Forgetting Alma Ata. The routes of medicines in Ghana as an example of the difficult relationship between traditional medicines and Transnational agencies.

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The social actors in the arena of therapies

What I intend to do is to briefly summarize the various figures, or if you prefer the social actors, who crowd the scene of the field of forces of therapy in Ghana to contextualize the discourse on medicines, intended as remedies used by traditional healers. In the following paragraphs, after discussing the integration projects, I will focus on what are generally referred to as traditional medicines, and on the issues related to them, in order to reflect on the difficult relationship between them and the transnational agencies. Finally, I will try to discuss some paradoxes arisen from the encounter, even "from below", between biomedicine and traditional mecicines.

The development of biomedicine has a long history in Ghana, beginning during the colonial period.[1] In 1878, the first hospital was inaugurated in Accra, which had become the capital of the colony a year earlier; this was the embryo of the colony's new healthcare policy that was developed during the last decades of the nineteenth century and the turn of the twentieth century. In fact, in 1878, the colony issued the first law that regulated the organization of hygiene and public health systems in cities (Gale T. S. 1995: 191). Permission was required from the civil authorities to build a new residence; dilapidated houses, if not repaired, were to be demolished; appropriate places to deposit garbage and to slaughter animals were found; the construction of public latrines was encouraged and, lastly, the personal hygiene habits of citizens were, to a large extent, also regulated (Addae S. 1997: 87).

[1] Cf. Addae S. (1997), Gale T.S. (1995), Schirripa P. (2005).

This new health policy was in response to various requirements; first and foremost, there was a new approach to the implementation of the colonial policies. Although colonialism was an experience that lasted nearly a century, during that time it is possible to trace the various policies that arose from different necessities, such as the need to control and govern the country. The first phase, that of conquest, in which military control of the region and its population was the predominant necessity, was, in fact, followed by a period in which, by contrast, aspects connected to the government of the region, and thus to its improvement in terms of infrastructure and economic exploitation, become paramount. It was no longer about control but rather government, which therefore created a very different relationship with the population.

Thus, the new health policies responded to a different need, one which was based on the government of the population through the disciplining of their bodies and which worked through institutions and systems that created new processes of subjectification. Medicine played a central role in this.

Control of the region was obtained through its sanitation and the governance of the bodies of the native peoples. Making the colony healthy was essential, since, for centuries, the entire coast of Guinea had been known as the "The White man's grave". Endemic diseases, such as malaria and yellow fever, and poor hygienic conditions made it very difficult for Europeans living in the region to survive. Addae wrote:

> Before 1880, the towns along the coast of Ghana were notorious for their insanitary state. […] they all contained lagoons which bred swarms of mosquitoes and gave off pungent disagreeable odours. No public or private latrines existed. Excreta was deposited everywhere: in the alleys between the housing blocks of the native, in town outskirts, on beaches. Rubbish was similarly deposited anywhere and everywhere: there was no organized collection of waste and rubbish […] The streets were nothing more than alleyways and paths winding around groups of huts built without any sense of order […] Drinking water was abominable (Addae S. 1997: 86). [trans]

Throughout this period there was an increase in hygiene standards in the colony, while the healthcare facilities built by the government were seen a resource that was almost exclusively for Europeans. Facilities for the local population were limited to missionary dispensaries; however, there were a limited number of these in Ghana at the time compared to other areas colonized by the British: "In contrast to the extensive medical work of missionaries in Nigeria, mission health

work in Ghana was almost entirely limited to a few dispensaries and infant clinics" (Patterson D. K. 1981: 15).

If the health facilities, during this phase, were mainly directed towards the management of the health and sicknesses of the European residents, all the hygiene and sanitary regulations that the colonial government issued at this time, on the other hand, were aimed at disciplining the bodies of the natives. This is in line with what happened in other British colonies, as well as the colonies of other countries at this time; for example, the way in which the work of French psychiatrists in the colonies, was focused, among other things, not only on improving the mental and physical health of the colony, but also on bringing about a general increase in the quality of the living conditions in the colony (Keller R.C. 2007). Another, even more notable example is illustrated in the well-known article by Jean Comaroff who, speaking of the South African colony, makes certain claims that can also be adapted to the situation of colonial Ghana (Comaroff Je. 1993). Comaroff's analysis starts from how the black body was perceived: a place of biological disorder that made it easy prey for communicable diseases. However, this disorder was a sign of a deeper moral and social disorder. The black body was sick, because the behavior and social institutions of the natives were sick. The diversity of institutions and regulations, as often happened in those days, was seen as a weakness, as a lack of order: moral, social and hygienic. The three points listed here constituted three aspects of a single concept. The black man was sick because he was disinclined to abide by proper hygiene rules and due to his poor moral attitude, which made both his social relations and his relationship with the environment "disordered". A medical officer stationed in northern Ghana at that time wrote "it should be realized that the natives of this region are naturally dirty and it is with the greatest difficulty that one can have them washed" (cited in Patterson D. K. 1981: 19).[2]

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[2] This motif often recurs in the letters that residents of European origin write from various towns in the colony to the government asking for tighter implementation of laws regarding hygiene and health control. For example, in 1909 an Englishman who lived in Asamankese complained about the poor hygiene conditions in the town, stating that the streets were filthy and covered in garbage, and the stench that this gave off made the air fetid and unhealthy and had caused various inhabitants to become sick. Obviously, in the opinion of such European residents it was the black inhabitants who were responsible for such filth (*Ghana National Archives*, Accra, ADM 11/1/53, 1909). The inhabitants of Birim District (Eastern Akim) similarly complained about the unhealthy air caused by garbage covering the streets. However, there were also other complaints: the city had grown too quickly and lacked infrastructure. There was only one road wide enough to be passable for wagons and cars, but the natives – for which it seems that the width of the roads did not pose a

What was therefore deemed necessary was to discipline the bodies of the natives to make them compatible with the social, moral and hygiene rules and regulations that had been imported from the motherland. The objective of this form of discipline was to make the black body more docile and useful to the new organization of the market and the mode of production imposed by the colonial government:

> Talk of civilizing Africa [by colonizers] had given way to a practical concern with the hygiene of black populations – and to the project of taming a native workforce. Here, as elsewhere in the colonized world, persons were disciplined and communities redistributed in the name of sanitation and the control of disease. For as blacks became an essential element in the white industrial world, medicine was called upon to regulate their challenging physical presence (Comaroff Je. 1993: 306).

Disciplining the bodies of the natives was accompanied by the disruption of local healthcare practices. For example, this has been noted by Konadu in relation to Ghana, starting from a more general reflection on the relationship between biomedicine, colonialism and the bodies of the natives:

> […] nineteenth century imperialism and biomedicine, which was re-imagined as tropical medicine, they were inseparable and the intimate relationship between disease and empire, in terms of ailing African bodies constructed as vectors of infection, allowing for African exploitation and colonial imposition. The diseased African body, case as "other" or alien through the introduction of co-colonizing diseases such as tuberculosis, necessitated the denigration and suppression of "efficient indigenous healing systems in operation" (Konadu 2008: 48).

If, in the colonial period, the spread of biomedicine was essentially linked to the needs of the motherland to hygienically organize the region and to discipline the bodies of the natives, in the aftermath of independence we find policies that are better organized.

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problem – had a habit of building small wooden terraces on which to dry cocoa in front of their homes, which made the street even narrower. Thus, the natives needed to learn to be clean, to wash, not to throw garbage everywhere, to build their huts in an orderly manner and, above all, not to take up space on the streets with their drying areas, thus making it easier for vehicles carrying goods to pass (*Ghana National Archives*, Accra, 11/1/38 ADM, 1907).

The main objective of the governments that have followed, in accordance with the directives of transnational agencies – most notably the WHO – has been to create a widespread network of biomedical health facilities throughout the country. This has resulted in the building of hospitals, concentrated mainly in large urban areas, and smaller referral facilities, such as health posts; however, there is rarely a doctor to be found at these smaller medical center. In the initial period, trailer-based mobile clinics were also established, tasked with vaccinating the population and attending to the most urgent health problems.

The first president of independent Ghana, Kwame Nkrumah, inaugurated a policy with a socialist orientation, strongly focused on the concept of the developmental state, i.e. the state that becomes an engine for the development of the country through heavy investment in services and infrastructure and, in general, through its predominant presence in the economy and in manufacturing operations. As regards healthcare, the Nkrumah government was commitment to a healthcare system, focused on biomedical facilities, which would be widespread and free of charge. To ensure that possibility, a system of taxation was required, as well as revenue deriving from international aid.

In the following decades, there have been governments of different orientations. As regards healthcare, these various orientations, which can also be linked to the country's precarious financial situation, led to the reintroduction, in 1969, of a charge for health benefits and for medicines, which was intended to relieve the public healthcare deficit.

