ILLNESS AND CURING IN BEREKUM, GHANA

by

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ABSTRACT

The thesis examines the ways in which illness is conceived, explained and confronted in Berekum, Ghana. Starting from the assumption that illness experience is socially and culturally constructed, the explanatory models employed by laypersons and healing practitioners are examined. Patterns of health-seeking behaviour among patients are identified and analysed; and the various treatment procedures common in the community are described in detail.

The data upon which the thesis is based were gathered in two main ways; participant observation as a native of Berekum and as a fieldwork researcher in the community for four months in early 1990; and an interview survey of seventy-eight professional healers and laypersons in Berekum carried out during the fieldwork period. Participant observation centred mainly on situational analyses, both current and retrospective, of treatment sessions and illness episodes. Survey interviews elicited information on local conceptions and explanations of illness, as well as on factors underlying informants' health-seeking behaviour.

In general the investigation serves to fill some serious gaps in the current literature on illness in Ghana, which tends to deal mainly with etiological explanations in a normative fashion. More specifically, it documents a preference for naturalistic causal explanations of illness on the part of healers and laypersons in Berekum, despite the recognition given to spiritual causation in some situations. It is found that scientific or western medicine is typically the first choice for those who are ill. This choice is influenced not only by the type of etiological explanation espoused, but by a number of interacting factors such as the type of illness itself, the quality and cost of

treatment and the extent of state intervention in various healing practices. Finally, the thesis suggests ways in which fruitful co-operation might be achieved between indigenous and scientific medicine in Ghanaian communities.

DEDICATION

To Janet for her support

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CHAPTER I

INTRODUCTION

RESEARCH PROBLEM

The thesis has as its central aim the investigation and explication of the ways in which people conceive, explain and confront illness in Berekum, an interior Ghanaian community of about 25,000 people. Medical sociologists try to understand how Ghanaians respond to afflictions and misfortunes by emphasizing the etiological explanations Ghanaians provide for afflictions at the exclusion of some equally important areas in medical sociology in Ghana. Typical of most developing countries, Ghana's health care system is urban-oriented. The majority of the population who live in the rural areas do not have access to the modern health care facilities. In order to assess the status of traditional medical practice (which operates mainly in the rural areas) and its perceived contribution towards the implementation of a comprehensive health care system for Ghana, it is pertinent also to examine choices and evaluations of therapies, the hierarchies of resort, how traditional healers also confront illness, healing practices adopted by the traditional healers and so on. The scant emphasis given to these key issues in health behaviour leads to an inadequate portrayal of the nature of medical sociology in Ghana.

I am therefore interested in how the lay members of the community, as well as professional curers and purveyors of medicines and other remedies explain and confront illness. In Berekum there are several therapeutic options; these include different types of indigenous healers as well as modern health care facilities. Beliefs about the nature and causes of illness held by laypersons, professional curers and purveyors of medicines and other remedies will be sought to help us understand particular kinds of illness

behaviour and curing practices found in Berekum. The thesis will delineate the major differences and similarities in healing theories and practices in Berekum as perceived by different practitioners and lay members of the community. Here, I am especially interested in the degree to which the main healing practices display systemic properties, for example, intellectual consistency and professional organization or regulation. Also, I am interested in examining the choices of therapies available to individuals in Berekum, the factors that are influential in the evaluation of therapies and the hierarchies of resort to various forms of treatment in Berekum.

The thesis is also concerned with the generation of 'new' illness knowledge and the re-formulation of 'old' illness knowledge when confronted with new medical exigencies. In this connection I examine local conceptions and explanations of Acquired Immune Deficiency Syndrome (AIDS), which poses a health threat unparallelled in modern medical history. AIDS is already known in Berekum because of a series of campaigns mounted by the mass media about AIDS awareness in Ghana. AIDS is a new infectious disease for which at the moment scientists have not succeeded in either finding a cure or developing a vaccine, and it is likely that a cure is not imminent (Graubard:1989). The AIDS epidemic will worsen (Shulman and Mantell:1988) and mankind has to accommodate it at least for the next few years. AIDS is more than a health problem; it has affected the society in different ways that the old illnesses like malaria, smallpox, cholera and other infectious illnesses could not. The AIDS epidemic is a social and behavioural phenomenon as well as a biological one.

I am therefore concerned with how AIDS fits into the local medical terminology of illness and how people are responding to this new kind of illness. The extent of local knowledge of AIDS in terms of sources of information, causes, prospects of a cure and protective measures is discussed. There is a belief in Ghana that AIDS virus is contracted mainly through sexual intercourse, especially with a prostitute

(Konotey-Ahulu:1988 and Neequaye et al:1986). While we wait for a medical breakthrough or the development of a vaccine to prevent AIDS, a conscious effort in the form of educational programmes might slow down the spread of AIDS. An effective educational programme also depends on the extent of people's knowledge about the modes of transmission of Human Immunodeficiency Virus (HIV). The study investigates the people's conceptions and explanations of illness in general, and how this knowledge of illness may be applied to a new illness like AIDS. I consider how the old illness knowledge is re-formulated and new illness knowledge is generated in the face of a new epidemic such as AIDS. Local conceptions and explanations of AIDS are compared with old and familiar afflictions such as malaria and diarrhoea; with old but behaviourally 'unusual' afflictions such as insanity and epilepsy; and with other afflictions connected with the reproductive system such as venereal disease, impotence and barrenness. Another issue examined in the study is the role of morals in illness causation in Berekum. Do people become sick because of immoral practices? What are people's attitudes and beliefs towards 'morality' and 'illness'? Is illness conceived in morally neutral terms or is it regarded, in some circumstances and situations, as a consequence of morally inappropriate conduct? How does this affect conceptions and explanations, and also the curing practices to be adopted?

RESEARCH QUESTIONS

A number of research questions are subsumed under the general description of the research problem given above. Among the more important of such questions addressed are the following:

1. To what extent are the theories and practices of herbalists (adunsifo), priest healers (akomfo), spiritual healers (asore ayaresafo), Moslem healers (Nkramo-adunsifo) and Western medical doctors (dokotafo) conceived as distinctly

different domains by: a) their respective practitioners? b) lay members of the community?

2. To what extent are similarities and affinities recognized between these domains by: a) their respective practitioners? b) lay members of the community?
3. To what extent do these domains display systemic properties, e.g; intellectual consistency, professional organization or regulation, etc?
4. How important is knowledge of illness for the people in the community, i.e. what kind of knowledge do people need and how much do people really care to know about illness and its causes?
5. Under what circumstances do people have recourse to causal explanations of illness which can be regarded as: a) naturalistic? b) spiritualistic? To what extent are these explanations complementary or mutually exclusive?
6. Is there a morality of illness in Berekum, eg. is illness conceived in morally neutral terms or is it regarded, in some circumstances and situations, as a consequence of morally inappropriate conduct?
7. Under what circumstances do people resort to different types of healers and forms of treatment? What hierarchies of resort seem to be most common? How are these to be explained sociologically?
8. What is the extent of scepticism regarding the knowledge and abilities of healers in Berekum? How and in what circumstances is scepticism manifested?
9. What is significantly distinctive about local conceptions and explanations of AIDS as compared with those relating to: a) old and familiar afflictions such as malaria and diarrhoea; b) old but behaviourally unusual afflictions such as insanity and epilepsy; and c) other afflictions connected with the reproductive system, such as venereal disease, impotence/sterility and barrenness.

REVIEW OF RELEVANT LITERATURE

In their discussion of illness and healing among the Akan of Ghana, Brautigam et al (1979) stated that the Akan conceived of man as made of a physical-mortal part called *Onipadua* (Body) inherited from the mother, a spiritual part called *Sunsum* (Spirit) which could also be called personality and a life-force called *Okra* (Soul), which like *Sunsum*, is immortal. They further stated that good health depends on a balanced relationship between these components. Some illnesses are identified as being purely physical, thus involving only the *Onipadua*. By contrast illnesses affecting *Sunsum* or *Okra* are not readily located, and not so susceptible to treatment and are usually chronic and have supernatural cause. The problem with this explanation is that the authors did not indicate in their study how any ordinary Akan perceives this balanced relationship to maintain good health.

Nukunya et al (1976) related social relations and attitudes to disease and misfortune, and emphasized that ancestors act to punish someone because the victim is known to have violated some accepted kinship or family ideals. A witch may strike due to greed, hatred or bad feeling, while a sorcerer's action likewise may result from his own or client's relationship with his victim which requires such action to be taken against him. They further indicated that diseases caused by natural agencies might be attributed to supernatural agencies at some point. Nukunya et al (1976) studied attitudes towards health and disease in selected urban and rural comunities in Ghana. The purpose of the study was to find what the people did when they were sick, the precautions they took to maintain good health and their notion of the causes of diseases. They found that 76.0% of the respondents indicated preference for taking the person to hospital when sick. With regard to precautionary measures taken to maintain good health, 5.5% claimed they used both spiritual and herbal practices, 71.1% used

natural methods like taking drugs, cleaning up their environment, eating nutritious food and occasionally having bodily exercises. Regarding beliefs about the causes of disease, 34.8% attributed it to evil forces, while 62.5% indicated that most diseases were caused by specific germs. This particular study is significant in two ways. First, it was able to give some selected communities' perceptions and explanations of illnesses. Second, it was also seen as an example of biased interpretation of the results of research. The result of the study showed that 62.5% of the respondents indicated that most diseases were naturally caused, but contrarily, Nukunya et al (1976) stated that the people of the communities explained most diseases as supernaturally caused. The reason for this biased interpretation may be ideological, but it has shown how the values of researchers could distort the results of their study.

In another study, Fosu (1981) investigated the classification of diseases at Berekuso, a rural Ghanaian village with a population of 927. He found that the basis of Berekuso disease classification was the attributed cause or source of disease. Furthermore, he noted that the people differentiated between serious and non-serious diseases, diseases which affected only males and childhood diseases as well as preventable and non-preventable diseases. Fosu therefore found that the people of Berekuso classified diseases in three main types; diseases caused by natural agents, those caused by supernatural agents and those whose causes embraced both natural and supernatural. His interviews yielded 1532 responses, dealing with 62 specific diseases: 46.6% of the responses classified diseases as naturally caused, 39.3% as supernaturally caused, while 14.1% noted that diseases were both naturally and supernaturally caused. Other aspects of the health utilization behaviour of the people of Berekuso, Fosu noted were the influence of age and education on disease classification. In terms of age, over 54% of all those below 30 years of age classified diseases as naturally caused. Conversely, less than 40% of all persons above 30 years classified

diseases as naturally caused. Among the illiterates 33.1% classified diseases in natural terms, while 51.8% classified diseases in terms of supernatural. Also among the literates 55.9% and 30.7% classified diseases as naturally and supernaturally caused respectively. However, we should be cautious in using such factors as age, education and religion to predict health utilization behaviour of a group of people. For example, Warren (1978) indicated in his study of the Bono of Ghana, that education and religion had little influence in one's preference for modern scientific medicine.

The impact of social change on the level of recruitment of different types of medical practitioners in Kwahu and Kumasi districts of Ghana was examined by Anyinam (1987a). In the Kwahu district, Anyinam found that 33% of the traditional medical practitioners were younger than 35 years, while 67% were 35 years and above. In Kumasi district also only 13% were younger than 35 years, as against 87% who were 35 years and above. Studies elsewhere in Africa (Maclean:1966; Oyebola:1980; Good:1980) have indicated that traditional medicine is becoming less and less attractive as a career. Good (1980) predicted that traditional healing in rural locations is unlikely to survive long as a viable system given its present decline, 8 out of 10 rural healers in Kenya were 50 years of age or older. Despite the age factor in the recruitment of traditional healers, age alone cannot be used to predict the decline in their number, and it does not give us any idea of the number of their clients. The number of healers may decline if they are unable to replace themselves in future. Mullings (1984) noted that the Gas of Ghana recognized both naturalistic and spiritualistic explanation of causes of diseases. However, Mullings observed that diseases that are thought to be naturally caused may reach a stage where they are not easily cured, and it will then be assumed that some supernatural agency has become involved. Despite the high utilization of biomedical facilities like Mental and Pantang Hospitals in Accra and Ankaful Hospital near Cape Coast, Mullings stated that chronic

illnesses, especially mental disorders are not effectively treated by biomedicine. This may be an overstatement because there is not enough evidence showing how the indigenous healers surpass biomedicine in the area of psychiatric problems.

Twumasi (1975) also observed that within the traditional context of the Asante cosmology, illness is not considered as just the result of pathological change; the supernatural is invariably invoked as the main causal factor. Within this framework, the concepts of the etiology of health and illness are far more behavioural than biological. He further stated that health and illness are not isolated phenomena, but part of the whole magico-religious fabric. Apart from failing to provide evidence for this assertion, Twumasi also failed to show what the religious life of the Asante was. He located health and illness of the Asante within magic and religion, but his work was silent on these two areas.

Appiah-Kubi (1981), in his analysis of the healing practices among the Akan of Ghana, emphasized that traditional medical practice has cultural relevance in terms of diagnosis and treatment. In this respect, he stated that both the traditional practitioner and his patients share the same world-view. Traditional Akan practitioners often determine the cause of a disease or problem through divination. Traditional Akan practitioners are able to deal with diseases associated with witchcraft; and Akan medicine has made strides in healing madness. However, Appiah-Kubi did not cite any evidence to support these assertions, and they may be classified as mere assumptions which still conceal some aspect of Akan healing practices.

Field's (1960) work also points to an indication in the belief of supernatural causation of disease in Ghana. She stressed that besides causing illness, death and sterility, witches are believed to blight crops and to cause accidents, financial losses, ill-luck and disasters of all kinds. She further stated that according to African dogma

sickness and health are ultimately of supernatural origin. Field, however, remarked, "Witchcraft exists only in fantasy in the minds of certain mentally sick people, and is a bewilderment to others" (1960:38). This remark was surprising, because the information she had on the belief in witchcraft was not wholly collected from people who were mentally sick. Many studies (Wyllie:1973; Mullings:1984; Debrunner:1961; Appiah-Kubi:1981) on Ghana have brought to light the belief in witchcraft in Ghana not as "a primitive interpretation of mental disorder" (Field:1955), but as a fact which still has roots in Ghanaians' interpretation of illness and misfortune.

Warren (1978) indicated that the Bono of Ghana regard most diseases as naturally caused and the Western Hospital (Techiman Holy Family) is being perceived as an extension of the number of alternative healing systems for treating naturally caused diseases. One interesting aspect of this study is the observation that the majority of the Techiman-Bono indigenous healers also go to the hospital for various types of treatments. Similarly, Wyllie (1983) observed a tendency towards naturalistic explanations of illness among the healers of Winneba.

The literature on medical sociology in Ghana can be classified into two; the works which attest to the primacy of spiritualistic explanations among Ghanaians and those which suggest that naturalistic explanations are equally or even more pronounced among Ghanaians. In spite of this documentation on disease causation in Ghana, blind spots or gaps exist in this literature.

Illness Causation

Murdock (1980) identified two broad typologies of theories of illness; namely, theories of natural causation and theories of spiritual causation. He defined theories of natural causation as "any theory, scientific or popular, which accounts for the impairment of health as a physiological consequence of some experience of the victim in

a manner that would appear reasonable to modern medical science" (p.9). Five distinct types of theories which fall into this category are illnesses caused by infection, stress, organic deterioration, accident and overt human aggression. Under theories of supernatural causation, Murdock identified three separate theories of causation: theories of mystical causation, theories of animistic causation and theories of magical causation. He defined theories of mystical causation as, "any theory which accounts for the impairment of health as the automatic consequence of some putative impersonal causal relationship rather than by the intervention of a human or supernatural being" (p.17). He identified four specific types of causation falling into this category as fate, omninous sensations, contagion and mystical retribution. Murdock (1980) further defined theories of animistic causation as, "any theory which ascribes the impairment of the health to the behaviour of some personalized, supernatural entity --a soul, ghost, spirit, or god" (p.19). Soul loss and spirit aggression fall into this category of illness causation. Finally he defines theories of magical causation as, "any theory which ascribes illness to the covert action of an envious, affronted, or malicious human being who employs magical means to injure his victims" (p.21). Two distinct types of illness causation fall into this category, namely, sorcery and witchcraft.

The problem with Murdock's classification of illness causation is that an agent in illness causation may not necessarily be the ultimate cause. For instance, to classify accident under natural causation will conceal the ultimate cause of the accident which may be attributed to witchcraft. It is important to note the underlying cause of illness rather than the immediate cause.

An earlier study by Foster (1976) foresaw this problem of classification of illness causation. Foster identified two basic principles that seemed to him to account for most of the etiologies that characterize non-western medical systems. A personalistic medical system is one in which disease is explained as due to active purposeful intervention of

an agent who may be human or supernatural. A naturalistic medical system, on the other hand, explains illness in impersonal systemic terms. In this type of medical system, disease is thought to stem from natural agents, and above all by an upset in the balance of the basic body elements. Foster however, cautioned that in practice people who invoke personalistic causes to explain most illnesses usually recognize some natural, or chance causes. He further identified several areas of distinction between the two areas of etiologies. The personalistic medical etiologies are part of more comprehensive or general explanatory systems, while naturalistic etiologies are largely restricted to illness. That is, in personalistic systems illness is but a special case in the explanation of all misfortune. He also noted that personalistic etiologies have at least two levels of causality; the deity, ghost, witch or other being whom ultimate responsibility for illness rests, and the instrument or technique used by this being. Naturalistic etiological systems require single levels of causation. Also in personalistic systems, the primary role of the practitioner is diagnostic, while in the naturalistic systems it is therapeutic. In other words, in personalistic etiological systems diagnosis (to find out who and why) is the primary skill that the patient seeks from his curer. In the naturalistic systems however, diagnosis is made, not by the curer, but by the patient or members of his family. Finally Foster (1976) observed that in the personalistic etiological systems one has less control over the conditions that lead to illness, while in the naturalistic etiological systems the locus of responsibility resides with the patient.

Foster's conception of etiologies of illness seems more appropriate to use in classification of illness causation than Murdock's because Foster took into consideration not only the agents in the causes of illness, but also the ultimate causes. In looking at illness causation among the people of Berekum, we will also be interested in the ultimate causes since the immediate cause may be just an instrument to achieve an

end. Seijas (1973) made a distinction between immediate and ultimate causes. He stated that immediate causes account for disease in terms of the perceived pathogenic agent, while ultimate causes on the other hand govern or condition the occurrence of disease.

Choosing And Evaluating Health Care Alternatives

Kleinman (1980) views choosing and evaluating health care alternatives in terms of Schutz's (1968) structures of relevance or what Romanucci-Ross (1977) refers to as hierarchies of resort. It is health ideology and values which guide the individual's health-seeking process. These values function to order illness within frameworks of relevance, and these frameworks will define which health problems are most important and which require immediate action. The same structures of relevance are also used to decide when to switch from one type of care to the other.

In her analysis of illness behaviour in Ivory Coast, Lasker (1981) found that the choice of therapy depends more on its accessibility than any other characteristics of the patients. She identified several dimensions of accessibility, namely, the actual location of facilities, the cost of services, social-psychological accessibility relating to communication between providers and consumers, and the user's satisfaction with the encounter. However, these factors alone may not be helpful in trying to understand an individual's health utilization behaviour, even though they have strong influence in the choice of therapy.

Uyanga (1979) also observed in Southeastern Nigeria that patients of spiritual healing homes and traditional doctors resorted to these healers after they had failed to obtain rapid treatment in hospitals or private clinics. In this case the choice of therapy was based on Lasker's conception of accessibility, that is, the user's satisfaction with the encounter.

Romanucci-Ross (1977) studied the choice of medical treatment in the acculturative situation of the people of Manus. She noted a hierarchy of resort in the traditional culture as to which illnesses were to be empirically treated and which were to be magically treated. Both indigenous and western medical systems in Manus actively compete and which is chosen depends more upon the natives' classification of the moral components of the specific illness than upon their perception of what each medical system can do. She identified two sequences of hierarchy of resort: acculturative and counter-acculturative. She referred to acculturative sequence as the practice where European medicine is the first resort or if the sequence starts with more recent, modern modes, and the trend is toward earlier cultural modes of treatment and explanation. Counter-acculturative sequence on the other hand refers to the situation where the first resort is the earlier mode and the trend, in the event of failure, is then to seek more recently introduced modes. Romanucci-Ross identified three levels of hierarchy of resort; namely, European medicine, the treatment through the church and traditional medicine. These sets of alternatives may be ordered in hierarchies of resort, where sequences of more alternatives may be resorted to as the illness passes from one phase to another when cure is not forthcoming. The first resort is taken as a superficial index of the acculturative stance of the group or individual. A last resort is reached as earlier choices are exhausted. However they may be ordered, the alternatives are not equal. Each choice has a different socio-moral function and therefore represents greatly different meanings to the chooser.

A different situation was observed by Chen (1981) in Malaysia where the people patronized modern and traditional medicine simultaneously. However, Nurge (1977) indicated that in a fishing and agricultural village in the Philippines, some people had the western-style medicine as the treatment of the last resort when all else in the traditional system had been tried and found wanting. Contrary to this situation in the

Philippines is Mume's (1976) observation in Nigeria that patients consult traditional healers after they have failed to obtain treatment from modern scientific medicine.

Foster (1977) noted that economic and social costs are important in determining the choice of therapy. He cited Ndeti's (1972) study of tuberculosis control in Kenya which showed that bus fare kept large number from coming to the clinic. A relative of a village midwife, after considering the social cost involved would go to the village midwife for treatment, even though she could get better treatment at the clinic.

The literature on the choice of therapy, noted above, has shown that the hierarchy of resort may follow different orders. In some instances both modern and traditional medicine are used simultaneously. In other instances, preference is given to either of the two. At certain times not only the laypersons have choices to make from different therapies, but the healers also may make several choices. Asuni (1977) stated that a traditional healer who had an asthmatic attack was brought to the emergency room of a hospital in which he worked. In Ghana this observation was made only in Techiman by Warren (1978) who indicated that the traditional healers were going to the western hospital in the town for treatment.

African AIDS Research

The paucity of easily accessible information about AIDS in Africa makes a review of relevant literature difficult. In addition, the data collected about the prevalence of AIDS in Africa also seem unreliable. A large portion of the literature on AIDS in Africa centres on the controversy about the African origin of the AIDS epidemic (Piot et al:1988; Mann et al:1988; Norman:1985; Quinn:1986; Newmark:1986). It seems this controversy has distracted many researchers from studying the prevalence of AIDS in Africa, while some also uncritically use some data to support their view (Packard:1989). Others also rely on unrepresentative samples (Neequaye et al:1986; Packard:1989).

Evidence for the African origin of the AIDS virus arises from several sources. One factor used to advance the argument is that more Human Immunodeficiency Virus (HIV) related viruses are found in African primates which may be the possible origin of the human virus (Essex and Kanki:1988). Also the HIV-I virus has been found in blood stored in Zaire as far back as 1959. Finally, AIDS indicator diseases (chronic diarrhoea and generalized Kaposi Sarcoma) were diagnosed in Central Africa in the late 1970s (Quinn et al:1986). However, the origin of the AIDS epidemic is still controversial (Pela and Platt:1989). Konotey-Ahulu's (1987) reaction to the information on the origins of AIDS in Africa prompted him to make an extensive tour of Africa. It was a six-week tour of 26 cities and towns in 16 Sub-Sahelian countries, including those afflicted by AIDS. The purpose of the tour was two-fold; to learn about AIDS in the African population and also to assess the veracity of media pronouncement and publications. Konotey-Ahulu rated AIDS in Africa on an arbitrary scale ranging from grade I (not much of a problem) to grade V (a catastrophe). He stated that in no country was the AIDS problem consistently grade III (a great problem), nor in none could it be called a catastrophe (grade V). He therefore observed that the world's media appeared to have conspired with some scientists to misinform people about the AIDS problem in Africa. However, now AIDS is seen as a global malady which strikes both the developed and the developing world with equal vengeance (Christakis:1989). The consequence of this argumentation about the possible origin and prevalence of AIDS in Africa is that several African countries delayed in admitting the presence of AIDS in their countries, and thereby allowing AIDS to get firmly established before any preventive measures were taken. For example, Neequaye et al (1986) stated that until March 1986, no clinical case of AIDS was seen in Accra, Ghana. The rationale behind this is that no AIDS case existed in Ghana by that period.

Unrepresentative sampling of people infected with the AIDS virus has been another feature of the literature on AIDS in Africa. De Zalduondo et al (1989) observed that the frequency of sexual partner change appears to be the most likely risk factor for adult HIV infection in Africa. This assumption is based on several studies which indicate seropositivity among prostitutes in many countries in Africa (Denis et al:1987; Van de Perre et al:1984; Mann et al:1988; Nzilambi et al:1988; Neequaye et al:1986). If the sample size covers only prostitutes, then a large section of the population has been excluded. It is no wonder that 63 out of the 72 seropositives in Ghana by September 1986 were identified as females because only females are seen as prostitutes (Neequaye et al:1986). Wagner (1989) has also asserted that in Sub-Sahelian Africa heterosexuality and mother-to-infant are the major sources of transmission of the AIDS virus. Most of the studies which cover a large section of the population also use unrepresentative sample in terms of age. Melbye et al (1986) found that in Africa high levels of HIV seropositivity occurs in women and men between 20 and 60 years of age. The sample covered 1087 subjects; 12 were under 15 years, 21 were over 70 years, while the rest were aged between 20 and 60 years. The prevalence of AIDS among the cross-section of the population in Africa is distorted by studies that use unrepresentative samples.

The transmission of the HIV has been observed not only as through sexual activity but also through transmission by blood transfusion, transmission by intravenous drug-use and perinatal transmission (Friedland and Klein:1987; Pela and Platt:1989; Biggar:1986; Bennet:1987; Velimirovic:1987). However, literature on AIDS in Ghana sees sexual transmission as the main source of the AIDS virus, especially sexual contact with prostitutes (Neequaye et al:1986; Konotey-Ahulu:1988). This means there is still much work to be done on AIDS in Ghana.

