Razum, 2014:224). Budget allocation enhances the integration of healthcare if the government puts together a proper administration and strengthens the accountability of health systems. Ensuring accountability within the govenance system requires joint action at all levels to enhance the organisation and implementation of programs, health and non-health policy, public and private sectors and individual, against a shared purpose (World Health Organization (WHO), 2016:7).

To improve the effectiveness of scientific research is to participate in policy-making. Figure 1.1 below shows policy cycle to address how an ideal policy process from various stages of development, design and implementation. The policy cycle is made up of roughly six stages.

Figure 0.1
Adopted Policy Cycle



Source: adopted from https://www.egu.eu/policy/basics/cycle/

2.4 Theoretical Framework

To improve implementation of TAM integration into public healthcare system, the notion of integrated care, policy regulation, collaboration, finance, workforce training must be addressed. Healthcare systems are made of different functions that come to together to provide better service delivery to its users. The essence of using the framework means strengthen healthcare strategies that will lead to better implementation of TAM integration. The inclusion of various level of healthcare functions and structures in the implementation strategies mean financial, performance and political/democratic accountability (Brinkerhoff, 2003:xi).

Integrated care explains the need for TAM integration, which requires policies and regulations bring users, policy-makers and professionals to order through collaborations. Financial investment and training inspires better performance of healthcare service delivery.

Integrated care

Integration means the increase of healthcare coverage through collaboration, communication, harmonisation, and partnership building between biomedical and traditional systems of medicine (World Health Organization [WHO], 2000:1). Integrated healthcare is defined as health service management and implementation for individuals to obtain a continuum of health promotion so they can prevent, treat and manage within different levels of a collaborated system that is either within or out of the healthcare system depending on their need (World Health Organization (WHO), 2016:2). The focus of integration is people-centred care, which is an approach where families', communities', individuals and professionals' are considered to be participants and beneficiaries in a trusted system (World Health Organization (WHO), 2016:2).

Healthcare integration has four models of approach; (i) the parallel approach – where integrations of TAM is recognised but practised separately from biomedicine, practiced in South Kora and India and (ii) the integrated approach – TAM recognised through education, training and it is practised within the healthcare systems (Bodeker, 2001:165), (iii) Tolerant a health system – is where biomedicine determines what the capacity TAM can be practised (England practices this form, allowing only osteopathy and chiropractic practices), and (iv) Inclusive health system – This is when TAM is not fully integrated into health delivery, education and training but can be practised (Nigeria and Mali are examples that practice this form of approach) (Othman and Farooqui, 2015:5.9).

Policies and Regulations

Before the integration of TAM into healthcare delivery, member states were to develop a strategy which will focus on the way healthcare is delivered. The policy documents were to cut across interventions which involved expect opinions and consultations (World Health Organization (WHO), 2016). The policy framework was to include evidence-based research and safe traditional herbal medicines and practices and its related intellectual property rights (Bodeker, 2001:165). The policies were to include scientific validity requiring collaborative research from various stakeholders to discuss ethical requirement (meaning research must be reliably tested) (Tilburt and Kaptchuk, 2008:596).

The use of TAM and its implementation into public healthcare is not a "one size fit all". The enforcement of TAM policies have been implemented in diverse ways; example in Africa, several countries are searching for the best way to use TAM service as an integral part of limited healthcare packages. Whiles in countries like China and India, governments are

using TAM to improve primary healthcare in remote areas (Othman and Farooqui, 2015:5.8). Before TAM policies are developed, governments are to institutionalise TAM by (i) setting a permanent agency/department to promote and recognise its historical importance (2) policy must include training, education, standardisation of products, treatment of common diseases and availability of raw material for production (iii) They must have laboratories and authorisation centres, licencing and regulatory bodies provided by the government and (iv) funding and budget allocation (Hussain and Malik, 2013:2955).

Policy plays a critical role in determining the guidelines under which practitioners and organisations must run people-centred and integrated health service. Organising of workshops to promote traditional medicine had to follow national guidelines developed (World Health Organization [WHO], 2000:3).

Stakeholders and responsibilities

According to the WHO (2016:10) framework, stakeholders are categorised as (i) communities, families and individuals, (ii) civil society organisations, they are representatives of communities, families and individual who advocate on their behalf so they can make their own healthcare choice (iii) the states/governments – they set the agenda for strategies, policies and regulations to achieve integrated health for people. (iv) healthcare professionals – they form part of the framework consultations and provide health services to users, (v) academicians, training and research institutions – they develop curriculum, develop professionals for health workforce and also implement the policy (vi) private and public sector – NGO's, governmental ministries, faith-based organisations, international donors and development partners, pharmaceutical industries and insurers – these people contribute financially towards the healthcare delivery (World Health Organization (WHO), 2016:11).

Healthcare Financing

Health financing forms the central core of health systems, its enhancement to the effective delivery of service leads to universal healthcare. Lack of finance means lack of motivation, and lower-wage in the labour market, especially for health workers, it also means scale and quality of professional training will be a constraint (Savedoff, 2011:27). Policies and budgets of public sector and insurance organisations are more decisive in funding healthcare (World Health Organization [WHO] Report, 2000:26). When health systems are well-financed, it means people's expectations will be met, and there will be equity in healthcare delivery without discrimination on how people are treated. Integration involves investment and funding; this implies a well-established benefit and repayment mechanism to bring the financial interest of revenue and manufacturers in line with the system.

Healthcare workforce

As healthcare is being integrated, there is the need to train, educate and recruit for new roles. The implementation of TAM integration demands professionally trained personnel's as well as creating new roles for them to fit well into the healthcare system to bring continuity and collaboration between the two systems. It is essential to educate both TAM and biomedical professional, first, by adequately providing training, knowledge and qualified TAM professionals and second, by providing each of the practitioners with basic knowledge on both TAM and biomedicine for easy collaboration (Hussain and Malik, 2013:2956).

Challenges

Although the use of TAM as gained enormous recognition globally, there is still little information regarding its efficacy, safety and quality (Othman and Farooqui, 2015:5.8). Paying for healthcare out of pocket has exposed families to unexpected financial burdens, the cost of accessing healthcare has left the poor from obtaining healthcare (World Health Organization [WHO] Report, 2000:34). Integrated care was designed to address emerging health challenges such as urbanisation, rising healthcare cost and disease outbreaks (World Health Organization (WHO), 2016:2). The lack of knowledge on medicinal drugs has led to the inability to categorise them. The drugs are sometimes identified as, food supplement, food or herbal medicine. The active ingredient used in producing herbal medicine is mostly unknown(it contains more than one active ingredient) (Othman and Farooqui, 2015:2956). Other significant challenges are the inadequate allocation of resources, lack of official recognition of TAM, inadequate research support, lack of communication among practitioners and unstable use of medicinal plant resources (Othman and Farooqui, 2015).

Chapter 3: Methodology

3.1 Introduction

This chapter explores the method used for data collection to address the study's main and sub-research questions. This chapter will explain the research design, sample technique and the method used to collect data, how the data was collected, how it has been analysed and limitation of the research. A qualitative research method was used to focus on specific characteristics and experiences of the study participants (Hennink et al.,2011). Both data gathering tools gave respondents the room to express themselves freely and give their personal views on issues.

3.2 Research Design

This study is a multi-method design that combines two qualitative methods – a case study and netnography. The use of qualitative research is to interpret a specific phenomenon, and it does not only consider small participants but specific characteristics that can best inform the research. These respondents have experience that is relevant to the study (Hennink et al. 2011:84). A case study is to explore existing data and articles from Ghana, including content analysis of policies, programs and legislation. A case study is used for comprehensive descriptive analysis of a situation or case (O'Leary, 2017:169).

Netnography means virtual (internet) ethnography. This method is considered because it is participant-observational research based on online fieldwork (Kozinets, 2010). The use of netnography provided the researcher with skills, that was used during data collection; that is by using interviews which provided an opportunity for people to learn about causes, narratives and portrayals of the social world. Key informant felt comfortable to discuss private policy documents, cultural beliefs and their ongoing opinions. The use of this method also gave key informants the space to express themselves freely.

For a better understanding of the research topic and to critically analyse the questions, data gathering tools, such as In-depth Interview, and Focus Group Discussion, were used. In-depth interview was used to get insight into the perception of integration of TAM into public healthcare in a cultural context , and Focus Group Discussion (FDG) was used to get a range of opinions among service users. Desktop research was also used to collect information and data as well as to review and analyse existing literature (e.g. articles, books, newspapers, policies) to give a better understanding to the factors hindering the integration of TAM into public healthcare. The in-depth interview and focus group discussion were conducted through Zoom and WhatsApp online platforms.