As I will explain in more detail in the next section, along with the dissemination of primary healthcare, Nkumah also ushered in a policy of recognition of traditional healers.

Below, I will discuss the primary healthcare policy, promoted by the WHO on a global level at the end of the 1980s, and taken up at a national level with the aim of integrating traditional medicines. For the purposes of what I want to explain here, it is important to emphasize that the efforts of these governments – when efforts were made – did not, in fact, change the situation of strong inequality in the access to healthcare resources. Even today, such resources are available mainly in cities, while in rural areas they are rarer and sometimes poorly supplied with medicines and other medical devices.

Economic restructuring plans, which were promoted by the International Monetary Fund in many African countries starting in the 1980s, had a visible effect on Ghanaian healthcare. The retreat of the State from the main sectors of the economy has meant, in the field of healthcare, an increase

in the role played by the private sector. Since the 1980s, successive governments have substantially increased the rates for each type of service: consultations; laboratory tests and other diagnostic procedures; medical, surgical and dental services; hospitalization. At the same time, the price of medicines has also increased, brought about by a change in policies relating to medicines: from a system where the price paid by the patient covered only a portion of the actual cost of the medicine, the rest being borne by the healthcare system, new policies have meant that the price paid by the patient should actually cover the real cost of the medicine used.[3]

Who are the other social actors present in the field of therapies? To summarize, we can think of two main actors: therapeutic practitioners of the spiritual-charismatic and Pentecostal churches, and the various categories of traditional healers.

There is a wide range of literature on the therapeutic role of Pentecostal and spiritual-charismatic churches in Ghana.[4] In relation to what I wish to illustrate here, it is possible to synthesize the discourse by referring briefly to a general description of these types of churches and the underlying concepts of health and disease processes that inform their therapeutic practices.

Although there are profound differences, not least in terms of the history of their creation, between the spiritual churches, also known as independent churches – heirs in many ways of the syncretic churches that emerged in the colonial period – and the Pentecostal churches – which, on the other hand, recognize a direct or indirect ancestry from the Pentecostal movement born in the United States at the beginning of twentieth century – it is possible, in this case, to discuss both together under the same heading. This is also possible due to the fact that in recent decades, the differences have become more nuanced and churches have arisen where it is difficult to discern the Pentecostal aspects from other source elements. In fact, as pointed out by Meyer in a noted review on studies on African churches, it is more correct, today, to define them as charismatic and Pentecostal churches (Meyer B. 2004).

Although the role of churches in the field of therapies is often underestimated by the policy planners of transnational agencies (De Rosny E. 1992), in many ways, their popularity is due in part to their therapeutic work, which is very wide-ranging. In recent years, various authors, for

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[3] On the effects of structural adjustment plans on Ghanaian healthcare, see, among others: Oppong J. R. (2001); Senah (2001); Vasconi E. (2012).

[4] Among others, here, I would like to mention Lanternari V. (1988); Van Dijk R. (1997); Meyer B. (1995; 1997); Onyinah O. (2012); Schirripa P. (1992; 2008; 2014b).

example, have insisted on how these churches provide an overall answer – supernatural, moral and material – to the spread of HIV/AIDS.[5] However, their work is not limited to this. Therapeutic intervention is all-encompassing and covers all the moments in the processes of health and disease. Van Dijk, for example, as regards Ghana, clearly shows how the prayer camps of these churches also act as a protective and propitiatory element for people wishing to migrate to Europe (Van Dijk R. 1997).

As much as profound doctrinal and ideological differences exist between the various churches – especially between the spiritual and Pentecostal churches – I shall endeavor to briefly summarize the perspective behind their therapeutic intervention.

In short, the therapeutic intervention of pastors, or those who have received the gift of healing from the Holy Spirit, is based on the idea that sickness is the result of the action of the Devil upon the world, which, in these cases, is concentrated in the body of the faithful individual. Rather than sickness, we should talk about evil, which should be understood to mean the overarching action of demons that goes beyond the experience of the disease itself, which, in fact, is only one of the possible ways such evil can manifest itself in order to affect the life of the victim as a whole. All kind of misfortune – from financial setbacks to personal problems and disease – may be related to the actions of the Devil. This action is often the result of sinful behavior by individuals who, through this misconduct, pave the way for the Devil: this is the case, for example, of stories related to the occult. In such cases, the individuals, often through the mediation of traditional healers, make a pact with the Devil to get rich. This generally results in disaster and ruin because the Devil claims, in return, the lives of family members or others. This kind of narrative has become widespread in recent years in both rural and urban environments: it is no coincidence that the theme of enrichment, and its (im)morality, is a central point in Africa's neo-liberal narrative.[6]

Therefore, the core of this therapeutic work is the fight against Satan and demons. The story of the disease is then transposed onto a meta-historical plane, and individual experience becomes a refraction of the eternal struggle between divine and demonic principles. Thus, the body of the

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[5] There is now an extensive bibliography on this subject; here I refer, by way of example, to Dilger H. (2007).

[6] On witchcraft in present-day Africa, cf. among others: Comaroff J. - Comaroff J. L. (1993); Geschiere P. (1997); Moore H. L. - Sanders T. (2001) Pavanello (2017). On the relationship between Pentecostalism and neo-liberalism, cf. among others: Comaroff J.- Comaroff J. L. (2001); Comaroff J. (2009); Gifford P. (2003); Meyer B. (2007).

sufferer becomes the theater of war where the struggle between the Holy Spirit and the Devil is played out. The ritual therefore stages this conflict, which is one of the cornerstones of the church's belief system, re-establishing in the faithful a link to this central religious tenet.

With a few exceptions, typically in both the spiritual and Pentecostal churches the therapeutic action takes place through prayers and invocations, or through the laying on of hands. The use of perfumes and oils is rare, and the use of traditional medicines, which are considered demonic, is banned; the synthetic pharmaceuticals of biomedicine are tolerated but not encouraged. For this reason, Lanternari defines them "churches of healing through prayer" (Lanternari V. 1988).

However, when we shift the focus towards so-called traditional medicine, there is a wide and varied landscape to investigate. It is not possible here to summarize all the social actors present, not least because the internal movement of the populations, and the widespread development of new figures, have further complicated the general picture.

I will refer to some specific figures, which I have spoken at length about in my monograph on medical therapies in Ghana. There are two types of healers, which can be traced back to the therapeutic practices of the Akan peoples, i.e. the collection of peoples who live in the central and southern parts of Ghana. Simplifying the picture, I will refer to two types of healers: herbalists (*ninsinlima*, sing. *ninsinli*) and inspired healers (*akomfo*, sing. *okomfo*). In addition, I will speak briefly of the new figures that have appeared in recent decades in the field of therapies. Naturally, in so doing, I will limit myself as much as possible to concentrating primarily on the use of medicines.

Firstly, it is necessary to mention that the boundary between the two categories is not clearly defined. In fact, it is not possible to clearly differentiate between herbalists and inspired healers: both refer to the same perspective on the processes of health and disease and, more importantly, both maintain special relationships with spiritual entities. While it is true that only inspired healers are possessed by the gods, herbalists, too, through divination or invocations when collecting herbs, establish a particular relationship with them.

Moreover, it is not possible to reduce the scope of the *akomfo*'s actions solely to therapeutic activity. Possessed by the traditional gods, they are the guarantors of the proper relationship between the gods and the community. The relationship between a person and his gods is extremely complex; if, on the one hand, possession is the key to spiritual power, on the other

hand, the gods dictate their wishes to the priest, through food or sexual taboos or by forcing him at times to make extremely complex existential choices.

The relationship between an individual and a god very often fits into an intricate tapestry of relations that take place along a matrilineal line for many generations. Indeed, the Akan gods, upon the death of their human host, tend to possess a relative. As I have discussed extensively elsewhere, there are, in fact, specifically prescribed conventions for the transmission of spiritual power and for the subdivision and distribution of the income derived from priestly activities.[7] The god, or rather the particular relationship that is established between the god and the human host, becomes part of this patrimony, in the polysemous sense of this term, as it relates to family and inasmuch as is it passed down through the generations.

As guarantors of the mediation between gods and men, these healers are the leading figures of the annual festivals that each village dedicates to its patron gods. Moreover, they manage and organize all sacred activities: invocations, requests and blessings. Of course, the advance of "religions of the book", most notably Christianity in its various forms, which is dominant in southern Ghana, has reduced, but not eliminated entirely, their public role. Their therapeutic work remains, nonetheless, strong. This too takes place through the intervention of the gods that inhabit them. An *okomfo*, or priest-healer – to reapply the terminology used by Lanternari for the Nzema (Lanternari V. 1988) – during the therapeutic process, from diagnosis to the resolution of the ailment, relies on his special relationship with the gods. It is they who, by possessing him, reveal the root causes of the evil that has afflicted the suppliant; and it is they who will guide the priest-healer in the choice of treatment, indicating whether it should involve sacrifices or expiation, or, conversely, if it should be based on taking herbal medicines. Finally, if the suppliant is persecuted or haunted by a god, they will lead the complex negotiation that will lead to his or her liberation or – something which is a frequent occurrence – the suppliant's decision to become, in turn, a living altar for the god. The path to becoming a priest is complex and painful.