What this body of literature on AIDS in Africa lacks generally is reliable data on the ordinary person's conception and explanation of AIDS. The main concern of the literature is the origins and transmission of the AIDS virus, and we know little about the extent of the knowledge of the ordinary person about AIDS. These materials on AIDS have little direct bearing on our study, but they serve to show how the knowledge of the ordinary person about AIDS has been either ignored or taken for granted. The explanatory accounts of the ordinary person about AIDS are necessary for planning preventive education programmes since AIDS is not only social and biological but also behavioural problem.

THEORETICAL ORIENTATIONS

Illness and curing in Berekum occur within the health care system. Health care systems, which are forms of social reality, are also socially and culturally constructed (Kleinman:1980). The individual internalizes social reality as part of his/her socialization process, and this brings differences in perceptions of social realities. Kleinman (1980) observes that clinical practice creates particular social worlds, and beliefs about illness and responses to them are all aspects of social reality. He further notes that cultural systems are grounded in concepts and sources of legitimated power in society. Of much interest here is Glick's (1967) hypothesis that knowing a culture's chief source of power allows one to predict its beliefs about the causes of illness and how it treats illness. In Ghana, scientific medicine has been legitimized by the government by the use of certification from a qualified medical officer if someone wants either sick leave, maternity leave or a refund of medical expenses. The government of Ghana has legitimized the scientific medical practice in other forms also. Scientific medicine has been institutionalized in the form of hospitals and clinics in several parts of the country. The maintenance of these institutions, the importation of drugs and research in

the health sector are all financed by the state. The practising medical doctors in the public sector receive attractive remuneration from the state. The indigenous medical practitioners practise in privately constructed structures, usually inferior in quality, and have to finance their practices themselves. With this governmental intervention in the practice of scientific medicine, the quality of services rendered and ability to provide such services by both practices become unequal in some sense. Despite the fact that legitimated power in society has a strong influence on the choice of therapy, it is not in itself an adequate criterion to help us understand the beliefs about the causes of illness and choice of treatment. The people's conception and explanation of illness should be sought from the people themselves by examining their explanatory models.

The health care system in Berekum will be analysed using Kleinman's (1980) structural model which comprises three overlapping parts: the popular, professional and folk sectors. Kleinman describes the popular sector as the lay, non-professional cultural arena in which illness is first defined and health activities initiated. The popular sector evaluates the treatment that should be given to a patient and then decides what to do next. The individual sick person is perceived differently within these sectors. An individual is a sick family member in one setting, a patient in another and a client in yet another context (Fox:1968; Siegler and Osmond:1973; Twaddle:1972). In each of these sectors, illness is perceived and interpreted, and special care is applied. The sick person encounters different medical language as he/she moves within these sectors (Cassell:1976; Quesada:1976).

Kleinman further notes that the professional sector of the health care system comprises the organized healing professions; that is, modern scientific medicine. Kleinman observes that the folk sector on the other hand is non-professional and non-bureaucratic and is a mixture of many different components. However, the structural components of health care systems interact because patients pass through them. I examine some

characteristics of folk medicine in Berekum and also to consider whether it constitutes a 'system'. In this I consider some features observed by Last (1981) when he was examining how far traditional medicine at Malumfashi in Nigeria constituted a system. He noticed three main features. First, there should be the existence of a group of practitioners all of whom clearly adhere to a common, consistent body of theory and base their practice on a logic deriving from that theory. Second, patients recognize the existence of such a group of practitioners and such a consistent body of theory and, while they may not be able to give an account of the theory, they accept its logic as valid. Third, the theory is held to explain and treat most illnesses that people experience. Another aspect in considering folk medicine in Berekum as a system is to examine how far the healers in Berekum are able to regulate themselves by reference to specific rules they have made. Last (1986) refers to this as professionalisation of traditional medicine. He identifies four main characteristics of this process of professionalisation. First, the ability to retain a measure of independence through its right to regulate itself. Second, the professional also has a statutory monopoly over a defined sphere of work. Third, a code of ethics governing relations between a professional and the client and limiting competition between professionals is formally set out and can be enforced by the profession's own institutions. Finally, a profession is responsible not only for teaching and examining recruits to the profession but also for promoting research so that the profession can effectively reproduce both its membership and its claim to expert knowledge. In other words, I am interested in finding the similarities and differences among folk medical practitioners in Berekum in terms of their theories and practices.

Kleinman (1980) identifies the core clinical functions of health care systems and explanatory models in illness and clinical care. He notes that illness experience is culturally constructed; it is put into a particular cultural form through some categories

used to perceive, express and valuate symptoms. In labelling someone as sick, the afflicted person and his family make use of the explanatory accounts available to them in a particular cultural, historical, and health care sector. That is, symptoms are socially constructed. I will therefore be interested to find how illness is socially and culturally constructed in Berekum.

Additionally, health care systems establish criteria for choosing and evaluating health care alternatives. The structures of relevance (Schutz:1968) or hierarchies of resort (Romanucci-Ross:1977) are used to decide when to continue one type of care and when to change to another. Value structures play a crucial role in evaluations of therapeutic efficacy. Health care includes more than cure. The management of therapeutic outcomes, besides cure, ranges from treatment failure and impairment to dying. In addition to finding how these core clinical functions operate in Berekum, the study will also be interested to find out how these functions operate in Berekum with the emergence of a new illness like AIDS.

The explanatory accounts given by individuals in Berekum with regard to their conceptions and responses to illness, will be analysed within Kleinman's explanatory model framework. He notes that explanatory models are the notions about an episode of illness and its treatment by all parties engaged in the clinical process. The study of practitioners' explanatory models shows how practitioners understand and treat illness. The explanatory models of patients and family also indicate how they make sense of given episodes of illness, and how they choose and evaluate particular treatments. Kleinman further notes that explanatory models held by individual patients and practitioners differ in analytical power, metaphor and idiom. To understand explanatory accounts of illness and its treatment in Berekum, the study will utilize explanatory models adopted by both patients and practitioners. Explanatory models seek to explain illness episodes in terms of etiology, time and mode of onset of symptoms,

pathophysiology, course of sickness and treatment. In effect, explanatory models determine what is considered relevant clinical evidence and how that evidence is organized and interpreted to rationalize specific treatment approaches.

The guiding assumption underlying my enquiry is that illness experience is socially and culturally constructed; and to understand people's conceptions and explanations of illness and adoption of specific therapeutic options, it is important to investigate the explanatory models held by both individual patients and practitioners.

METHODOLOGY

Apart from library research that was necessary for the literature review and formulation of a theoretical perspective, the thesis was based upon data gathered in the course of four months fieldwork in Berekum in the Spring of 1990, and my own personal experiences as a native of Berekum. Financial reasons and the time-limit for collecting the data were influential in selecting Berekum as the area for the research. Berekum is my home community and that could help me reduce expenses. Most importantly, however, was the fact that my knowledge of different parts of Berekum could be helpful in locating the healers in a short period of time. Some aspects of the healing practices of the healers have been shrouded in secrecy, and the healers would feel more comfortable sharing their views with a member of the community.

The investigation involved direct observation and situational analyses of treatment sessions of the following kinds: herbalists' clinics, priest healers' shrines, spiritual healers' church services and hospital outpatients. Herbalists had a stock of herbal medicines in their clinics where patients went for consultations and treatment. Priest healers had shrines and specific days (mostly Fridays) had been set aside for consultations and treatment. Spiritual healers had special healing services for both

members and non-members of their churches. In the case of the outpatient clinic, patients went for consultations and treatment throughout the week. I accompanied a drug pedlar on his motor cycle rounds to observe how he dealt with his patients. My role in direct observation and situational analyses was both of participant observer and observer during the spiritual healing church services and the healing sessions of the herbalists and priest healers.

In the initial stage of the fieldwork in Berekum, I consulted the authorities at the Holy Family Hospital for permission to interview some nurses and patients at the outpatient clinic of the hospital. The Hospital Administrator introduced me to the various departments, doctors and other health care workers at the hospital. I conducted interviews with 18 patients at the hospital. These were those who had already consulted the doctors and waiting for their drugs at the pharmacy section. I selected those whose illnesses were not serious and would be able to respond to questions. I also selected 10 patients who consulted the priest healers for treatment, while 8 each were chosen from among the patients of the herbalists and spiritual healers.

I used a set of core questions, and asked the patients (laypersons) not only how they explained certain illnesses but also questions about their own experience of illness. These included: the type of illness, hierarchies of resort to various healers and the explanations of illness provided to them by the healers. I elicited information on the previous illness experience during the past 12 months along the same lines. The laypersons were asked to indicate the differences and similarities they observed among the healers and the laypersons' assessment of the healers' competence in the community. Information was sought on specific illnesses like malaria, diarrhoea, madness, epilepsy, gonorrhoea, barrenness, impotence/sterility and AIDS. In addition, I also sought explanations provided for illnesses in general. Here, I was interested in two main things: firstly, to find the relative emphasis laypersons in Berekum placed on

spiritualistic/naturalistic types of explanation; and secondly, to find the extent of consensus or lack of it among laypersons trying to explain the causes of illness.

I conducted interviews with 19 healers (9 priest healers, 4 herbalists, 4 spiritual healers and 2 Moslem healers). I mainly relied on individuals who knew the healers, and who introduced me to them. Initially, they explained our presence to the healers, after which I explained the purpose of the enquiry in details. In some cases, the healers agreed for the interview the same day. In most cases, however, they scheduled dates for the interviews. Only one healer objected to the use of a tape recorder during the interviews. After the interviews with the healers, I was allowed to interview some patients who had come for treatment. If no patient had consulted them that day, the healers would give me some dates I was likely to meet some patients. The healer treating *aduto* invited me on three occasions to watch him treat some patients. I participated in their treatment sessions, and also conducted interviews with laypersons during such occasions.

I conducted these interviews using a set of core questions designed to elicit information like how a healer conceived his/her theories and practices as distinctively different from others, the recognition of similarities and affinities between the domains by their respective practitioners and also the display of systemic properties by these domains. In addition, the interviews covered such areas as how important knowledge of illness was for the people in the community, the moral aspects of illness in Berekum, the extent of scepticism regarding the knowledge and abilities of healers and the distinctiveness of local conceptions and the explanations of AIDS compared with those for other types of illness. However, the healers were encouraged to raise and discuss issues of their own volition, so the interviews were relatively open and unstructured.

I also interviewed five nurses at the Holy Family Hospital. I was interested not only in the explanations they provided for illnesses but also more specifically the extent of their knowledge about AIDS, the transmission of HIV and its prevention. There were other persons who provided useful information, although I acquired the information from them in informal talks and discussions rather than in interviews. Informal discussions with some of the medical doctors at the Holy Family Hospital centred on AIDS, the doctors' experiences with AIDS patients, some measures they used at the hospital to help reduce the spread of the HIV, and their experiences with some of the traditional healers in Berekum. The pharmacist explained the medicinal uses of the herbal garden attached to the hospital. The Medical Records section of the hospital also provided information on AIDS cases reported at the hospital between August 15, 1988 and January 15, 1990. The Hospital Administration also gave me a copy of the Hospital's Annual Report for 1988.

I sought information from five prostitutes and five members of a youth gang through informal discussions. I was interested in discovering the prostitutes' views and explanations of illness, and how such knowledge of illness was transferred to their conceptions and explanations of AIDS, especially the modes of transmission of the AIDS virus and its prevention. Regarding members of the youth gang, I was interested in their conceptions and explanations of illness in general and AIDS in particular, as well as the extent of intravenous drug use among them.

The main problem encountered during the fieldwork was a technical one related to scheduling appointment for interviews with some of the healers. Some of the healers had gone to their villages because in Berekum the farming season would normally start between January and April. In Biadan the healers had a local healers' association. When I contacted them they expressed the desire to accept the interviews upon the arrival of the president of the association, who had travelled to his village. He

returned after three weeks, but he was not informed by the other healers. The first time I saw him he agreed to be interviewed and this helped me secure co-operation from his colleagues. Occasionally, funeral celebrations disrupted some of the appointments for interviews. The healers usually attended all funeral celebrations in the area, irrespective of their relationship to the deceased. At the pharmacy section of the Holy Family Hospital some relatives and friends would interrupt me in the middle of interviews, and in such cases I had to stop and talk with them before continuing with the interviews. In general, however, there were no serious obstacles placed in my research activities, and most people I encountered were interested in what I was doing and were keen to help.

CHAPTER II

THE SOCIO-CULTURAL CONTEXT OF ILLNESS IN BEREKUM

INTRODUCTION

This chapter presents the social and cultural context within which illness and curing take place in Berekum. I briefly examine the social organization, marriage, the economy, the polity, religion and festivals of Berekum. These will provide the necessary background for my analysis.

Berekum is located in the Brong Ahafo Region of Ghana. Ghana is an Anglophone West African country which covers an area of about 239,460 square kilometres. It lies between latitudes 4.5° North and 11.5° North, and longitudes 3.5° West and 1.5° East. Its southern border is the Atlantic ocean, and it is sandwiched between three Francophone countries; Burkina Faso in the north, Togo in the east and Cote d'Ivoire in the west. The mean temperature for Ghana as a whole is about 80° F. There are two marked seasons, rainy and dry. However, rainfall varies with geographical location. Ghana is divided into 10 administrative regions, and Accra is the national capital. According to the latest population census (1984) 12.2 million people live in Ghana. The Akan, the Mole-Dagbani, the Ewe and Ga Adangbe are the dominant ethnic groupings. The Akan, which is the largest ethnic group, comprises groups which are linguistically and culturally homogeneous. These groups include Adansi, Akwamu, Akwapim, Akyem, Asante, Assin, Brong, Denkyira, Fanti, Sefwi and Wassa.

Berekum is the headquarters of Berekum district, one of the 13 districts in Brong Ahafo. Berekum district shares borders with four other districts in the region; namely, Wenchi in the north, Dormaa in the south, Sunyani in the east and Jaman in the west. Berekum is about 21 miles north-west of Sunyani, the regional capital of Brong

Ahafo. Berekum is served by four main routes, from Sunyani, Dormaa, Sampa and Seikwa. It has experienced increasing population since 1948, it rose from 5,378 in 1948 to 11,148 in 1960, and from 14,296 in 1970 to 21,000 in 1984. By 1990 the population was estimated at about 25,000.

SOCIAL ORGANIZATION

The indigenous people of Berekum are among the Brong speaking tribes of the Akan. Like the other groups of Akan, the rule of matrilineal descent is the key to Berekum's social organization, for it forms the basis of a localized lineage organization. A group of people who trace their descent in the matrilineage to a common ancestress form an *abusua* (lineage). Each individual is by birth a member of his/her mother's lineage. The head of the *abusua* is the *abusuapanin* ('lineage elder'), usually an older member of the lineage because of his/her experience in life, superior wisdom and personal qualities. The head also represents the lineage on the chief's council of elders. Berekum has been divided into *abrono* (wards). The majority of the members of each lineage live in a specific *brono* (ward). Some of the *abrono* in Berekum which are organized on the basis of lineage are Ahenboboano, Amangoase, Atanotia, Awerempe, Ayaakorase, Kyiritwede and Nyamebekyere. The lineage is a smaller unit of the *nton* (clan). Eight exogamous matrilineal clans are spread throughout Akanland. At the moment not all members of the lineage could be located on the ancestral land or households. Yet on various occasions many come together to their natal homes. The smallest group on the scale of social relations in Berekum is the *efie* (household).

MARRIAGE

The prohibition of marriages among members of the same clan has been relaxed. It is strictly observed with regard to marriages between members of the same lineage. In Berekum marriage between a person from one lineage and another in a different lineage is not a contractual relationship between the two spouses only. Marriage serves to link two lineages together. So much importance is attached to marriage that it is not left in the hands of the two persons involved. It is therefore seen as more or less a social contract between lineages. The choice of a sexual partner is usually left in the hands of the two people involved, but the ceremony for the recognition of the union should be an issue between two lineages. Normally the parents of the prospective spouses or the parents' representatives are expected to be present at this ceremony. The prospective husband submits bridewealth to his future in-laws. Upon the acceptance of the bridewealth by the lady's parents, the couples are pronounced married. When two people cohabit without the payment of the bridewealth the union is regarded as *mpenawade* (illegitimate marriage).

During the ceremony the in-laws stress the importance of childbirth to the newly-weds. On the part of the woman, children are important in many respects. Children are by birth members of their mother's lineage. When a woman is barren, her line of descent is terminated. Only the children of the females are members of the matrilineage. In view of this, barrenness is seen as a great disaster. Every effort is made to know the causes of barrenness. The explanations vary, but they are usually related to the activities of witches, sorcery, wrongdoing and envy, if no natural explanation could be provided. The type of healer to be consulted depends on the individuals involved. However, the choice could be made from scientific medical practitioners, priest healers, herbalists, Moslem healers and spiritual healers. Though not

very common, there are occasional accusations in Berekum that some women collect *aware suman* ('marriage talisman') to establish a good marital relationship. It is believed that this talisman could hypnotize the husband, and he would devote his attention to his wife and children. If such a situation happens, the husband will be less concerned about his own matrilineage. However, if the power of the talisman is misdirected to the woman, she may become mad.

If after some period no child has come out of the marriage, the man is pressured by some members of his matrilineage to look for an explanation or possibly take an additional wife. The man also needs children, though they are not part of his matrilineage. On his death, it is the responsibility of his children to buy a coffin to bury him. If he has no children, the responsibility lies with his own matrilineage and his father's matrilineage. During the funeral celebration the deceased's children are expected to dress in a special way to distinguish them from the other mourners. When the children also die, they are buried in their father's hometown, despite the fact that they belong to a different matrilineage. An exception to this is a situation where the matrilineage of the deceased would plead for the corpse to be sent to the matrilineage for burial because of the special position he held in the matrilineage. To be sterile means to be denied these privileges widely cherished in Berekum. Generally, if married couples are unable to have offspring the females are blamed because they attribute that to some factors like abortion or menstrual problems. If the fault is found to be the male partner, then the causal explanations are believed to be related to some spiritual factors.

THE POLITY

Both the traditional and modern political systems in Berekum exist contemporaneously, each with a clearly defined range of functions. The chief of Berekum is the *Omanhene* (Paramount Chief or literally 'State chief') of the Berekum Traditional Area. Unless he is impeached, the *Omanhene* of Berekum is appointed for life. When impeachment occurs, the the royal lineage selects a candidate. The *ohemmaa* (Queen Mother), who is also a member of the same royal lineage as the chief, endorses it, and he becomes the *ohene* (chief). Once his candidacy is endorsed, he represents the dead (ancestors), the living and the yet unborn. He is accorded new respect in the community, and his new respect has corresponding new roles. He is addressed as *Nana*. (*Nana* is used to address grandparents or chiefs).

The council of elders of the *Omanhene* of Berekum comprises the divisional chiefs of nine villages/towns. Each councillor represents a number of villages/towns, but I indicate here only the military seats. These military wings are headed by the following villages/towns:

MILITARY WING	MILITARY SEAT
Adonten	Kotaa
Akwamu	Biadan
Ankobea	Abisase
Benkum	Nsapor
Gyase	Jinijini
Kurontire	Senase
Kyidom	Fetentaa
Nifa	Domfete
Twafo	Adom

The Traditional Council, comprising the divisional chiefs, the *Omanhene* and his appointees, meets occasionally to make laws, usually related to some customary practices. One such law that has been strictly enforced is the law requiring people to reduce expenses on funeral celebrations. Offenders are fined, and the court and the law enforcing agencies in Berekum do not interfere in the laws made by the Traditional Council. The allocation of building plots is made by the Council, assisted by the Town Planning Officer. The Traditional Council retains a larger portion of the proceeds accruing from the sale of the building plots.

The day-to-day administration of the district is in the hands of the District Secretary. He is the political head of the district, and his appointment is not based on lineage affiliations as is the case with the chiefs. He is directly appointed by the government. The District Administrative Officer, who heads the District Council, is the civil service head of the district. Both the District Secretary and the District Administrative Officer run the administration of Berekum. In principle, the District Assembly, composed of elected representatives and government appointees, is the highest political authority in Berekum. However, its functions are limited to initiating development projects, especially the imposition of taxes to generate revenue. The District Secretary and a representative from the Traditional Council are members of the District Assembly.

THE ECONOMY

The predominant occupation in Berekum is farming; the stress is on the cultivation of cocoa. Other crops like cassava, yam, cocoyam (taro), plantain and different kinds of vegetables are grown. Of late, active interest is taken in the

cultivation of maize on large scale, and the Ghana Food Distribution Corporation has silos to store and sell during the lean season. The massive cultivation of cocoa in Berekum started during the 1950s and the early 1960s. During the early 1960s the farmers had expanded their farms, and the problem they faced was related to the land tenure system. The land tenure problems in Berekum induced cocoa farmers to shift to new cocoa growing areas such as Sefwi-Wassaw. The traditional system of landholding has resulted in the widespread distribution of farms, which is reflected in the small farm acreages. Some of the farmers realized that it was uneconomical to cultivate small acreages, hence the attraction to the new cocoa growing areas where they could acquire large tracts of land. The greater portion of the income of most people in Berekum is derived from the sales of cocoa. However, most of the cocoa trees are too old to bear fruits now, and this has been exacerbated by the decline of price of cocoa at the world market. Cocoa thrives in the forest areas, but at the moment most of the forest lands in Berekum have turned into secondary forest, making the cultivation of cocoa less viable. The cultivation of food crops brings little income since most of them do not have ready markets. These crops depend on the rainfall regimes; more rain or no rain at all ruins the farmers.

The timber industry in Berekum is a lucrative business. Three sawmill companies operate in Berekum, and have been licensed to cut the timber logs. These are small timber companies, generally using their own power generators. There are no major firms in Berekum. Commerce, consisting largely of retail trading, occupies an important position in the economy of Berekum. There are numerous trading stores dealing in assorted articles ranging from manufactured goods to food items. Some of the farmers and the business community in Berekum occasionally benefit from the lending facilities granted by the three banking institutions (Ghana Commercial Bank, Agricultural Development Bank and Co-operative Bank) in the town. In short, the economy of

Berekum is a rural one, depending mainly on agriculture.

BEREKUM: A TRANSIT CENTRE

Berekum is one of the most important towns (if not the most important) in Western Brong Ahafo which serves as a transit centre. Its close proximity to Cote d'Ivoire makes it an important transit centre for the people leaving or entering Ghana through the western part of Ghana. This is facilitated by a reliable transportation system which links Berekum with the other towns in the region. Through Dormaa, Berekum is about 40 miles to Cote d'Ivoire, while it is about 60 miles through Sampa. There are some people in Berekum who practise prostitution in Abidjan (the capital city of Cote d'Ivoire). Other prostitutes from different parts of Ghana use Berekum as a transit point on their way to Abidjan. It is believed by some people that the number of AIDS cases in Berekum in particular could be related to the activities of these prostitutes.

Berekum also serves as a market centre. On Thursdays people from different parts of Ghana bring merchandise for sale. Most of these traders arrive on Wednesday, and leave for their destinations on Friday. A lot of activities go on during the market day. The youth gang engages in gambling on that day, and usually the villagers are their victims. In the market and other nearby places (especially the lorry park) the purveyors of African medicine will be displaying their herbal concoction. They usually ring bells to attract people to buy some. At the entrances to the market are fortune-tellers who make money on people burdened with problems. Preaching the word of God from the Bible is also common in the centre of the market. People are encouraged to give money to help spread the Gospel.

RELIGION AND FESTIVALS

The religious life of the people in Berekum is significant in trying to understand the explanations they provide for suffering and misfortune, and how they respond to adversity. Some people are Christians, others Moslems, while still others are Traditionalists. The Christian faiths in Berekum can be grouped into three; the Orthodox churches, the Pentecostals and the indigenous African Christian churches. The dominant Orthodox churches (in terms of their membership) in Berekum are Catholic, Presbyterian and Methodist. Faith healing is less emphasized in these churches, even though lately they have practised spiritism. Despite emphasizing that Jesus was the greatest of all healers, they still urge their members to consult medical doctors for all kinds of afflictions. However, the religious composition of our informants who sought medical treatment from the healers in Berekum showed that some members consulted all types of healers. The Pentecostals (Assemblies of God, Church of Pentecost and Baptist, etc.) on the other hand emphasize faith healing, but healing does not form a major component of their doctrines. Occasionally members of these churches fast and pray for the sick. This type of healing is exclusive, it is directed only to members. The bulk of healing in Berekum is concentrated in the indigenous African Christian churches (Aladura, Ossamadi, Twelve Apostles, Christ Church of Peace Mission and Bethany, etc.). Their leaders usually provide explanations for sufferings and misfortune, and generally there are elaborate rituals involved in treating the sick. The general public and members of these churches are invited to their healing services. Here, conscious effort is made by the leadership to entreat members to patronize the healing services.

The Islamic faith is not at the forefront of faith healing in Berekum. However, several individual Moslem healers operate in Berekum. Apart from the preparation of

some herbal concoctions, the Moslem healer, usually called *Mallam or Kramo,* supplements his medicinal knowledge with the Koran. This was exemplified by a *Mallam* who was treating a mad person during my research. (The detailed discussion of this is in chapter 5). The Moslem healers move from house to house, hawking their arboreal preparations. Some of them claim they have remedies to make males sexually potent, while others specialize in curing barrenness and some types of afflictions in Berekum. Fortune-telling is very pervasive among the Moslem healers in Berekum. While some of the healers claim that they can tell some people's future from the designs in their palms, others believe they can identify it through the supernatural powers they possess. *Aware suman* ('marriage talisman') and *sikaduro* ('money medicine') are some of their specialties. Some individuals may cope with the competition among co-wives by consulting some of these *Mallams* who claim to have the power to reverse love relationships. When these medicines are misapplied, the woman may become mad. Men are usually noted for securing *sikaduro.* Some of the *Mallams* claim they have the powers to turn a poor person into a rich person overnight. Normally the healers assign several reasons for the poverty, and then assure their clients that by the Grace of God they would be able to offer the necessary help. It is not uncommon to hear people gossiping about the source of someone's riches in Berekum, trying to link the riches to the death in the family immediately preceding the riches. The typical explanation given is that they have exchanged the life of a relative for riches.