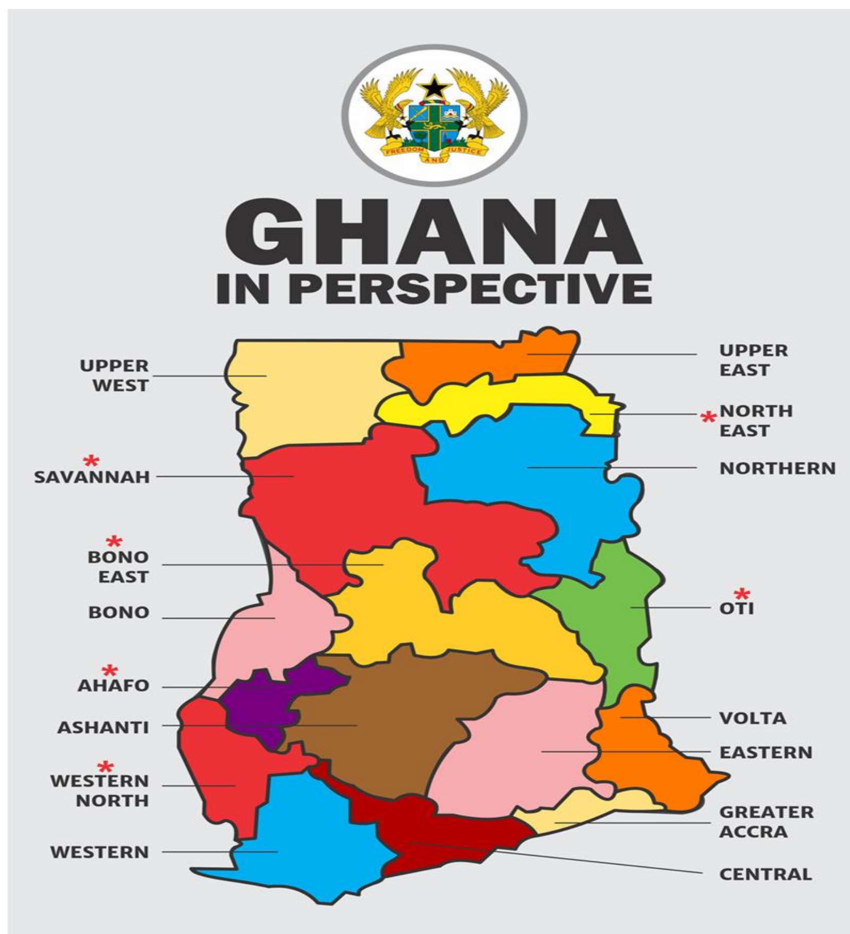
3.3 Study Area

The focus of this research was based on an ongoing pilot project in Ghana that seeks to integrate Traditional and Alternative Medicine into the public healthcare system. The Ministry of Health through the Ghana Health Service and Traditional Medicine Directorate started the integration in regional hospitals, which has now expanded to district hospitals. I

collected data from the Greater Accra region, Central region, Eastern region, Ashanti region, Volta region and Upper West region.

Ghana is located within the Sub - Saharan Africa region with a total land mass of 238 540 km2 (92,099 sq. mi). Ghana shares boarders with Côte d'Ivoire to the west, Burkina Faso to the north, and Togo to the east. To the south are the Gulf of Guinea and the Atlantic Ocean. The country is divided into 16 administrative regions with a population of 29.46 million as at 2018 (http://www.fao.org/). The healthcare sector is managed by the Ghana Health Service (GHS) an agency of the Ministry of Health (MoH). The Traditional and Alternative Medicine Directorate (TAMD) an agency of MoH, is responsible for policy monitoring and evaluation The Traditional Medicine Practice Council (TMPC) is responsible for regulations and is part of the implementation of TAM integration. Map1.1 below show a map of Ghana with its 16 administrative regions.

Map 0.1
Map of Ghana



Source: https://mfa.gov.gh/index.php/about-ghana/regions/

3.4 Sampling technique and sample size

Total number of respondents were twenty (20). Fourteen (14) respondents from six regions were interviewed and focus group discussion was used for six(6) respondents ; Two policy makers; one (1) from the Greater Accra region and one (1) from Eastern region. Two (2)

hospital administrators; one (1) from the Volta region and one (1) from the Central region. One (1) biomedical practitioner from the Eastern region. Eight (8) medical herbalist; two (2) from Eastern region, two (2) from Ashanti region, one (1) from Central region, one (1) from Upper West region, and two (2) from Greater Accra Region. Seven (7) service users; Four (4) from the Greater Accra region and three (2) from Volta region. One (1) of the service users is highly educated (PhD holder), one (1) is a bachelor degree holder, two (Senior High School) and three (3) are not educated. Eight of the respondents were female, and twelve were male. Fifteen (15) of the interviewees were interviewed in English, and they spoke fluently whiles five (5) could not speak fluently, some interviews were done in "Ewe" and translated. Out of the twenty (20) interviewees; six (6) were practising medical herbalist. Two (2) were from The Institute of Traditional and Alternative Medicine and were the first batch of medical herbalist to start the integration. Two (2) were hospital administrators and quality researchers; one (1) was from the Centre for Plant Medicine Research (CPMR). One was from The Traditional and Alternative Medicine Directorate; one (1) was a biomedical doctor from the USA practicing in Ghana; One was a director of an NGO/ and six (6) respondents who used focus group discussion were patients/service users. Three (3) from the volta region and three (3) from Greater Accra region.

3.5 Methods

The research began with an extensive literature review and analysis. A thematic analysis approach was used to analyse government reports thoroughly, polices, newspapers, results from the online interview and focus group discussion, this was done by using data triangulation and other digital technologies (e.g. atlas.ti and excel). A thematic approach is an analytical tool used for the processing of data.

Whiles, the sampling of the respondents were purposive from selected hospitals where the integration is ongoing, and other respondents were contacted through referrals from key informants during the process of data collection. Respondents were contacted through phone calls and emails to the hospitals. Five out of all the respondents were interviewed through "snowballing". The snowballing process involves getting respondent referrals when an initial respondent is identified (these respondents must meet the study criteria) (O'Leary, 2017:211)

3.5.1 Interview

In order to understand how the integration started and its progress, the researcher conducted formal in-depth online interviews using zoom, audio and WhatsApp phone calls.

The interviews were conducted with semi-structured questionnaire designed by the researcher. The respondents were allowed to give personal opinions by using probing, and auxiliary follow up questions that arose during the interview. Respondents' permission was sought for the recording of the interviews. Interviews were recorded using notability app.

All the interviews recorded were transcribed verbatim, and this allowed the researcher to cross-check the content of the responses with the interviewees and draw appropriate inferences and analysis that informed conclusions of the study.

3.5.2 Focus Group Discussion

I selected respondents for the focus group discussion using the snowball technique. I interviewed six respondents. After interviewing the respondents, I asked the respondent to recommend the next interviewee until the sixth respondent.

The total number of respondents for the focus group discussion was six (6). The respondents consented for the meeting to be recorded using notability app. Semi-structured questions were used to conduct the discussion. I gave all the focus group participants adequate time to participate and contribute to the discussion; ensuring all participants got the opportunity to express themselves without feeling intimidated by others.

The respondents were three (3) female and three (3) males. Two of the respondents were from the rural part of the Volta region (Dzelukope) of Ghana, two from per-urban (Haatso Bohye), and the remaining two participants were from an urban area (Tema). I conducted the focus group discussions virtually using WhatsApp and Facetime. The meeting took approximately 35 mins. The meeting began with an introduction of the research theme and its purpose and by introducing other participants. Key discussion included personal experiences and why they use of herbal medicine.

3.6 Analysis Techniques

I collected data, analysed and interpreted it to give meaning to the information received. The interview transcripts (i.e. the transcribed interview recordings) were interpreted with the guidance of the research questions. Findings were grouped into themes based on research questions. The analysis was done based on respondents information provided and the researchers' evaluation of the meaning made to the research questions. The discussions of the analyses helped in arriving at key findings. Further attention was given to how the ongoing pilot integration has been done in the past, how it is done currently and the challenges to the integration implementation. What informs user choices of the two types of medical systems and how that impacts on integration, who are the main actors/stakeholders and their respective roles and the opportunities that have been created by the integration process.

The transcripts were read twice against notes and recordings; then the transcripts were analysed using Atlas.ti qualitative analysis software. Qualitative data analysis requires immersion in knowledge from which the perspectives of the research respondents can be described and interpreted. The analysis includes balancing the different and conflicting viewpoints of people and making sense of them (Hennink et al., 2011:205). Different colours were assigned to different codes. During the analysis, the researcher had to read some transcript several times to get an understanding of the interviewee's responses. The analysis was done by consciously avoiding researcher's feelings or personal thoughts to affect results. Only respondents perceptions, experiences and responses were reported. Quotes from respondents were used to support the discussed themes.

The researcher gave the interview transcript names from A to N to differentiate the transcripts. FDG transcript used first and middle names of respondents to which they gave their consents.

3.7 Coding of Themes

The research questions were categorised as themes, and its corresponding coding emerged from the interview recording that was transcribed. However, there were other themes (questions) that emerged which were not part of the main research question; these questions were deemed important and had relevance in achieving the objectives of the research. The coding was done to understand the interviews better and also to reduce the long responses. Atlas.ti software was used in the analysis of the transcription.

In order to be able to answer the research questions, the findings of the interviews are displayed and analysed. Table 1.1 below shows the themes and its corresponding coding.