The choice of the god to use an individual as his vessel becomes evident through a disease or sickness; he or she will began to present a variety of symptoms, the most common being linked to bizarre and antisocial behavior, and it is the duty of a priest to discern in them the signs of the calling. Once that is done, the patient, now having become a novice, will begin the special training that will lead him to becoming a healer. He must learn to dance the sacred dance, to control being

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[7] On this topic, cf. Schirripa P. (1995; 1998; 1999; 2001a; 2005).

possessed, to invoke the gods and to recognize the plants that will help him to treat and cure others, as well as the proper way to gather them without nullifying their spiritual power.

More often than not, however, the suppliant who turns to the priest is recognized as a sick person. He or she is plagued by some evil that may be due to the action of a god or a living person, or even, in other cases, due to a cause that refers more immediately to the natural world, as we shall see in the following pages. The treatment is often long and complex and requires, especially if it is a difficult case, the continuous intervention of the priest-healer, who must ensure that the patient scrupulously complies with the prescribed course of treatment and takes the medicines in the right amount and in the appropriate manner. That is why patients are very often transferred, accompanied by family members, to the residence of the priest, who has huts that are set aside for this purpose.

A *ninsinli*, on the other hand, is different. First of all, he is not possessed by the gods. The choice to work as a healer is very often the result of a family tradition: parents or other relatives, who were *ninsinlima*. These family members usually impart herbal knowledge when the individual is an adolescent and they direct him towards this career path. That being said, it is sometimes an interest that develops independently. In any case, a long period of training is required, during which the novice must learn to recognize the signs and symptoms of sicknesses, to divine, to ask for confirmation from the gods on the causes of the problem and on the appropriate action to be taken and, above all, to recognize healing herbs and learn the proper way of collecting them. Indeed, it is believed that the plants will remain inert – they will not be able to counteract the ailment – if they are not collected in the correct way. In this case, it is not only knowing *when* to harvest the plants, a particular root for example, but above all *how*: the power of these plants, as well as parts of animals used in the therapeutic practice, is not inherent in them, but connected to supernatural qualities. These qualities that would inevitably vanish if the *ninsinli* did not follow the proper rules when collected them, for example, if he forgot to pray to ask the gods for permission to uproot a plant.

Like the *okomfo*, the *ninsinli*, in the event of particularly difficult cases, may invite the patient to remain in his compound for the time required to treat the sickness and he usually has some rooms set aside to host patients and those who accompany them. At other times, he will simply prescribe herbal mixtures, poultices or decoctions that the patient will administer personally.

Both *Akomfo* and *ninsinlima* operate by sharing the same point of view as regards the processes of health and disease. There could be several causes. Firstly, there may be an infringement of a taboo or precept. In this case, the gods are punishing the transgressor and consequently, he or she will become sick or be the victim of a series of misfortunes and financial setbacks. In other cases, the disease is a result of a curse sent by another individual or it may be due to the action of another *okomfo* or *ninsinli* using special mixtures that result in the development of the sickness. Very often this course of action was requested by the victim's enemy. In the cases mentioned so far, what emerges is the idea that sickness is the consequence of cosmic or social tension. In short, it stems from a bad relationship between the gods and mankind or between one individual and another.

In recent decades, new figures that do not fall into the two categories described above have also increased in number. Firstly, there are those who claim to be traditional healers, but who are not recognized as such either by the community or by the associations of healers. Individuals who often have not completed their training, who are on the margins of those practices and who try to use their knowledge to make and sell medicines and amulets. They are usually to be found on street corners, on the edges of the market or, more often, at bus stations, alongside the jumble of a myriad of vendors offering fresh water in nylon bags, soft drinks, fruit, raw and cooked food, newspapers, Bibles, books of all kinds, sunglasses and anything else that is possible to sell. Typically, they get onto buses and keep passengers busy during stops, which are often long and tedious stops, by expounding on and praising the healing powers of the plant poultices, creams and powders that they have made in an effort to sell them.

Then, there are those who use the knowledge and practices related to Akan medicine in a syncretistic manner. Often these are accompanied by forms derived from biomedicine, or by Western or Eastern massage techniques or lastly, by oriental medicines. These are figures who enter the field of therapies by claiming a role that distinguishes them considerably from the social actors connected to the world of both traditional medicine and biomedicine. It is difficult to describe them in a unified manner; but I have already described some of them in my monograph on Ghana (Schirripa P. 2005).

As regards the use of substances with a pharmaceutical purpose, there are no substantial differences between the different types of healers briefly outlined here. In general, vegetable, mineral and animal substances are used.[8] Plants can be dried or used freshly picked. As regards

[8] For the types of plants used by healers, see, for the Nzema, Gullà R. (2008).

animals, except in rare cases, dried parts of the body or the fat are used. In any case, the production of these medicines is a complex process that involves knowledge that is not only of a technical nature. In short, it is not enough to know which plant or animal part to use for a specific therapeutic purpose, nor is it enough to know how to make up a poultice with various substances: what is essential, throughout the process – from harvesting to production – is knowledge of the ritual acts that accompany the concrete preparation. As mentioned, this is due to the fact that the collection of a plant for therapeutic use is accompanied by ritual instructions on the time of year and the day of harvest, on the location and on any spells or incantations that are to be uttered during the process. The same goes for the production of medicines, which therefore cannot be considered a purely technical act, but rather a religious activity.

The processes of legitimation, which I will discuss in the next section, and more generally the entry of traditional medicines into a larger market, have led to profound changes in the production and circulation of these medicines, which will be illustrated in the fourth section of this chapter.

The processes of legitimation of medicine in Ghana

I have worked extensively in Ghana: from 1989 to 2006, albeit with a few years of interruption, and also since 2014, as director of the Italian Ethnological Mission in Ghana. Between 1992 and 1998, I worked mainly, although not exclusively, on what was defined at that time as the process of professionalization of traditional medicine. This involved investigating the forms and the ways in which the traditional medicines present in the country were being legitimized in order to plan and organize their inclusion in the national health system. This was not a recent process in Ghana, as the processes of reassessing traditional medicine had begun with its independence, thanks to the actions of Kwame Nkrumah. It was not even a process that was particular to that country alone. Following the impetus that resulted from the WHO's new policies, in particular, which were inaugurated at the 1978 World Assembly in Alma Ata, that focused on primary healthcare and that were in favor of traditional medicines, integration projects between biomedicine and traditional medicines were established or increased in many countries (Schirripa P. - Vulpiani P. 2000a). I will refer briefly to these processes because they are useful to better contextualize the discussion of traditional medicines, how they are marketed and how this fits in with the positioning of traditional healers in the wider field of forces of therapies.

In Ghana, there is a long tradition of policies that focus attention on local therapeutic practices. Immediately after independence,[9] the then president Kwame Nkrumah implemented a policy aimed at renewed appreciation for and the revitalization of African culture, art and medicine, based on the fact that "there was a conscious quest for an African way of doing things to distinguished the African from the European" (Twumasi P. A. - Warren D. M. 1986: 122). This arose from the fact that Ghana, from a simple administrative unit of the colonial era that governed over peoples who were quite different from and often in competition with each other, had become a single nation state. Therefore, it was necessary to create a form of national consciousness and identity as the foundation of a feeling of unity among the different peoples in the country, which would unite them in common opposition to the European colonizer. Hence the need to *invent* a super-tribal, "African way" that was in opposition to the European system.

Nkrumah's policies regarding traditional medicines resulted in the creation of an association whose purpose was to bring together all the traditional healers, both herbalists and spiritual healers, in the country (*Ghana Psychic and Traditional Healers Association*). In 1974, General Acheampong, who in many ways continued the policies of Nkrumah, established the *Centre for Scientific Research into Plant Medicine*, whose main objective was the scientific study of the herbal remedies used by healers, to isolate potential active ingredients in order to enable the industrial production of medicines that could be derived from those remedies (Twumasi P.A. - Warren D.M. 1986; Schirripa P. 1993).[4] While these initiatives did express a genuine interest in the traditional knowledge of the people of Ghana, it is possible to spy a purely political motivation: the creation of a national consciousness. In this sense, traditional medicine acted as a symbolic operator; as a reminder to the Ghanaian peoples of their own knowledge, of the pride they should take in their roots rather than the culture that was imposed by the colonizer (and later by the European foreigner), of the rediscovery of the value and the techniques of this knowledge, of the importance of the unity of the Black peoples against the power of Europeans. These are the messages that the new-found appreciation that traditional medicine has reclaimed still today convey in Ghana and in many other African countries. It goes without saying that in this way the advocate of the official recognition of traditional medicine, who has, in fact, become the defender of *true* African values and tradition, has acquired new-found legitimacy.