Generally, the religious festivals (Christmas, Easter and Ramadan) of both the Christians and Moslems in Berekum do not stress healing. These seem significantly different from Traditional religious festivals where the well-being of both the individual and the community as a whole is emphasized. The Traditionalists are pantheistic, (believing and worshipping all gods) but these gods are hierarchically structured. At the apex of this hierarchy of deities is the Supreme Being *(Onyame, Onyankopon or*

Tweaduampon). He is the creator of all things, and the other deities derive their powers from him. He is believed to be a male, while Mother Earth *(Asaase Yaa)* is regarded as a female spirit of fertility. Unlike the other deities or shrines *(abosom)* who have special priests/priestesses, both *Onyame* and *Asaase Yaa* do not have them. *Onyame* is so highly venerated that he can only be approached through the intermediary of *abosom* (lesser gods). This view reflects the authority structures of the Akan political system. The *ohene* speaks through the *okyeame* (linguist), and other people also speak to the *ohene* through the *okyeame.* The *abosom* are therefore playing the role of *akyeame* (linguists). *Abosom* may be found in temporary abodes such as rivers, streams and trees, and usually have their own priests/priestesses and followers who regularly worship at their shrines. Below the *abosom* are minor deities, *asuman,* which derive their powers from the talismans or amulets worn on the body to give protection and help to the wearers against evil spirits. The spirits which affect the life of the Traditionalists more directly are the *nsamanfo* (ancestral spirits). People regularly consult them, make offerings, and seek their guidance in most important matters. *Nsamanfo* are the point of reference in religious feativals like *Munufie* and *Kwafie.* They are also addressed as *Nana* (just like the chiefs). In Berekum, *nsamanfo* are believed, however, to have little influence in the causes of afflictions.

Two main types of religious festivals *(afahye)* are celebrated annually in Berekum; one by the *akomfo* (priests/priestesses) for the *abosom* and the other by the *ahenfo* (chiefs). The *abosom* have devotees, and once every year they help the *akomfo* in planning for the *afahye.* These *abosom* are believed to be witch-hunting, and also serve as powerful social control. The individuals who consult them for treatment are put under their care, and these suppliants send their *aboade* (pledge) during the festivals. *Afahye* are meant to be a yearly affirmation of loyalty to the *abosom* by the *akomfo,* their devotees and some former patients. Some people pledge to the *abosom* to help

them in several activities in life. During the *afahye* they come to give their *aboade* and at times make further pledges. These *aboade* could take the form of monetary contributions, fowls, sheep and cows. Some infertile couples who have been helped by the *abosom* to have children submit their *aboade,* and a special libation poured for the children. Some parents who have been helped this way may name their children after these *abosom.* During these *afahye* new patients are accepted by the *akomfo.* While some of the *akomfo* may have some purification rites on behalf of the community, most of them concern themselves with individual treatment.

Many religious festivals are celebrated annually by the *ahenfo* of Berekum. Each divisional chief has his own *afahye.* However, the most important of these is the *Kwafie afahye* celebrated annually in December by the *Omanhene* of Berekum. All the divisional chiefs and the general public are expected to attend at the *Omanhene's Park.* He sits in state, and the divisional chiefs and individuals pay homage. The State (Berekum Paramountcy) shrine, *Tane Kwasi,* is consulted on the eve of the *afahye* by the *Omanhene.* The ancestral stools are purified, and the *nsamanfo* are remembered. The *Omanhene* pours libation for good harvest and well-being of the community. These festivals also serve as forum for public opinion, and a means of checking those in authority. During these occasions the citizens of Berekum living outside the community also come and contribute in kind or cash to help the development of the community.

The concept of ill-health in Berekum, therefore, involves not only pathological changes but is also related to issues dealing with social behaviour and moral conduct. It is recognized that natural factors like climate, water and insects can cause several kinds of afflictions. The treatment of such afflictions need physically-applied procedures. However, the main aim of the *afahye* is to deal with the social behaviour and moral conduct. Illnesses could be caused through the activities of evil spirits, sorcery, witches or inappropriate conduct. These annual festivals take care of the spiritual component of

the lives of the people in Berekum. The propitiation of *nsamanfo* could avert a great disaster likely to happen to the community. The treatment of some illnesses believed to be spiritually caused would involve spiritual mechanisms. It is also important to stress that in Berekum, whether an illness is naturally or spiritually inspired, the role of relatives is very crucial. The relatives serve as a support group in the treatment of illnesses. If the illness is very serious, they usually decide which type of healer should be consulted. In most cases they share the expenses incurred during the treatment.

I have so far shown that the people of Berekum are mostly Akan, with farming as their predominant occupation. Berekum is therefore a rural community, without any major industry. Both the traditional and modern medical systems compete in treating illnesses. In the same vein, the explanation of afflictions make reference to both the spiritual and natural factors.

CHAPTER III

LAYPERSONS' EXPLANATIONS OF ILLNESS

INTRODUCTION

Generally, every society has devised some ways to explain the causes of afflictions and other misfortunes in the society. The individuals' explanatory models indicate how they make sense of given episodes of illness, and in some cases, how they choose and evaluate particular treatments. It is expected that the explanatory models held by laypersons and medical practitioners will differ in analytical power, metaphor and idiom. While the authoritative pronouncements on the nature and causes of illness are the preserve of Berekum's various healers, it would be wrong to assume that they alone confront the problem of explaining illness. Illness is a fact of life for many ordinary people, and it is discussed with interest in the home, at work and on numerous social occasions when people meet and exchange news of personal, family and communal affairs. Laypersons' ideas about illness causation seem to be one important element which enters into their treatment-seeking behaviour, and possibly these may also be an important ingredient which helps shape the diagnostic encounter between the patient and the healer.

One area in medical sociology that has attracted a lot of research in Ghana is the explanation provided for illness. Yet, it has been the area where divergent research findings have been rampant. The literature on disease causation in Ghana can be classified into two: the works (Twumasi (1975, 1981a); Nukunya et al (1976); Brautigam et al (1979) and Appiah-Kubi (1981)) which attest to the primacy of spiritualistic explanations among Ghanaians, and those (Warren (1978); Fosu (1981) and Wyllie (1983)) which suggest that naturalistic explanations are equally important or

even more pronounced among Ghanaians. This chapter therefore aims at two things: first, to find the relative emphasis laypersons in Berekum place on spiritualistic/naturalistic types of explanation, and second, to find the extent of agreement (or consensus) or lack of it among laypersons trying to explain the causes of illness. The rationale for this kind of enterprise is the promise it may offer in throwing some light on the controversies surrounding the diverse views on disease causation in Ghana. In addition, laypersons are the consumers of the health care system in Ghana, and the explanations they provide for the causes of illnesses may give a clue about the health care system that may benefit them.

The 44 informants were selected from among the patients of different healers in Berekum. Eighteen were selected from the Holy Family Hospital, 10 from the priest healers and 8 each from the herbalists and the spiritual healers. Twenty-four of these informants were males, while 20 were females. Comparatively, the patients were younger than the healers; the youngest was 17 years, while the oldest was 68 years. The average age was about 36 years. Unlike the healers, the majority (72.7%) of them were literates. Most of them were affiliated to the Brong tribal group. We hope to achieve the aim set out in this chapter by analysing the laypersons' explanations of illness at three levels: general illnesses, specific illnesses and the informants' own illness experiences. These will be supplemented by my own personal experiences since I was born and grew up in Berekum. Local ideas about the spiritualistic/naturalistic explanations of illness will be used as the basis for the key concepts in this chapter. *Sunsum mu yade* is used here to denote spiritually caused illness. *Sunsum mu yade* refers to any kind of illness which is believed to be caused in some way by some supernatural force: namely; gods, witches, sorcerers, spirits and magical powers. Naturally caused illness in the local terminology is *honam mu yade.* It refers to any kind of illness in which supernatural forces are not believed to be involved.

EXPLANATIONS OF ILLNESSES IN GENERAL

Foster (1976) identified two basic principles that account for most of the etiologies that characterize non-western medical systems, personalistic and naturalistic medical systems. In a personalistic medical system disease is explained in terms of active purposeful intervention of an agent who may be human or supernatural. A naturalistic medical system, on the other hand, explains illnesses in impersonal systemic terms, where disease is thought to stem from natural agents, and above all by an upset in the balance of the basic body elements. The categorization of non-western medical systems this way leaves very little room for the other medical systems where naturalistic and spiritualistic explanations are not mutually exclusive. I analyse here the explanations informants provided for illnesses in general in Berekum. I also hope to demonstrate how the classification of medical systems based on this conception of disease etiologies may not be wholly applicable to Berekum. The analysis centres on two main issues about the informants' etiological explanations of illnesses. (See Appendix A for Tables).

The informants were asked:

a) If some illnesses were *sunsum mu nyarewa*

b) If some illnesses were *honam mu nyarewa.*

Spiritual Causation

According to Table 30 the informants placed little emphasis on spiritualistic explanations of illness; few (7) of them regarded some illnesses as *sunsum mu nyarewa.* The illnesses they identified as *sunsum mu nyarewa* were epilepsy, impotence/sterility, typhoid, malaria, barrenness, amputation of the leg or arm, chicken pox, severe stomach pains and infant mortality. The informants, however, stressed that *sunsum mu nyarewa* could be caused under the following conditions:

> The causes of these illnesses are very difficult to trace, and they also seem mysterious. They are the illnesses which disappear when the invalid goes to the hospital, but re-appear when she/he leaves the premises of the hospital. *Aduto* (intrusion into the body some alien spirit force) is another type of *sunsum mu yade.* Each type of illness has specific form of treatment; when it is applied and the health of the person does not improve, then it could be explained as *sunsum mu yade.*

Based on the above conditions, two main circumstances under which *sunsum mu yade* may be caused are its mysterious nature and the invalid's response to treatment. An informant recounted a mysterious death of a middle-aged man at the Holy Family Hospital in the following manner:

> A man was knocked down by a bicycle in Berekum. He sustained severe head injuries, and was rushed to the Holy Family Hospital. He was taken to the operation theatre for surgical operation. Half-way through the operation there was a power failure in the whole of Berekum. By that time the hospital did not have a stand-by generator, and the result was that the man died.

The mysterious nature of this kind of death stems from two main issues; usually bicycle do not kill people this way, and the power failure at that time was very unusual. The informant believed these could not have happened by chance. Here, it is found that the informant's conception of mysterious occurrence was influential in regarding the death of the man as spiritually inspired.

Another instance where an illness could be spiritually inspired is the invalid's response to treatment. In this case the informants resort to spiritualistic explanation of illness when the invalid does not positively respond to treatment. An informant explained:

> A patient spent about one month at the Holy Family Hospital, but his health never improved during the period. Rather, his health deteriorated every day. Knowing that he could not successfully treat him, the doctor asked that the relatives of the patient should try somewhere else. The patient was taken to a priest healer who did not explain the cause of the illness, but offered to treat him. He successfully treated the patient, because

the illness was *sunsum mu yade.* Doctors cannot do much about that.

The explanation provided here could not have been expressed in spiritual terms if he had responded positively to the treatment at the Holy Family Hospital.

Illnesses caused through *aduto* are normally regarded as *sunsum mu nyarewa.* (Treatment of *aduto* will be explained in detail in chapter 5). Here, it is generally the healers who indicate which type of illness could be viewed as *aduto,* and under what circumstances. The patients are taken to the shrines, which also identify the cause. As soon as an illness is recognized as *aduto,* its cause is expressed in spiritual terms. From this conception of the etiological explanations of illness, it is not easy to delineate a purely *sunsum mu yade* in Berekum. The social context of illness or the invalid's response to treatment could turn the explanation in either way, since they do not seem to operate with fixed system of illness classification. This shows that Foster's (1976) classification of medical systems based on disease causation may not adequately explain the situation in Berekum.

Natural Causation

Table 31 shows that most informants (84.1%) regarded most illnesses as *honam mu nyarewa.* Some of the illnesses they regarded as *honam mu nyarewa* were headache, diarrhoea, malaria, stomach pains, waist pains, sore, cut, rheumatism (arthritis), measles, bodily pains, piles and eye problems. The informants identified some features of these illnesses as:

> They are quickly treated, and the patients get cured easily. Their treatment procedures are physically applied. The causes of these illnesses are easily traced since most of them are through insect bites, 'unsuitable' food, 'bad' water, hot weather, carelessness and negligence.

Generally, the informants regard these illnesses as naturally caused because they are familiar afflictions, without any mysterious causes. The preference for naturalistic explanation here tends to support Fosu's (1981) study in Ghana where he observed

that generally the people at Berekuso explained illnesses in natural terms. In this study, he observed that the people classified diseases into three types; diseases caused by natural agents, those caused by supernatural agents, and those whose causes embraced both natural and supernatural. It is therefore difficult to make disease classification of this kind in Berekum based on their etiological explanations. The same illness may be interpreted differently under different conditions. However, illnesses are generally explained in natural terms.

EXPLANATIONS OF SPECIFIC ILLNESSES

It was noted in the previous section that generally the informants explained illnesses in natural terms. However, the spiritualistic and naturalistic explanations of illness were not regarded as mutually exclusive. Perhaps the general nature of illnesses influenced their perceptions. In this section I will examine the explanations provided for some specific illnesses in order to point out the emphasis on spiritualistic or naturalistic etiologies of illnesses in Berekum. On the explanations of some specific illnesses I will examine three different types of illnesses: familiar afflictions, unusual afflictions and the afflictions connected with the reproductive system. The explanations the informants provided for these illnesses have been classified into two; spiritual and natural. In order to differentiate between spiritual and natural explanations of specific illnesses, I use the following specifications; for example, if an informant attributed the cause of a lorry accident to a witch, resulting in the death of someone, I recorded 'witchcraft', and not lorry accident. This type of explanation is regarded as spiritually inspired. The informants provided explanations for these specific illnesses in terms of the main and other causes. I will also examine the explanations the informants provided for their own illness experiences. (See Appendix A for Tables)

EMPHASIS ON SPIRITUALISTIC/NATURALISTIC EXPLANATIONS

Familiar Afflictions: Malaria and Diarrhoea

The emphasis on naturalistic etiological explanations of both *abunu* (malaria) and *ayamtuo* (diarrhoea) was very striking. While Table 34 shows that most (97.9%) of the explanations provided for *abunu* were regarded as naturally caused, there was only one spiritualistic explanation. For *abunu*; mosquitoes, hot weather, food related problems, bad water, witchcraft, anaemia and constipation were the main causal explanations. According to Table 35 most (97.8%) of the explanations provided as the main causes of *ayamtuo* were in natural terms, while one informant could not provide any causal explanation.

This pattern changed slightly with other possible causal explanations of *abunu* and *ayamtuo*. Although the naturalistic explanations were still dominant, we see here the inclusion of some spiritual explanations also. Table 34 indicates that most (88.2%) of the other causal explanations of *abunu* were in natural terms, while few (11.8%) were expressed as spiritually caused. The other possible causal explanations of *abunu* were hot weather, mosquitoes, food related problems, bad water, witchcraft, constipation, lack of fresh air, high body temperature, sorcery and the devil. According to Table 35 most (79.0%) of the other causal explanations provided for *ayamtuo* were natural, while few (21.0%) were spiritual. The other causal explanations of *ayamtuo* were food related problems, bad water, excessive drinking, sorcery, witchcraft, compilations of illnesses, curse, stomach pains and wrongdoing.

The general feature of the main and other possible causal explanations provided for *abunu* and *ayamtuo* is the evidence of more emphasis on naturalistic explanations. Perhaps, the recourse to the naturalistic explanations of these familiar illnesses may be due to the informants familiarity with them. Another notable feature of these

explanations is the inclusion of spiritualistic explanations when they resorted to other possible causes. At this point the informants seem to have exhausted all their explanatory accounts, and that may account for the inclusion of spiritual factors.

Unusual Afflictions: Madness and Epilepsy

Despite its unusual nature, we see from Table 36 that most (87.0%) of the explanations provided for *dam* (madness) were natural, while a few (10.9%) were in spiritual terms. Only one informant could not provide any explanation. The main causal explanations provided for *dam* were the use of drugs, brain damage, witchcraft, too much worrying and devilish practices. The use of both licit and illicit drugs was the single largest causal explanation of *dam*. Two of the commonest drugs which informants believed could cause *dam* were marijuana (cannabis) and valium 10mg or diazepam (locally called 'blue blue'). The other types of drugs identified were librium, amphetamines, mandrax (diphenhydramine) and proplus. An informant vividly gave an account of the effect of the use of drugs:

> A young man in his twenties became addicted to the use of marijuana. The initial symptom was a peppery sensation in the head, leading to unusual utterances. He was taken to a psychiatrist in Sunyani General Hospital. He was put on medication, and advised to refrain from smoking marijuana. The recovery was very fast, but sadly, he again relapsed into smoking marijuana. Now he is completely a mad person. Apart from smoking marijuana, recently most people have resorted to taking a drug called 'blue blue' as a sedative and tranquilizer. The continued use of this drug wears down the brain, which leads to madness.

The youth may have several reasons for taking these drugs, but as Oviasu (1976) observed in Nigeria, basically it is instrumental. The reasons given by his informants for taking amphetamine or proplus were to improve intellectual or physical performance, and postpone inattentiveness and sleepiness. Obot (1990) in his study about substance abuse in Nigeria also identified three factors that could facilitate the

use of drugs in Nigeria. First, these drugs serve as means of escape from the harsh realities of life. Second, more avenues for employment means more disposable income to maintain the new lifestyle of alcohol and drug consumptiom. Finally, the drugs are available and accessible to consumers. The first and the last factors seem to be applicable to the situation in Berekum since the youth resort the use of drugs as a way of coping with the pressures of life. Also, medically these drugs are generally prescribed to induce sleep, relaxation and relief from tension and anxiety; they could be easily bought in drug/pharmacy stores. Some of these drugs are hawked by itinerant drug vendors. In Berekum, the use of drugs is mainly confined to the Zongo; most of these users are unemployed. Pela and Ebie (1982) observed in Nigeria that in a clinical setting a great deal of psychosis is associated with the use of drugs. These findings in Berekum attest to an apparently common belief that a causal connection exists between the use of drugs and *dam*.

An informant stressed the instrumental role played by witches in inflicting *dam* on some people in the following terms:

> Most witches are very destructive, but they limit these malignant activities to the members of their own extended family. They can spiritually remove their victim's brain or may use the victim's head as a football. When this happens the victim becomes mentally deranged. In addition, when an offer of witchcraft is rejected, the witch will continue to threaten the person in dreams. If the person still refuses to accept it, it will be forced on him/her. But if the soul of the person still refuses, then the last resort is to strike the person with madness.

In stressing how the devilish practices could cause *dam*, an informant stated:

> In a fast changing society, the tendency to get rich quick is very pervasive. This has led some people to consult mediums and mallams to get *sikaduro*. If the individual fails to obey the rules when performing the rituals associated with it, the punishment by these powerful spirits may be the infliction of *dam*. A woman who also wants a successful marriage can consult these spirits for *aware suman*. Deviation from how to use this can lead to *dam*.

These two concepts; *sikaduro* ('money medicine') and *aware suman* ('marriage talisman')

are very important in understanding laypersons' explanation of *dam* in Berekum. Consultations with the mediums will normally require a strict adherence to some given rules. For example, a woman who wants a good marriage is given a talisman and some supporting rituals. She is then instructed not to talk to anybody until she arrives at her residence. After performing the initial rituals her husband should be the first person she must speak with. If she violates these rules, the spirits turn against her. This may eventually turn into *dam*. *Sikaduro* also works the same way.

Although Table 37 indicates that there was some evidence of the emphasis on naturalistic explanation of the main cause of *twa* (55.2%), the emphasis was less than that of *dam*. While a few (21.4%) of the informants explained the main causes of *twa* in spiritual terms, about one-fourth of the informants could not provide any explanation. The main causal explanations provided for *twa* were convulsion, envy, wrongdoing, witchcraft, curse, 'in person at birth', worms, starchy food and heredity.

Some of the informants who could not provide any explanation for *twa* either indicated 'no idea' or 'don't know'. This problem of no idea or don't know showed up in a study conducted by Nukunya et al (1976), while Last (1981) also raised this issue. In their study, Nukunya et al (1976) asked their informants about the precautions they took to maintain good health, and about one-fifth of them indicated they had no idea about the question. The study therefore probed further into this attitude. Is it a genuine attitude? Or just to get rid of the researcher? Most of the informants explained that familiarity with some of the illnesses would increase one's awareness of their causes. Since neither they nor any member of their family had experienced *twa* they could not provide any explanation. However, it was learnt that *twa*, like *kwata* (leprosy), carries a stigma in the community, and some of the informants did not care to know some facts about it. The stigma attached to it in Berekum seems to derive from two main factors; the nature of the illness and its

prolonged treatment. Compared with the other types of illnesses, *twa* is less prevalent in Berekum. An epileptic may fall down in a fit anywhere. During this period of seizure, an epileptic may sustain injuries or burns. The person virtually becomes a dependant, and his/her condition is similar to a helpless infant. This negatively affects the individual's role in the community. In addition, the treatment of *twa* may be prolonged, and usually extends over one's lifetime. There are, therefore, very few educational and employment opportunities for an epileptic. In sum, an epileptic in Berekum is seen as playing a limited role in the community as a result of the nature of the illness. In addition, few people (if any) will enter into a marriage relationship with an epileptic.

According to Table 36 the majority (71.4%) of the informants explained the other causes of *dam* in natural terms. Among the other causal explanations provided for *dam* were the use of drugs, too much worrying, brain damage, heredity, disagreement, curse, witchcraft, competition, disappointment, and magic. One of the interesting accounts of using curse as a causal explanation of *dam* was expressed this way:

> Recently a certain woman was suspected of stealing foodstuffs from her neighbour's farm. An appeal was sent to persuade her to desist from that, but she continued to steal. She could not be prosecuted since she was not caught in the act. The owner of the farm therefore sent some foodstuffs as a suppliant to *Asuo Koraa* (River Koraa) to strike the offender with *dam* if the person continued to steal. The woman continued, and now she is mad.

This is one instance where an aggrieved person could verbally curse an offender or send some presents to a shrine or a river to inflict some illness on the offender. In the case cited above, *Asuo Koraa*, regarded as the most 'powerful' river in Berekum, is seen as a very strong and powerful enforcer of the moral values. According to Table 37 the majority (97.7%) of the informants regarded the other causal explanations provided for *twa* as spiritually caused. The other possible causal explanations provided for *twa* were wrongdoing, envy, witchcraft and worms.

The naturalistic etiological explanation provided for *babaso* (gonorrhoea) was very marked. Table 38 shows that the majority (97.7%) of the informants cited sexual intercourse with affected person as the only main causal explanation of *babaso;* only one informant did not provide any explanation. According to Table 38 most (85.2%) of the other causal explanations provided for *babaso* were in spiritual terms. The informants cited the following as the other possible causes of *babaso:* sex with someone else's partner, wrongdoing, penis related problems, magic, envy, 'same name' and rivalry. The importance of limiting one's sexual activity to his/her own partner was exemplified by an informant in the following words:

> Some people with spiritual powers want to punish others who take delight in having sexual intercourse with someone else's partner. These spiritually developed persons will invoke some spiritual powers on their partners, and anyone who will have sex with these partners may contract *babaso*.

Sex with someone else's partner needs explication here because it is different from sexual intercourse with a person who has been infected with *babaso*. "Partner" here also means someone else's wife or girl-friend. The invocation of spiritual powers to inflict *babaso* on offenders works in two different ways: an aggrieved person may punish the offender personally or an aggrieved individual without any spiritual powers may consult a spiritualist to punish the offender on his behalf. A fee is charged for this service. Most of the healers interviewed during the fieldwork conceded that they had the powers to inflict *babaso* on offenders. Among these healers were the herbalists, priest healers and Moslem healers. However, other spiritualists who were non-healers like sorcerers, mallams and magicians could equally inflict illnesses on offenders. Despite being regarded as custodians of morality in Berekum, these spiritualists do not punish offenders other than the two conditions stated, being personally aggrieved or having been consulted by an aggrieved person. When one of these conditions is met, the

aggrieved person would procure medicine and use it on the partner. When the partner continues with the affair, her male lover will be inflicted with *babaso* without necessarily having sexual intercourse with an infected person. The female may also be punished in a similar way if her partner sees a possibility of ending their relationship.

Another interesting causal explanation provided for *babaso* is the effect of 'same name'. An informant stressed this in the following terms:

> A spiritually prepared object is placed at a spot where the targeted person normally passes. Anybody who walks over this object bearing the same name as the targeted person will be inflicted with *babaso*.

Here the afflicted person is seen as a scapegoat, because bearing the same name may mean sharing misfortunes in some circumstances. For example, if the name of the targeted person is Kofi (a male born on a Friday in Berekum), then anybody bearing the same name, Kofi, is equally vulnerable. It is believed that this kind of affliction is less severe, and could be more easily treated than the affliction on the actual targeted person.

According to Table 39 the majority (91.2%) of the informants attributed the main causes of *bononi* (barrenness) to natural factors. They cited the following as the main causal explanations: menstrual problems, abortion, 'barren at birth', complications in fertilization, damaged womb, contraceptives, witchcraft, exposure to early sex life, venereal diseases, envy and wrongdoing.