Table 0.1
Summary of Themes

Research Questions (Themes)	Coding Categories (sub-themes)
1. Who are the main actors and what are their role in the TAM implementation process ?	- MoH and GHS - TAMD - TMPC - CPMR - FDA - KNUST - GHAFTRAM
1. How is national policies on TAM enforced in the implementation process ?	- Regulation process and Policies - HR and Training - Facility Selection - Herbal Products - Progress of TAM integration
2. What are the challenges and opportunities of the implementation of TAM into public health?	**Opportunities** - Employment - User choice and preference - Efficacy - Focus of Research **Challenges** - Lack of change management approach - leadership - Lack of Insurance - Bureaucracy through procurement - Lack of information for public awareness and Publicity - Inadequate allocation of resources and funding towards research - Attitude biomedical practitioners towards the use of herbal medicine
3. What is causing the increasing use of TAM in Ghana	- Trust Beliefs and Practices - Perceived side effect of biomedicine - Improved efficacy and research

3.8 Limitations

Contacting respondents was problematic because most of the respondents as medical practitioners, had to deal with hectic schedules owing to the Covid-19 pandemic. Several international phone calls had to be made in contacting hospital administrators, individuals and regulators of the two medical systems being studied. The calls came with very high financial burden and time. Some of the respondents were not in locations where they could be accessed via the internet and other online communication tools. The only option for the researcher to contact these respondents was by cell phone, thus exacerbating the cost of telephone bills for the respondents. The researcher was unable to read the respondents body language since all interviews were virtual, and due to poor internet connection, cameras were off. The media technologies did not allow the interviewer to assess the body language., emotions and gestures of the respondents, something that could have aided assessment of the personal feelings of the respondent to inform to a reasonable degree how authentic and convinced they were with their responses.

Another limitation is the reluctance of policy-makers to talk to the researcher. Since the research is being conducted close to elections in Ghana (December 2020), policy-makers/institutions did not want to be interviewed on policy matters. Where they consented to an interview, they were cautious about making categorical statements. They did not want to be quoted as having expressed their views of delicate matters about the challenges that the integration of the two medical systems may have faced or could be facing presently or in the future. The researcher had excellent initial conversations over the telephone with three policy-makers who agreed to an appointed date for a structured interview. These policy-makers subsequently did not honour agreed times for the interview and refused to pick phone calls from the researcher. Later on, the researcher had to go through many acquaintances to assist in contacting new health policy persons in various institutions. Even with these efforts, some policy people had to be assured that the researcher is not a journalist wanting to pick their thoughts for news items.

3.9 Ethical Consideration

The researcher got ethical approval from The International Institute of Social Studies through the teaching and learning support team (TLST) by requesting for an introduction letter. The introduction letter was sent to some respondents and institutions before the interview was granted. Researcher informed respondents of the purpose of the research, objectives and sent a draft of the semi-structured questionnaire to the respondents through WhatsApp and emails. Respondents who gave their consent were recruited for the research. Respondents were assured of confidentiality and privacy; this was done by researcher informing all respondents that the research was for academic purposes only. Respondents were then informed that the researcher would destroy all recordings of the interview after the research and that no excerpts of the interview will be used for any other purpose.

3.10 Reliability

To ensure the reliability of this study, the researcher used the same semi-structured questionnaires for all the respondents of the same category, for example, biomedical practitioners,

medical herbalist, users of either medical service. The researcher was consistent in the use of medical jargons and terminologies in the semi-structured questions. The use of these medical terms ensured that all sampled respondents had the same understanding of the questions. All questions were in the English language. When the researcher was interacting or interviewing service users from rural areas, the same questions were translated into the local langue and crossed checked with native speakers of local vernacular dialects/language to ensure that translations conveyed the same meaning and understanding.

Chapter 4: Analysis and Findings

4.1 Introduction

This chapter commences with the summary of the key findings, followed by the findings which were categorised using the themes (research question) and ends with the discussion of the findings with relevant literature to support in the context of TAM integration.

4.2 Summary of Key Findings

The finding showed that TAM integration started with institutionalising main actors who directly and indirectly are agencies under the Ministry of Health (MoH). Within the Ministry exist policies, guidelines and regulation for TAM. These regulatory frameworks are critical if two or more healthcare delivery systems are to operate effectively in a country. The study unveiled clearly that policies formulated, human resource capacities that has been enhanced through training for practitioners and health facilities, herbal product improvements over the years since the commencement of TAM integration has contributed to the recorded success of the integration process. The extent of the success is evidenced by the fact that, the integration began in 19 hospitals in 2011 but has to date covered 40 hospitals in the country.

The integration is still on going. It however faces some challenges. Lack of information for public awareness and publicity was identified as a challenge why service users are not accessing herbal medicine within the healthcare delivery service. The lack of advertisement is attributed to low funding and investment in the integration process. Creating public awareness will give the public knowledge on the ongoing process; users will trust that educated and qualified practitioners are now practising herbal medicine. Publicity of herbal medicine will give public healthcare delivery a competitive advantage over private healthcare delivery. Herbal medicine used to be practised by untrained, uneducated as well as fake practitioners, these factors discouraged some people from using it. Lack of public awareness keeps some users in this mindset therefore loosing trust in herbal medicine. The lack of public awareness also gives illegal vendors the opportunity to keep marketing fake and unregistered herbal medications at bus stations, in cars and markets.

Another challenge hindering the integration of TAM is partial insurance coverage, the integration of herbal medicine into public health delivery system according to the Alma-Ata, is for government to formally recognise and accept herbal medicine and also give healthcare access to all. The lack of insurance forces most users who are financially constraints to pay out of pocket; those who cannot pay are restricted by not getting access at all. The difficulty in categorising herbal according to respondents has led to it not been covered by NHI. The national health insurance policy was being reviewed (as at the time of this research) to include herbal medicine coverage according to the director of TAMD. What cannot be specified is, how long the policy review will take. Practitioners expressed that including herbal medicine coverage to national health insurance will increase user access and inclusiveness.

A third challenge identified was inadequate investment in research. The unacceptability of herbal medicine by most biomedical practitioners globally stems from is inadequate

scientific bases. For herbal medicine to gain global recognition, government need to invest more into research and clinical testing. Some respondents stated that some users trust in alternative medicine more than herbal medicine because of its global acceptance and scientific bases although its origin is from another country. The use of homeopathy and chiropractic has been accepted globally because of consistent research.

Finally, the reluctance of biomedical professionals was also identified as a challenge delaying the integration process.. From the findings, it was identified that some biomedical practitioners viewed herbal medicine with a biased lens of perception such as its practise beginning with spiritualist and untrained people. Other practitioners also view the integration as competition; this is because in case of biomedical practitioners going on strike medical herbalist will be available to work accept in the case of surgical issues, hence the reluctance to accept the integration. It was also discovered that when medical herbalist were integrated into the public healthcare, they were physician assistance to the biomedical practitioners. This gave the biomedical practitioners superior authority over the medical herbalist therefore refusing to refer patients to the medical herbalist and causing a delay in the integration process.

Though these challenges have to be addressed it has brought along with it some form of opportunities in the healthcare system. For example service users who may have purchased herbal drugs in public transport (usually deceived by advertisement), can now find their medicines in some hospitals. This has created jobs for the medical herbalists who are well trained and educated to serve users at the identified health facilities.

Another result that emerged from the analysis is the reasons why service users are increasingly using TAM instead of biomedicine. Research-based information on the safety of herbal medicines, testimonies of user efficacy of herbal medicines, its improved packaging and trained practitioners has improved user confidence, which facilities the integration of TAM for a market exists for an alternative medical system.

The study discovered that medical herbalist believe that there is inadequate public awareness on herbal medicines. This may have resulted partly because of the lack of government involvement in publicity to promote the integration of TAM. Whiles publicity is an issue; the paying out of pocket to purchase herbal medicine due to lack of insurance coverage puts so much burden on service users, especially those who cannot afford it. Medical herbalists are motivated to prescribe and serve users with herbal medicine; however, there are times when prescribed herbal medication has to be purchased outside the facility due to unavailability of medication as a result of procurement bureaucracy at the health facilities. The bureaucracy is exacerbated by the fact that some herbal medicines though users confirm its potency and efficacy has not passed the government official clinical tests, and cannot be available in the public facilities identified for the TAM integration. Additional aspects of the findings on general bureaucracy at the implementing hospitals of TAM is the frequent change in management positions which takes away people with enough knowledge on herbal medicine replacing them with people with little or no interest in herbal medicine. The attitude of management toward herbal medicine will determine how it is accepted in the hospital facility. The consequence is that many biomedical practitioners have become reluctant to accept herbal medicine for promotion.

4.3 Main actors and their respective roles

To answer this research question, 12 out 20 of the interviewees expressed their knowledge by listing the actors involved in the implementation of TAM in Ghana. This question also leads to the fact that Ghana's decision to integrate TAM into public healthcare has formerly been institutionalised but there was no easy access to policy documents and hence researcher relied on interviews even for some information that would normally be accessible via policy documents, hence, the question how stakeholders are involved the implementation in the integration process.