[9] Ghana achieved independence in 1957.

In the colonial era, European powers generally assumed a closed-minded attitude towards the therapeutic practices of colonized cultures. Such an attitude was born, on the one hand, from the ethnocentric conviction of the fallacy of the therapeutic knowledge of the subjugated peoples, seen as belonging to the same category as magical and superstitious practices; on the other, by a desire to weaken the social prestige and charisma of traditional medicine practitioners. Indeed, these latter, who also played a religious role, had a strong influence on their society and thus could become potentially dangerous political leaders against the colonizers.

The legislation concerning the practice of therapeutic activities were modeled in the colonies on those of the motherland. Differences – at times significant differences – may be discerned between the laws in force in the colonies of Britain, France or Germany, etc. but despite these differences, they all imposed what Stepan defines as a monopolistic system:

> […] the monopolistic system under which health care were dispensed by university-trained physicians and a few other profession with formal training, such as dentists, pharmacists, and nurses (Stepan J. 1983: 293).

Of course, this legislation weakened the role and prestige of traditional healers, who very quickly found themselves forced to operate in clandestine conditions and on the margins of the healthcare system.

This type of legislation was accompanied by a healthcare policy that was entirely based on biomedicine and on creating the necessary infrastructure for its development (pharmacies, dispensaries, hospitals etc.). This development was focused on the inner cities, where the European population mostly resided. Yet, it should be added that the numerous missionaries present on the continent built dispensaries and other health facilities in rural areas or at least in areas which were more isolated from the point of view of healthcare (Schirripa P. 2000b).

In the aftermath of independence, this situation did not change much. The subsequent governments in charge of these new countries had different, and often contradictory, attitudes towards traditional therapeutic practices. In brief, three different options can be distinguished here (Kikhela N. -Bibeau G. - Corin E. 1979; Stepan J. 1983). The first is the failure to legalize traditional medicine, leading to its continued existence on the margins of the healthcare system, as happened in Kenya and the Ivory Coast where, at least for a time, the policies that prevailed tended towards modernization and progress, understood as the acquisition of Western technology and the

repudiation of their own traditional techniques. The second consists of a passive admission, with the informal recognition of traditional practitioners; according to this criterion "the state is officially concerned only with the modern medical sector, leaving the traditional one to develop on its own without state control" (Kikhela N. - Bibeau G. - Corin E. 1979 1979: 218). The third, which encompasses the situation in Ghana, involves the legislative recognition of traditional healers. Often, however, this recognition did not mean the enactment of laws that clearly regulated the spaces of intervention they were allowed to operate within. In principle, this legal recognition allowed for traditional healers to be licensed, and for the recognition, or the creation, of associations of healers.[10]

Efforts made to receive official recognition for traditional medicine did not have a significant influence on the healthcare policies of various countries. Indeed, it could be said that these newly independent African countries continued with the decisions that had already been adopted by the colonial administrations: their main concerns were focused on strengthening and expanding the existing modern healthcare infrastructure, and only to a lesser degree on prevention policies based on sanitation and environmental improvements. Undoubtedly, what lay behind this was the provision for spending, both in terms of propaganda and politics, on works that were immediately visible, such as hospitals (Twumasi P. A. 1981: 148 ff.), and the emergence of a healthcare policy based on emergency management (Hours B. 1987). Naturally, the emergence of such policies were not extraneous to the attitudes of international bodies, mainly of the WHO and organizations dealing with aid and international cooperation projects, that conceived of healthcare aid only in terms of the development of a system based on the precepts and the specificity of biomedicine.

Around the 1970s there was a profound change, even by the World Health Organization, in the approach to the therapeutic practices of African cultures.[11] It was a long and laborious process that resulted in the implementation of primary healthcare programs based on the inclusion of traditional healers in primary healthcare facilities. The culmination of this attitude can be considered the declaration adopted by the World Health Organization in 1978 in Alma-Ata (Kazakhstan), in which member countries were advised to promote and facilitate, in areas where

[10] For more information on the actual conduct of the various governments that may be included in this third option, see the essays contained in the first part of Last M. - Chavunduka G. L. (1986).

[11] On the development of the WHO's policies towards African healers, see, in particular, Akebele O. (1984); Bernardi B. (1984); Bibeau G. (1979); Coppo P. (1988); Coppo P. - Keita A. (1990).

this could prove useful (as is the case in third world countries), the use of traditional medicine in the implementation of healthcare programs, and its interaction with biomedicine (WHO 1978).

In that document, to achieve the ambitious goal of healthcare for all in the span of two decades, what was proposed as the cornerstone of the strategy, primarily in developing countries, was the strengthening of primary health care. In short, rather than investing in the construction of expensive centralized facilities, it was necessary to give priority to the creation of a network of basic services. This new perspective stemmed from a series of very critical considerations on the results achieved by the WHO in previous decades, and especially after having taken stock of the harsh reality of the healthcare situation in third world countries at the time. In fact, it was easy to see that in those countries, 80% of the population did not use healthcare services, which were generally focused on biomedicine, and that they almost exclusively turned to the different therapeutic traditions – i.e. traditional medicines – present in the country. The reason for this situation was easy to intuit. Most of the health services in those countries were concentrated in urban areas. There were several reasons for this: first and foremost, because these are the areas with the greatest concentration of the population; but also these urban areas were richer, making it easier for doctors to open clinics there rather than to provide services that offered little in the way of remuneration in rural areas.[12] Therefore, these areas were underserved by healthcare services, and the dispersion of the population made it difficult for a large number of people to have easy access to such services. For several decades, it was thought that the solution essentially consisted in expanding the network of healthcare services throughout in the region. The problem was that the idea of developing this network and bringing medical personnel to these rural areas was revealed to be unmanageable: there were too few resources, both financial and human, to hope for a positive outcome. Furthermore, investments in healthcare continued to be concentrated in the urban areas and mainly on curative rather than preventative practices.

The ever-increasing costs involved in the construction of infrastructure and, especially, the technological dependence on the West in the medical sector, as well as the need to import a large number of medicines, has caused an increasingly burdensome debt for the various national governments (Destexhe A. 1987).

[12] However, it should be pointed out that in urban areas, precisely because they are wealthier, all types of resources could be found, not only biomedicine. In fact, in cities it is possible to find quite a significant number of traditional healers and certainly a greater number of services offered by them. This is, for example, what has been highlighted by Anyinam C. (1991) as regards Kumasi, Ghana's second largest city.

Naturally, the centralization of biomedical healthcare resources is but one of the difficulties that can be detected. In reality, what should also be noted is how such services, precisely because they are based on biomedicine, have often proved incompatible with the views and concepts of health and disease processes of the local populations. Thus, there were undoubtedly structural difficulties – the concentration of services in urban areas – but also a cultural divide. As I will clarify in more detail in the next section, the premises of biomedicine are far removed from the local concepts as regards etiologies and the methods of therapeutic intervention. This made the use of those healthcare services even more problematic.

The new strategy inaugurated by the WHO was mainly based on Primary Health Care (PHC), the use of resources already available *in situ* and the participation of the community to plan and improve healthcare services. With the inauguration of the PHC strategy, the WHO moved its interest from a healthcare policy based on hospitals to one based on communities; moreover, rather than concentrate resources and efforts on the education of a limited number of doctors, through a multi-year educational process, who then often went on to carry out their activities in large urban centers, the preference was to focus on the education of a greater number of village health workers (known as local health workers or community health workers) through short courses.

It was just as this concept was being outlined that Pillsbury (Pillsbury B. 1979) published an article in the prestigious journal of *Social Sciences and Medicine* whose title almost seems as if it were a programmatic manifesto: “Reaching the rural poor: indigenous health practitioners are there already”. This text proposed the use of traditional healers to ensure widespread primary healthcare coverage, which was becoming the new backbone of intervention policies. What is more, the work that anthropologists had carried out, in Africa and elsewhere, up to that point, had made it possible for traditional medicines to be understood in a new light. In fact, this research led people to consider "other" therapeutic traditions not as a juxtaposed collection of herbal and manipulative practices – empirically proved to be more or less effective – and conceptions of sickness and magical intervention of a more dubious operational nature, but rather as integrated and coherent systems where the empirical dimension derives from, and is strongly correlated to, a broader scheme made up of symbolic and cognitive aspects. Furthermore, such systems, in addition to manifesting a high degree of internal coherence, operate not only on the level of the etiology and treatment of the disease, but they are established on a more global dimension in which even the prevention of disease and the maintenance of the state of health play a

fundamental role (Janzen J. 1978; 1979). Traces of this new awareness, which could be called legitimacy –certainly cultural legitimacy, but also in terms of the operational and therapeutic nature of traditional medicines – can be found in the aforementioned document from Alma-Ata, where it is not by chance that traditional medicines are defined as: available, accessible, adaptable and compatible (Anyinam C. 1987). They are available because they are widespread throughout the region; accessible because they are easy to reach, although it must be said that their cost is not always less than those found in biomedical facilities; adaptable because, unlike what one might initially think, these are not therapeutic traditions that are fixed and immutable, on the contrary, they are permeable to change and adaptable to changing contexts; finally, they are compatible, precisely because they share the same cultural perspectives and the same language as the local population in relation to health and disease processes. Of course these propositions appear, in the eyes of an anthropologist, much too optimistic and decidedly simplistic, since they do not take into account the complexity of ongoing cultural dynamics, nor the power relations within the field of therapies through which biomedicine and traditional medicines position themselves and, in many ways, create for themselves (Schirripa P. 2005).