According to Maclean (1982:176):

> The life of the barren woman is undoubtedly a miserable one; she may be easily be displaced to make room for a fertile wife; she is denied the pleasures and pre-occupation of child rearing; in later life she is without the support of sons and daughters, upon whose work and affectionate attention she might otherwise have hoped to depend.

The plight of the barren woman in Berekum reflects Maclean's observation of Yoruba folk medicine and fertility in Nigeria. In Berekum descent is traced matrilineally, and

in order to see to the continuity and persistence of their line of descent, women take desperate measures to get children. They therefore see *bonini* as the greatest obstacle in achieving this goal. It may seem rather surprising that most women in Berekum crave for children, while at the same time about one-third of the informants cited abortion as one of the single largest explanations of *bonini.* Some of the informants believed that in Berekum some barren women might have had abortion once in their life. This may be partly explained by the influence of the school system. In Ghana, apart from the Diploma Awarding Institutions and the Universities, a pregnant woman will be required to withdraw from school. In most cases pregnancy leads to dismissal. Some of the women who go through the school system are therefore faced with this dilemma: to continue with the schooling and lose the baby or to have the baby and discontinue the schooling. In addition to the effect of the school system, some teenagers also think they are too young to be mothers. Childbirth becomes very crucial to them after they have completed the level of education they desire.

In addition to these main etiological explanations provided for *bonini,* Table 39 indicates that the informants also resorted to other less common causes. Here, there was more emphasis (63.4%) on spiritualistic causal explanations. Among these causal explanations were envy, wrongdoing, abortion, witchcraft, menstrual problems, curse, venereal diseases, barren at birth, complications in fertilization, piles, family disagreement and affection.

The pattern followed in the previous discussions, where the main causal explanations provided for the specific illnesses were naturally expressed, changed with *kotewui/kotekra* (impotence/sterility). According to Table 40 the majority (66.7%) of the informants regarded *kotewui/kotekra* as spiritually caused. They cited the following causal explanations: envy/hatred, wrongdoing, affection, venereal diseases, weak sperms, 'in person at birth', penis related problems, witchcraft, magic, difference in blood group,

hernia and sex with someone else's wife. In referring to how affection affects sterility, an informant stated:

> A young man who has a strong affection for his mother will not care for his mother when he gets married. He will redirect his affection to his wife and children at the expense of her mother. If the mother still wants to retain the son's affection after his marriage she will make him sterile.

Affection and envy here seem to be inter-related. However, there is a distinction between affection-caused illness and envy-caused illness. The mother prevented her son from having children because she did not want to lose his attention and care. The son would redirect his affection to his children. The mother would then invoke some spiritual powers to make her son sterile. This type of affliction is regarded as affection-caused. On the other hand, the mother could prevent her daughter-in-law from having children by making her barren. In this case her son would be potent, if he were to marry an additional woman he could have children. When a mother-in-law makes her daughter-in-law barren, it is regarded as envy-caused affliction.

It is believed that some mothers who are witches, and want their sons to be rich, exchange their sons' potency for riches. An interesting case of this type was given by an informant in the following way:

> A married young man with two wives had a large cocoa farm. The mother of this young man wanted him to be the richest person in the family, and since the children of her son would not be members of the matrilineage, she spiritually exchanged the potency of her son for riches. The young man became 'fabulously rich', and even married a third woman. He is yet to get a child, and he may not get one.

This explanation is similar to Debrunner's (1961) finding about witchcraft in Ghana. He indicated that a quarrel between a young man and his sister resulted in the sister spiritually removing her brother's testicles and thereby rendering him sterile. The sister accepted this before a shrine, and brought an empty cigarette tin supposed to contain the testicles. The young man was able to get a son after the return of the invisible

testicles.

At the shrine of Nana Maase (the chief priestess of Brong Ahafo) I interviewed a patient (Marketing Manager of a Timber Firm in Kumasi) who had travelled one hundred miles for treatment. His second wife, who wanted a better marriage, used some magical powers to make him impotent, but only with respect to his first wife. He recounted his experience with his second wife this way:

> I am married with two wives. I have children with only my second wife. Recently I found that I lacked the sexual power to have sex with my first wife, even though I can have sex with my second wife. I travelled to several places for treatment, but none of them was successful. I finally came here, and Nana asked me to bring my second wife. As soon as she arrived at the premises of the shrine she started confessing all the magical powers she had used on me to have a good marriage. I have been responding to treatment since I arrived here, and I hope my potency will be restored.

Like the other causes of some of the illnesses discussed earlier, Table 40 shows that the tendency to explain the other causes of *kotewui/kotekra* in spiritual terms increased. The majority (72.5%) of the informants regarded the less common causes of *kotewui/kotekra* as spiritually inspired, while only few (27.5%) explained it in natural terms. The other causal explanations they cited were envy/hatred, wrongdoing, weak sperms, witchcraft, affection, sex with someone else's wife, magic, venereal diseases, 'in person at birth', penis related problems and excessive drinking. It must be stressed that most of these factors were also cited as the main causal explanations of *kotewui/kotekra.*

I have demonstrated that the majority of our informants in Berekum regarded illnesses as naturally caused. The emphasis on naturalistic explanations for the specific illnesses was very striking, except for *kotewui/kotekra,* which was spiritually explained. This finding in Berekum lends support to the literature (Warren (1978); Fosu (1981) and Wyllie (1983)) which suggests that naturalistic explanations are more pronounced

among Ghanaians.

CONSENSUS/LACK OF CONSENSUS ABOUT ETIOLOGICAL EXPLANATIONS OF ILLNESS

It was noted in the preceding section that there was more emphasis on naturalistic explanations of illness among our informants in Berekum. In this section, I am interested in the extent to which consensus/lack of consensus was manifested among our informants. The informants provided causal explanations for the three specific kinds of illnesses discussed in the previous section. The measure of consensus/lack of consensus here is based on the extent to which many of the informants agreed or disagreed on a single largest main causal factor for that type of illness.

Consensus was more evident in the explanations the informants provided for *abunu, ayamtuo, dam, twa* and *babaso,* while there was less consensus in the explanations of *bonini* and *kotewui/kotekra.* The majority (51.1%) of the informants cited mosquito bites as the main cause of *abunu,* while 58.7% believed food related problems constituted the main cause of *ayamtuo.* Similarly, there was consensus among the informants in the less common explanations they provided for *abunu* and *ayamtuo.* Both hot weather and food related problems were the single largest less common causes of *abunu* and *ayamtuo* respectively. The use of drugs, the most frequently mentioned cause of *dam,* was cited by some 73.9% of the informants; while convulsion constituted 46.8% of the explanations provided for *twa.* Consensus on etiological explanations of *babaso* was the strongest; sexual intercourse with an infected person accounted for 97.7% of the explanations. Consensus among the informants was weakest for the explanations they provided for *bonini* and *kotewui/kotekra.* Both menstrual problems and abortion constituted 34.7% each of the explanations provided for *bonini.* Envy/hatred constituted

33.3% of the explanations provided for *kotewui/kotekra*. Generally, the lack of consensus became even more pronounced when the informants resorted to secondary or less common causes of most of these specific illnesses. The extent of consensus among the informants was generally high. Of the seven specific illnesses, the informants agreed on a single largest etiological explanation each for five of these illnesses.

INFORMANTS' ILLNESS EXPERIENCE

I have examined the explanations the informants provided for illnesses, both general and specific. In this section, I analyse the informants' explanations of experienced illnesses, both previous and present.

Previous Illness

It seems the informants did not know much about their own illnesses. It was observed that they were able to provide several etiological explanations for the specific illnesses, but according to Table 48 most (52.3%) of them could not provide any explanations for their previous illnesses. Only 47.7% of the informants were able to provide some explanations for their illnesses. However, they provided only naturalistic explanations for their illnesses. None of the informants recognized any supernatural force involved in their experienced illnesses. Most of these illnesses were less serious. They were malaria, headache, hypertension, madness, piles, jaundice, hernia, diarrhoea, rheumatism, burns, eye injury, broken leg, asthma, miscarriage and so on. They attributed the causes of these illnesses to such factors as problems related to food, weather, insect bites, malfunctioning of the body, physical injury and so on. Thirty-six of the informants sought treatment for their previous illnesses. Scientific medical treatment was the first choice for about 61.1% of them, while 27.8% resorted to self-treatment. Only 8.3% of them consulted practitioners of herbal medicine, and 2.8%

had faith healing as their first choice. Most of the healers they consulted offered to treat them without providing any explanation for their illnesses.

Present Illness

Table 49 shows that only 29.5% of the informants were able to provide explanations for their present illnesses. While 22.7% of the explanations were in natural terms, 6.8% of them were regarded as spiritual. The majority (70.5%) of them could not provide any explanations for their present afflictions. Among these afflictions were barrenness, madness, impotence, jaundice, snake bite, piles, paralysis, poverty, hernia, swollen eye, swellings, severe headache, abdominal pains, diabetes, malaria, hypertension, broken leg and so on. Some of the explanations they provided for these afflictions were hot weather, lorry accident, malfunctioning of the body, family disagreement, bad water, peppery food, insects, abortion, curse and so on.

It seems there are some possible relationships between informants' attempt at causally explaining their current illnesses and the treatment choices they made. Those who cited hot weather, malfunctioning of the body, lorry accident, abortion, swollen eye, curse and family disagreement as the causes of their afflictions made scientific medical practice their first choice of treatment. It is interesting to note that the informants who mentioned curse and family disagreement as the causes of their afflictions first consulted the practitioners of scientific medicine for treatment. In the case of curse, the informant had swollen feet. When she consulted the doctors at the Holy Family Hospital she was asked to refrain from eating salt, but that did not improve her condition. She switched to a priest healer for further treatment. The other informant also had bodily pains, cold and swollen feet, but she believed it was a family disagreement which had not been resolved. She went to the Holy Family Hospital first because her spouse was a worker at the hospital, and that qualified her for free

medical care. At the same time that she was receiving treatment at the hospital she was also consulting a herbalist. In general, the informants believed scientific medicine is better equipped (in both technology and personnel) to treat most of their illnesses.

Some of the informants also resorted to self-treatment before switching to other types of treatments when they realized that the self-treatment could not cure their illnesses. They attributed the causes of their illnesses to bad drinking water, peppery food and constipation. They first resorted to self-treatment because they felt their illnesses were less serious. While some bought drugs from the drug/pharmacy stores, others prepared herbal concoctions.

Snake bite and broken bone were all treated by herbalists. The informants regarded them as naturally caused. They consulted herbalists first because these herbalists were regarded as specialists in treating these kinds of afflictions. The Holy Family Hospital usually refers some patients with simple fractures and chronic psychosis to some of these herbalists. This kind of referral could assure the patients that the herbalists were better in treating such kind of afflictions than the other types of healers. One healer informed me that he was consulted by some doctors at the Holy Family Hospital to treat a patient who had been bitten by a snake. He claimed to have successfully treated the patient in the 'Isolation Ward' at the hospital. I could not get confirmation from the hospital since the doctors involved in inviting him had been transferred from the Holy Family Hospital.

One informant who believed his paralysis was through *aduto* first consulted a priest healer. He did not accept the explanation provided by the healer that it was the result of a wrongdoing on his part. He therefore switched to a Moslem healer, but he discontinued receiving treatment from him because his condition was not improving. Another priest healer also provided an unacceptable explanation to him, and finally the

informant accepted the explanation given by a herbalist. The patient initially speculated that it was *aduto,* but it was not through any wrongdoing on his part. This was confirmed by the herbalist. Another informant stated that abortion was responsible for her barrenness, but she first consulted a Moslem healer. A friend testified to her that the healer had successfully treated her and others who were barren. However, she became dissatisfied with the treatment. She consequently consulted two herbalists and a spiritual healer, until she finally went to the Holy Family Hospital as the treatment of the last resort.

Generally, most of the informants (77.2%), according to Table 50, resorted to scientific medical practice as the first choice of treatment. Herbal treatment, comprising treatments by herbalists, Moslem healers and priest healers, was the treatment of the last resort. More than one-third of those informants who resorted to more than one level of treatment consulted the practitioners of herbal medicine when other types of treatment had failed. (The factors involved in choosing and evaluating therapies in Berekum are further discussed in chapter 5). The quality of treatment seems to be very influential in the choice of therapies in Berekum. Some of the informants who believed their illnesses were spiritually caused even first consulted scientific medical practitioners before switching to the other types of treatments. Since the majority (70.5%) of the informants could not provide any causal explanations for their current illnesses, their choices of treatments could be more related to the quality and the cost of treatments than the causal explanations of those illnesses.

CHAPTER IV

HEALERS' EXPLANATIONS OF ILLNESS

INTRODUCTION

Illness has become part of the human condition which threatens the life of the individual, his/her group and society as a whole. All societies have therefore developed coping mechanisms (Pflanz and Keupp:1977) to interpret and treat illness since health care systems are socially and culturally constructed. It is expected that traditional healers, with expert medicinal knowledge, will have a more elaborate and cogent etiological explanation of illness than laypersons. The nature and causal explanations of illness may be crucial in the therapeutic options the healers adopt. The same illness interpreted differently may require different treatment procedures. The traditional healers had been viewed as witch-doctors, sorcerers, diviners or mediums, and these perceptions influence some writers to portray the healers as spiritually inclined in their explanations of illness (Weisz:1972; Uyanga:1979; Fassin et al:1988). Unfortunately, this inadequate perception still pervades most of the literature on traditional medical practice in Ghana. Twumasi (1975:25) indicated that "the potentiality of traditional medical practice is derived from the supernatural assumptions underlying its practice". Another study (Twumasi 1979:349), stressed that "the common essential element in traditional medicine is the utilization of magico-religious acts and symbols in diagnosis and therapeutics". Further portrayal of the traditional Ghanaian society which has been least influenced by modernization and secularization became evident in Twumasi's (1981a:171) later study. He emphasized that "the existing traditional social structures have not been affected by modern theories of health; the traditional belief system is pervasive. Ideas about disease causation are sought in the realm of supernatural agencies".

The main objective of this chapter, therefore, is twofold. First, to find the extent to which emphasis is placed on spiritualistic/naturalistic etiological explanations of illness by the healers in Berekum. Second, to find the extent to which consensus/lack of consensus about the etioilogical explanations of illness is manifested among the healers in Berekum. The purpose underlying this twofold objective is the promise it may offer of assessing the status of traditional medical practice in Ghana, in relation to its perceived contribution towards the implementation of a comprehensive health care system for Ghana. Besides, the World Health Organization has given recognition to the role played by traditional medicine in the Primary Health Care programmes in the developing countries. It is hoped that this chapter will shed some light on the healers' explanations of illness in Berekum, which may give a clue about the future role of traditional medicine in Ghana.

The 19 informants were selected from among the different kinds of healers in Berekum: namely; priest healers (9), herbalists (4), Moslem healers (2) and spiritual healers (4). Eleven of these healers were males, while the rest were females. The average age of the healers was 60 years, even though the youngest and the oldest were 21 years and 95 years old respectively. Generally, the healers had had a long period of practice (an average of 31 years); with the shortest and the longest being 4 years and 80 years respectively. It is expected that the two main objectives set out earlier in this chapter will be achieved by analysing the healers' explanations of illness causation, both general and specific. Local ideas about the spiritualistic/naturalistic explanations of illness will be used as the basis for the key concepts. *Sunsum mu yade* is used here as the equivalent of spiritually caused illness. (Literally translated, *sunsum mu yade* means 'in spirit illness'). *Sunsum mu yade* therefore refers to any kind of illness which is believed to be caused in some way by some supernatural force: namely; gods, witches, sorcerers or magical powers. Naturally caused illness in the local

terminology is *honam mu yade.* (Literal translation of *honam mu yade* is 'in body illness'). It refers to any kind of illness in which supernatural forces are not believed to be involved.

EXPLANATIONS OF ILLNESSES IN GENERAL

Attempts have been made to categorize medical systems according to the explanations given to illness causation. Murdock (1980), for instance, observed a basic dichotomy between theories of natural causation and theories of supernatural causation. He regarded illnesses caused by infection, stress, accident and overt human aggression as naturally caused, while those due to fate, mystical retribution, soul loss, sorcery and witchcraft were believed to be supernaturally caused. Apart from identifying the emphasis on spiritualistic/naturalistic explanations of illness by the healers in Berekum, and the circumstances under which they resort to each type of explanation, I shall in this section demonstrate how Murdock's (1980) typology is inadequate for the categorization of illness causation in Berekum.

The informants were asked:

a) If some illnesses were *sunsum mu nyarewa*

b) If some illnesses were *honam mu nyarewa.*

(Nyarewa used here is the plural of *yade)*

Spiritual Causation

According to Table 32 a few of the informants (8) regarded some illnesses as *sunsum mu nyarewa.* Some of the illnesses that could fall in this category were impotence, madness, turgidity, barrenness and epilepsy. However, they stressed that several other illnesses could be regarded as spiritually inspired under certain circumstances. Among such situations or circumstances were violation of some taboos,

the response to treatment, curse and shirking from responsibility.

Berekum is predominantly an agricultural community, and tilling the land is a basic survival activity for many people. Despite the fact that the lands are privately owned, there are some restrictions on land-use. Chiefs usually supervise these, and culprits are fined, and pacification rites called *yi mmusuo* ('remove taboo') performed. During festive occasions like *Munufie, Fofie* and *Kwafie* (types of religious festivals), farming activities are forbidden in several parts of Berekum. Apart from these general festivals, there are other smaller ones which take place in some limited areas. One such festival is *foda.* Unlike the general festivals, there is no elaborate performance of rituals for *foda.* Individuals observe the occasion by refraining from any farming activities that day. *Foda* follows a seven-day cycle. If *foda* falls on Sunday, the following week it will fall on Saturday. The concept of *nnawotwe* (a week) is eight days. (Literally translated, *nna* means days, and *nwotwe* means eight). This explains why *foda* does not fall on the same day every week. Also, one day is counted twice, for example, when counting starts on Sunday, Sunday will be counted twice. In addition to these, no farming activities are allowed on the banks of River Koraa, and none of the fishes or animals in this river is eaten. It is a taboo to eat them. Some illnesses in Berekum are therefore related to the breaking of these taboos. If an individual works at his/her farm on a forbidden day or eats any fish or meat from River Koraa, his/her affliction will be explained spiritually. An informant explained the death of a certain woman in the following way:

> Here in Berekum, we have certain areas where farming activities are forbidden on specific days like Munufie, Fofie and Kwafie. A woman went to farm on a forbidden day. She was struck dead by a falling tree. When the news of her death was announced many people attributed the cause to her disobedience to the gods.

This statement points out the social context or circumstances under which different interpretations could be used in the causal explanations of illness. If the woman had

gone to her farm on any ordinary day the people would probably not have been unanimous in attributing the cause to the gods. It could have been categorized as *asiane or nkwanhyia* (an accident), but under this circumstance accident had been categorized as spiritually inspired. I must stress here that the violation of these taboos does not necessarily mean the culprit will have an affliction; it is only when there is an affliction that the explanation is sought spiritually. I have seen several people who violate these with impunity. Apart from the designated persons who enforce compliance to these customary practices, others overlook and do not report offenders. However, when someone is arrested for failure to obey these taboos, he/she is sent to the chief's house. Here, the culprit is fined (submission of a fowl or a sheep), and the chief and his elders *yi mmusuo* to avoid any misfortune to the community as a whole.

Another situation where an ordinary illness could be spiritually explained is the invalid's response to treatment. According to a healer:

> Headache, for example, does not kill, and can also be easily treated. If the affected person goes to a healer or a hospital for treatment, and it is becoming worse every day, then this type of headache will be regarded as *sunsum mu yade*. But if the person is easily treated, it will be regarded as *honam mu yade*.

The problem with this kind of explanation is that the healers do not have any special instruments to test the severity of the illness. They could only infer from the reaction of the patient, and the same illness may need different treatment procedures at different times. In the context of the explanations by the healers in Berekum, Murdock's (1980) illness classifications according to their causal explanations seem inadequate. For example, he categorized accident under natural theories of illness causation. In Berekum accident may be interpreted differently, depending on the circumstances preceding the accident. People resort to spiritual explanation of accidents when you hear them saying: *Yei de nye asiane kwa, biribi taa akyire.* (This is not an ordinary accident, something is behind it). By this, the event does not cease to be

accident, however, the cause is spiritually explained.

My own experience with some co-tenants in Berekum on the Christmas Eve of 1986 may give further indication of the belief that supernatural force could cause lorry accidents. A chief of one of the suburbs in Berekum planned to spend the Christmas with his family in his village, about 90 kilometres away from Berekum. The chief and his family, except one grandson, left with one vehicle for the village. The grandson, who had just completed elementary school, was asked to buy some quantities of drinks (schnapps), and join them in the village with a different vehicle. The village was about two kilometres away from the main road. At that point they had to go on foot through a bush path. The grandson signalled for the driver to stop at the junction, but the driver went about fifty metres beyond the junction. The lorry had an accident within that distance, and the grandson of the chief and one woman died. When they came back to Berekum there was a consensus of agreement among them on the cause of the accident; a sister to the boy's mother was accused of killing him. The explanation they gave was that prior to the accident, the boy picked up a quarrel with her, and the exchange of words that took place offended the mother's sister. She was reported to have told the boy that he would pay dearly with his life for the gross disrespect and insolence shown to her. Even though the boy was very young, about 18 years old, his death through lorry accident could have been regarded as naturally caused if his mother's sister had not verbally threatened him some months before the lorry accident. Initially she was ostracized by others, but was 'superficially' re-integrated. In some cases the accused may be unaware of such allegations.

When a persons becomes sick after he/she has been cursed, the explanation provided for such kind of illness is easily categorized as spiritual. A patient was taken to Nana Maase (a priest healer) to be treated because it was thought that she had been cursed. (This will be explained in chapter 5). It is also believed that the priest

healers who would shirk their responsibility could be inflicted with illnesses by the shrines. The custodians of the shrines are expected to devote a lot of time in attending to the needs of the shrine. I was told by a priest healer that several people in his matrilineage died. They consulted some shrines for an explanation. The explanation they all gave was that the matrilineage had neglected the shrine, and the shrine would wipe out the family unless someone was appointed to be a custodian. In other cases, the custodians violate some taboos (especially refraining from having sexual intercourse with someone else's wife), and when this is done, any afflictions on the custodians are spiritually explained (that is, as punishments from the shrine).

One interesting case of a spiritually inspired explanation occurred in my encounter with a Moslem healer who lived at the outskirts of Berekum. We (I was accompanied by a friend who introduced me to the healer) were given some chairs, but were asked to wait for some time. The healer walked away from us and stood near a barrel filled with water to the brim. She was gazing in the water, and muttering some words. She continued this for about five minutes, and came back to us. Characteristic of some of the traditional healers, she began like a medium, to foretell some events about me in the following way:

> You have planned to travel outside Ghana shortly. It was revealed to me that you have a bright future, but *abayifo* (witches) are making frantic efforts to change your destiny. This is what was revealed to me about you; tell me why you are here.

The significance of this water-gazing ritual is that it helps the healer to provide interpretation for an affliction or event. To tell the patient the purpose of consulting the healer in advance also increases the patient's confidence in the healer, especially if the patient recognizes such events in his/her life. It may also lead to decreased confidence in the healer if the explanation does not apply to the patient. The therapeutic significance of using supernatural powers to explain illnesses is discussed in detail in the chapter on treatment of illness.

As a native of Berekum, my own experience seems to be consistent with the healers' conception of spiritually caused illness. In the late 1970s and the early 1980s, two students at the University of Cape Coast and University of Ghana died, and there was a general belief in Berekum that they were killed by witches. The interpretation of the cause of their deaths could have been differently explained if they had been students in the elementary or secondary schools. Here also, it is seen that one's social position in Berekum may influence the explanations given for his/her affliction. In 1988, when rain did not come in time for the growing season, the acting Gyasehene (one of the divisional chiefs in Berekum) performed some rites to appease the gods so that they could get rain to help them get good crops. Coincidentally (or perhaps as an answer to the pacification rites) there was heavy downpour a few days later. The social context of illness therefore seems to be very crucial in the causal explanations of illness in Berekum.

Foster's (1976) conception of etiologies of illness seems more applicable to the situation in Berekum than Murdock's (1980). Foster took into consideration not only the agents in the causes of illness, but also the ultimate causes. Seijas (1973) also made a similar distinction between immediate and ultimate causes of illness; immediate causes account for disease in terms of the perceived pathogenic agent, while ultimate causes on the other hand govern or condition the occurrence of disease. In Berekum the healers do not seem to operate with a fixed system of illness classification. Both naturalistic and spiritualistic explanations are complementary, and not mutually exclusive. The etiological explanations of illnesses in Berekum take into consideration both the immediate and ultimate causes, especially under certain circumstances or if some peculiar events precede the illness.

Table 33 shows that most healers (17) regarded most illnesses as *honam mu nyarewa*. Among some illnesses that were generally classified as *honam mu nyarewa* were malaria, headache, hernia, piles, waist pains, rheumatism and guinea worm. The healers attributed the causes of *honam mu nyarewa* to such factors as excessive exposure to heat or cold, food related problems, too much work, unhygienic drinking water and insect bites. It is also believed that patients whose illnesses are regarded as *honam mu nyarewa* quickly and positively respond to physical treatment.

Another important feature about the healers' explanations of illnesses in Berekum is the influence of geographical distribution of illnesses. The distribution of some illnesses in specific areas in Berekum and its influence on illness causation has been exemplified by a healer in the following terms:

> In Berekum some illnesses are found in specific areas. Among the residents of these areas, these illnesses are generally regarded as *honam mu nyarewa* because they are very common. *Mfa* (guinea worm) infection, for example, is classified as *honam mu yade*. This classification becomes more marked if the affected person is a resident of Koraso or Mpatasie.