Table 0.1.2
Actors and their respective roles

Actors	Roles	Quotes
Ministry of Health (MoH) and Ghana Health Service (GHS)	The MoH is the executive body of the government spearheading the integration of TAM. The ministry operates through the Ghana Health Service. Ghana Health Service coordinate activities in all TAM integration regional hospitals to inform government decision. According to Interviewee G	*"The selection came from the MoH…"(Interview J)* *" The Minister of Health and His Deputy were of immense help. The deputy was then in charge of herbal Medicine" (Interview G)*
Traditional and Alternative Medicine Directorate, Ghana (TAMD)	The directorate was set up to review and issue regulatory policies concerning TAM integration. According to interview respondents although TAMD is "in charge of the integration process", the directorate does not have autonomy. If the herbal units have issues at the regions, reports are sent to the medical directors/superintendents. TAMD is responsible for " monitoring and evaluation of TAM integration". According to Interviewee G,	*"…Traditional Medicine and Alternate Directorate (TAMD) is in charge of the integration process... the herbal medicine unit does not report to the directorate but to the Ghana Health Service… issues cannot be addressed at the hospital level goes to the district level. If it cannot be addressed by district, it goes to regional then to the national level" (Interview G)* *"The MoH and its TAM directorate operationalised the policies. We are not implementing; we are policy formulators and TAMD monitors and evaluates projects. Based on the policies, the health sector began to look at the direction to integrate traditional medicine" (Interview N)*
Traditional Medicine Practice Council (TMPC)	TMPC is the regulatory body for all herbal practitioners and handles all " issues of herbal medicine malpractice ". They also provide oversight of certification. Students who graduate from the university write "professionals exams" to qualify for	*"…an agency which is responsible for regulating the traditional medicine practitioners and also bring together all practitioners" (Interview B)*

	membership. TMPC is an agency under the MoH and was commissioned by Act 2000.	
Centre for Plant Medicine Research (CPMR)	CMPR is an agency under the MoH which is responsible for scientific research and development of medicinal plants. The key role of the centre is to analyse herbal products. The products have to pass the "microbial analysis test" before it is approved for public consumption. The centre also trains practitioners on new ways of "improving and packaging" herbal products hygienically. CMPR works in collaborations with all stakeholders to approve "specification and standardisation of herbal medicinal products".	*"CPMR trains and educates (medical herbalist and GHAFTRAM member)... CPMR collaborates with all stakeholders to decide on the specification for the herbal medicine… the analysis means the product has passed some test (e.g. safety analysis, microbial load analysis)" (Interview A)*
Food and Drugs Authority (FDA)	The FDA has a department of herbal medicine that regulates and registers products before they are sold to users; they also have a monitoring unit which inspects the herbal centres within the hospital to ensure they meet the required standard. The FDA issues "certificate of analysis" to herbal manufacturers when their products have been approved for public consumption.	*"Food and Drugs Authority (FDA), this unit is responsible for regulating and registering herbal products before it is used…Before FDA registers, the herbal products must be analysed" (Interview A)*
Kwame Nkrumah University of Science and Technology (KNUST)	KNUST was responsible for the training of the "new calibre" of medical herbalist. The university has a Bachelor of Science program in herbal medicine. Medical herbalist goes through different forms of training, after which they are integrated into public hospitals to practice	*"The course is taken for four years on campus then two years off-campus…during the last year, six months is spent at the Tetteh Quashie Memorial Hospital then the last six month at a private herbal clinic…"(Interview G)*
Ghana Federation of Traditional and Alternative Medicine Practitioners Association (GHAFTRAM)	GHAFTRAM is made of up of different associations of "trained and untrained" practitioners and manufacturers of herbal medicine. The federation was actively involved with the integration of TAM into the public healthcare system by "representing all practitioners from local level".	*"…this federation is made up of all herbal practitioners in Ghana including trained and untrained… local level practitioners were represented by GHAFTRAM"(Interview I)* *"GHAFTRAM is collaborating with the council, and if unregistered practitioners are caught, they face the required legal actions" (Interview G)*

4.4 TAM implementation and policy enforcement

Also of interest in this study is how policies were formulated, human resource and training to fill the herbal doctor positions in the hospitals, product manufacturing, facility selection and progress of the integration (from 2011-2020).

Policies

As part of the integration process and indicated in the WHO Alma-Ata declaration in 1978, all member states were to develop research-based policies, guidelines and regulations before the integration of TAM into public healthcare delivery system. Ghana started developing these policies since the year 2000. One of the ways Ghana institutionalised and recognised TAM, was to set up a Traditional and Alternative Medicine Directorate (TAMD) followed by developing policies such as Act 2000, and Ghana Herbal Pharmacopeia. Some of the policies, guidelines and regulations identified through my desk review and confirmed by respondents are

"*the TAM policy, Act 2000, herbal pharmacopoeia, Strategy for formal institutionalisation of plants medicine services, medical herbalism, manual for disease management and complementary medicine in Ghana 2010-2014"(Interview I & G)*

The practitioners considered policies to be the most important part of the implementation process. These policies will help in decision making and inform each institution on their respect roles in the process. They perceived that authorities have expectations towards them, but these expectations cannot be achieved if TAM process are not well regulated. A practitioners stated that "if there is no insurance policy I cannot force users to use the service". Another practitioner stated that "medical herbalist are guided by some of form policy guidelines but biomedical doctors do not have any idea we use these documents".

"*recommended herbal medicine list (this list gives you a compilation of all the medicine to be used at each herbal centre and patience charter and code of ethics that guides herbal practitioners" (Interview K & E)*

Human Resource and Training

During the integration, health professionals with expertise in herbal medicine were needed. Interviewees revealed that " MoH collaborated with the KNUST to introduce a bachelor's degree course on traditional medicine". The trained professionals are then posted to public hospitals after completing their course and a 2-year internship training.

Herbal medicine used to be practiced by uneducated people who inherited the process from family stated one practitioner, but for herbal medicine to be accepted as part of national and global healthcare practitioners needed to be trained.

"Since the integration was going to be in the mainstream healthcare, there was the need to train a new kind of professionals due to the governance structure" (Interview N)

Training of practitioners was and continuous to be an important aspect of the integration process since new forms of medications are being produced and untrained practitioners are included in the integration process. Some users still use the services of these local practitioners due to lack of access stated another practitioner. KNUST, CPMR and other institutions are responsible for the trainings. An interviewee stated that" KNUST use to train indigenous practitioners".

"Before the integration, KNUST stated training the indigenous practitioners (traditional herbalist), but the school later realised they needed to train a different calibre of people. In 2001, September, KNUST admitted its first batch of herbal medicine students. One year is spent at the Centre for Plant Medicine Research (CPMR). During the last year, six months is spent at the Tetteh Quashie Memorial Hospital and the last six month at a private herbal clinic. Within or after the two years a professional qualifying exam is written that is conducted by TMPC" (Interview G)

Facility Selection

The selection of the hospital for the implementation of TAM was a decision made by MoH. The medical herbalist responded that they do not know how the hospitals were selected. However, the facility manager (medical superintendents) and the TAMD director responded that " there was a collaboration between GHS and the facility manages". Another interviewee also responded, that " letters were sent to hospitals from GHS indicating that the hospitals provide spaces for the herbals unit".

The public healthcare system in Ghana is managed by GHS, they are the implementors of TAM integration spear headed by MoH. The GHS is responsible for filling every role with the hospital facility.

"consultations between the Ghana Health Service and the facilities managers through the healthcare structure for the availability of space since it was a pilot integration. The government support through WHO funding for infrastructures like desk, logistics and beds. In some facilities, there was the building of a new separate structure" (Interview N)

One hospital administrator stated that, a letter was sent to the facility informing them to create available space for the herbal units. The medical herbalist were already posted to the facility before the letter was received.

"a letter was received from the Ghana Health Service (GHS) that the hospital has been selected and a site must be made available for those who will be posted to work there. Two herbal physician assistants were posted to the hospital in 2012. The hospital had to provide the herbal medicines for the prescription" (Interview C).

Herbal Products

For an integration to happen, there is a need to develop products to serve the population. Mostly practitioners manufacture the products. The interviewees believed that members of GHAFTRAM advocated mostly for the integration because they were producers of herbal medicines. CPMR also produces herbal medication, which is distributed and bought by herbal units.

Practitioners stated that most herbal medicine practitioners were the producers of the herbal medication. CPMR is also a herbal medicine producer. The medicines comes in forms of powder, capsules, concoctions and tea.

"The centre (CPMR) also produces at the herbal medicines which are used in other herbal units" (Interview A)

Progress of TAM integration

The piloting of TAM integration started in 19 hospitals in 2011. LEKMA hospital and the Ghana Police Hospital in the Greater Accra region were the first projects. LEKMA currently

has a herbal and an Alternative medicine unit which is managed by medical herbalist and a team of Chinese doctors. The integrations, as of 2020, have been expanded to 40 hospitals across regions and districts.

Herbal practitioners stated that, their expectations of TAM integration has not been met. This is because some practitioners who got the opportunity to train at private herbal centres witnessed the number of consultations per day. The level of user consultation within the public healthcare system is not as really low comparing to private healthcare centres.

"Currently, the integration has been successful in 40 public health facilities. CPMR also has a herbal clinic. The average attendance is between 50-80 patience per day" (Interview A)

A hospital administrator stated that the number of TAM users the public healthcare is increasing but not so encouraging. The perceived reason was that the integration is focused mainly on herbal medicine. The focus on the alternative medicine is on hold. So far only 2 public hospitals in Ghana has both herbal and alternative medicine.