White man's things? What remains of the integration projects

In the previous sections, I introduced the social actors of medical therapy and the broader context in which the integration projects, often carried out by international agencies and NGOs, between the various types of medicine should be placed. Here, I will instead reflect in more detail on the projects themselves and their results, which are often very disappointing in relation to the expectations they had created.

These projects have often encountered many difficulties in their implementation. At times it was simply the very idea of cooperation that was opposed, by both biomedical staff and traditional healthcare workers. Certainly, there were a greater number of projects developed that often exclusively involved traditional midwives (Pillsbury B. 1982). In Ghana, too, a similar process occurred: in 1970, the *Danfa Comprehensive Rural Health Project* was inaugurated, which was based directly on the training of traditional midwives with the aim of ensuring greater hygiene and healthcare protection for the mother and the unborn child.

Albeit less widespread, there were, nevertheless, several projects that had the development of forms of collaboration between traditional healers and the healthcare system as their primary focus. Merely in order to better highlight the potential, the risks and the uncertainties that I mentioned in passing at the end of the last section, I will briefly describe the experience of the first of these projects: the *Primary Health Care Training for Indigenous Healers Programme* (PRHETIH), which was established in 1979 in Techiman, in the Brong-Ahafo region. The program provided training for traditional healers that focused on the preparation and conservation of medicinal plants in ways that conformed to basic hygiene standards. Moreover, it also taught these healers some basic concepts that would allows them to recognize – from the point of view of biomedical nosology – some of the most widespread diseases in the region (from infantile diarrhea to convulsions and measles), while also equipping them with basic first aid tools and instruments so as to enable these healers to perform first aid. They were also informed of the need to send serious cases to the nearest medical center and lastly, they were given family planning items.

The program ended in 1988; up to that point, more than 120 healers had been trained. It was then revived in 1990, but with less ambitious goals; in fact, it was limited to merely providing healers with some elements of first aid and basic medicine.

How can the outcome of that initiative be assessed? The objective was clear, at least in the intentions of one of its main organizers, D. M. Warren: starting from substantial mutual respect for both forms of medical therapy, to encourage cooperation between the two so as to improve the health of the population. We have seen how this objective was translated in practice: traditional healers were instructed in a number of basic biomedical concepts, both in terms of hygiene and healthcare, with the objective, on the one hand, of making their practices safer and, on the other hand – through the encouragement of collaboration – of ensuring that the most serious cases should be sent to the nearest biomedical unit. However, not much was done to familiarize medical staff with a biomedical background with the therapeutic practices of the healers.

A few years later, a Dutch anthropologist, Peter Ventevogel, while carrying out research in Techiman, assessed the outcome of what remained of that experience. The title of his book demonstrates to what extent he is critical of the results: *White man's things*. The content of these courses were considered by the healers he interviewed not as basic concepts that they should apply but, in reality, as "white man's things", thereby emphasizing the cultural distance, if not effectively the incompatibility, between the two traditions of knowledge (Ventevogel P. 1996).

The first criticism relates to the exchange of knowledge itself: the program was organized in such a way that traditional healers were given the basics of biomedicine, but not, conversely, that biomedical professionals acquired information about traditional practices and their horizon of meaning. In addition, the program was based on an idea that proved delusive: that it was enough to provide these traditional healers with biomedical tools to make them change their medical intervention practices. In other words, it did not take into account the fact that these practices are interwoven with a precise horizon of meaning, and that they derive from specific ideas of health and disease processes. In short, in spite of these training programs, Ventevogel's study demonstrates how the healers continued to apply their own practices without taking biomedical etiologies and practices – *white man's things* – into account. It is the extent of this cultural distance and the lack of consideration of traditional practices as part of a larger system of reference that are used to measure the limits of that intervention project.

Thus, should the outcome of this program, which is similar to many others, be negatively assessed? Undoubtedly, we must bear in mind the limits that have been reported so as to plan more effective healthcare cooperation interventions in the future. Programs that succeed in taking into account the fact that traditional therapeutic practices should be seen within the entire horizon of meaning. That such an exchange, if it is to be productive and lucrative, should be conceived of along the lines of an equal exchange of concepts and practices rather than a one-way transfer of ideas. In addition, such programs must take account of the wider context, and therefore must not overlook an analysis of the therapeutic practices in their complexity, as well as the dynamics of exchange and syncretism and, even more so, the relationships of power and resistance within the field of therapies.

But is there reason to consider a possible and profitable collaboration as something that might be feasible? Speaking about the behavior of patients Ventevogel writes:

> Inhabitants […] stated that they freely use both the Western and the traditional medical facilities, independent of age, sex or religious denomination. People distinguish between diseases that should be treated with traditional therapy and diseases that are better brought to a biomedical institution. Illnesses are treated in two 'circuits' of health care: the official biomedical system and the traditional 'system' of healers using mostly indigenous remedies. Patients present different kinds of complaints to each system. Both forms of medicine label complaints with their own diagnoses, based on different etiologies, and apply different therapies (1996: 117).

It goes without saying that this “bottom-up integration”, albeit positive, should be investigated in terms of the social dynamics that it triggers. In the following sections, while discussing markets and the practices of indigenization, I shall endeavor to analyze some of these dynamics.

Herb markets and the illicit sale of medicines: the informal circuit of the circulation of medicines

I can say that since 1992, when I started to work on the processes of professionalization of traditional medicine in Ghana, I quickly encountered and had the opportunity to reflect on medical herb markets. My PhD research, which was on African independent churches, had taken place in Accra and therefore, I was moving in a familiar environment. Many of the people I had met during my initial research accompanied me once again in the years I was to spend working on traditional medicine.[13] It was a friend of mine, whom I had met through the owner of the house I was staying in, who one day, having heard about my interest in traditional medicines in the country, brought me to the largest market of medical herbs in Accra, normally called by the inhabitants of the city the *juju market*. These are my first impressions, which I reported in an article published a few months later:

> In the center of Accra, located between crumbling buildings and others that still show the vestiges of the colonial era, near the Anglican cathedral, is the timber market, where the masons and carpenters come from all over the city to buy what they need. If you move deeper into this market, between the warehouses that sell wooden beams and other construction materials, you will find yourself confronted with a very particular place. Suddenly, the wood and building materials give way to a space for stalls, placed within the perimeter of a small block, in which a haphazard pile of objects are offered for sale, including amulets, clay cones, roots, dried, powdered or fresh branches and leaves, dried chameleons and parts of other animals. What is most striking to first-time visitors are the strong smells: the enveloping scent of plants and flowers and the strong and penetrating odor of pieces of animals left to dry;

[13] Here I am referring to Frempong, a priest-healer I had met as a member of the Neotraditional Church of Afrkania (Schirripa P. 1992), and who, precisely because he was a healer, worked for quite some time with me, accompanying me during my long observations at the consultation rooms of healers and carrying out the role of interpreter, as well as providing me with important first-hand information.

> these prevail considerably over the swirl of colors and objects on display. This is the *juju market*, where the sellers of items connected with magic and traditional medicine are concentrated, and where the *akomfo* and herbalists of Accra, as well as ordinary people, visit on a daily basis to buy what they need to prepare plant poultices, decoctions or to procure what is needed for spells, charms and protection rituals.
> Confined, hidden inside the large carpenters' market, the *juju market* buzzes with people and activity, which is no different from the many other markets where other types of goods are sold that are scattered throughout the city. At every stall there are people intent on looking through the merchandise in search of a particular product, or busy negotiating the price of what interests him or her. (Schirripa P. 1993: 63)

The market I visited is just one of many medical herb markets found in Ghana. Sometimes they are autonomous markets, but more often they make up part of a larger market. The goods that are found there are varied, and therein lies the big difference with what we have seen earlier in relation to Ethiopia. Next to the raw, unprocessed products, there are packaged medicines. In addition, the variety of raw products for sale is greater than what I encountered, years later, in Ethiopia. Herbs, roots and barks are accompanied by live animals, such as chameleons, or dried animals, available to buy whole or sold in individual parts.