Both Koraso and Mpatasie are suburbs of Berekum which are connected with the town's water supply system. In general terms, they have access to good drinking water, but at least three out of every four residents have had the infection once in his/her lifetime. A resident of any of these two areas who has been infected by *mfa* may resort to the local commonsense explanation that this type of illness has no supernatural component. This may be partly explained by the fact that *mfa* is a very common and familiar affliction in these areas; and therefore it has been recognized that there is nothing extraordinary about its cause. The commonality and familiarity with some illnesses seem to be influential in their causal explanations. (This is discussed in detail in the section on explanations of specific illnesses). As discussed in the previous

section, there is no clear-cut distinction between spiritually and naturally caused illness. However, illnesses are generally regarded as *honam mu nyarewa* if they do not occur under any extraordinary circumstances.

EXPLANATIONS OF SPECIFIC ILLNESSES

In this section, I examine the emphasis on spiritualistic or naturalistic explanations of illnesses in Berekum. The healers' explanations of three different kinds of specific illnesses are analysed here; familiar afflictions, unusual afflictions and afflictions connected with the reproductive system. In order to differentiate between the spiritual and natural explanations of specific illnesses, I use the following classification; for example, if someone is inebriated due to witchcraft influences, and consequently has diarrhoea, I indicate 'witchcraft' but not 'excessive drinking'. This explanation is categorized as spiritual, but if the explanation is 'excessive drinking', then it is regarded as natural. I hope this classification will be helpful in identifying the emphasis on spiritualistic/naturalistic explanations of illnesses in Berekum. The informants were asked to give the etiological explanations of some specific illnesses in terms of the main causes and other possible causes. This analysis mainly deals with the main causal explanations.

EMPHASIS ON SPIRITUALISTIC/NATURALISTIC EXPLANATIONS

Familiar Afflictions: Malaria and Diarrhoea

The emphasis on naturalistic etiological explanations of both *abunu* (malaria) and *ayamtuo* (diarrhoea) was very marked. According to Table 41 and Table 42 all the informants explained the main causes of *abunu* and *ayamtuo* in natural terms respectively. The main causes of *abunu* identified by informants were hot weather,

mosquitoes, food related problems, low blood pressure, tiredness, bad drinking water and others believed to have *abunu* at birth. For *ayamtuo*, the main causal explanations comprised food related problems, contamination in stomach, 'in person at birth', bad drinking water, worms in stomach, change in drinking water, excessive drinking and contaminated blood.

In terms of the other possible causal explanations of *abunu* and *ayamtuo*, the pattern changed slightly. Although the majority explained them as naturally caused, we see here the inclusion of spiritual explanations. Most of the explanations the informants gave were similar to those they gave as the main causes of *abunu* and *ayamtuo*. However, they resorted to spiritualistic explanations also. Some of these spiritualistic explanations were envy/hatred, witchcraft and wrongdoing.

The most significant feature of the main and other possible causal explanations provided for these familiar afflictions is the emphasis on naturalistic explanations. The possible reason for this may be the familiarity with these afflictions. Other possible causes seem less significant here since they are regarded as secondary or less common causes. It is therefore pertinent to see the increase in spiritualistic explanations provided for these familiar afflictions as the healers resorted to other possible causes. Despite the emphasis on naturalistic explanations for these familiar afflictions, a healer, who indicated that he was a witch, explained the influence of witchcraft in *ayamtuo* causation in the following words:

> Let me tell you how witches can cause *ayamtuo*. It is generally accepted that *ayamtuo* is *honam mu yade*, but witches can use these *honam mu nyarewa* as a camouflage to achieve their aim. Recently, a man (also a witch) wanted to rescue his stepson from a coven which had 'spiritually' tethered him to an invisible tree. The rescue mission could be achieved in one of the two ways: plead or use force. The man chose the use of force, and a venue was scheduled. In the confrontation that ensued, he was hit with a club in the belly. As a result of this he had *ayamtuo*, and he became dehydrated after three days. The man died of *ayamtuo*, but what was the cause of the *ayamtuo?* It was

the club which was 'spiritually' hit in the belly.

Unusual Afflictions: Madness and Epilepsy

I now turn to less prevalent and behaviourally unusual afflictions such as *dam* (madness) and *twa* (epilepsy). Unlike the familiar afflictions like *abunu* and *ayamtuo* where emphasis was on naturalistic explanations, Table 43 and Table 44 show that *dam* and *twa* were regarded as *sunsum mu* and *honam mu nyarewa* respectively. The majority of the informants regarded *dam* as spiritually caused. The pattern in the previous discussion on *abunu* and *ayamtuo* is reversed here. The main causal explanations provided for *dam* were the use of drugs, wrongdoing, envy, damaged womb, malaria and evil spirit. A spiritual church pastor had a revelation about a member of his church who would become mad because of her evil spirit. He stated:

> A woman who was a member of our church was a witch, possessing evil spirit. During one of our healing sessions in the church the Holy Spirit revealed this to me. She came forward for prayers, and I told her to confess her sins so that we could exorcize the evil spirit, but she refused. This continued for some period of time, and she was overpowered by the evil spirit. The woman is now mad, and her restoration to sanity, while possible, may not be expected.

The other possible causal explanations provided for *dam* also followed a similar pattern. According to Table 43 the majority of the informants explained *dam* as spiritually caused. Among the other causal explanations they provided for *dam* were wrongdoing, the use of drugs, envy, excessive drinking, 'in person at birth', witchcraft and worrying. (These factors have been explained in detail under laypersons' explanations of illness).

Contrary to the assertion by Tekle-Haimanot et al (1991) that in Africa epilepsy is associated with evil spirit and witchcraft, Table 44 indicates that in Berekum the healers believed the causes to be natural. The informants cited the following causal explanations: convulsion, wrongdoing, 'in person at birth', phlegm in stomach, stomach

pains, envy/hatred, worms in stomach and evil spirit. The informants emphasized spiritual causes of *twa* when they resorted to other possible causal explanations. Here also, envy/hatred and wrongdoing featured prominently. Among the others were worms in stomach, witchcraft, convulsion and disagreement.

The most interesting feature is that *dam* was believed to be spiritually caused, while *twa* was considered to be naturally caused. Another significant aspect of the explanations provided for *dam* and *twa* was the resort to spiritualistic explanations when the informants exhausted their stock of main causes. They seem to be groping for other possibilities when it comes to secondary or less common causes.

Afflictions of the Reproductive System: Gonorrhoea, Barrenness and Impotence/Sterility

Like the familiar afflictions, the naturalistic causal explanations for *babaso* (gonorrhoea) was very striking. According to Table 45 the majority (94.7%) of the informants believed *babaso* could be contracted through sexual intercourse with an affected person. One healer, however, gave an interesting explanation of how witches could inflict *babaso* on their victims:

> It is recognized that a witch may turn herself/himself into a beautiful lady or a handsome young man in the night purposely looking for a sexual partner. However, she/he operates in a targeted area. Anyone who solicits her/his services may contract *babaso*. That is why it is important not to have sexual intercourse with strangers. *Babaso* contracted through this means may be incurable.

Apart from the main causal explanations, Table 45 shows that the informants also recognized other, less common, causes of *babaso*. Here, spiritualistic explanations (83.3%) were predominant. Among these causes were sex with someone else's partner, envy, wrongdoing, competition, penis related problems, witchcraft, sexual intercourse and magic. Sex with someone else's partner needs explication since it differs from sexual intercourse with an affected person. None of the culprits may necessarily be infected,

but after the sexual intercourse they will contract *babaso*. The aggrieved husband or the boy-friend may solicit the help of magicians, sorcerers or mediums when he suspects his partner is having sexual intercourse with someone else. A spiritually prepared object is procured and used on the partner. Anyone who has sexual intercourse with her will contract *babaso*. The most interesting feature of this is that only the aggrieved husband or boyfriend inflicts *babaso* on their unfaithful female partners. In Berekum the custom invests males with the right to have more than one sexual partner. This may account for the situation where only female partners are punished for their unfaithfulness. The only alternative left for the aggrieved female partner is to complain or, if unbearable, terminate the relationship. As indicated by the healer, magical powers could be used to inflict babaso on others. In his words:

> When a lady collects some amount of money from a man but refuses to have sex with him, he will collect some medicine and smear it on a broomstick. This is placed at a certain spot where the lady is likely to pass. When the lady walks over it, she will contract *babaso*. If the lady is not treated anyone who will have sexual intercourse with her will also be affected.

According to Table 46 *Bonini* (barrenness) was regarded as *honam mu yade*. About two-thirds of informants attributed the causes of *bonini* to such factors as menstrual problems (the retroversion of the womb (*anidanee*) and irregular menstrual periods which are accompanied by severe pains) and abortion. The rest of the main causal explanations -- envy, wrongdoing and witchcraft -- were regarded as spiritual. The influence of witches on infertility was expressed by a healer in the following way:

> About three days ago a lady in her thirties and her mother approached me about the lady's infertility. I consulted my *mmoatia* (dwarfs). (You know they tell me the causes of all illnesses brought to me). They told me that the lady's mother who accompanied her was a witch, and had removed her womb and hung it on a tree near Kutrie. I told the lady to come alone the following week. (I did that to prevent family squabbles). During this period I will plead with her 'spiritually' for the release of the womb to me. If God permits the lady will have a baby soon.

Apart from these main causal explanations provided for *bonini*, Table 46 indicates that the healers also explained its other less common causes. Here, there was a greater emphasis on spiritual explanations; 60.5% of the responses mentioned spiritual causes, while 39.5% explained in naturalistic terms. The other possible causes of *bonini* included envy, wrongdoing, 'in person at birth', piles *(kooko)*, the use of contraceptives and complications in fertilization.

We see a completely different picture when it comes to the explanations the informants provided for *kotewui/kotekra* (impotence/sterility). *Kotewui* and *kotekra* are used here interchangeably. *Kotekra* means inability to produce offspring, while *kotewui* refers to a condition where a man is unable to have erection for sexual intercourse. While *kotekra* may not necessarily involve *kotewui*, *kotewui* on the other hand involves *kotekra*. What is important about these two concepts is the fact that they prevent males from producing offspring. Table 47 indicates that the majority (57.6%) of the responses regarded *kotewui/kotekra* as spiritually caused. The informants cited the following factors as the main causal explanations of *kotewui/kotekra:* 'in person at birth', envy/hatred, wrongdoing, weak sperms, witchcraft, weak penis and the use of magical powers. Explaining how young people's use of magical powers to pursue money could lead to *kotewui/kotekra*, a healer stated:

> Now the young prefer riches to children; that is why *sikaduro* ('money medicine') is common these days. They consult a sorcerer for the necessary ritual to be performed. There are several ways open to the client; to submit a name of a member of your matrilineage or (if married) your wife. When the name is used for the ritual the person will die, and shortly you become fabulously rich. On the other hand some people submit their male organs. They will become rich, but can never have any children.

Apart from these main causal explanations, Table 47 indicates that the informants also resorted to other possible causal explanations. The informants' spiritualistic conceptions (88.8%) were very marked. The factors cited as the less common causes of

kotewui/kotekra were envy/hatred, wrongdoing, witchcraft, evil spirit, curse, weak sperms and venereal diseases.

I have so far shown that the majority of healers in Berekum regarded illnesses as naturally caused. The emphasis on naturalistic explanations for familiar afflictions and the afflictions connected with the reproductive system was overwhelming. Of the seven specific illnesses only *dam* and *kotewui/kotekra* were explained spiritually. This finding in Berekum tends to support Warren's (1978) study of the Bono healers of Techiman (about 60 miles away from Berekum) where he found that the predominant etiological explanation of illness was expressed in natural terms. Wyllie (1983) similarly observed a preference for naturalistic explanations of illness among the healers of Winneba. The study also seems to contradict Twumasi's (1981a:171) study in Ghana in which he indicated that modern theories of health have not affected the existing traditional social structures, and that ideas about disease causation are sought in the realm of supernatural agencies.

CONSENSUS/LACK OF CONSENSUS ABOUT ETIOLOGICAL EXPLANATIONS OF ILLNESS

It was seen in the preceding section that there was more emphasis on naturalistic explanations of illness among the healers in Berekum. In this section, I am interested in the extent to which consensus/lack of consensus was manifested among the healers of the same kind. The healers provided causal explanations for the three specific kinds of illness discussed in the previous section. The measure of consensus/lack of consensus here is based on the extent to which many of the healers of the same kind agreed or disagreed on a single largest main causal factor for that type of illness.

Consensus was more evident in the explanations of *abunu, ayamtuo, babaso* and *bonini* by the priest healers. The majority (60.0%) of them pointed to hot weather as the main cause of *abunu,* while 55.6% believed food related problems constituted the main cause of *ayamtuo.* Further evidence of consensus among the priest healers became clear with the explanations they provided for *babaso* and *bonini.* Most of them (88.9%) cited sexual intercourse with affected person as the main cause of *babaso,* while 62.5% also attributed the cause of *bonini* to menstrual problems. Consensus on etiological explanations of *twa* was the weakest; wrongdoing (the single largest causal factor among the priest healers for *twa)* accounted for only 27.3% of the responses. Similarly, the consensus for *dam* and *kotewui/kotekra* was very weak. The use of drugs was the single largest causal factor, but it constituted only 36.4% of the explanations for *dam.* Both envy/hatred and wrongdoing were the most frequently mentioned main cause of *kotewui/kotekra.* Each of them constituted 33.3% of the responses. As expected, the lack of consensus became even more pronounced when the healers resorted to secondary or less common causes.

The extent of consensus among the herbalists was higher than that of the priest healers. Consensus was more evident in explanations of *babaso, bonini, twa* and *ayamtuo.* All the herbalists pointed to sexual intercourse and menstrual problems as the main causes of *babaso* and *bonini* respectively. Convulsion, the most frequently mentioned main cause of *twa,* was cited by some 75.0% of the herbalists. Hot weather and mosquitoes constituted 40% each of the responses provided for *abunu,* while 50% of the herbalists believed some people had *ayamtuo* at birth. Consensus among the herbalists was weakest for the explanations they provided for *dam,* where both wrongdoing and envy constituted 33.3% each of the responses. Lack of consensus became more pronounced in the explanations they provided for *kotewui/kotekra.* Each herbalist provided a different causal explanation for *kotewui/kotekra.* Unlike the priest

healers, there was some evidence of consensus among herbalists when they resorted to other causal explanations of *ayamtuo, dam* and *twa.*

All the spiritual healers cited sexual intercourse as the main cause of *babaso.* Both hot weather and food related problems constituted 50% each of the main causal explanations provided for *abunu* and *ayamtuo* respectively. Similarly, the use of drugs and convulsion also accounted for 50% each of the explanations for *dam* and *twa.* Consensus was less evident in the explanations of *bonini* and *kotewui/kotekra.* Forty per cent of the spiritual healers pointed to menstrual problems as the main cause of *bonini,* while those who believed some people have *kotewui/kotekra* at birth constituted 40.0%. Generally, there was evidence of more consensus among the spiritual healers than the other kinds of healers.

Apart from *bonini* and *babaso* where all the Moslem healers cited menstrual problems and sexual intercourse respectively as the main causes, there was lack of consensus on the etiological explanations provided for the other types of illnesses. Here, each healer cited different causes for the other types of illnesses.

The extent of consensus in the healers' explanations of illness in Berekum is rather surprising. There is generally a low level of professional interaction among them. Suspicion and jealousy seem to pervade their healing practices, and the exchange of medical ideas and knowledge is felt by them to be detrimental to one's practice. Some healers pursue personal fame, and are therefore preoccupied with their work alone. A healer lamented:

> When a herbalist approached me to help him treat a convulsive patient, I explained the herbs used in the treatment. He did exactly as I told him and the child was cured. He never thanked me for this, and instead he is now claiming credit for himself as a specialist in treating convulsion. How do you expect me to share ideas with others? He has become rich at my expense.

Some of the healers divulge information about their healing practices to intimate friends

only. Similarly, treatment of their own illnesses is done by intimate friends. However, most of the healers consult medical doctors when they have serious illnesses. Trust therefore tends to be crucial here, since exchange of medical ideas and knowledge among intimate friends may not jeopardize one's work. Despite the existence of Berekum Traditional Healers' Association, comprising priest healers and herbalists, not much has been done to remove this kind of suspicion and jealousy among the healers. Some members who have become successful in their healing practices, and therefore regarded as comparatively wealthier than their colleagues are ostracized. I learnt from some of the healers that they had not been paying their annual dues. The main reason for this was that the association had been monopolized by a few rich healers. Of greater concern to some of these healers was the allegation that the leadership of the association was controlled by a group of a few wealthy non-indigenous healers. The president of the association is now turning her premises into a township, and this has been viewed with great concern by some healers who have few rooms to house their patients. However, there has not been any allegation of embezzlement of funds by the leadership of the association. I was also told that when it was possible for the leadership to convene any meeting, the discussion mainly centred on their concern about the government not doing much to recognize their healing practices. Among the spiritual healers the only point of interaction among them was the occasional prayer meeting, where not much was discussed about their healing practices. The Moslem healers did not have any association, and individual healers controlled their own healing practices.

There is, therefore, a latent rivalry among some of these healers. When I was in elementary school there were two spiritual healers in the town who were in the same spiritual church. The rivalry between them was so intense that patients had to choose the one to be consulted. When the choice had been made the other healer would reject former patients of the rival healer. This kind of rivalry has not completely vanished,

and it is not surprising that secrecy about their healing practices is rampant. Even among friends the exchange of ideas may not go beyond certain limits.

A different situation is portrayed by Oyebola (1981) about Yoruba traditional healers of Nigeria. He examined the professional ethics and discipline among Yoruba herbalists. The associations were charged with the responsibility for drawing up guidelines and codes of conduct to discipline erring members. It was also the responsibility of the association to assess the quality of the herbalists who wished to become members through interviews, and consequently certificates of proficiency were issued by the association to successful applicants. In Berekum the healers go through their training independently, and when they feel they can practise as healers they join the association without going through the screening process pointed out by Oyebola (1981) in Nigeria. The only disciplinary measure which keeps the association in Berekum together is sanction related to failure to pay association dues. Defaulters are denied any benefits when they are bereaved. There has not been any occasion when the association has punished a charlatan, and the public may not be protected from the false pretence by some of these healers.

It is very significant here to point out the relevance of Last's (1981) findings about the Malumfashi traditional healers of Nigeria. He observed that the lack of system of traditional medical practice is seen in the disunity of the healers, the healers lack a single consistent theory and there is also wide variation in meaning in the medical terminology in daily use. Last (1981) stressed that traditional healers that serve the Malumfashi area lack these systemic attributes. The disunity of the healers in Berekum is further attenuated by suspicion and jealousy. Each healer has to protect his/her own domain of medical knowledge in order to survive unregulated competition among them.

In another study, Last (1986) examined the professionalisation of traditional medicine. He identified four main characteristics of this process of professionalisation. First, the ability to retain a measure of independence through its right to regulate itself. Second, the profession also has a statutory monopoly over a defined sphere of work. Third, a code of ethics governing relations between a professional and a client and limiting competition between professionals is formally set out, and can be enforced by the profession's own institutions. Finally, a profession is responsible not only for teaching and examining recruits to the profession but also for promoting research so that the profession can effectively reproduce both its membership and its claim to expert knowledge. These professional attributes reflect the highly developed profession, like the Medical Association. However, it must be stressed that the Berekum Traditional Healers' Association has limited ability to retain a measure of independence to regulate itself. The association has a very restricted code of ethics governing the relations between the professional and the client. Their inability to examine recruits (as done by the Yoruba Herbal Associations), and limiting competition among members points to the fact that the traditional healers in Berekum do not form a cohesive group.

However, the high level of consensus among the healers in Berekum in their explanations of illness may indicate that the re-organization of the association, where it will play a meaningful role, may lead to regaining some lost systemic attributes in future. The healers could enhance their professional competence if they would be able to exchange medical ideas and knowledge about their practices. At the moment the healers in Berekum are unorganized, and this makes different application of herbal or arboreal preparation to the same type of illness possible.

CHAPTER V

TREATMENT OF ILLNESS IN BEREKUM

INTRODUCTION

In the previous chapter, I examined the explanations the healers in Berekum provided for illnesses; both general and specific. I now analyse the treatment approaches adopted by these healers, and how their explanations of illnesses are reflected in the treatment of illnesses in Berekum. This chapter has four main sections: namely; scientific medical treatment, herbal treatment, faith healing, and the choice and evaluation of therapies. Under scientific medical treatment, I discuss the infrastructure sustaining this type of treatment, with emphasis on the Holy Family Hospital (HFH), and also the extent of quackery within the system. Herbal treatment covers the treatment approaches adopted by the priest healers, herbalists and Moslem healers. Apart from analysing the general treatment procedures by these healers, I also contrast the treatment approaches used by a priest healer and a herbalist in order to bring out the similarities and differences in herbal treatment. With regard to faith healing, a general analysis is made, and a case study used to illustrate and expand some general points raised. Finally, I examine how individual sick persons choose and evaluate therapies in Berekum. It is hoped that this chapter will shed some light on alternative therapies, despite the seemingly dominant role played by the Holy Family Hosiptal in the treatment of illnesses in Berekum.

SCIENTIFIC MEDICAL TREATMENT

Generally, scientific medical treatment in Berekum is dominated by the Holy Family Hospital. The other institutions involved are the public and private clinics, maternity homes and a homoeopathic clinic. The Holy Family Hospital is the only hospital in the district and serves more than 90,000 people. It is a Catholic Diocesan hospital, and the first referral level of the Primary Health Care programme. The first three medical mission Sisters arrived in Berekum in April 1948, and the Holy Family Dispensary was officially opened on 20th June 1948. The facility has increased from two buildings (the Dispensary and the Sisters' House) to 14 units providing 162 inpatients' beds and 32 bedside cots with full medical, surgical and obstetrical services. The Emergency Service, which operates 24 hours a day, has 14 beds. There is also a Paediatric Ward, very close to the Labour and Maternity Wards. In addition to these facilities, the Hospital has the Nurses Training College and the School of Midwifery Complex; the only professional schools for the health workers in the Brong Ahafo region (of more than a million people). The Dispensary grew into the Holy Family Hospital when the Main Ward and the Operation Theatre were completed in 1952. It became a Diocesan Hospital in 1978 when the medical mission Sisters transferred ownership to the Catholic Diocese of Sunyani. According to Holy Family Health Services Report (1988), the number of patients admitted at the Hospital decreased from 8,152 in 1987 to 7,807 in 1988 (that is, a decrease of 4.2%). The number of outpatients on the other hand increased from 104,711 to 110,778 (that is, an increase of 5.8%) during the same period.

Besides giving inpatient/outpatient services, the Hospital is also involved in outreach curative and preventive services. The outreach medical officer visits patients mainly in the Jaman district; and by this approach some patients are referred to the

Hospital. Until 1988 the Holy Family Hospital was serving two districts: Berekum-Jaman. Now the Drobo Health post in Jaman district has been turned into a hospital. The outreach curative services are now limited to Berekum district. The District Health Service comprises Ministry of Health, Catholic Mission, Private and Community Health Workers and Traditional Birth Attendants. The District Medical Officer of Health and the Primary Health Care Fieldworker are assisted by the Medical Field Unit and Environmental Health Personnel in the efforts to cover the eligible population for immunization against some communicable diseases. In 1988 the ten most frequent causes of death among inpatients and Emergency Room patients at the Hospital were prematurity, meningitis, anaemia, tetanus, pneumonia/bronchopneumonia, cerebrovascular disease, septicema, malaria, malnutrition and neoplasms.

The Holy Family Hospital co-operated with a herbalist, Seidu Sabi from Nsoatre (9 miles away from Berekum). During the 1970s and the early 1980s when the co-operation was at its peak, it boosted interest and confidence in herbal treatment. Seidu Sabi had a herbal garden containing different medicinal plant species. The healer was a specialist in treating chronic psychosis and simple fractures. Patients with these kinds of problems were referred to the healer. On the other hand, the healer also referred some patients with acute psychosis and compound fractures to the hospital. Some of the doctors visited the healer occasionally to check how the referrals were responding to treatment. This kind of co-operation was not the official policy of the hospital, and therefore when the doctors who were interested in the exchanges left Berekum in the mid-eighties the interest receded. A new kind of co-operation between the hospital and the traditional birth attendants is developing. It is in its rudimentary stage, and hopefully it will become official policy to allow continuity when new medical doctors are posted to the hospital. Perhaps the co-operation between the hospital and Seidu Sabi has been instrumental in the establishment of a herbal garden at the

premises of the hospital in 1989. The herbal garden is now in the care of the pharmacist. I was shown around the garden by the pharmacist. She explained to me that the herbs would be able to cure different kinds of illnesses. She stressed that it was an experimental garden, and they may not use any of the herbs now. The significance of the herbal garden attached to the hospital is that now the potentiality of the medicinal plants is probably being recognized.

The activities of the Holy Family Hospital have overshadowed both the private and public clinics, and the homoeopathic clinic in Berekum. All these clinics lack the infrastructure to treat serious illnesses, and therefore refer serious cases to the hospital. They continue to function because generally they charge less for treating less serious illnesses than the Holy Family Hospital. They are also time-saving since the individual patient passes through few bureaucratic bottlenecks. However, it will be stressed later in this chapter that the choice of therapy and its evaluation in Berekum depend on multifarious factors, and all these factors interlink in their influence.