"In 2016 total attendance is 415, 2017 attendance 360, then in 2018 attendance 383, and 2019 is 494" (Interview B)

4.5 Challenges of TAM integration into public healthcare

About 70 percent (12 out of 20) of the interviewees responded that although the integration is a good initiative for public healthcare, there are challenges with implementation. The main challenges identified through the survey and focus group discussions are as outlined below:

Lack of information for public awareness and Publicity

Interview respondents expressed that the lack of information for public awareness is the main challenge. The medical herbalist stated that although there has been some form of publicity, it is very minimal, comparing to the private herbal centres across the country. The healthcare delivery providers do little to inform the public of the ongoing integration. The lack of public awareness leads many users to private centres.

All herbal practitioners responded that the low patronage of TAM within the public healthcare system is due to poor publicity. Although some form of publicity is ongoing such, sign post within health facilities and local radio advertisement. The general public does not have any idea of the integration of TAM into public healthcare system.

"Inadequate advertisement and competition between private herbal centres. Even though the integration has been ongoing for a year, most of the service users are still uninformed about the ongoing process. The patronage is not as high as expected stated one respondent. " (Interview C)

Another response was "MoH involvement in awareness is shallow, and this is also contributing to hindering factors. Respondents seem to believe that with the involvement of the ministry of health and its implementing agencies through radio and television advertisement, the general public will be aware of the integration process.

"Due to the fact that most of the awareness is done at the local level service users do not know MoH and its agencies are involved. The ministry has not done anything to confirm their involvement in the integration process" (Interview D)

The promotion and funding by government is another challenge that was revealed by another interviewee. Although there is a National Day for TAM celebration, there is no national publicity. A respondent stated that the lack of funding s stalling the integration process. At

the start of the integration hospital facilities were given ₵10,000.00 (€1,450.00), currently the facilities are been given ₵6000.00 (€870.00) to setup a herbal unit including the stocking of herbal medicine.

"no national awareness campaign to create awareness and The government has not invested in creating awareness"(Interview I)

All seven service users responded that they were not aware of the ongoing integration. The responses of the service user indicated that had no idea about the ongoing integration process although the use TAM.

"No, I am not aware, but I know there is a centre for plant medicine research (CPMR). whether there is a national effort to integrate herbal medicine is what I do not know" (Interview M)

Partial Insurance Coverage

Insurance coverage for herbal medicine prescription has been a long going challenge. Consultation and laboratory test are covered by insurance, but the prescription medicine is not covered by national insurance. According to the respondents, the lack of insurance is a major challenge hindering users from accessing the herbal unit in public hospitals.

"Most of the drug at the hospital is covered by medical insurance, but herbal medicine is not covered by insurance. A committee is currently working towards the implementation of insurance coverage being chaired by the director of TAMD (Dr Mrs Anastasia Yirenkyi)" (Interview N)

Herbal medicine is produced with more than one active ingredient due to this, and it is difficult in categorising under insurance. Since different herbs are used for production the active ingredient differs stated a medical herbalist. Another respondent also stated that insurance policy is able to categorise biomedicine because the active ingredient can be identified .

"insurance does not cover the medication. This lack of insurance coverage for herbal medicine is due to the categorisation, and because herbal medicine cannot be categorised, insurance could not cover these medicines"(Interview G)

Procurement of Herbal Medication and inadequate research

Respondents expressed that procurement of herbal medicine takes a longer process than usual. The bureaucratic structure to apply for funds and restock medications delays herbal medicine delivery. Respondents stated that to procure herbal medicine, they needed to send a report after which a tender is published for invoice submission. This delays in procurement process makes it challenging to serve users on time.

Respondents stated that to procure herbal medicine, they needed to send a report after which a tender is published for invoice submission. This delay in the process makes it challenging to serve users on time. The public sector is known for its bureaucratic structure and delay and this process is causing a huge challenge in the healthcare sector stated a respondents.

"Restocking of herbal products takes much time and hence difficult to serve service users. It takes as long as four months to wait for approval for the restocking of medication"(Interview H)

Some participants expressed that due to the lack of clinical test and most herbal drugs not meeting standardisation requirement, it is difficult to get specific medication for some form of ailments.

"Getting some medication for chronic diseases is difficult due to the lack of clinical trials. Some drugs medication do not pass clinical trials; hence getting clinical care becomes limited. e.g. some drugs may say they can treat diabetes, but when tested, they do not treat these diseases" (Interview N)

Lack of change management approach

Respondents mentioned that the frequent change in management in the hospitals and the directors contributes to the delay in the implementation process. Time and resources are spent on the training management team, but when there is a change in political government, these people are changed without a succession plan.

Leadership positions within the public sector comes is by appointments. Lots of resource in terms of time and cost is spent training these people to hold positions but there frequent change on positions without succession plans leaves gaps and delays the in the integration process.

"Frequent change in hospital management leadership – one hospital where leadership has been trained can be changed, and a new person appointed delays the process because the new person does not have any idea of the progress of the integration and need to be trained before progress can be made"(Interview N)

Attitude biomedical practitioners towards the use of herbal medicine

The reluctance of some of the biomedical practitioners towards medical herbalist and herbal medicine leads to the challenges within the medical facility. The time it takes to agree on a given medication and prescriptions delays processes for the medical herbalist.

One respondent stated that the delay in the integration process is caused by the lack caused understanding and conflict between the both practitioners. Biomedical doctors perceive themselves to be the dominate profession in the healthcare system therefore will not agree or refer patients to medical herbalist.. Another practitioner stated that, they are seen as treats to the biomedical doctors because they can attend to patients accept for surgical emergencies in case biomedical doctors go on strike action.

"level of conflict between biomedical practitioners and the herbal practitioners, this causes delays"(Interview A)

Respondents expressed that due to the difference in training and education of both practices, the biomedical practices do not think they are competent enough. All practitioner agreed that biomedical doctors need training to inform them on the new form of herbal medicine.

"Due to the inadequate education and training of biomedical practitioners on herbal medicine and its uses, the level of support is a challenge, and also they are the dominating healthcare practitioners"(Interview D)

Another respondent also stated that the existing structures in the public service make it difficult for change to be readily accepted. Medical herbalist were posted to hospital facilities as physician assistance , this gave the biomedical doctors the impression that they were they to serve them Changing their position and putting them at almost the same level with the biomedical doctors seems to be a treat.

"Public healthcare systems have an existing structure, where biomedicine is dominating then a group of herbalist are asked to join them. First of all, herbal medicine for years was practised by

untrained and indigenous people. Therefore, the perception of herbal medicine being harmful lingers on"(Interview J)

4.6 Opportunities for TAM integration and Implementation

TAM integration into public healthcare is not only facing challenges but has also brought about opportunities. All respondents indicated that the integration of TAM into public healthcare was good, and they showed a positive attitude toward the implementation process.

User choice and preference
Due to the increasing use of herbal medicine, medical herbalist believed that the integration allowed users to choose their preferred healthcare service delivery. The implementation of TAM has given service user the freedom to choose their healthcare. One respondent stated that when patients get to the hospital the nurses inform them about the options they have and the users decide which service the prefer.

"service user will have the option of choosing the healthcare service they want"(Interview E)

"The integration was done to give service delivery choose for service users"(Interview H)

A service user stated that the preference helps in making a personal decision. One service users stated that the use of TAM is not about cost or access but because they are prefer that due to personal experiences.

"Based on personal experience I need to choose to determine which of these systems I prefer, under what conditions and at what cost"(Interview M)

A respondent also indicated that the integration would allow medical herbalist to educate users on dosage and safe ways to use medication. Patients use to use herbal medicine without professional consultation, this causes complications but giving them the preference now consult with professionals stated one practitioner.

"Some service users also have used the integration process to access herbal medicine from professionals instead of using quack practitioners"(Interview K)

Employment
The integration has created job opportunities for graduates, and manufactures /producers stated some of the respondents. A practitioner stated that the integration of TAM into public healthcare system created job opportunity to join the police force since the respondents was posted to the Ghana Police Hospital. Another practitioners also stated that the integration has created employment for young unemployed youths who are being recruited at herbal medicine manufacturing companies.

"Through the integration medical herbalist have been recruited. I also joined the Police Service due to the integration process"(Interview K)

Focus on Research
The integration has increased the scientific bases of herbal medicine; this has improved users attitude towards the use of TAM started two respondents. The integration has also given scientific research focus to herbal medicine. The acceptance of herbal medicine is based on its efficacy ,safety and scientific findings.

"The integration has helped to improve the image of herbal medicine and its efficacy. This has also given service users trust in the use of herbal medicine"(Interview C)

Revenue Generation
Due to the improvement of herbal medicine and scientific backing, the products can be sold globally stated by a respondent. If herbal medicine gets the scientific basis that it need, it will be accepted globally as a safe method of healing, stated one practitioners. By its global acceptant, Ghana can export to generate revenue whiles reducing the importation of other drugs.

"It will create revenue generation for the country and reduce the importation of medicine . Hopefully, the herbal drugs can be exported worldwide as China and India currently have"(Interview A)

4.7 Increasing use of TAM

To understand why people use herbal medicine and why the use of herbal medicine is on the rise, we asked respondents *"In your view, what is causing the increasing use of TAM?".* This question is to address the perceived reasons why herbal medicine is used. The analysis indicated that sometimes, herbal medicine is used as an alternative to biomedicines. In other times, it is preferred as the first choice over biomedicine. All service users indicated that the use of herbal medicine is not associated with cost but rather is a matter of personal preference, trust, and belief in the efficacy of the medication and treatment.