The packaged products come in various forms, and this is the case both in the larger markets of urban centers and in those found in rural areas. Indeed, it is easy to come across decoctions and infusions in soft drink bottles, or cones of clay mixed with herbs. Or, finally, herbal compounds that are kept in tin boxes or in bags before being sold. However, along with these, it is increasingly easy to find new types of packaging. More and more traditional medicines can be found pre-packaged, and in forms that explicitly resemble the synthetic medicines of biomedicine. Tablets made of crushed and pressed herbal compounds come in blister packs placed inside cardboard box-style packaging on which the medical indications and directions for use are printed; the same is true for infusions and ointments.

However, it would be reductive to read this process as a mere aping of biomedicine, or even as an adaptation strategy, which, in his time, Landy had done for the American *curanderos* (Landy D. 1974), or as an indicator of the transition of healers towards modernity,[14] which is inevitably

[14] For example, Oppong reads the current changes in the practices and the underlying ideologies of the processes of health and disease of healers as signs of their "transition" (Oppong A. C. K. 1989).

presumed to demonstrate their progressive movement towards the practices and ideologies of the West. I would like to remind the reader of the strong criticism of this attitude made by Jean and John L. Comaroff in the introduction to *Modernity and its malcontents* (Comaroff J.- Comaroff J. L. 1993). The two anthropologists emphasized how behind the idea that modernity could only manifest itself in the forms that have prevailed in the West, both in terms of use of the technology and the disenchantment in the world, there was an underlying, and widespread, evolutionary option: those who do not participate in the forms of modernity that have been historically established in the West cannot be called modern, thus outlining a teleology that has had its own outcome in Western modernity. The climate at the time of their work was fully postmodern, and it was with a good dose of irony that the Comaroffs noted that modernity was, all things considered, the last great narrative that – unlike what had happened to the Enlightenment, Marxism, etc – not even the corrosive Postmodern criticism had managed to undermine.

What is more, this is not about old wine (traditional medicines) in new casks ("modern" packaging). In fact, the new forms in which traditional medicines are presented in the markets refer to the complex dynamics of legitimization that I have outlined above. Moreover, this cannot be seen outside of a more general analysis of the overall circulation of medicines, including synthetic biomedicines.

For this reason, I believe that analyzing both the circulation of these new forms of traditional medicines and the illicit sale of synthetic medicines together will allow us to find unprecedented connections.

The traditional medicines sold in markets, as I have mentioned, can appear in very different forms. Sometimes, it is not correct to talk about packaging: the compounds are stored loose in large sacks then sold by weight or in the quantity required by the customer or, if liquids, in bottles of every shape, material and color. What we are dealing with here are containers that have been re-adapted for use with these medicines. When dealing with loose medicines the same principle is found: the product is given to the customer in small bags, wrapped in newspaper or in plastic bottles. In other words, there is nothing in the packaging that distinguishes a given compound from another: the patient knows what he or she has bought because they have talked to the seller and requested a specific medicine or they have entrusted the herb seller to indicate which product would be more effective to tackle a given problem.

The markets of medicinal plants in Ghana have been analyzed, in addition to my own research, by Renato Libanora, in Accra (Libanora R. 1999; 2003) and by Barbara Quarta, in Nzema (Quarta B. 2008). The picture that emerges, despite the different tone of the analysis, is, in essence, that the sale of raw products and traditional medicines is a mostly female activity, even if the same level of exclusivity that I noticed in Ethiopia cannot be found here. As already mentioned, alongside the raw products, pre-prepared medicinal compounds are also available for sale. There is an interesting fact to be highlighted here: as has already been seen for Ethiopia and as Libanora and Quarta have reported, there is, once again, a noticeable conflict and tension between the individuals who sell herbs in the markets and the traditional healers. The reason for this tension is connected to the monopoly of therapeutic work: by selling packaged remedies, the herb sellers provide their customers with recommendations on their use and prescribe them for certain diseases and therefore, they are in open competition with the healers. Thus, this tension is based on the positioning of the two groups of social actors in the field of forces of therapies: by prescribing medicines and dispensing advice, the sellers claim their own therapeutic autonomy, which puts them in direct competition with healers. From this perspective, a fact provided by Barbara Quarta is of particular interest: “In order to have permission to sell traditional medicines, membership to one of the associations of healers in the district is required, as well as payment of license and membership card fees” (Quarta B. 2008: 55). In practice, these herb sellers, in order to conduct their trade, must be affiliated with one of the associations of healers. Thus, these associations, apart from obtaining a moderate monetary gain, impose their control over sales, and position the sellers within the hierarchies of traditional medicine. Such associations are dominated by healers: to be eligible, herb sellers must be authorized by the leaders of the association, thus, inevitably by the healers themselves. Through affiliation, the sellers join the ranks of traditional medical practitioners, but at the price of legitimizing the authority of the healers. This is the “double game” of legitimization (Schirripa 2005): those who legitimize receive in return a form, albeit different, of legitimacy. Whenever the role of herb sellers is recognized, the healers receive legitimacy, because it is they who ensure the quality of those they have legitimized. By conferring on themselves the authority to legitimize, the healers, by legitimizing herb sellers, legitimize themselves as “guarantors” of traditional medicine.

The products sold at markets, as already seen for Ethiopia, have different origins. Some are procured directly by the sellers, especially herbs, others are purchased from wholesalers. Even more so than in Ethiopia, we are faced with a purchase chain that goes beyond national

boundaries: some of the products come from other West African countries, such as Nigeria. Moreover, just like in Ethiopia, sellers buy their goods on credit, and pay the wholesalers on their next visit. However, what varies enormously in the case of Ghana is the quantity of goods and the variety of products available.

In addition, for over a decade, the sale of traditional medicines which have been produced in a semi-industrial manner has become increasingly common, both in the markets and in stores. I do not use the term semi-industrial to specifically refer to the size of production, nor the extent of its dissemination. I have just mentioned how the raw materials and some traditional medicines travel through national and transnational chains of commerce. Rather, I am referring to how they are produced and packed: these are medicines that undergo a process of material processing that can no longer be considered handcrafted and, most importantly, they are packaged according to industrial standards.

This is not a phenomenon that is limited to Ghana, but one which is found in many African countries. For example, Emanuelle Simon analyzed these types of medicines in Benin (Simon E. 2008). His analysis is part of a larger work on the use of various herbal medicines in the treatment of HIV/AIDS, taking into account both traditional medicines and herbal and phytotherapeutic products that are imported from Europe and Asia. For the purposes of the current discussion, it is important to underline how, when talking about what she calls the neo-traditional revival, Emanuelle Simon also discusses semi-industrially processed traditional medicines. The anthropologist returns to this topic in an article written in collaboration with Marc Egrot, also on the situation in Benin (Simon E. - Egrot M. 2012). Here, once again, the two authors, while discussing the market for traditional medicines, in this case from a wider perspective covering the entire industry, reiterate what Simon had already said earlier: such medicines have their own sales circuit and they are presented in packets similar to Western medicines. The two authors also take up once again the discussion of phytotherapeutic medicines that are imported from the West. What is very interesting, in their analysis, is that these products are considered traditional medicines; moreover, they both occupy a market segment that is seen as opposite to biomedicine. In short, the rift between medicines appears not to depend on their origin, i.e. local or Western, but rather on other factors: firstly, the nature of medicines of plant origin, as opposed to those which come from synthesis in biomedicine. In many ways, I would say, what is re-proposed here is the subdivision that has already been discussed by Dozon: what is meant by the term “traditional” is all the knowledge and therapeutic products that differ from biomedicine. Whatever their origin

and provenance, such medicines are grouped together as being the same because they are opposite to those of biomedicine.

These traditional medicines come in packaging similar to those of synthetic medicines: not only are they given a specific trade name, but they also include therapeutic indications with a list of ingredients and an expiration date. Although they show these similarities, this packaging relies heavily on references to tradition and, in many ways, to Africa. This can be seen, in the names of the products, but perhaps more obviously in the illustrations on the packaging, which are stylistically reminiscent of traditional designs, have references to traditional healing tools, healers, or lastly, to a map of the continent. Therefore, there is an interesting antinomic game being played here: while presenting themselves in "modern" packaging, these medicines are claiming a link with "tradition", or better yet, with a reified and essentialized tradition, which is, above all, abstract from the concrete dynamics that they have invested in in recent decades.

Through this rhetorical game, which refers to both tradition and the material form of Western medicines at one and the same time, the manufacturers of semi-industrial traditional medicines have carved out their own space in the market of therapies, differentiating themselves both from traditional products and from those of biomedical synthesis.

This has been carried out through a process of "branding" that is not related to a specific trademark or brand name or even a group of brands. The rhetorical game revealed by the product labels rests on a larger dynamic: the legitimacy of traditional medicine. The processes of legitimation, through precise social and cultural dynamics, have produced a certain idea of reified traditional medicine, which has become one of the signs of the identity of the nation. In this sense, it is tied to identity politics that, as I said in the introductory chapters, should also be interpreted as the process of museumification. If traditional medicine has become a usable brand in the labeling of semi-industrial traditional medicines, it is because it has already become a cultural commodity (Palumbo B. 2013).