In addition to scientific medical treatment from the Holy Family Hospital and the clinics, there are other purveyors of Western medicinal drugs without any formal training. They deal in drugs bought from pharmacy/drug stores. These drug pedlars, through their quackery, are able to make drugs accessible to many people in the outlying towns and villages in Berekum every week. They seem to operate as the itinerant herbalists. I joined one of these pedlars on his motor cycle rounds to sell these drugs in the nearby towns and villages. When the noise of his motor cycle was heard from the distance, some children stood in the doorway to draw his attention that his services were required by some of his customers. In the house he entered the complaint was: "Today you have been late". He had to satisfy them by linking the delay to the problems he had with his motor cycle. He knew all the members of the house, and enquired about those who were not present. He also asked how the drugs

they bought the previous week worked, and the reply was positive. He combined some drugs and explained how they should be taken. His presence in the house attracted other customers from the nearby houses. He enquired from the first woman about her illness, and she retorted, "Ah! you already know". The pedlar started wrapping some tablets of paracetamol, ampicillin, tetracycline and codeine in some pieces of old newspapers. The woman promised to pay the amount at his next visit. The pedlar later explained to me, "Now you understand why we sell these drugs; some of them cannot pay for the cost at the hospital. At the hospital you will be given the same drugs". The pedlar moved from house to house until those interested had bought some. He did not keep any records of those who bought these drugs on credit; but he explained he had been doing that for many years, and had not forgotten any debtor.

Generally, these pedlars treat minor illnesses like stomach-ache, headache, waist pains and some febrile conditions. They also relate to their customers as if they have formal training. Some of the customers who have younger children also buy these drugs and keep them in case of emergency. Some of the quacks who own pharmacy/drug stores also go around the towns and villages with drugs in their vehicles. These quacks do not move from house to house, and therefore sell drugs in large quantities, thus preventing the poor from buying. The last category of these quacks consists of those who sell drugs and, at the same time, give injections to their customers. It is illegal in Ghana for quacks to give injections, and therefore they go to the remote areas to avoid arrest. This kind of quackery may lead to the spread of the AIDS virus since generally unsterilized needles are used. They operate undercover, and it is therefore difficult to control their activities.

HERBAL TREATMENT

Herbal treatment in Berekum is mainly conducted by priest healers, herbalists, Moslem healers and other purveyors of African medicine. Despite the obvious differences among these healers, there are some common trends that pervade their treatment procedures; that is, the use of herbs and the recourse to the use of supernatural powers. The etiological explanations of illnesses seem to reflect the herbal treatment approaches adopted in Berekum. The emphasis on naturalistic explanations of illness may also reflect the emphasis on naturalistic approaches to the treatment of illnesses in Berekum. I indicated in the previous chapter that the healers in Berekum did not generally share ideas and knowledge about their work. As a result, they may use different herbs in treating the same illness, and when the same herbs are used different treatment approaches may be adopted. This will be demonstrated later in this section by contrasting the treatment approaches adopted by Nkonkonsa and Nana Maase in how they treated *aduto* (intruding some foreign object in the body by the use of magical powers).

Priest healers seem to be more easily located and more established than the other types of traditional healers because of their attachment to shrines. They normally go through a long period of training, between 3 and 4 years, and during this period they adhere to strict taboos, and learn the names and uses of herbs. In addition, the priest healers have shrines which are mainly family-owned, and the shrines usually persist for some years. The use of these shrines makes the priest healers more popular. For example, Tane Kwasi is a state-owned (Berekum Paramountcy) shrine. The custodian of this popular shrine therefore becomes very popular. Nana Maase is gradually turning her premises into a township; housing many patients.

The herbalists, on the other hand, practise in their own houses, and generally do not have extra spaces to accommodate many patients. However, some of them are very popular; for example, Nkonkonsa treats patients from different parts of Ghana. The herbalists have a shorter period of training than priest healers; usually they learn from their parents without going through any formal training. Unlike Ebin's (1982) observation among the Aowins of Ghana where herbalists treat only physically-caused illnesses, in Berekum their treatment procedures involve both spiritualistic and naturalistic approaches. Many parts of West Africa are dominated by herbal pharmacopoeia that includes several hundred plant species (Etkin et al:1990), and 187 species of medicinal plants have been documented by Ayensu (1978). The availability of these medicinal plants in the immediate environs makes it easier for the healers in Berekum to use roots, barks, stems/twigs and leaves of trees. The same plant species may be used to cure different illnesses. In Ghana (Ayensu:1978) *agyama* (alchornea cordifolia) is used for several purposes. Dysentery can be cured by macerated *agyama* leaves with *nyankoma* (myrianthus arboreus) and water. The leafy twigs of *agyama* with lime juice can be used as purgative/cathartic. The roots of *agyama* with white clay, peppers and water can be used as enema to check abortion. The fruits of *agyama* can be used as laxative. In Berekum some of these medicinal plants are ground, crushed/squeezed or macerated in water. Depending on the type of illness, the preparation may be used for enema, bathing or taken orally, while others are put in the eyes, ears or nostrils. The healers normally recite some incantations over the preparation before administering it to a patient.

The treatment approach by a priest healer described below typifies herbal treatment in Berekum. Aged 21 years, he is the youngest of all the healers. He was possessed by a shrine in the Cote d'Ivoire, and went through 27 months' formal training. After the training he moved his shrine to Fetentaa, Berekum, where he has

practised for 9 years. At the time of the fieldwork, a young boy of about 16 years who was under his care was in his final year of training.

Treatment Procedures By a Priest Healer

Malaria: Grind the root bark of *kakapenpen* (rauvolfia vomitoria), and the leaves of nim tree. Add water, boil and give to the patient to drink.

Diarrhoea: Grind a combination of root barks (did not specify), ginger and pepper. Add water and give to patient to drink.

Madness: Grind the root barks of *kakapenpen* and *nsamanua* (clausena anisata), and *sorowisa* (piper guineense). The patient takes up the preparation into the nose by sniffing.

Epilepsy: Put ground roots of pawpaw, *toatini* (paullinia pinnata) and a combination of other herbs in a calabash. Put one egg in the preparation. Add water; wash the face with the preparation and drink seven times.

Gonorrhoea: Grind the root bark of *kunkumadenkum* (cussonia bancoensis), ginger and pepper. Boil and drink

Barrenness: Grind a combination of root barks and seven pieces of *hwentea* (xylopia aethiopica). Add water and take two spoonfuls daily, morning and evening.

Impotence/Sterility: Treatment same as barrenness.

Moslem healers do not differ significantly from the priest healers and the herbalists. They also use herbs in treating illnesses. However, they use the Koran to supplement these herbs. I interviewed a Moslem healer who was treating a mad young man. Mallam (the healer) is 51 years old, and has completed both elementary and Arabic schools in Ghana. He is married with three wives. He was taught the art of healing by his father, and he supplemented that by his knowledge of the Koran. He has practised as a healer for 32 years, and believes he has prepared his son enough

to take over after his death.

Mallam had moved to the house of the patient he was treating. The patient had been earlier on put in chains by the District Administration for his rampageous rape of women in Berekum. The mother of the patient, a member of the Jehovah Witness sect, had rejected all attempts to treat her son, except through faith healing. She became suspicious of me when I went to the house to conduct the interview with the healer. In order to satisfy her, the healer asked her to sit in the interview, because she thought I was collecting some information about her son for the District Administration. Mallam had prepared some medicine comprising roots, barks, twigs/stems and leaves of some trees. In addition, Mallam stated that he wrote some verses from the Koran on a slate, washed into the preparation, and the patient drank and bathed. The patient took the preparation twice daily. After the first dosage in the morning the patient was required to sleep for several hours, while the healer monitored all his activities. I recognized some signs of improvement in the health of the patient after one month's treatment. The patient was able to involve himself very well in conversation with others, and was able to recognize that I had previously played for a local soccer team. Also, his relationship with other members of the house became intimate. However, the healer informed me that he had discontinued the treatment because the patient's mother had failed to give him money to hire some people to collect some medicinal plants in the bush. Mallam did not charge any initial amount for the treatment, but when the patient recovered his mother would be expected to voluntarily give him some amount of money to commensurate with the services rendered. Mallam additionally prepares these herbs in powder or liquid form, and moulds others in balls. He moves from house to house with his medicine. On Thursdays (the market day in Berekum), he directs his attention to the market-place.

The other purveyors of African medicine in Berekum are the itinerant herbalists, bone-setters and traditional birth attendants. The itinerant herbalists are the purveyors of African medicine who go round to sell the medicines they have prepared themselves. These herbalists are normally seen on market days in Berekum. Their preparations are similar to other healers dealing with herbal treatment. They usually treat illnesses believed to be naturally caused. However, it is not uncommon to see some giving amulets and charms to their clients to better their marriage relationship, to get well-paid jobs and to protect themselves from malevolent activities of witches. These healers are generally regarded as amateur practitioners, and they usually treat less serious illnesses. Some of them get settled down and establish a reputation.

Few healers in Berekum have bone-setting as their main speciality. However, it is one area where traditional healers in Berekum have had a lot of co-operation from the Holy Family Hospital. Occasionally, the Hospital refers some patients with broken bones to some of these healers. They prepare herbal concoction, like the other healers, smear it over the affected part and bandage it. Traditional birth attendants still operate in Berekum, despite the preference now for delivery at the hospital. They also use herbs in treating their patients.

ADUTO: TWO CONTRASTING TREATMENT PROCEDURES

It is believed that through the use of magical powers *(aduto)*, some persons could intrude some foreign objects into their victims' body. When such a speculative conclusion is arrived at, the invalid and some members of his/her family may accompany him/her to consult a healer for confirmation of the explanation they initially gave. Two of the most important shrines which are believed to be very effective in treating this kind of illness are Nkonkonsa and Nana Maase. Turgidity is the most

usual symptom recognized with *aduto*. I had the opportunity to watch how some patients were treated. After my initial interview with Nkonkonsa, he promised to notify me when he had a patient during the period of the research. Fortunately, he had three patients, but I was able to watch him treat only two of them. The date for the treatment of the third patient coincided with that for an interview I had arranged with another healer. With regard to Nana Maase, she did not have elaborate and formal procedures for treating this kind of illness. The patients who went through the treatment procedures were staying at the premises of the shrine; they explanied the treatment and its outcome to me by answering questions from the healer and myself.

In this section I try to show some similarities and differences between two treatment approaches adopted by a herbalist and a priest healer. The contrast will also help to assess these procedures. It must be stressed that these treatment approaches do not apply to all types of illness; they only refer to the intrusion of a foreign object into the body. I have already indicated that Nkonkonsa and Nana Maase refer to the shrines. However, in the remaining part of this section Nkonkonsa and Nana Maase refer to the healers in charge of these shrines respectively.

Nkonkonsa: Treatment of Aduto

Nkonkonsa is an illiterate who is 71 years old. He is also a farmer who is married with one wife. He has practised herbalism for the past 40 years. His initial training started in Nsoatre, a town which is 9 miles from Berekum. After his initial exposure to herbalism, he went to Dormaa where he underwent one month's training. In all, the training took 3 years and 7 months. More than 3 years of this period was spent in the Cote d'Ivoire where the actual training to be a herbalist started. During this period he was taught how to commune with the shrine, but most importantly, he was taught the names of the medicinal plants and their uses. This opportunity to be

the custodian of the shrine came when a member of the matrilineage who was the caretaker of the shrine died. The shrine is a family shrine, and therefore it is only the family which decides a successor when the custodian dies. This arrangement has enabled the shrine to persist for some years. In addition, Nkonkonsa is under surveillance by the family, and in case of any abuse of trust, he will be accordingly replaced. The fear of severe punishment in the event of the abuse of trust always serves as a powerful source of control over the custodians of this shrine. Nkonkonsa is a peculiar type of a herbalist, because generally, only priest healers own shrines. What distinguishes him from a priest healer is that he does not use white clay as bodily marking which distinguishes priest healers from the other types of healers. His shrine is referred to as *obosom*, but since he does not use white clay he is not called *okomfo*. He is referred to as *odunsini* (herbalist) even though he owns a shrine. When a specific day is set aside for the treatment of *aduto*, the ritual is open to the general public. On the two occasions that I watched these ceremonies, there were about 40 and 70 people who watched the first and the second treatment procedures respectively.

The First Patient

He was a tailor in Abidjan (the capital city of Cote d'Ivoire) who had attended the Holy Family Hospital for more than six months without any improvement in his condition. He complained of general weakness which was gradually leading to turgidity. He had heard of the expertise of Nkonkonsa in this field, and was convinced that no positive results would come from the hospital because his condition deteriorated, despite the fact that he was asked to refrain from eating salt. He was accompanied by some members of his family to Nkonkonsa. The patient told Nkonkonsa that he had swellings all over his body, and had come for explanation and treatment. He went into a dark room, which housed the shrine, with Nkonkonsa and his *okyeame* (linguist). A

metal object, like a handcuff, was placed on the floor and the patient was asked to stand on it. This process is called *w'agyina dadeso* (He has stood on a metal). Nkonkonsa became possessed, and started talking in a 'strange language'. The *okyeame* interpreted to the patient that some foreign object had been injected into his body spiritually. Because of the gravity of his condition, as the shrine indicated, only one week was fixed for the object to be removed from the body. If the condition of a patient was not serious, Nkonkonsa could extend the time of the removal of the object to a longer period. At this stage no detailed explanation was provided for the cause of the illness (this was done during the ceremony); only the nature of the illness was verified. There had been some occasions when the patients had been told that their illness was not *aduto*. If such a thing happened different treatment procedures would be used.

A day had been fixed for the object to be removed. All preparations had been made, and the ritual was supposed to start at noon, but it was delayed for one hour. Both Nkonkonsa and the patient were not supposed to eat or drink until the ritual had started. However, the nature of the treatment was such that it was only the patient who would neither eat nor drink by the end of the ritual. Nkonkonsa, while performing the ritual, would be served with palm wine and schnapps. These were meant to help him regain strength to speed up the treatment procedure. Two gourds containing water with crushed herbs were placed in the centre of the house. (This ceremony did not take place in the shrine house, but in a house behind it). Also, two used brooms were placed beside the gourds. A star-shaped leaf was put on the handcuff, which had been placed about two metres from the doorpost. Several other talismans were put at different vantage points in the house. Nkonkonsa, who appeared relaxed, was holding some objects containing feathers and a mirror in a wooden structure. Palm wine was served for several people, especially the elderly, who had

been given special seats.

The ritual began with the pouring of libation by the *okyeame*, introducing the patient to the spirits, and requesting them to make the ceremony a success. The patient, with only his pants on, was asked to stand in the centre of the ritual ground. The *okyeame* then recited:

> Nananom nsamanfo monsa ni. Amoe Nkonkonsa wonsa ni. Mo mmegyina y'akyi akyigyina pa. Y'ahyia a enye bone. Abubakari nte apo. Obaa ha no womaa no gyinaa dadeso. Wose eye aduro na obi ato no. Enne na aduro no yie aduru so. Pa mmusuo ne asiane gu mma yen.

Translation from Twi into English

> Ancestors here is your drink. Amoe Nkonkonsa (the name of the shrine) here is your drink. Give us your good support. We have met here in peace. Abubakari is sick. When he came here you asked him to stand on handcuff (a metal). You explained that some foreign object had been intruded into his body. Today is a day for the removal of the object. Remove any disaster we may encounter.

The crowd, which seemed pleased with the proceedings when he poured the last drop of palm wine on the ground, spontaneously stated: *Mmo ne kasa* (Thanks for your rhetoric).

One person was holding the gourd containing the herbal preparation, while the *okyeame* was dipping the broom into it. He beat the patient's body with the broom, thereby smearing the *dudo* (herbal preparation) all over the body. This process continued for some period of time until Nkonkonsa stood up. With his objects (feathers, horns and mirror in a wooden frame) he went round the patients, using these instruments to detect the spot where the intruded object might be. He began muttering some words, but the *okyeame* interpreted them.

The explanation of the illness was provided at this stage. According to the interpretation given by the *okyeame* the object was intruded into the body of the patient by a friend as a result of jealousy. The *okyeame* continued to beat the broom against the patient's body. Nkonkonsa threw an unboiled egg on the floor, but it did not break. An old woman was called to smear a blackish substance on the stomach of the patient. She slapped in the stomach two times. Nkonkonsa was still searching for the object; and when it became clear that it could not be easily detected, a second person joined the *okyeame* to beat the broom against the body of the patient. A talisman was put under the left foot of the patient, and another object like red clay was placed between both feet of the patient. Nkonkonsa continued to moved round the patient, and the horn got stuck on the patient's chest. That was where the object was supposed to be hiding. Nkonkonsa asked a cut to be made on the chest, and immediately blood began oozing out. He put his mouth on the spot and started drawing out the blood. He asked further openings to be made in the cut. He drew blood out with his mouth again, and this time the object came out. It was put in one of the calabashes.

The patient started shivering, which probably indicated that another object could be still detected. Nkonkonsa finally detected a spot in the head of the patient. That part of the head was shaved, and a cut was made. The old woman held the *dufa* (talisman) against the occiput of the patient. More openings were made in the cut, and with much difficulty, Nkonkonsa removed the second object with his mouth. At this stage the *okyeame* reiterated that a friend was responsible for the intrusion of the object into the body. The patient who had been demented with worry until this stage, heaved a sigh of relief. However, the ritual was not over. The concluding ritual seemed even more important since that would indicate the extent of the success of the ceremony.

The identification of the objects was done outside the house where the ceremony took place. All but the patient were at liberty to watch the indentification of the objects. When I enquired why the patient should not see the objects, I was told that they would return into the body of the patient if he knew any of the objects identified. Those who watched the identification of the objects were supposed not to tell the patient anything they saw. I watched as the *okyeame* cut the object open with a knife. In the object were hair, finger nails, sponge, ear-rings and a combination of other small objects which were supposed to have been taken from the patient. One surprising aspect of this identification was that the two objects removed from the body of the patient were put in the calabash containing water, but during this time only one object was removed from the calabash. All efforts to get a clarification from the *okyeame* proved futile.

A fowl had to be slaughtered at the end of the treatment procedure. The *okyeame* again poured libation, and asked the patient if he had unresolved issues in his family. The patient did not have problems with any of his relatives, and so two elderly men were asked to be his *akyigyinafo* (supporters). The fowl was slaughtered, and when it died lying flat on its back, there was a loud approbation from the crowd because it was a sign of a successful treatment. If the fowl had died lying flat on its belly, it would be regarded as unsuccessful, and in this case another fowl must be slaughtered. The treatment lasted between 2 and 3 hours.

The patient was asked to stay until Nkonkonsa had pronounced him healthy enough to leave. After ten days I watched the second patient at the same venue. When the ritual ended, I visited the first patient to see how he was recuperating. He was in good mood, and felt he had now been fully cured. He did not know when Nkonkonsa would allow him to leave finally. The charge for the treatment would be known after the patient had fully recovered. However, in most cases the patients were

asked to give any amount they wished as *aseda* (thanks).

The Second Patient

Even though the second patient was a female, there were no significant differences between the treatments these two patients went through. As she was a native of Berekum, it was not surprising that more than twice as many people watched her treatment. The first patient also had an opportunity, after ten days of his experience, to watch another patient go through the same process. Her treatment was also much longer and more difficult than the first one. Unlike the first patient, she was given some blackish substance to eat in the course of the treatment, and a mark was made between her breasts. Nkonkonsa continued the ritual, and at a certain point it became evident that he was too drunk. He was helped on several occasions when moving round the patient. The *okyeame* poured a second libation. Nkonkonsa looked in the sky and started talking. The *okyeame* explained that the cause of the illness was a quarrel between the patient and her husband. The patient was asked to give a sacrifice to a river in the area where the woman and her husband were farming. This would be done when she had recovered. An old man was asked to pour the third libation to put the ceremony in good shape. A chair was given to the patient, and the ceremony continued. The patient was given some drink (schnapps), and after that she was asked to stand up. A woman was asked to smear the stomach of the patient with some blackish substance, and she slapped the patient's stomach several times. At this stage, another woman was asked to smear the substance in the stomach and slap it several times again. During all this period two people were beating brooms against her body. Three different objects were removed from the body of this patient: on the right foot, on the left foot and between the patient's breasts. They were removed in the usual way by Nkonkonsa.

It was also an occasion for Nkonkonsa to call out individuals from among the crowd to explain some 'spiritual battle' they were facing in their lives. A young boy of about 15 years old was called out by Nkonkonsa. He entreated the boy to apologize to his uncle for the disrespect shown to him. The boy was asked to give details of what happened if he wanted to live. He admitted insulting his uncle. The boy's uncle was also watching the treatment, and so the boy apologized to his uncle, and the apology was accepted. The identification of the objects followed the same trend as the first patient. Even though three objects were removed, during the identification only one object as we saw in the first treatment was seen in the calabash. The object contained similar things as the first one. As usual a fowl was slaughtered, and it died lying flat on its back, indicating the success of the ceremony. I could not contact the second patient to see her recuperation.

Nana Maase: Treatment of Aduto

Nana Maase, a 46-year old widow, is the chief priestess of Brong Ahafo, and also the President of the Berekum Traditional Healers' Association. She is illiterate, and has practised healing for 19 years. In addition to her healing practices, she is also a farmer. She was possessed by a shrine; and after several consultations with some shrines in Berekum it came to light that the 'parent shrine' was in the northern part of Ghana. She was required to be a custodian of one of the subsidiary shrines to the 'parent shrine'. After a few years training, she brought the shrine to Berekum. Nana Maase is practising at the outskirts of Berekum, and now her premises comprise more than twenty houses. During the period of the research there were more than sixty patients with different types of illnesses in her care. She has trained her daughter, Nana Benne, who has been perceived to be more 'powerful' than her mother. The continuity of her healing practices seems to be firmly established. She depends on the shrine for the explanations and treatment of illnesses. When a patient arrives, she/he

is first taken to the shrine for the explanation and the treatment of the illness. Nana Maase usually uses herbal and other arboreal preparations in treating most of the illnesses. The shrine reveals the names of the herbs and their uses in dreams, especially at nights. However, she emphasizes naturalistic treatment of illnesses.

Unlike Nkonkonsa, she has a secretary who keeps records of some specific illnesses brought to the shrine. These records are limited in scope, since they are mainly concerned with the witches who have been hunted down by the shrine. The record-keeping started from 24th March 1972, and the last one was dated 21st March 1990. The accused or self-accused witches are required to confess their malicious activities before the shrine accepts the responsibility to treat them. In the records you would come across self-confession like:

> I am *So and So*. I come from Gyankufa. I have been a witch for more than 20 years now, and the name of my witchery is *Fametu/Atufaa*. I have killed more than 50 people during this period. In my last attempt, I was struck by an object in this nocturnal flight. At once I felt my power had been completely drained off. I discontinued these marauding activities, but I have been sick since then.

The secretary writes every word down, and the literate patient reads and signs. If the patient is illiterate, the secretary reads in the hearing of the patient, and she/he is required to thumb-print it. Despite keeping records on newly arrived patients, no records were kept on the treatment procedures they went through. Nana Maase explained that the shrine normally directed them in the treatment approaches they should adopt; keeping records might not be necessary. In all cases patients are accompanied by some members of their family.

For naturally-caused illnesses, treatment procedures involve the use of several types of herbs, roots, stems/twigs and barks of some trees. They are ground, and water may be added, depending on the type of illness. Some are used as enema, others put in the nostrils; while some are drunk or smeared over the affected part.

Bandages are also applied where necessary. Illnesses brought to Nana Maase range from snake bite, jaundice, madness, barrenness, impotence to turgidity.

I met a woman who had had a newly born baby at the shrine. Nana Maase explained that for about six years the lady was receiving treatment at the Holy Family Hospital as a result of her barrenness. She was told by the doctor that she was infertile, and there was no possibility that she would be able to have a child. The woman came to Nana Maase with her husband to find the cause of her infertility. Nana Maase did not give them the explanation, but rather agreed that she would be able to help them get a child. She prepared different kinds of herbs for the woman to use as enema. The lady continued to use this for some period of time, and became pregnant. The lady delivered at the premises of Nana Maase. In some cases if Nana Maase feels she cannot treat a patient she allows those who accompany her/him to take her/him away. There was a case where a middle-aged woman in a coma was brought to the shrine, and it was reported that she had been cursed. Nana Maase explained to me that she told the relatives to take her away because she found that nothing could save her life. She explained further that the woman cheated on some amount of money, but lied when confronted. She was cursed, but she still continued to lie. The curse had worked up to a point where nothing could be done about it. The relatives of the woman persistently pleaded on her behalf, and Nana Maase agreed to treat her, even though she knew she would die.

The First Patient

A 15-year old girl, accompanied by some relatives, consulted Nana Maase to treat her. Nana Maase consulted the shrine and found that it was *aduto*. Unlike the treatment by Nkonkonsa, immediate action was taken on this case. Each case was treated with equal urgency, but no elaborate ritual was required. Also, there were no

restrictions on either the patient or the healer about eating or drinking until the ritual would start. The ritual lasted for a few minutes, and only the attendants at the shrine were present. Also, Nana Maase spoke directly to the patient without passing the word from the shrine to the patient through the *okyeame*. The object was not removed the same day the patient reported to her. She collected some herbs from the bush and ground them. She added some drops of water, and with a prayer to the shrine, she smeared the preparations on the girl's legs (where the signs of swellings were more evident). At this stage, Nana Maase had finished her part in the treatment procedures. After a few days (about three days) the object came out on the left foot. The patient was required to show the object to Nana Maase. In order to monitor her activities, Nana Maase asked the patient to stay at her premises until her treatment was complete. The patient therefore showed the object to her, and another preparation was made and smeared over the part where the object came out. (This is mainly the accounts given by the healer and the patient). Here the patient saw the object; unlike Nkonkonsa where in order to prevent the re-occurrence of the illness the patient was required not to see it. Also, no cut was made on the patient to remove the object. In this case it was not obligatory for the patient to submit a fowl at the end of the ritual. Nana Maase also did not provide any explanation for this kind of illness. When the treatment was successful, she poured libation for the shrine's protection for the patient. No fixed amount was charged for this service, but the patient voluntarily offered a fowl and some amount of money to her.

The Second Patient

The treatment of the second patient also followed a similar process. She was accompanied by her husband to Nana Maase. In her case the object was different, and it came out on the fourth day through the upper part of the left leg. Just as in the first case, no explanation was provided for the cause of the illness. At the end of the

treatment procedure the woman also thanked Nana Maase by giving her a fowl and some amount of money.