Trust and Belief
Herbal medicine "is the form of medicine I have known since childhood", stated an interviewee. The trust and belief that herbal medicine heals faster than biomedicine is a perceived thought and most respondents still hold on to that view. Some users belief that the use of herbal medicine is a personal view whiles others belief and trust in the use of herbal medicine because generations have used it and can attest to its efficacy.

"I know from history that my grandparents and ancestors used a lot of herbs to treat many diseases so the potency and efficacy of herbal medication from tradition and growing up as a child is known to be good. It was not based on any scientific evidence. My grandparent used herbal medicine in several ways, even in the treatment of snake bites. Many people can attest to its efficiency and efficacy. I can also confirm that because it worked for me too"(Interview M)

The trust in herbal medicine has also increased because the industry has improved over the years in the packaging of these medicines to make them more appealing. The growth in plant or herbal medicine research and the fact that highly educated people are seen practicing and administering herbal medicine has further boosted the confidence of users and the general preference of people when it comes to herbal medicine and biomedicines.

"Herbal medicine is also gaining its efficacy level. It is now well packaged and comes in capsules hence prices have gone up. The use of it is not about price, but the belief in it"(Interview D)

Respondents also indicated that the use of herbal medicine is not because they do not have access to medical facilities but because of the trust they have. All respondents have access to medical facilities but the trust the use of herbal medicine is because it is easily prepared.

"I have access to some of the most qualified hospitals, surgeons and also because I live in Accra and there are many private and public hospitals"(Interview M)

A respondent stated that the use of biomedicine is mostly for emergency cases. The respondent stated that they have private health insurance but the that is only for emergency cases, respondents believe minor ailments and diseases can be treated with herbal medicine.

"I also have insurance and have access to a hospital, but I prefer herbal medicine except in emergency cases. Even with emergency cases, when the situation is stabilised I will use herbal medicine"(Lydia, FDG)

Herbal medicine now has to be registered, proven and tested before producers are allowed to market it. This has increased user perception that it is clinically safe to use it. The notion that herbal medicine is practiced by untrained people has been laid to rest with scientific research, new packaging and trained professional sated a practitioner. Herbal medicine is now safe to use without worry about complication or mixing it with biomedicine, another respondents stated.

" on-going research with scientific backing and there is some level of evidence that herbal medicine is useful"(Interview D)

Side effects of biomedicine

The side effects of biomedicine are causing people to use herbal medicine stated two respondents. Although, the herbal medicine also has side effects, its users seem to believe that its natural components is of a quality than biomedicine. Herbal medication are prepared with none or little amount of artificial ingredients.

"Herbal medicine has more natural components even though it has its side effects if overdosed. Some people are used to it"(Interview N)

4.8 Discussion of findings

The discussion of the findings of the study will focus on the research questions, which were used as themes. The questions were organised around the main actors and their respective roles, TAM implementation and policy enforcement, challenges of TAM integration into public healthcare, opportunities of TAM integration and implementation and increasing use of TAM.

4.8.1 Stakeholder participation

One of the most important decisions taken by the government of Ghana before the integration of herbal medicine was to develop a framework that will guide and direct stakeholder institutions. The development of this framework, as expressed by the interviewees in the study, revealed that there was little involvement with stakeholders. Respondents revealed that the lack of stakeholder involvement in the development of policies and regulations is hindering the effectiveness and efficiency of the implementation process, therefore leading to under regulation. Biomedical doctors do not have in-depth knowledge of why the integration is ongoing, and are reluctant to accept medical herbalist, stated one of the respondents. One of the focus of the traditional medicine policy is the need to network, collaborate and exchange information locally and internationally among stakeholders. This focus has not yet been fully realised.

Getting grassroots participation and involvement has not been achieved. Key informants stated that to regulate the unauthorised sales and use of herbal medicine; there will be the need to restructure. Restructuring means to revise policies, guidelines and regulations that are necessary for the enhancement of the implementation process; this can be done through stakeholder analysis—implying that when stakeholder institutions are involved in policymaking, policy work can significantly improve.

4.8.2 TAM implementation and policy enforcement

The use of herbal medicine in Ghana has been long in existence. Users have gotten accustomed to self-medication by acquiring the medicine from registered and unregistered vendors. All respondents agreed that herbal medicine should be regulated and before the implementation, some steps were taken. In developing policies and regulations, although there is a national policy for traditional medicine, the policy does not indicate stakeholders' responsibilities and how to hold them accountable.

The absence of a clearly defined policy guideline has contributed to unclear objectives. While the implementation is ongoing, the regulation of unregistered herbal products that is the responsibility of TMPC has not been fully accomplished. The lack of regulation has led to biomedical doctors still have the perception that herbal medicine is dangerous for consumption. Some interviewees responded that " strong regulations and policies will legitimise practitioners and professionalise the practice".

Not much was said about training and recruitment, to the knowledge of the respondents. Training and recruitment towards integration are working well so far. Some other interviewees also taught that the recruitment of medical herbalist is limited in some facilities based on the financial capability of the hospital facility.

Increasing traditional medicine access to users has to do with it being affordable and accessible. The selection was made within the main regional hospital, which is accessible by users within cities and towns. This was a test project to inform users about the integration and monitor its utilisation. It is also believed that the best way to regulate TAM is within a biomedical-established facility. The pilot project began with 19 selected facilities in 2011, but with implementation progress after nine years this has reached 40 facilities within regional and district hospitals.

4.8.3 Challenges of TAM integration into public healthcare

There were some factors deduced from the findings that were impeding the implementation of TAM into public healthcare. Medical herbalist revealed that the lack of national health insurance had compelled users to pay out of pocket for herbal medicine. Medical herbalists think that this challenge is causing service users to seek for health treatment either from biomedical practitioners or seek the assistance of unregistered herbal practitioners. This finding is supported by (Bodeker, Kronenberg and Burford, 2007) who related the challenge of national health insurance to lack of policy issues. Other countries such as England, New Zealand and China have successfully implemented herbal medicine into national health policies.

The recommendation by one respondent is to train and invest more in herbal medicine research. The more research conducted means the more medical products can be researched on and therefore testing for clinical use. Bodeker, Kronenberg and Burford's (2007) study is

consistent with this findings recommendation; stating that if more focus and priority is set towards building more robust research for TAM, then market demand can be met through information generation leading to cost-effective programs and policies. The use of research has not yet convinced some biomedical practitioners, they still believe that the use of TAM is culturally related and, in some cases, involved spirituality has led to the difficulty in accepting TAM as part of healthcare delivery system. Medical herbalist stated that some practitioners ask them if herbal medicine works as perceived by users. Green and Colucci (2020) research findings are consistent with these findings when they discussed that biomedical professionals have a sense of reluctant acquiescence.

4.8.4 Public Awareness of TAM

The need to educate and create public awareness is needed to promote the safe use of TAM. Interviews stated that creating public awareness would draw user's attention to the new and improved way of herbal medicine whiles also drawing their attention to the fact that they can access TAM within public healthcare centres. Creating awareness is a collaborative effort between government and private agencies of TAM and corporations who are responsible for consumer protection. This finding is not different from a study conducted in Lebanon by Alameddine et al. (2011).

Whiles the need to ensure that herbal products are safe for public consumption and must go through a series of standardisation and certification of approval, this process also hinders local herbal manufactures from taking their products for testing. The manufactures assume that their drugs will not get the required approval, hence they sell illegally, causing it to be challenging to get approved and certified manufacturers.

4.8.5 Opportunities for TAM integration and implementation

The opportunities identified in this study include employment. Medical herbalists were pleased to say that the integration of TAM has created opportunities for employment for them. Unlike the situation where graduates have to go through series processes for job hunting, the medical herbalists are immediately posted to public healthcare centres to complete their hands-on learning as part of their training, after which they are employed. This process has given created avenue for young adults to be interest in the knowledge and skills of herbal medicine, its practise and product manufacturing.

Herbal medicine has improved through research; this has allowed service user to choose their preferred delivery service. Aspiring towards universal healthcare for all includes allowing users to select what they prefer freely. Once service users are not forced to make a choice, they will unreluctantly adhere to all instructions to take medication as need. User preference is related to a study by Yuan et al., (2016), which confirms that giving preference to service user will stop them from doctor shopping and switching form one healthcare delivery to another.

Respondents also talked about common diseases such as stroke, malaria, sexual weakness, arthritis that are treated with herbal medicine. Research and safety information has increased the trust in TAM. This information has become revenue generation avenues for countries such as Japan, China, and Korea. This finding is related to what Yuan et al., (2016)

discussed in a study, recommending that high-quality research can lead to categorisation of herbal medicine.

4.8.6 Increasing use of TAM

The use of TAM is related to culture, trust and belief and some respondents from also stated that they prefer the use of herbal medicine because of some side effects experienced from biomedicine. The increasing use of TAM is associated with the positive experiences from its users, as well as traditional belief attached, such as passing it down from generation to generation. Respondents believed that biomedicine has too much chemical component added to it, which when taken ends up giving users side effects such as cancer and lung diseases.

The trust in herbal medicine is because the products are naturally made from leaves and barks of trees. For example, pregnant women use some herbs such as cocoyam leaves ("kontomire") and "turkey berry". Other respondents indicated that the use of herbal medicine was because it was easily accessible and self-medicated. They collect mango leaves and boil, which is perceived to heal fever. This form of treatment is believed to be more efficient than going to the doctor for biomedicine. The practice has been done for years in families, and it is a tradition that keeps on living. Welz et al., (2018) findings were similar to the findings in this study – that users become experts in using herbal medicine and do not discuss the side effects of herbal medicine.