In adjacent areas, and often in the same areas, when it comes to small stalls outside of markets or by the side of the roads, synthetic medicines can also be found. The illicit sale of synthetic medicines has been widely analyzed in various African countries, especially in West Africa.[15]

[15]Cf. for Ghana: Bierlich B (2000), for Senegal: Fassin D. (1985; 1992), for Cameroon: van der Geest S. (1987; 1991).

It is not possible to interpret the phenomenon in the same way in different countries, because the rules of procurement and distribution of medicines are different. In Ghana, which follows the customs of other countries that were once part of the British Empire, the sale of medicines has a good degree of liberalization. The same is true for import channels. Yet, in spite of the fact that even in medium-sized villages there are pharmacies and drug-shops, the phenomenon of black market sales is widespread. Most of those medicines are of an illicit origin, but that does not mean that their price is lower than in pharmacies. It is a complex and multifaceted phenomenon that cannot be explained univocally, except at the risk of seriously oversimplifying the issue. Certainly, being able to acquire medicines immediately, without a prescription and without consulting a healthcare professional is an important consideration. In addition, there is the possibility of purchasing minimum quantities, which would therefore have less of an impact on an individual's daily budget; when medicines are purchased in pharmacies, the staff member gives the customer the quantity indicated in the prescription: so if, for example, a two-week treatment involves taking two pills a day, the customer will receive 28 pills. Naturally, in this case, the customer will have to immediately pay a considerable sum of money. In contrast, if the customer turns instead to a street vendor, he or she can purchase a smaller number of pills, thus spreading the expense of treatment over a longer period of time. For those who making a living from a small business, occasional work or legal and illegal odd jobs, the deferment of expense becomes an important tactic in the management of their personal finances. Moreover, these vendors are often to be found on the edge of the markets, which makes buying from them easier and faster. Finally, it may also happen that the vendors of illicit medicines help to supplement shortages of medicines in pharmacies.

In many ways, the two circuits that I have described here overlap, defining what we can call the informal market of medicines. A market where the rules are very different from those of the formal market. Where trading and distribution spaces are more flexible, and where the purchase of goods follows the rules of the traditional markets.

Semantic translations and indigenization practices

I have already discussed the circulation of medicines (Schirripa 2015, 2019), reflecting - among other things - on how they move beyond the context in which they were produced and, also, beyond the medical traditions in which those objects are inserted as part of therapeutic practices.

It is precisely the materiality of medicines, in many ways, that facilitates their fast circulation, as well as a type of circulation which goes beyond the context of production (van der Geest S.- Whyte S. R. 1989). Materiality contributes to creating a particular “regime of values” and encourages certain forms of circulation. It is precisely because medicines are “things”, material objects, that they travel so fast: they move quickly, they are exchanged easily from hand to hand, they are preserved for future use. Being material objects, they can be extracted easily from the context of human relationships and of the symbolic and practical meanings in which they were produced. As objects, they pass through different contexts and travel faster than the traditions and the overall apparatus of the therapeutic knowledge in which they were produced. They move about and, in new contexts, can enter different exchange circuits, and, even more so, can take on different meanings and uses than were present in their original context, thereby following the fate of many objects in their move from one social context to another context.[16]In

During their travels, the material objects of medical care carry with them, or rather they leave behind, entire symbolic structures and sets of practices, both susceptible to being re-signified in the new context. Anthropologists often refer to this using the expression “practices of indigenization” (Bledsoe C. H. - Goubaud M. F. 1985).

Sometimes such practices can affect the way a medicine is used. For example, Kenyan fishermen spread antibiotic powder directly onto wounds after breaking the capsules, which have been manufactured to be swallowed (Birungi H. 1998). Often what changes is the context in which a practice takes place. Birungi also clearly explains how the use of injection therapy has entered the scene of therapeutic practices in Uganda through a process of “domestication”, which has involved a change of the social actors involved.

In many ways, in various African situations, syringes and injection therapy are treated as a synecdoche for biomedicine and synthetic pharmaceuticals (Whyte S.R. - van der Geest S. 1994). Injecting the medicine is considered to be the most effective way of taking it, because it “works fast” by injection. What is interesting in the case of Uganda is that in order to be used, the

[16] Although it may appear trivial, I would like to point out how Lévi-Strauss, referring to the circulation of objects between different cultural and social contexts, remarked on the need to consider the new symbolic connotations that they may take on: “An ax, on the contrary, does not generate another axe. There will always be a basic difference between two identical tools, or two tools which different in function but are similar in form, because one does not stem from the other; rather, each of them is the product of a system of representations” (Lévi-Strauss C. 1963 [1958]: 4).

injection must be administered by a person with whom the patient has had a pre-existing social relationship. This means that the injection will be made by a relative or neighbor; people will only go to a hospital if they are certain of having had direct or indirect social contact with a nurse or some other staff member. The effectiveness of injection therapy, therefore, does not rest on the action of the medicine per se, but rather on the fact that it is inserted into a network of social relations: it is the trust that the patient has in another person, trust that derives from a prior social relationship, that guarantees the accurateness of the clinical act. In this way both the medicine and the therapy take on a symbolic dimension of medical care. Thus, we have a reversal: injection therapy, rather than representing a neutral act, a technique that introduces into the body a medicine whose efficacy depends on the pharmacodynamics of molecules, which relates to the "naturalization" of the disease and the treatment, becomes a social and symbolic act, a way through which the disease and treatment are "denaturalized" and "re-socialized". The domestication of the therapy, therefore, allows for the social data that the naturalization process of the disease carried out by biomedicine had eliminated to once again take center stage.[17]

These types of practices are referred to as "indigenization", meaning:

> the process of adaptation to the local social and cultural environment that Western biomedicine undergoes when it becomes part of a non-Western medical system. However, it could also refer to the inclusion of aspects of non-Western medical traditions into biomedicine (for example acupuncture) (Pool R. - Geissler W. 2005: 101).

Thus, it is not merely the process by which biomedical devices, technologies, techniques and objects travel through different contexts and are translated and adapted within these contexts. This is also an inversion process through which biomedicine must translate and adapt to aspects of other traditions. The example of acupuncture is particularly apt: to be accepted within the sphere of biomedicine, where it is now mainly used as a means of relieving pain, it had to face a reduction process in which aspects that are more properly related to an overall idea of the correspondence

[17] Here, I am referring to those social actions through which biomedicine is conceived of, precisely through naturalization and de-socialization, as universal. Angel Martínez Hernáez speaks of this process emphasizing three fundamental principles: asociality, universality and neutrality, which are seen as devices to provide a certain invisibility to the condition of biomedicine, which is instead a system of knowledge that has historically been constructed from and equipped with specific socio-political and cultural conditions (Martínez Hernáez A. 2000).

between macrocosm and the human body, understood as a microcosm, and especially the more symbolic and religious references were obscured or removed.[18] In short, its adaptation process led to it being reduced to a mere technique.

However, here I would like to reflect on the process of indigenization that I observed in Ghana and which strikes me as interesting due to the elements of semantic translation that it involves.

I have already discussed *kooko* elsewhere (Schirripa P. 2001b; 2005), here, I will summarize the fundamental features of this Akan nosological category to contextualize the process of indigenization that I will discuss later.

It is obviously impossible to constrain a nosological category that belongs to a given therapeutic universe within those of biomedicine. This is a problem that is cautioned against in medical anthropology,[19] because very often we are faced with fluid, indeterminate, sometimes contradictory categories. In other words, the therapeutic knowledge of the healers that we are confronted with in the field does not belong to a rigid and permanently defined corpus. More often than not, it is a flexible knowledge system, in which diagnoses and interpretations are adjusted and shaped as the therapy is carried out and during meetings with patients. What is more, the same nosological category can have different descriptions when one asks different healers. The etiologies, signs and symptoms with which they manifest, the procedures and forms of intervention all change.

This makes the nosological universe seem confused, contradictory; most likely, what are most contradictory are those texts which attempt to solve the problem by forcing multifarious meanings into a framework of coherent sense. The approach taken by the texts that I proposed in the

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[18] In reality, for acupuncture, the process of stripping away the elements that immediately referred to the traditional religious aspects had already begun in post-revolutionary China. After an initial phase, from 1949 to 1954, when the new government tried to eradicate traditional therapeutic practices in favor of biomedicine, there was a complete turnaround that allowed therapeutic staff, such as barefoot doctors, and their practices, to be reintroduced. However, this came at the cost of reducing their knowledge of more technical and eminently more empirical elements. Although this process was based on the government's need to harmonize traditional Chinese medicine with the new Socialist credo, it might be said that this created the right conditions for the exportability of acupuncture. Cf. Bibeau G. (2000)

[19] Of course, the bibliography is immense on this topic. Here I will refer, by way of example, to a limited number of texts: Bibeau G. (1982); Bruni E. (2010); Caprara A. (2001); Pool R. (1993), Pavanello M. - Schirripa P. (2008)

previous footnote, for example, and which I will also follow in the following pages, is entirely different. This approach takes indeterminateness as a constituent fact of such nosologies; thus, the problem is not to find coherence, perhaps in unconscious patterns, but rather to follow a thousand streams and the many meanings that each nosological construct reveals. Therefore, it is not about reconstituting a coherent sense, but rather about accepting the complex challenge of the polysemicity of local constructs.