Aduto: Appraisal of The Treatment Procedures

Two different treatment approaches have been examined. It is not surprising to see each healer adopting a different approach in treating patients with similar types of illnesses since it is not expected that a herbalist and a priest healer will have similar healing practices. Despite the fact that both the priest healer and the herbalist belong to the Berekum Traditional Healers' Association, very little is exchanged between them about their healing practices. Comparing the treatment approaches by both Nkonkonsa and Nana Maase also gives us the opportunity to appraise these practices. It was noted that Nkonkonsa had an elaborate ritual for the removal of the injected object from the body. This approach has some therapeutic significance; it helps to build up the confidence of the patient in the healer. The patient is required not to eat just as going through a surgical operation. During the treatment the patient wears only pants; with one or two people beating him/her with brooms. At the same time the healer would be going round the patient with the array of talismans and amulets looking for the supposed object in her/his body. The patient learns from the proceedings that she/he is a helpless prey waddling through the 'wilderness of the spiritual world', and could only be protected by trusting that the healer would be able to 'deliver the goods'. In addition to this, among the crowd are ex-patients who have gone through such procedures. They also give encouragement to the patients, using their experiences to give them moral support.

Despite the therapeutic significance of the approach adopted by Nkonkonsa, a lot of questions are left unanswered by this procedure. For example, why should the patient not see the objects supposed to have been removed from her/his body? Why is

it that in the case of Nana Maase, the patient sees the object, and even required to show it to the healer? Also, during the treatment (in the case of Nkonkonsa) two and three objects were removed from the first and the second patients respectively. But in identifying the objects, in each case, only one object was found. With regard to Nana Maase, different objects were removed from the body of the patients. My efforts to find answers to these questions from the healer and his *okyeame* proved futile. However, the most important aspect of the two treatment approaches is that the patients seemed to be satisfied with the exchanges.

FAITH HEALING

I discuss here faith healing by the indigenous African Christian churches in Berekum. The discussion involves mainly interviews and participant observation I made in four churches: namely; Aladura, Christ Church of Peace Mission, Ossamadi and the Twelve Apostles. However, this description may be applicable to most of the indigenous African Christian churches. Apart from spreading the Gospel of Jesus Christ, these churches serve as therapeutic communities. The 'established denominations' like Catholic, Anglican, Presbyterian and Methodist generally de-emphasize faith healing. The indigenous African Christian churches attract a lot of people not only because they serve as therapeutic communities, but they also give economic, social and emotional support to their members. Their church services involve drumming, singing, and clapping of hands. They seem to have blended Christianity with some aspect of African culture, and that may have accounted for their proliferation in Berekum. Compared with the 'established denominations', their membership is smaller. Generally, the educational background of their leaders and congregation is low (mainly elementary school level). However, some of the patients of these faith healers have university degrees.

These churches are located mainly on the outskirts of Berekum. The most familiar sights at the premises of these churches are the crucifix, and the statues of angels and Saint Mary. The healing services of these spiritual churches usually take place three days in a week, mainly on Sundays, Wednesdays and Fridays. However, the majority of them conduct their healing services on Fridays. Prayers and fasting are two important things every participant of these services is exhorted to observe. The healing services are open to members and non-members of these churches. The session starts with individual prayer time under the direction of a member of the church. During this period they prophesy and 'speak in tongues'. The leader of this session signifies an end to the session after some minutes by clapping her/his hands. The time of worship follows this session. Several mellifluous songs are sung in vernacular (with few songs in English), and everyone is encouraged to dance and clap hands. The person who leads this period of worship also exults participants to be happy and count on the healing power of the Lord. A sermon conducted by the faith healer follows the time of worship. Here, several references are made from the Bible to show that God is the only true healer. Psychologically, this sermon prepares the patients for the healing session.

Generally, women outnumber men in these churches. The types of illnesses brought to these healing services vary from week to week, but they range from less serious illnesses like headache, stomach pains, fever and diarrhoea, to more serious ones like madness, epilepsy, turgidity and skin cancer. Other problems are barrenness, impotence/sterility, seeking successful marriage and warding off the supernatural forces to create a successful business environment. The healing sessions may take different forms, varying from church to church. In some churches, the healing is done in public at the premises of the church, while in others a specific room is set aside for that purpose. In the process of healing, Florida water, ordinary water (blessed), lavender

and candles are used to apply to the affected part where appropriate. Normally the whole day is used for healing. In addition to these healing sessions, individuals may also have some consultaions with the faith healers on other occasions, and it is during this time that herbal or arboreal preparations are used in treatment. In one of my rounds, I went to the premises of one of these churches to book an apppointment with the healer for interview. I was told to wait for the healer in one of the rooms. In the centre of the room (later I identified it as the healing room) was a large basin containing water, and covered with calico with a big red cross imprinted in the middle. There was also a big wooden cross leaning against the wall. Symbolically, the cross indicates the source of the healer's power, and this re-assures the patient that, with Jesus at the centre of this healing, all problems will be solved. As part of building a 'strong church' with dedicated and committed Christians, members of some of these churches are entreated to attend an 'all-night vigil'. The details of the faith healing in Berekum has been exemplified below by members of the Ossamadi church led by Osofo Kyere.

FAITH HEALING IN OSSAMADI CHURCH

Osofo Kyere is a 39-year old pastor of the Senase branch of the Ossamadi church. He has completed elementary school, and is married with two wives. After completion of elementary school, he worked with the Forestry Department for a few years until he started his ministry as a pastor 16 years ago. He engages actively in farming, and in case of any emergency a messenger is sent for him. His healing services are conducted fortnightly; usually on Fridays. Occasionally, some of these services are also conducted on Sundays. However, he is consulted throughout the week. I went to his residence to book an appointment for an interview with him on one Saturday, which he was supposed to be less busy. At his premises three of the five

long benches, seating about ten people each, were occupied that day. I had to join the queue for about two hours before I was able to see him to schedule an interview. During the healing sessions he treats between one hundred and two hundred people a day. Not all the patients are treated; he only prays for some.

He claims that his power to heal is 'a gift from God', and that he did not learn it. A spiritualist had informed his parents, who were still expecting a child after 10 years of marriage, that they would give birth to 'a child of God'. The necessary rituals were performed. The head of the family who had travelled far away from home was told by a certain pastor that he should go home because 'a child of God', who was bald, had been born into the family. He should give the child a pastor's robe, and the child should not be given any strong drink. Osofo had these spiritual powers at primary three (third year in elementary school). After the completion of elementary school, he claimed to have had a vision in which he went to heaven and hell. He saw the glory in heaven and the torture in hell. The angels gave directions of what he should do. To sum up the source of his power, Osofo stated, "It's a gift from God".

Apart from claiming that he derives his source of power from God, Osofo also has some symbols at his residence which put confidence in his patients. He has one room for consultations only on any ordinary day, and the other room is set aside specifically for healing days. Above the door of the room is a big cross which symbolizes the victory of Jesus over death, and his healing power. On the walls of the room are pictures of Jesus (on the Cross and Ascension), Daniel in the lions' den, the serpent deceiving Adam and Eve, and others which re-assure the patients that they are in the 'house of God'. His relationship with the patients helps the therapeutic process; they 'feel at home' to discuss their problems with someone who is very sympathetic and understanding. The patients are from different social backgrounds. An

informal discussion with some of them revealed that six were certificated teachers, one was a student in a diploma awarding institution; while others were traders, farmers, drivers and other occupations. They were all in a long queue waiting for their turn. In some cases, Osofo directs some patients to go to hospital. Some of these patients had also travelled from long distances to see him. About 100 metres away from his residence some buildings have been constructed through 'communal labour' by the members of the church. These are the premises for the in-patients and some relatives who accompany them. The treatment at the healing services are mainly directed towards the out-patients. The in-patients are visited every day, and prayed for. The number of these in-patients varies from ten to twenty.

The patients consult Osofo for a variety of reasons; some types of illnesses brought are jaundice, barrenness, sterility, madness, severe headache and stomach pains. Some also present special problems, for example, to get rid of their witchery, to have a successful business, to establish a successful marriage, to protect themselves against witches and help some people in their studies. Some of the patients who have been treated for some illnesses have joined the church. In addition to his healing power, Osofo believes God has also given him the power to prophesy; and this 'spiritual gift from God' makes his healing attractive to many people. He notes that a key to successful healing is obedience to God: "those who obey God will do just as Moses did". He is also able to exorcize demons from witches by putting his hand on their heads and praying for them. He claims that he can treat some specific illnesses in the following ways:

Treatment Procedures By Osofo

Malaria: Add some drops of 'sanitas' (disinfectant) to cold water. Bless it, and the patient baths for three days.

Diarrhoea: Mix sugar and salt, and add some drops of water. Bless and give it to the patient to drink. OR: The patient eats white clay.

Madness: Fasting and confession on the part of the patient. Add some drops of 'sanitas' to water, and wash the head of the patient. OR: Lay hands on the patient and pray for him/her.

Epilepsy: Fasting and prayer on the part of both the healer and the patient.

Barrenness: If damaged womb, chew palm kernel and add to a crushed shoot of a palm tree. Grind them together, and have enema daily. After seven days bless before enema.

Impotence/Sterility: Through prayers.

Skin Cancer: Put a handful of salt in water. Place in the sun until sunset. When the sun is setting pour this salty water on the affected part. Mix liquid and powder penicillin, and smear it on the affected part. OR: Grind the shell of a snail, and add penicillin. Smear on the affected part.

Jaundice: Peel a pineapple, squeeze the juice and boil. Give it to the patient to drink.

Anaemia: Bless palm oil, and give it to the patient to drink.

Healing Service

Members of the church went to the residence of Osofo early to prepare the place for the healing session. Most of the patients had arrived to join the queue by sitting on the long benches provided. The patients went through a time of prayers individually to prepare themselves 'spiritually' for the healing session. Osofo appeared in a black and white robe, and the individual prayer sessions ended. About thirty minutes was

used as a period of worship where they glorified God in songs to indicate the might of God and his healing power. Some songs sung were *Yesu ye ohene* (Jesus is King), *Se m'anya Yesu a anka m'ayera* (I would have lost if I had not received Jesus), *Yesu mu na nkwa wo* (Salvation is in Jesus) and *Calvary na meyaa m'ayaresa* (I got my healing at Calvary). All these songs were meant to show that Jesus would heal them. Typical of Ghanaians, almost everybody danced, and broad smiles were seen in their faces. Psychologically, this time of worship and praise put the patients in a good shape for the healing session. The person who led this exulted everyone to be happy and trust that "God cares for us" (1 Peter 5:7). The faith of the individual patients that God would heal them was also stressed.

A pre-healing sermon was conducted by Osofo. This sermon served several purposes. He tried to show the people the source of his healing power and authority. That is, God has the ultimate power to heal, and this healing was done by God through Osofo. Another important aspect of this pre-healing sermon was to let the patients know that healing depended so much on the faith of the patient. As Kearney (1978) observed among the Mexicans, the healing mediums claimed to cure 'in the name of God', if only the client had sufficient faith. The burden of failed cures is placed on the client for lack of sufficient faith. The significance of faith in healing is twofold. First, "a prayer of faith saves the sick" (James 5:15). Second, the faith of the patient is instrumental in spiritual healing. The third purpose of the pre-healing sermon was to admonish the people to confess their sins; which was a pre-requisite for healing (James 5:6). Unconfessed sins would thwart any effort at healing. The last significance of this sermon was to put confidence in the people that God has power to heal (Exodus 15:26; Deuteronomy 32:39; Psalms 103:3; Psalms 107:20 and Hosea 6:1). The psychological significance of the pre-healing sermon was immense. Attempts were made "to dispel doubt and disbelief, both individually and collectively" (Kearney

1978:24).

During the sermon Osofo made references to Jesus; the greatest of all healers and preachers. He stressed that "people are healed by the stripes of Jesus" (Isaiah 53:5 and 1 Peter 2:24). Jesus had also commissioned his disciples to preach the kingdom of God, and to heal the sick (Matthew 10:8; Luke 9:2 and Luke 10:9). Osofo stressed that healing had been one of the greatest commissions by Jesus to his disciples. Jesus also had power to heal all kinds of diseases (Malachi 4:2; Luke 9:11 and Matthew 4:23). He indicated that Jesus was able to accomplished this because the 'spirit of the Lord' was on him (Luke 4:18; Luke 5:17 and Acts 4:30). After making reference to the healing power of Jesus, Osofo directed attention to the powers Jesus had given him to heal the sick. He stressed further that a faithful prayer could even heal the sick. In sum, the message of the sermon by Osofo was clear; confess your sins, trust and have faith in God that he would heal you.

In order to listen to individual problems and treat them individually, the healing was done in a room set aside for that purpose. Osofo, in his robe, had a wooden cross in his hand, and was well seated in his chair. The patients wrote down the names of the people in the queue and submitted the list to him. He called out the names for the healing in that order. The patient entered the room to meet Osofo seated in his chair, who seemed to be imbued by the power of the Holy Spirit. This put further confidence into the patient that he would easily solve his/her problem. In a friendly manner, Osofo showed the patient a chair to sit on. Both of them entered into a short session of prayer. After this, he asked the patient to present her/his problem before God (literally to Osofo). Osofo listened attentively, nodding his head, and changing his wooden cross from one hand to the other several times presumably, indicating that the situation was under control. After the problem had been presented, he asked a few questions on the nature of the illness, when it started and previous

treatments. Osofo explained that at that stage the Holy Spirit would lead him as to what should be done and in most cases, instant solutions were given to some problems. In other cases Florida water, ordinary water (blessed), candles and lavender were used during the healing process. In most cases, the patient would continue to use these when she/he went back home.

During the healing process the patient was asked to kneel before Osofo. He put his hand on the patient's head, and 'prayed in the spirit' (spiritually possessed). Osofo started speaking in tongues. Both the patient and the healer might close their eyes at this stage. He explained the cause of the illness to the patient, and accordingly prescribed a solution. He blessed Florida water, ordinary water, lavender and candles; and gave one or more of these to the patient to use, either by bathing or drinking. The problems brought by the patients generally ranged from less severe to severe ones. A short session of counselling followed the laying on of hands on the patient. The purpose was to reassure the patient that God had answered her/his prayer, and the problem brought had been solved. No fee was charged for this healing; however, the patients could voluntarily give some amount of money to Osofo. In this sense, healing is not seen as an important income generating activity, but as 'a gift of God' (1 Corinthians 12:9,28) to expand his church.

Individual patients went through similar procedures, but the explanations for the illness and what should be done differed. As indicated earlier on, some of the patients, after going through this treatment procedure would be asked by Osofo to go to the hospital. It must be stressed here also that the patients who went through the healing sessions were those whose illnesses were not serious. The seriously sick patients were taken to some rooms at the premises where the in-patients stayed. In such cases, Osofo would visit them, but as he stressed, "we heal by the power of God". Plant medicine was also used alongside these faith healing sessions. He would prefer to make

the preparations himself, and bless it before giving it to the patient. The treatment sessions would normally end late in the afternoon. No formal closing ceremonies were made; each patient would leave after receiving her/his treatment. Osofo would therefore end the treatment session when the last patient had left.

CHOOSING AND EVALUATING THERAPIES IN BEREKUM

The individual's health-seeking behaviour is guided by the health ideology and values (Kleinman:1980). These values function to order illness within frameworks of relevance or hierarchies of resort (Romanucci-Ross:1977), and these frameworks define which health problems are most important and which require immediate action. The same structures of relevance are also used to decide when to switch from one type of care to the other. In the event of illness, the invalids in Berekum have different therapeutic options to choose from. The individuals may resort to self-treatment if the illness is less serious; within the scientific medical practice they choose either the hospital, clinic or homoeopathic. On the other hand, they may choose either herbal treatment or faith healing. However, some also patronize these types of treatments simultaneously. In this section, I am interested in the factors that influence these choices, and the evaluations of the treatment procedures. Some of the most influential factors are: the quality of treatment and the cost of treatment; types of illness and their explanations; and the state intervention in these healing practices.

The quality of treatment is very influential in the individual's choice from the therapies in Berekum. Also, the quality of treatment determines when to switch to other therapies. The former patients of these healers are instrumental in assessing the quality of that type of treatment. During the treatment of *aduto* by Nkonkonsa there were several former patients who talked about their experiences to the new patients,

and that increased their confidence in the healer. Most of them consulted Nkonkonsa based on the recommendations by these former patients.

One of the doctors at the Holy Family Hospital was always recommended in the cases of infertility. Very often you would hear people saying, "If Doctor X fails to treat your infertility, then no doctor can do it". Consumers generally become satisfied with the services given by this doctor. Her office is always deluged with patients. Another reason which points to the high quality of her treatment, and which thereby attracts many infertile couples, is her relationship with her patients. This provides effective communication which makes her patients explain their problems in detail, and therefore rate the quality of her treatment very high.

The response to treatment is also a crucial factor in deciding when to switch from one treatment or healer to the other. A young university graduate had rashes all over her body. She moved from one hospital to another in Accra in order to get a successful treatment. She finally went to Korle Bu Teaching hospital (the largest teaching hospital in Ghana), and her condition continued to deteriorate until she became paralysed. The family took her to Berekum (her hometown), and she had a successful treatment from a herbalist. In some cases the quality of a specific form of treatment is judged by how others are responding to the same type of treatment. In recounting his experiences at the Holy Family Hospital, a healer explained:

> I became seriously ill, and was sent to the Holy Family Hospital. I was informed that I would go through a surgical operation. All the four patients in the same ward who had surgical operation died. I thought I would also die if I stayed. I requested for discharge, and it was granted. After discharge, I went to Sunyani General Hospital where I had a successful operation.

The more profound the scepticism about a specific type of treatment or healer, the less favourable the evaluation would be. Potential consumers are discouraged from patronizing. In Berekum, there are several accusations about some traditional healers or

spiritualists who agree to treat some patients because of monetary gains. In a situation like this, the quality of treatment is sacrificed for financial gains. One healer was accused: "She is not treating people, she is deceiving them and collecting their money". The quality of treatment is evaluated positively when a referral is made. The Holy Family Hospital occasionally refers some patients with chronic psychosis and simple fractures to some of the traditional healers. After a period of time some relatives would advise the patient to contact specific healers because even when they go to the hospital they would be referred to them. These referrals give consumers confidence in these healers, and usually the treatment is highly evaluated.

Another significant factor affecting the choice of therapy in Berekum is the cost of treatment. A lady wanted to avoid the time delays at the hospital, and so she went to one of the private clinics in Berekum. The cost was very high, but she was told to see the doctor again. She came back to the hospital to cope with the time delays there, and paid about five times less than she paid at the clinic. However, many people now find the cost of treatment at the hospital rising very fast. One visit to the hospital means spending a week's income. Generally, in terms of the cost of treatment, it is cheaper to consult a traditional healer. However, some may request sheep, fowls and other items which make the cost of their treatment higher. Ndeti (1972) made a similar observation in Kenya in a study of tuberculosis control that the bus fare kept a large number of patients from coming to the clinic to receive free treatment. The high cost of treatment at the Holy Family Hospital has been recognized by the hospital itself. It has been found out that some patients who have travelled from long distances, and are therefore difficult to trace, normally leave the hospital without paying for the cost of the treatment. The hospital has therefore instituted a measure to reduce this. A deposit is required of patients before admission is granted. This puts some patients off, and they try to seek treatment somewhere else if they

cannot afford this deposit.

In addition to the economic cost of treatment, the social cost is also influential in the choice therapy in Berekum. When a relative who is a healer is side-stepped in the choice of therapy, it amounts to rejection especially if the healer can treat that type of illness. Members of the same church are expected to patronize the healing sessions, and those seeking treatment from another spiritual healer are seen as 'deserters of the faith'. Social costs are therefore seen "as too high a price to pay for perceived advantage" (Foster 1977:530). Those who seek treatment outside their own church should do so in disguise. Time delays at the Holy Family Hospital discourage some patients from receiving further treatment from the hospital. Apart from the time delays in seeing a doctor, after the treatment the patient spends several hours at the pharmacy section for drugs. The patient puts her/his chart in a box and waits on the benches to hear her/his name called out. During the interviews I took advantage of that and sat among the patients on these benches. While talking to some patients, I saw a man who had been waiting for some hours, sleeping most of the time. I asked him a few questions and found that he had been waiting for four hours. I asked his name and checked from the personnel at the pharmacy section. I was told his name was called out but nobody responded. The man was very weak, and during that time he was fast asleep. The patient was given medicine, and he told me: "Thank you very much; this is my last time of coming here". However, these time delays are minimized if you have 'contacts' at the hospital. The whole process of treatment may take about thirty minutes. At the pharmacy section some patients do not put their charts in the box but give them to the personnel on duty. This procedure may take less than five minutes. In this case, the treatment at the hospital favours those who have 'contacts'.

The most influential factor in the choice of therapy in Berekum is the type of illness and its explanation. The individual sick persons differentiate between serious and

less serious illness. In the less serious cases they normally resort to self-treatment. There are many pharmacy/drug stores in Berekum, and the only thing you do is to explain your condition to the one behind the counter. A typical response from the vendor is, "You need ampicillin, tetracycline, codeine or paracetamol. Combine this to this, and take three times daily after meals. You will be sweating after taking, and that means you are fine". You can buy any medicine in the pharmacy/drug stores in Berekum without prescription form. If there are laws in Ghana with regard to this, they are inoperative. The unfortunate aspect of the availability of drugs in the stores is that they are usually not staffed by specialists or pharmacist. Overdose and wrong application of drugs are prevalent. On the other hand, if the illness is serious, the person solicits help from a specialist on that type of illness. One herbalist is regarded as a specialist in treating convulsion. As soon as it is recognized that it is convulsion, the conclusion is clear: "Go to healer Y". If the illness is very serious the patients have very little say in the type of treatment they choose. At the shrine of Nana Maase, a woman who was believed to have been cursed was brought there. She had resisted coming there initially but was forced and brought there by her relatives. Patients sent to the traditional healers are required to have *okyigyinafo* (supporter), and that may suggest that the choice of the type of treatment may have to be endorsed by some relatives of the patients.

The explanation provided for a particular illness is very influential in the choice of therapy. If a person believes that he has contracted gonorrhoea for having sexual intercourse with someone's partner, the hospital may be one of the last places of resort. If a patient cannot explain her/his illness she/he may move from healer to healer for confirmation or contradiction. A patient went to a spiritual healer about her barrenness. After about thirty minutes' 'commune with God in prayer', the healer came out and said, "Praise God, your prayer has been answered". The lady wanted a

confirmation from the hospital, but to her dismay she was informed that she was infertile. She finally consulted a priest healer who prepared some herbal concoction for her. She was able to have a child. Contradictory explanations are generally given by the traditional healers, and those who solicit their help have to 'shop around' to get common grounds. My experience with the water-gazing Moslem healer during the fieldwork throws further light on the significance of explanation of illness and the choice of therapy. She claimed to have some supernatural powers to explain any problem presented by gazing in water. (I explained this in the previous chapter). The explanation she provided for my presence there, and my plans of travelling outside the country were deceptive. This could have deterred some potential patients from consulting her.

Foster (1984) suggests that modern medicine has become the first choice of most traditional peoples most of the time, and that the benefits of modern medicine are not being 'thrust down the throats of unwilling villagers'. Such observations tend to ignore the influence of state intervention in the practices of modern medical system. In Ghana, scientific medical practice has been legitimized by the government through the use of certification from a qualified medical officer if someone wants either sick leave, maternity leave or a refund of medical expenses. If the individual is a worker, in order to get a medical report from a qualified medical practitioner, she/he should somewhere along the line include scientific medical practice in the choice of therapy. This may not necessarily be a "free choice" as Foster (1984) claims. A teacher recounted her dilemma when she had a broken leg:

> I knew there was a bone-setter who could have treated me in a very short period of time. But I needed a note from a medical doctor to support my application for sick leave. I spent about four months in the hospital; a process which could have taken only one month if I had gone to the bone-setter. After discharge from the hospital I still had some pains in my leg. I contacted the bone-setter who applied some ground herbs on my leg. I am now fine, but you know, I achieved my purpose.

The point here is that this situation impinges on the choice of therapy. This is not to state that there are no constraints in the use of the other therapies in Berekum. Each therapy has its own built-in mechanisms which influence individual choices.

During the healing sessions of some of the spiritual churches, the over-riding theme was: "God Heals". Members of these churches were discouraged from seeking treatment from traditional healers since their practices were considered to be associated with paganism. They were, however, encouraged to some extent, to go to hospital. In addition, they stressed the power of God to heal. It could not be established how religious affiliation would influence the choice of therapy in Berekum.

I have indicated that the quality and the cost of treatment, the type and explanations of illness, and state intervention are some of the factors influencing the choice of therapy in Berekum. It must be stressed that none of the factors standing alone can explain the choice and evaluation of therapies in Berekum. For example, if the quality of treatment is good but the consumer cannot afford to pay the cost involved, a shift to an inferior one may be preferable. However, there is a pattern of hierarchy of resort to various types of treatment in Berekum. This is clearly seen in the choices of treatments laypersons made with respect to their previous and recent illnesses. In terms of their previous illnesses, the majority (61.1%) of them first consulted scientific medical practitioners, while self-medication, herbal treatment and faith healing followed in that order. The majority (77.2%) of the laypersons first sought scientific medical treatment for their present illnesses, while herbal treatment, self-medication and spiritual healing followed in that order. Herbal treatment is the treatment of the last resort in Berekum. More than one-third of the informants resorted to herbal treatment when the other types of treatment had been tried and failed. Both Uyanga (1979) and Mume (1976) observed in Nigeria that patients resort to traditional and spiritual healers after they have failed to obtain rapid treatment in

hospital and private clinics. Romanucci-Ross (1977), however, identified two sequences of hierarchy of resort: acculturative and counter-acculturative. Acculturative sequence refers to a practice where the sequence starts with more recent, modern modes, and the trend is toward earlier cultural modes of treatment. Counter-acculturative sequence refers to the situation where the first resort is the earlier mode and the trend, in the event of failure, then to seek more recently introduced modes. She further identified three levels of hierarchy of resort: namely; European medicine, the treatment through the church and traditional medicine. As we observed in Berekum, in the event of failed treatment, the individual may resort to other healers or hospital within the same kind of treatment. For example, a patient asked for discharge from the Holy Family Hospital and went to Sunyani General Hospital where he was successfully treated. Contrary to the situation in Nigeria (Uyanga:1979; Mume:1976), Nurge:(1977) observed in a fishing and agricultural village in the Philppines that some people used the Western-style medicine as the treatment of the last resort when all in the traditional system had been tried and found wanting. Similarly, Asogwa (1979) and Jegede (1981) also observed in Nigeria that patients came to seek cure from experts in Western medicine after traditional healers had failed to cure them. The situation in Berekum seems to lend support to the observation by Romanucci-Ross (1977), Uyanga (1979) and Mume (1976) that traditional and spiritual healers are consulted as the last resort.