The findings of the study were like other studies done on the integration of TAM into public healthcare in Ghana. The findings show that the integration is being implemented, but its effectiveness and efficiency is lacking due to policy issues and hence need collaboration among stakeholders. Also, there is the need to work towards including herbal medicine into national health policy. These findings also support the need to focus on research on herbal medicine and its regulation to prevent unethical practices.

Chapter 5: Conclusion and Recommendation

5.1 Introduction

At the outset of this research, questions were presented in order to explore what lies behind the integration of Traditional and Alternative Medicine into mainstream public healthcare delivery system in Ghana. I was guided by the concept of "good enough governance". Good enough governance according Grindle, (2011:553), implies that not all govenance deficits needs/or may be resolved as once, and that institutional and capacity building are products of time meaning government's achievements are reversible. The concept of good enough governance provides a platform that discusses institutional capacity and the consistent changes within these institutions. This concept is used to explore gaps within policies or government agendas that are deemed to be interventions that must address weak and illegitimate status of a fragile states (Grindle, 2011:3). Governance differs depending on the context, that is taking into consideration time, financial resource, knowledge and capacity (human and institution). To achieve good enough government in the integration of TAM into public healthcare, there should be agendas that are considered to be short term such policy formulation, training and human capacity building. Whiles long term goals look at a more robust research based knowledge on TAM, financial investment into TAM expansion more than focusing on only biomedical expansions. "Good enough govenance" within the context of TAM integration should not just be about providing equity in healthcare delivery service but according to Grindle (2004:525-6), it should be about improving aspects of the public sector, that is (i) institutions - they set the rules of the game for economic and political interaction, (ii) decision making structures - they determine the priorities among public problems and allocate resources to respond to the problems (iii) organisations – they manage the administrative systems and deliver goods and services to its citizenry (iv) human resources – they are the staffs of the government bureaucracies and (v) officials – they are the interlace of citizens that occupy the political and the bureaucratic arenas.

Questions posed were, who were the main actors of the implementation of the integration and how were they involved in the process? What policies are available, and how are they enforced during the implementation? What are the challenges and opportunities of TAM implementation, and what is causing the increasing use of TAM? The study explored a case study and a netnographic qualitative design by using purpose-sampling approach.

Data collection began with a letter of introduction obtained from the Teaching and Learning Support Team (TLST) of the Institute of Social Studies (ISS), which was used to inform selected respondents about the background of the research and its purpose. The data gathering tools used was a semi-structured guide for an in-depth interview and focus group discussions. Twenty interviewees were recruited for the study. With the consent of the respondents, all interviews and focus group discussions were recorded with notability app, and transcriptions were done verbatim. A thematic analysis was used to analyse all data, and coding of the transcript was done using atlas.ti.

5.2 Conclusion

The study concludes that respondents are aware of the main actors involved in the implementation of TAM integration. That the process is still on going, but the level of stakeholder involvement in policymaking leaves much to be desired. The inadequate stakeholder involvement has led to weak policies and delays in the implementation process. The implementation of the integration of TAM has progressed from 19 hospitals to 40 hospitals.

Service users are not accessing TAM within public health centres as expected. This is due to the lack of health insurance coverage and publicity. Most of the users are not aware that TAM can be accessed at public healthcare centres. Procurement of herbal medicine to serve users go through a bureaucratic process that delays the stocking of relevant medication that are prescribed. Research has improved the packaging and safety of herbal medicine such that herbal medicine can now be found in capsules, tablets and powdery forms as compared to what herbal medicine users knew decades ago. The frequent change in leadership is contributing to the delay of the integration process since trained leaders are replaced with untrained ones who may initially have no knowledge of TAM or not interested in alternative medicines apart from biomedicine. Policies and regulations that governed the implementation of the integration focused on how to sustain the process through healthcare financing. Healthcare workforce needs to ensure to give professional knowledge and skills that are relevant to the practice and focuses on customer-centred care. Finally, although many healthcare challenges exist and hinders the effectiveness of the integration, other opportunities have been created by the integration process, which among others has led to the increased use of TAM,

5.3 Recommendation

Based on the findings and conclusions of this study, I suggest the following recommendations:

MoH and Stakeholders

- Collaboration between MoH and stakeholders to review TAM policies and regulations is critical at this stage of the integration process to re-align the integration abased the gained experience and knowledge so far. This effort must be pursued through stakeholder analysis and tolerance of different viewpoints towards having the needed input for policy decision-making and the needed institutional reforms to fast track the integration and enhance accountability.
- Some policies need to be reviewed to include more herbal medications, for example the recommended herbal medicine list and policy guidelines.
- There should be an update on the implementation of TAM for public access since existing documents still call the integration a pilot project after nine years.
- Review of the national insurance policy to include herbal medicine needs consideration and careful analysis as the country pushes more and more for health for all as recommended under the SDG objectives.
- The integration process has focused on herbal medicine, whiles the Alternative Medicine is broader. Hence the Ministry of Health (MoH) must learn from other

countries that has developed and presently practices a plural health system, which encourages varied forms of AM as it works towards the universal health for all.

- The monitoring and evaluation team should enquire why service users are not accessing TAM in public hospitals; this will help enhance the implementation.

Training

- Biomedical practitioners should be oriented and trained for them to have some form of knowledge on herbal medicine and its uses. The curriculum of universities that produce medical doctors must be relooked to include modules that would lead to a deeper appreciation of bio medics to other alternative health care approaches that are also science-based and not faith/spiritual.
- Whilst pursing a revision of the academic training programme of biomedical doctors in the universities, practicing bio medics must be trained through series of workshops, retreats, hands-on practical sessions on herbal medicines and other alternative health delivery approaches that are informed by science and research. This may include international training exchange programmes with countries like China, Japan and South Korea where alternative medicines have been promoted for years and are well integrated into the national health delivery systems.

Publicity

- A nationwide awareness campaign on herbal medicine use and integration should be done with MoH and stakeholders working together.
- A national documentary should be televised for public awareness.
- A sponsored public screen should be used to create awareness.

Research/Health Financing

- The government should invest in research, the more rigorous scientific research, analysis is done on herbal medicine, the more it gets closer to global recognition and acceptance, and it will generate revenue for the country.
- Appropriate national budget for the health sector must delineate the portion for TAM integration.
- The need to increase national budgetary allocation must factor in the initial allocation of government budgets to support health insurance institutions as they are engaged progressively towards covering health cost of users that prefer TAM.

Appendices

Appendix 1
Semi-Structured FDG and Interview Questionnaire

Interview Questions

1. What is the level of directorate (TAM) at the national, district and grassroot level?
2. Does the directorate make decision concerning medical issues?
3. What process is been taken to involve all stakeholders in the integration
4. Do patience have the right to choose preferred healthcare?
5. How will citizens know TAM has been integrated? In your view what can be done?
6. What challenges are affecting the integration of Traditional and Alternative medicine into public health?
7. What is causing the increase use of TAM in Ghana?
8. Do herbal doctors refer patients to biomedical doctors
9. What are the opportunities enabling the integration of traditional/alternative medicine into public health care impact the health sector?
10. How was the integration done? From selection process
11. What are some of the common disease treated with HM ?
12. Aside the TAM governance policies, what other regulations are guiding TAM integration?
13. Does government have budget allocation for the integration?
14. What can be done to improve the integration process?
15. What are your personal views about the integration of herbal medicine into mainstream healthcare?

Service Users

1. Why do use Traditional herbal medicine?
2. Did you consult a practitioner before using the medicine ?
3. How do you know the medication you are using is registered?
4. Since you were not diagnosed by a practitioner of any health issues, how do you know the needed medication?
5. Do you have access to hospital/orthodox medicine? Can you describe the access you have in terms of hospitals?
6. Do you use these services and when do you use them?
7. How do you access the efficacy of services you have had from biomedicine?
8. Explained some situations in which you use herbal medicine, can you tell me in what situations do you prefer either of these services?
9. Do you think a country like Ghana should have one or both of these systems? Why?
10. Do you think herbal medicine must be regulated?
11. What is your assessment of the general access to herbal medicine?
12. Are you aware of the ongoing integration of herbal medicine into the public healthcare?

References

Adams, J. (2013). P*rimary Health Care And Complementary And Integrative Medicine*: Practice And Research. Imperial College Press

Addo-Fordjour, P. *et al.* (2012) *ENGINEERING , AND Medicinal Plants*, *Medicinal Plants of Ghana P.*

Alameddine, M. *et al.* (2011) 'Stakeholders' perspectives on the regulation and integration of complementary and alternative medicine products in Lebanon: A qualitative study', *BMC Complementary and Alternative Medicine*. BioMed Central Ltd, 11(1), p. 71. doi: 10.1186/1472-6882-11-71.

Amzat, J. and Razum, O. (2014) *Medical sociology in Africa, Medical Sociology in Africa*. DOI: 10.1007/978-3-319-03986-2.