There is one point on which almost all the priests-healers I spoke to agree: *kooko* is a disease of natural origin. Not in the sense that its etiology is somehow linked to biomedical concepts, but rather due to the fact that, despite being a traditional nosological category, its origin does not derive from either a magical attack, nor a problem of social relations, nor from the vindictive or punitive action of a god or an ancestor. More simply put, *kooko*, just like a cold or diarrhea, exists; it is something which can affect individuals. However, unlike a cold, *kooko* can also be very serious and have lasting, if not chronic, consequences for the individuals who are affected.[20]

The difference between natural and spiritual diseases is a very common dichotomy in Ghana. While the latter refers to supernatural causes, such as the malevolent action of a god, the attack of a witch, the result of a curse or the preparations of a witch doctor, the former refers exclusively to the action of nature. Obviously, in this case, the concept of nature is culturally shaped in a way which is entirely different from the way it is usually conceived of in the West. In other words, there are no references to universal mechanical laws. Rather, in this context, nature is conceived of as a place populated with visible objects, such as rocks, trees, animals and humans, as well as unseen things: the gods who inhabit the rivers and trees, invisible beings of the forest and, indeed, diseases. Therefore, in this case, the difference between the natural and the spiritual rests on the juxtaposition between the symbolic and empirical. It refers, rather, to the primary cause of the disease: it is considered a spiritual disease when an action that can be traced back to that sphere is found, and vice versa, when a disease simply arrives, because it is one of the elements of the world around us, and thus relates to natural causes. Just to what extent the border between these two aspects is fluid and porous – and does not refer to a juxtaposition between symbolic and empirical

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[20] It should not be forgotten that even a disease for us, rich Westerners, which may be considered, on balance, trivial, such as childhood diarrhea, is still, in many cases, fatal in this part of the world, which is poor because it has been exploited,.

– is demonstrated by the fact that medical therapies cut across this dichotomy and that purely symbolic care practices are used for diseases that are considered natural (Schirripa P. 2005).

However, let us return to *kooko.* For most of the priests-healers with whom I worked, its etiology is traced to the presence of small impurities, or small beings (in Twi: *ekeba*, literally 'insect'[21]), which live in human blood. Some believe they are present in the human body from birth, others, conversely, are of the opinion that they are acquired over the course of a lifetime under certain circumstances, which are, all things considered, quite common: the type of food you eat or overexertion, for example. They move around in the blood. Sometimes, and this according to many healers is related to lifestyle habits or food, they grow in size, thereby obstructing blood flow.

Apart from being a carrier of *ekeba*, the blood is involved, albeit indirectly, in the pathological action of *kooko*. During its movement, as mentioned, the *ekeba* can become enlarged and come to a stop in a vein; at that point it is possible that the blood, finding the veins obstructed, may leak out or cease flowing, creating blisters that, for example, are particularly evident when this occurs in the anus, but which sometimes can also be observed in the eyes or ears.

Thus, wherever the *ekeba* stop, they give rise to the pathological action of *kooko* and the damage to the individual is evident and sometimes severe. If blisters form in the brain, they give rise to madness. In the ears and eyes to deafness or blindness. However, it must be said that the places where *kooko* seems to manifest most frequently are the anus and the genitals, both male and female.

The blisters that indicate the pathological presence of *kooko* are clearly visible when this attacks the walls of the vagina. It should be mentioned that, although almost all healers acknowledge that *kooko* may be responsible for infertility, often this is merely a theoretical possibility, since in cases of infertility other causes are almost always cited, such as witchcraft, the intervention of a god or an ancestor or physical problems. The relationship between *kooko* and infertility, as much as it remains merely a theoretical possibility, is seen as indirect by some healers. In fact, their belief is that *kooko* itself does not cause infertility in women, rather this would be the consequence of the presence of blisters in the vaginal channel. These would block menstrual flow making fertility impossible; according to other healers, on the other hand, the relationship between the blisters

[21] However, it is important to note that the term *ekeba* is also used in training courses that the staff of the healthcare service occasionally offer to herbalists and priests-healers to designate what, in biomedical terminology, is defined as a microorganism.

and infertility is weaker. In fact, these healers claim that the main issue is that the presence of blisters causes sexual intercourse to be extremely painful for women, so much so as to make it impossible. In this case, naturally, the issue is not one of infertility, but about being unable to have sexual intercourse.

Kooko can also seriously threaten male sexuality. As it moves around the body, if it directly attacks the penis, it will manifest, as already seen for other organs, in the form of blisters. The consequences for those affected are quite serious; in fact, *kooko* strongly affects sexual activity. Although all the healers I have spoken with have pointed out that *kooko* does not cause impotence, even if some of them have not entirely ruled out the possibility, its action causes a man's ability to have sex to be somehow weakened. Male sexuality is threatened by *kooko* even when it does not attack the penis directly, but settles in another part of the body, specifically the hips and torso. Many healers claim that one of the areas where *kooko* accumulates the most are the hips. When this buildup is significant, its main consequence will be a decrease in the sexual ability of the man. *Kooko* at the hips is not visible from the outside, in the sense that in this case blisters do not form on the body and its presence is reported only by this effect.

The body part that undoubtedly is most susceptible to evident manifestations of *kooko* is the anus, where it causes difficulty with defecation, frequent bleeding, pain and burning sensations. It is most likely precisely that last symptomatic description, which is very similar to what is defined in biomedicine as hemorrhoidal disease, as well as the fact that it is the most common manifestation of *kooko*, that has led to it being translated into English with the term *piles*.

Very often both the healers and other individuals, when speaking English, referred to *kooko as* piles. In this case, a complex and multifaceted category of traditional medicine, is reduced to a biomedical one which is, all in all, simple and limited. This semantic translation not only involves a reduction in terms of meaning of the disease and of the action of the agent that causes it, it also has different consequences that refer to those practices of indigenization which I referred to earlier.

As mentioned, the phenomenon of illegal biomedical pharmaceutical sales is rather widespread in Ghana. Without repeating what I have already explained, here, I would like to point out that, as I have witnessed personally while interrogating vendors, medicines that are used in the biomedical field to treat hemorrhoids are sold on the black market as remedies against impotence. Personally, I find this to be a particularly interesting process of indigenization. The identification of a similarity

between hemorrhoids and *kooko* has reduced the semantic scope and meaning of the sickness that is found in the traditional category. When hemorrhoid medicines enter the economic circuit of illicit sale, they are indigenized, which widens their field of action and treatment applications to all the possible consequences of the traditional pathological category. Thus, what is happening here is neither a misunderstanding of the medicine's therapeutic action, nor of an inability to understand the mechanisms of the action of the medicine: it is a practice that, by incorporating the medicine and its spectrum of therapeutic action into the sphere of meaning of the traditional nosological category, repositions its effectiveness for all possible pathological consequences. If *kooko* is the same as hemorrhoids, then hemorrhoids are the same as *kooko*. For this reason, a medicine that is indicated for the treatment of hemorrhoids will have the same effectiveness against impotence, this being one of many possible concrete manifestations of the pathological action of *kooko*. Therefore, the semantic translation which takes place rests on an action that creates an equivalence between two diagnostic categories that belong to two different nosological worlds. In this sense one can speak of the effect of a double reduction. The biomedical perspective reduced the complexity of the traditional diagnostic category of *kooko* to its most immediately visible manifestation: the swelling or inflammation of the vascular structures of the anal canal: to hemorrhoids. Thus, the complexity of the traditional category disappeared when faced with the evidence of swollen veins that refer to a precise biomedical nosological classification and a series of practices used in biomedicine for its treatment. Once this reduction led to an equivalence between hemorrhoids and *kooko* – something which was reiterated by many of the individuals I spoke to – this reentered the social game, leading to a new form of reduction: from hemorrhoids to *kooko*. It is here that the semantic translation is set in motion which makes, from the point of view and practices of the social actors, antihemorrhoid medicines useful in treating the full spectrum of disorders found in the traditional category of *kooko*. From the perspective of the social actors, antihaemorrhoids will work to treat impotence because the equivalence between *kooko* and hemorrhoids works, because what is most effective here is the double reduction that has taken place.