Appiah, B. *et al.* (2018) 'Identifying strengths and weaknesses of the integration of biomedical and herbal medicine units in Ghana using the WHO Health Systems Framework: A qualitative study', *BMC Complementary and Alternative Medicine*. BMC Complementary and Alternative Medicine, 18(1), pp. 1–8. doi: 10.1186/s12906-018-2334-2.

Appiah, B. (2012) '*African traditional medicine struggles to find its place within health care*', Cmaj, 184(16), pp. 831–832. doi: 10.1503/cmaj.109-4277.

Boateng, M. A. et al. (2016) *'Integrating biomedical and herbal medicine in Ghana - experiences from the Kumasi South Hospital*: A qualitative study', BMC Complementary and Alternative Medicine. BMC Complementary and Alternative Medicine, 16(1), pp. 1–8. doi: 10.1186/s12906-016-1163-4.

Bodeker, G. (2001) 'Lessons on integration from the developing world's experience', *Perspectives on Complementary and Alternative Medicine: A Reader*, 322(January), pp. 195–201. doi: 10.4324/9780203698372-24.

Bodeker, G., Kronenberg, F. and Burford, G. (2007) 'Traditional, complementary and alternative medicine: Policy and public health perspectives', *Traditional, Complementary and Alternative Medicine: Policy and Public Health Perspectives*, pp. 1–454. doi: 10.1142/P419.

Brinkerhoff, D. (2003) 'Accountability and Health Systems: Overview , Framework , and Strategies Prepared by ':, *Accountability and Health Systems: Overview, Framework, and Strategies.*, pp. 1–45. Available at: http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf.

Bruchhausen, W. (2018) *Medicine - Religion - Spirituality*,. Transcript. Doi: 10.14361/9783839445822.

Centre for Plant Medicine Research
https://www.cpmr.org.gh/product-category/capsules/> Accessed November, 9,2020

Ember, C. R. and Ember, M. (eds) (2004) *Encyclopedia of Medical Anthropology Health and Illness in the World's Cultures*. 1st edn. Springer-Verlag US: Springer, Boston, MA. Available at: http://www.kluweronline.com.

European Gepscience Union
< https://www.egu.eu/policy/basics/cycle/> Accesssed October 10, 2020

Garcés-mascareñas, B. and and Penninx, R. (2016) *Integration Processes and Policies in Europe*. Edited by B. Garcés-Mascareñas and R. Penninx. Heidelberg, New York, Dordrecht ,London: Springer, Cham. doi: DOI https://doi-org.eur.idm.oclc.org/10.1007/978-3-319-21674-4.

Green, B. and Colucci, E. (2020) 'Traditional healers' and biomedical practitioners' perceptions of collaborative mental healthcare in low- and middle-income countries: A systematic review', *Transcultural Psychiatry*, 57(1), pp. 94–107. doi: 10.1177/1363461519894396.

Greer, S. L., Wismar, M. and Figueras, J. (2016) *Strengthening health system governance. Better policies, stronger performance.*, *European Observatory on Health Systems and Policies Series*. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/307939/Strengthening-health-system-governance-better-policies-stronger-performance.pdf.

Grindle, M. S. (2011) 'Good Enough Governance Revisited', *Development Policy Review*, 29(SUPPL. 1), pp. s199–s221. doi: 10.1111/j.1467-7679.2011.00526.x.

Grindle, M. S. (2004) 'Good enough governance: Poverty reduction and reform in developing countries', *Governance*, 17(4), pp. 525–548. doi: 10.1111/j.0952-1895.2004.00256.x.

Health and Diet Blog
< *https://healthanddietblog.com/in-ghana-currently-doctor-patient-ratio-is-one-doctor-to-8000-patients/* > Accessed on October 6,2020

Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative Research Methods*. London, SAGE

Hewson, M. G. (2015) '*Cultural Studies of Science Education 10 Embracing Indigenous Knowledge in Science and Medical Teaching*', pp. 7–18. doi: 10.1007/978-94-017-9300-1.

Hussain, S. and Malik, F. (2013) 'Integration of complementary and traditional medicines in public health care systems: Challenges and methodology', *Journal of Medicinal Plants Research*, 7(40), pp. 2952–2959. doi: 10.5897/JMPR12.458.

Kozinets, R. V (2010) *Netnography: Doing ethnographic research online*, *International Journal of Advertising*. doi: 10.2501/S026504871020118X.

Ministry of Health (2005) 'Policy Guidelines on', *Policy Guidelines on Traditional Medicine Development*, pp. 1–4.

Ministry of Forenign Affairs-Ghana
< https://mfa.gov.gh/index.php/about-ghana/regions/> Accessed October 10,2020

O'Connor, B. B. (2014) 'Chapter 1. *Defining and Understanding Health Belief Systems', Healing Traditions*, pp. 1–34. doi: 10.9783/9780812200539.1.

O'Leary, Z., (2017) *The Essential Guide to Doing Your Research Project*. 3rd edn. SAGE Publications.

Othman, C. N. and Farooqui, M. (2015) 'Traditional and Complementary Medicine', *Procedia - Social and Behavioral Sciences*, 170, pp. 262–271. doi: 10.1016/j.sbspro.2015.01.036.

Park, Y. L. and Canaway, R. (2019) 'Integrating traditional and complementary medicine with national healthcare systems for universal health coverage in asia and the Western Pacific', *Health Systems and Reform*. Taylor & Francis, 5(1), pp. 24–31. doi: 10.1080/23288604.2018.1539058.

PharmAccess (2016) 'A Closer Look At The healthcare system in Ghana.', *PharmAccess*, (October), p. 1. Available at: https://www.pharmaccess.org/wp-content/uploads/2018/01/The-healthcare-system-in-Tanzania.pdf.

Savedoff, W. D. (2011) 'Governance in the Health Sector: A Strategy for Measuring Determinants and Performance', *Corporate Governance*, 1(May), pp. 780–0810. Available at: http://www.wds.worldbank.org/servlet/main?menuPK=64187510&pagePK=64193027&piPK=64187937&theSitePK=523679&entityID=000158349_20110509125737.

Suter, E. et al. (2009) '*Ten principles for Successful Integration', Healthcare Quarterly*, 13, p. 16.

The Herald Ghana: *What Is Alternative Medicine? Public Ignorance, Legality, Practice and Education*. < http://theheraldghana.com/what-is-alternative-medicine-public-ignorance-legality-practice-and-education/ > Posted on January 24, 2018, by Josephine Nettey in Health. Accessed May 6, 2020

Tilburt, J. C. and Kaptchuk, T. J. (2008) 'Herbal medicine research and global health: An ethical analysis', *Bulletin of the World Health Organization*, 86(8), pp. 594–599. doi: 10.2471/BLT.07.042820.

UNSCHULD, P., & Reimers, K. (2009) 'Summary for Policymakers', in Intergovernmental Panel on Climate Change (ed.) *What Is Medicine?: WESTERN AND EASTERN APPROACHES TO HEALING*. Cambridge: Cambridge University Press, pp. 1–30. doi: www.jstor.org/stable/10.1525/j.ctt1pnt6c.4.

Welz, A. N., Emberger-Klein, A. and Menrad, K. (2018) 'Why people use herbal medicine: Insights from a focus-group study in Germany', *BMC Complementary and Alternative Medicine*. BMC Complementary and Alternative Medicine, 18(1), pp. 1–9. doi: 10.1186/s12906-018-2160-6.

World Health Organization (2018) 'WHO Ghana 2018 Annual Report', p. 56. Available at: https://www.afro.who.int/publications/who-ghana-2018-annual-report.

World Health Organization (WHO) (2016) 'Framework on integrated, people-centred health services: Report by the Secretariat', *World Health Assembly*, (A69/39), pp. 1–12. doi: 10.1111/igs.13866.

World Health Organization [WHO] (1978) *Declaration of Alma-Ata*.

World Health Organization [WHO] (2000) *Promoting the role of traditional medicine in health systems: a strategy for the African Region 2001–2010*, *Ougadougou, Burkina Faso- WHO*. Available at:http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:Promoting+the+role+of+traditional+medicine+in+health+systems:+a+strategy+for+the+African+region#0%5Cnhttp://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:Promoting+the+role+of+traditio.

World Health Organization [WHO] (2019) *WHO global report on traditional and complementary medicine 2019*. Available at: https://apps.who.int/iris/bitstream/handle/10665/312342/9789241515436-eng.pdf?ua=1.

World Health Organization [WHO] Report (2000) *WHO report 2000*, *World Health Organization*. Available at: https://www.who.int/whr/2000/en/whr00_en.pdf?ua=1.

World Health Organisation International
< *https://www.who.int/hdp/en/* > Accessed on September, 12, 2020

World Health Organisation International
<*https://www.who.int/gho/health_workforce/physicians_density/en/*>Accessed on October 6,2020

World Health Organisation International
< *https://www.who.int/healthsystems/topics/stewardship/en/* >Accessed on October 10, 2020

Yevutsey, S., Heymann, B., Arhin, P., Nazzar, K. (2012) '*Rapid Assessment of the Pilot Phase of Integration of Herbal and Orthodox Medical practices in selected facilities'*. Available at: http://www.moh.gov.gh/wp-content/uploads/2016/02/2012.

Yuan, H. *et al.* (2016) 'The Traditional Medicine and Modern Medicine from Natural Products', *Molecules (Basel, Switzerland)*, 21(5), p. 559. doi: 10.3390/molecules21050559