In this chapter, I examined the types of therapies in Berekum, and their choice and evalutions. Both herbal treatment and faith healing reflect the explanations these healers provide for illnesses. The treatment approaches adopted by these healers therefore involve both natural and supernatural procedures. As a result of the absence of exchange of ideas and knowledge about their work, there are differences in the approaches adopted, even if the same medicinal plants are used. Several factors like the quality and cost of treatment; the type of illness and its explanation; and state

intervention interlink to influence health behaviour in Berekum.

CHAPTER VI

CONFRONTING A NEW ILLNESS: THE CASE OF AIDS

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS), which poses a health threat unparallelled in modern medical history, is decimating populations in both the developing and the developed countries alike. It has affected human society in ways that the old illnesses like malaria, smallpox, cholera and other infectious diseases could not. The AIDS epidemic is a social, behavioural and biological phenomenon. Confronting AIDS should therefore involve tackling the epidemic from these triplex dimensions. At the moment scientists have not succeeded in finding a cure or developing a vaccine, and it is almost certainly clear that a cure is not imminent (Graubard:1989). The AIDS epidemic will worsen (Shulman and Mantell:1988), and humanity has to accommodate it, at least, for the next few years. While we wait for a medical breakthrough or the development of a vaccine to prevent AIDS, one of the most effective ways to confront this pandemic is through the behavioural and social dimension. An effective educational programme may slow down the spread of the AIDS virus. The effectiveness of the educational programme hinges mainly on better understanding of the nature of AIDS, and especially the knowledge about the transmission of the AIDS virus by ordinary people. This kind of understanding may facilitate the efforts aimed at caring for the already afflicted, and create a climate of tolerance for them.

The number of AIDS cases recorded at Berekum Holy Family Hospital shows that Berekum has not been spared from the AIDS epidemic. The Medical Records section of the hospital puts the number of people who have gone for the human immunodeficiency virus (HIV) test between August 15, 1988 and January 1990 at 138.

Fifty-nine were tested positive (that is, antibodies to HIV were present), while 79 were tested negative (that is, HIV antibodies were not present). Of the people tested, 30 were men, while 29 were females. There were only three patients under one year of age. Those afflicted with the AIDS virus were aged between 18 and 50 years, and the highest level of education among these people was elementary school. The people who went for the HIV test did not do this voluntarily; some doctors at the hospital suspected they had contracted the AIDS virus, and requested that they should be tested. Perhaps there might be several others infected with AIDS virus who have not come to the notice of the hospital administration. The basic understanding of the nature of AIDS and the modes of transmission of the virus may be helpful in understanding how the epidemic has been confronted in Berekum.

The chapter therefore has two main objectives. First, to examine the general perceptions of the nature of AIDS, and how AIDS fits into illness knowledge in Berekum. Second, to assess the effect the general perceptions of the nature of AIDS in Berekum will have on the educational programmes to help reduce the spread of the AIDS virus in Ghana. In addition, I would also evaluate the educational programmes to improve AIDS awareness locally. I seek to achieve these objectives by analysing the views expressed about AIDS in Berekum by 78 informants. They comprised 44 patients, 19 healers, 5 nurses, 5 prostitutes and 5 members of a youth gang. Forty-one of these informants were men, while 37 were women. Their ages ranged between 17 and 96 years. The educational background of these informants cut across the whole spectrum of educational levels in Ghana; ranging from illiteracy to university degree. (See Appendix A for Tables 52-71).

PATIENTS' KNOWLEDGE ABOUT AIDS

The perceptions of AIDS among patients here involve two concerns: the informants' general description of AIDS, and the means by which they identify persons with AIDS. The purpose is to examine how much the informants knew about AIDS. All the informants had heard of AIDS. In the face of the AIDS epidemic, new illness knowledge has been generated in Berekum. About one-third of the informants regarded AIDS as a new kind of illness which is completely different from the old illnesses like malaria, insanity and gonorrhoea. The severity of AIDS compared with the old illnesses further attests to the perceptions held by informants that AIDS is a new kind of illness. More than one-quarter of the informants regarded AIDS as a deadly disease without cure, which kills after five years. Despite the generally held belief that AIDS is a new kind of illness, a few informants incorporated AIDS into the old illness knowledge. They believed that AIDS is a type of old illness like fever, measles or venereal disease which has taken on new dimensions. While a febrile condition for more than a month may indicate a symptom of AIDS, it does not mean AIDS is a kind of fever. Also, despite the fact that the main cause of AIDS transmission in Africa is through heterosexual vaginal intercourse (Larson:1990), it is certainly not perceived to be a kind of a venereal disease.

Another perception of AIDS among a small number of the informants is the belief that AIDS is contagious, and its patients should be isolated. Some of the informants also reduced the transmission of the AIDS virus to sexual intercourse only. This seems to reflect the general belief in Ghana that AIDS is mainly contracted through sexual intercourse, especially with a prostitute (Neequaye et al:1986; Konotey-Ahulu:1988). It is no wonder that in Berekum some informants regard AIDS as prostitutes' illness. At the national level prostitutes were singled out for testing,

giving the impression that prostitution was the only means by which the AIDS virus could be transmitted. This coincided with the return of a handful of prostitutes in Berekum from Abidjan who had contracted the AIDS virus. With this kind of perception, morality seems to be related to AIDS. The AIDS patients could be regarded as depraved since they may have once solicited the services of prostitutes. In other words, AIDS patients are sexually unrestrained. According to this conception AIDS, like any type of venereal disease, is associated with sexuality, and thererfore informants' perceptions carry social meanings and moral evaluation of sexual behaviour (Fee:1988). Also, the conception that AIDS patients should be isolated does not create a climate of tolerance for AIDS infected people, and that may work against attempts at caring for them. Some of the informants regarded AIDS as 'slim disease', and infectious, which also suppresses the immune system. Despite this general perception of AIDS among the informants, which could show that they were well-informed, some of the informants could not describe the nature of AIDS.

With regard to identifying persons with AIDS, less than one-half of the informants indicated they either had no idea or had no means to identify such people. Emaciation is the most identifiable feature about persons with AIDS that the informants recognized. Some of them also believed that vomiting, dry cough, continuous diarrhoea and shingles could be some signs of a person who may have contracted the AIDS virus. It must be stressed that these clinical manifestations are generally associated with "full-blown" AIDS. Some seemingly healthy persons may have contracted the virus, and since the interval between infection and the manifestation of symptoms characteristic of AIDS may be as long as ten years (Larson:1990), there may be several healthy people who may be carriers of the AIDS virus. Testing to see the presence or absence of the antibodies to HIV in the blood seems to be the best way to identify persons with AIDS.

Most of the informants first heard of AIDS on the national radio. At the national level news is broadcast on three radio stations: Ghana Broadcasting Corporation (G.B.C) One broadcasts programmes in all the major languages in Ghana, Ghana Broadcasting Corporation Two only in English, while the External Service of Radio Ghana broadcsts its programmes in both English and French. Some of the informants also first heard of AIDS through external radio networks such as the Voice of America (V.O.A) and the British Broadcasting Corporation (B.B.C). Some churches in Berekum have also co-operated with the Holy Family Hospital in disseminating AIDS information. A team from the hospital, comprising mainly nurses, went to these churches on Sundays to explain the nature of AIDS to the congregation. These briefing sessions, though very short, as they were held during the 'announcement time' in the church, were the first source of AIDS information for some of the informants. Few of the informants cited friends, books, newspapers and magazines as the first sources of information.

A large portion of the literature on AIDS in Africa generally centres on the controversy about the origin of the AIDS epidemic (Piot et al:1988; Mann et al:1988; Norman:1985; Quinn:1986 and Newmark:1986). The consequence of this argumentation about the possible origin and prevalence of AIDS in Africa is that several African countries denied the presence of AIDS in their countries, and thereby allowed AIDS to get firmly established before any preventive measures were taken to confront this epidemic. Ghana seems to be one of those countries caught up in this web of denial. Until March 1986, there was no clinical case of AIDS in Accra (Neequaye et al:1986). This meant that no AIDS cases existed in Ghana by that period. When the government finally conceded that there were some clinical cases of AIDS in Ghana in September 1986, efforts were made to get this across to the general population on the national radio. The initial response to AIDS by the government was directed towards

prostitutes in Ghana, most of them who tested were seropositives, and consequently AIDS was linked with prostitution. Studies by Neequaye et al:1986 and Konotey-Ahulu:1988 attested to this. The ordinary people's awareness about AIDS seems to have been thwarted as a result of the delay in accepting the presence of AIDS in Ghana. About two-thirds of the informants first heard of AIDS not more two years ago; that is, between 1988 and 1990. The rest first heard of AIDS between three and five years ago; that is, between 1985 and 1987.

As expected, all the informants regarded sexual transmission as the main cause of AIDS. Studies by Larson (1990) and Wagner (1989) indicate that in Africa AIDS transmission mainly occurs through heterosexual vaginal intercourse. The chances of becoming infected through sex with an infected person increase with the number of sexual partners and the number of times sexual intercourse has occurred with an affected person (Population Information Program:1989). The reference to heterosexual vaginal intercourse as the main cause of AIDS in Africa brings into focus the issue of polygyny. Multiple sexual partners may increase the risk of AIDS infection among unfaithful partners. It can be suggested that unfaithfulness on the part of the sexual partners may be the main reason for the sexual transmission of AIDS in Africa. Larson (1990) has tried to link the cultural, historical and economic forces together as sustaining multiple partner sex in Africa. However, sexuality is a complex issue which may not be fully understood when reduced to variables like culture, history and poverty.

Consensus among the informants that sexual transmission was the main cause of AIDS was very striking. In the explanations they provided for old illnesses, it was seen that not all the informants agreed on a single causal explanation of any type of these illnesses, even though in some cases majority agreed. Here, the trend changed, and the possible explanation for this may be the AIDS education programme mounted

at the national level stressing the sexual transmission of AIDS. It can also be partly explained that there has been less conscious efforts to explain the old illnesses than the government has done with AIDS.

In terms of the other possible causes of AIDS, more than one-third of the informants could not identify any causes. However, some of them identified four other important ways AIDS could be transmitted, indicating that they were well-informed about the other causes of AIDS. These are: the use of unsterilized instruments, blood transfusion, perinatal transmission and the use of contaminated blades. AIDS education programmes mounted at both the national and the local levels seem to be yielding some results. The Holy Family Hospital counsels some people at the hospital on AIDS, and also sends some nurses to various churches in Berekum to explain the nature of AIDS, and what they could do to help reduce the spread of the virus. Posters and booklets help in disseminating information about AIDS to the general population. One of the booklets by the Ministry of Health reads: *Love With Care: Stop AIDS*. Another one published by the National Catholic Secretariat also reads: *Wanted For Murder. AIDS, The Killer. You Can Help Stop Further Murders*. Unfortunately, these AIDS education materials benefit mainly the literates.

Despite the efforts made by the government and the Holy Family Hospital in disseminating AIDS information to the general population, some misconceptions about the transmission of AIDS virus still persist. Some of the informants believed handshakes, eating from the same plate or drinking from the same cup as persons with AIDS could lead to AIDS infection. Others also believed insect bites and kissing could cause AIDS. The persistence of the belief about the risk of contracting AIDS through casual contact indicates that the AIDS education has not had much impact. Another misconception is that AIDS is a more severe type of gonorrhoea. With this kind of misconception, AIDS is perceived as just any other venereal disease, and this may

militate against efforts made to prevent the spread of the AIDS virus.

The majority of the informants believed AIDS is incurable at the moment. Some reasons given for this are: not much is known about the nature of AIDS; it is very dreadful and dangerous disease; searching for a cure is not complete; and the person will already be dead when the clinical manifestations show up. They, however, believed that there might be a cure in future, but not now. On the contrary, a few of the informants believed the use of herbs and prayers could treat persons with AIDS. Most of them believed the Kwaku Firi shrine at Nwoase in Ghana could treat persons with AIDS. The media in Ghana spread this news so fast that some people believe AIDS is curable. This is mere speculation, but now the Ministry of Health and the Ghana Medical Association have co-operated with Nana Drobo (the chief priest of Kwaku Firi shrine) to assess the veracity of his assertions. In this connection the Ghana Medical Association has asked that ten persons with AIDS at Okomfo Anokye Hospital in Kumasi be transferred to Nana Drobo. He would be under surveillance, and after some period the patients would be re-tested. Any claim on the part of Nana Drobo at this stage is only speculation. Others also believed that a pastor of Asafo Pentecost (an African Pentecostal Church) in the Brong Ahafo Region of Ghana would be able to treat AIDS patients through prayers. In another study conducted at the local secondary school and training college, Wyllie et al (1990) observed a similar belief among the respondents that a cure for AIDS exists. The same healer was cited, and it seems they have great faith in the ability of the healer to cure AIDS. At the moment a belief that AIDS is curable may be destructive to AIDS education programme to change people's behaviour, especially sexual behaviour.

Despite recognizing the distinctive nature of AIDS in comparison with old illnesses, some of the informants believe AIDS is an old illness which has taken a new dimension; it has become a pandemic. The combination of a fairly accurate and less

accurate description of the nature of AIDS reflects the informants' perceptions of the methods to be used to prevent the spread of the AIDS virus. The informants' view about the protective measures to help reduce the spread of AIDS involve three main issues: those that deal with sexual behaviour, those related to the use of sterilized instruments, and others generally related to the role of food, kissing and insects in the spread of the AIDS virus. About two-thirds of the informants stressed the importance of changes in people's sexual behaviour in preventing the transmission of the AIDS virus. Among such factors they recognized are stopping indiscrminate sex, having a faithful sexual relationship, having sex with someone tested negative to HIV and using condoms. To stop indiscriminate sex, to have sex with someone who has not been infected with the AIDS virus and to have a faithful sexual relationship inter-relate. It is assumed that partners who have not contracted the AIDS virus might be the safest way to prevent sexual transmission of the AIDS virus. The use of condoms, while highly recommended because of its effectiveness, does not fully protect against HIV infection since condom breakage may occur. The preponderance of sexual transmission of AIDS in Africa generally calls for a critical evaluation of the sexual behaviour in Africa. A change in sexual behaviour seems to be the most effective way to confront AIDS in Africa at the moment. This is significant because the higher rate of sexual transmission of AIDS could lead to a higher rate of perinatal transmission in Africa.

Very often so much stress is made of the need to change sexual behaviour to help reduce the spread of the AIDS virus in Africa that other factors seem to be trivialized. It is therefore significant that a few of the informants also recognized the use of screened blood for transfusion and the use of sterilized instruments as some of the most effective ways in preventing the transmission of the AIDS virus. The risk of contracting the AIDS virus through the use of unsterilized instruments reduces when the instruments are used by specialists. Blood transfusion, usually taken for granted,

has been one of the potential ways the transmission of the AIDS virus occurs in the rural areas.

In Berekum relatives are very important in times of emergency. When a relative is in dire need of blood for a major surgical operation, the tendency is to notify other relatives to donate blood. Judging from the emergency nature of this kind of transaction, the transfusion procedures are simplified. During the period of the research, the Holy Family Hospital did not have the reagents for testing blood. The blood sample was usually taken to the Sunyani General Hospital, about 21 miles away from Berekum. This type of exchange of blood is very effective in the transmission of the AIDS virus. Since these issues are overlooked or taken for granted, the tendency always is to exaggerate the role of sexual transmission in spreading the AIDS virus in Africa. AIDS education programmes should equally stress such factors which are always taken for granted. Despite this high level of AIDS awareness among the informants, some of them believe that eating good food, refraining from kissing and preventing insect bites could prevent the spread of the AIDS virus. It is, however, known that kissing and insect bites do not spread the AIDS virus. It was observed that consensus was more evident among the informants in the explanations they provided as the main means by which the AIDS virus is transmitted; that is, sexual transmission. Likewise, the informants recognized the change in sexual behaviour as the most effective way to prevent the AIDS infection.

HEALERS' KNOWLEDGE ABOUT AIDS

I examine here the extent to which the healers could reasonably give an accurate description of AIDS by assessing the means of identifying persons with AIDS, and also their general ideas about AIDS. Like the patients, all the healers had heard of AIDS,

but none of them had had any AIDS patients among his/her patients. Compared with the patients, the healers were so much less-informed about AIDS that it would be doubtful if they could have recognized AIDS patients among their patients. In addition, the clinical manifestations alone would not be adequate to help recognize AIDS, and since they did not have reagents to test their patients, persons with AIDS might have passed through their hands unnoticed.

More than one-half of the informants regarded AIDS as a new and contagious disease whose nature has not been completely detected. However, some of the informants re-formulated their old illness knowledge and applied it to AIDS. This conception stresses that AIDS has existed for several years now, and it is a severe type of typhoid fever or gonorrhoea. However, some of the informants could not describe the nature of AIDS.

In order to assess further the healers' AIDS awareness, I asked them how they could identify AIDS patients. About one-third of the informants provided some clinical manifestations of "full-blown" AIDS, and the two main manifestations they identified were leanness (physical emaciation) and a continuous diarrhoea for more than one month. While some of the informants could not indicate any means of identifying AIDS patients, a few of them submitted that they could identify an AIDS patient by consulting the Koran, dwarfs, shrines and under Holy Spirit's guidance. Another interesting issue is that some of the informants regarded yellowish urine and swelling feet as clinical manifestations of AIDS. The healers generally gave inaccurate descriptions of AIDS, and they seemed to be less-informed about AIDS than the patients of these healers.

The majority of the healers regarded sexual transmission as the main cause of AIDS, while a few others also believed that gonorrhoea or febrile conditions could

develop into AIDS. Some of the healers, however, could not identify any main cause of AIDS. Consensus was more evident in the explanations the healers provided for AIDS than those they provided for the old illnesses. The extent of consensus was higher among the herbalists and the Moslem healers. All the herbalists and the Moslem healers cited sexual intercourse as the main cause of AIDS, whereas the majority of the priest healers and spiritual healers also cited the same cause. The herbalists also recognized other less important causes of AIDS, but like the explanations they provided for the old illnesses, they resorted to both natural and spiritual explanations. This is significantly different from the explanations provided by the patients of these healers. The patients cited only natural factors as the other less important causal explanations for AIDS. Some of the healers believed mosquito bites, eating with persons with AIDS and sharing a towel with persons with AIDS could spread the AIDS virus, while some of them also cited blood transfusion and sexual transmission. Among the spiritualistic causal explanations for AIDS are wrongdoing, envy and witchcraft. The recognition by some of the healers that AIDS is an old illness may mean that it could be explained in a similar way as the old illnesses. However, the majority of the healers could not identify any other less important causes of AIDS.

I observed during the research that the treatment of *aduto* could spread the AIDS virus in Berekum. (The treatment procedure has been described in the previous chapter). *Aduto* is supposedly intruding a foreign object into the body through the use of magical powers. I watched on two occasions how a herbalist removed the alleged intruded object. When the spot where the object was believed to be hiding has been identified, the healer asked that a cut be made on the spot. Blood was oozing out from the spot, and the healer drew out the blood with his mouth. In the process the object came out. Normally two or more cuts were made on the patient, depending on the severity of the case. During this treatment procedure the AIDS virus could be

easily passed on to each other. This healer knew that AIDS could be only contracted through sexual intercourse with a prostitute.

Like the patients, most of the healers believed that at the moment AIDS has no cure. While most of them stated that AIDS is a new kind of illness whose actual nature has not been identified, some of them stressed that they would not accept any persons with AIDS among their patients for fear of contracting AIDS themselves. On the contrary, some of the healers (all of them were priest healers) believed they could successfully cure someone with AIDS. Probably these priest healers have strong faith in the abilities of their shrines to help them treat persons with AIDS. They were all general in their treatment approaches (combining different kinds of herbs), except one. The healer who gave the details of his treatment procedures regarded AIDS as a severe type of gonorrhoea. He believed he could treat persons with AIDS through this preparation:

> Grind and boil the root barks of *konkroma* (morinda lucida) and mango, and peppers (small sizes). Drink the preparation.

This particular healer had not even tried this arboreal preparation on anyone, but he claimed that he could successfully cure persons with AIDS. This kind of claim tends to discount the generally held belief that a cure for AIDS is not imminent. In addition, the gravity of the AIDS epidemic is trivialized with this claim. It must be recognized that the healers generally lack information about the nature of AIDS. These healers are mainly illiterates, and it is expected that they do not benefit much from the posters and the booklets explaining the nature of AIDS. It has been already stated that some nurses from the Holy Family Hospital go to the churches and explain the nature of AIDS to the congregation. Most of these healers are traditionalists who do not go to church. Passing AIDS information through the churches seems to be limited in scope, since it covers only churchgoers. The role of the media in sensationalizing reports that a cure for AIDS exists in Ghana may also account for the claims by

some healers that they can cure AIDS patients.

Generally, the perceptions of the nature of AIDS and the knowledge of the transmission of the AIDS virus influence people's methods they adopt to confront it. I have already stated that the majority of the healers regarded sexual transmission as the main mode of transmission of the AIDS virus. In the same vein, the majority of them cited the change in sexual behaviour as the main measure to help prevent the spread of the AIDS virus. The sexual transmission of the AIDS virus could be prevented through having a faithful sexual relationship, refraining from indiscriminate sex and prohibiting prostitution. The first two factors involve a change in attitude towards people's sexual behaviour, especially sexual partners making commitment to be faithful to each other. On the third factor, while it may be plausible to prohibit prostitution, I do not think that may be practicable. The official pronouncement may ban it, but prostitutes will continue to operate so long as there are willing clients who are prepared to solicit their services. In addition, only a few people engaged in prostitution are officially recognized as prostitutes. In Ghana only the people who have registered with the state to engage in prostitution are usually called prostitutes. Banning prostitution in Ghana will affect only the officially recognized ones. Certainly prostitution is one of the important ways the AIDS virus is sexually transmitted. It needs a commitment from people to generally change their sexual behaviour to prevent AIDS infection. Apart from preventing the sexual transmission of the AIDS virus, the healers also cited other ways of preventing AIDS infection; namely, leading morally good life, avoiding eating with persons with AIDS and avoiding sharing towel with persons with AIDS.

The extent of consensus among the Moslem healers was higher than the other types of healers. However, consensus was evident among all healers of the same kind. Most healers mentioned a change in sexual behaviour as the major means to prevent

AIDS infection. This is not surprising because much more effort has been put into explaining the nature of AIDS in Ghana than the old illnesses.

NURSES' KNOWLEDGE ABOUT AIDS

All the nurses had heard of AIDS, and the general description of AIDS and the means of identifying persons with AIDS indicated that they were reasonably well-informed about AIDS. They indicated that AIDS destroys the body's ability to fight diseases, and thereby killing its victims gradually. In other words, HIV destroys the body's immune system. Unlike some of the patients and the healers, they did not recognize the existence of a cure for AIDS.

The high level of AIDS awareness among the nurses became evident when they identified nine signs related to AIDS. The presence of some or all of these signs may indicate the presence of the AIDS virus in the body. These signs are: weight loss, severe headache, a feeling of tiredness all the time, shingles, continuous diarrhoea, continuous fever, vomiting, dry cough and painless swellings. Despite this fairly accurate description of AIDS, and identifying some signs of the presence of AIDS virus in the body, it is not enough to use these symptoms to identify persons with AIDS. Those persons with AIDS who have most of these symptoms are those who already have "full-blown" AIDS. Some people who have initially contracted the virus may not show any of these signs. The best way to identify persons with AIDS is through the HIV test. A negative result to the test normally indicates that the virus is not present. However, a negative test does not necesarrily mean that someone is free from the infection (Richardson:1987). If someone were tested shortly after being infected the test would be negative. The presence of some of these symptoms may not necessarily mean the person has the infection. At the Berekum Holy Family Hospital the doctors

suspected that 138 people had the infection because of the presence of some of these symptoms, but only 59 were tested positive.

The majority of the nurses first heard of AIDS on the national radio. Some of them also heard of AIDS through a health magazine and television. I have already indicated that the first clinical cases of AIDS were reported in Ghana in September 1986. It is interesting to note that none of the nurses had heard of AIDS prior to 1986. Perhaps, the delay by the Ghanaian authorities in accepting the presence of AIDS in Ghana may have influenced this. Most of them first heard of AIDS in 1986, while some of them also heard of it in 1987.

All the nurses regarded sexual intercourse with an infected person as the main means by which the AIDS virus is transmitted. All of them also recognized blood transfusion and the use of unsterilized instruments as the other possible ways the AIDS virus could be contracted. Here, there is more evidence of consensus among the nurses in the explanations they provided for the main and other causes of AIDS. Among some possible ways in which the AIDS virus could be contracted, the nurses recognized perinatal transmission, insect bites, toilet seats, casual contact and kissing. Earlier in this chapter I stated that some of the patients first heard of AIDS through these nurses who went to the various churches in Berekum to explain the nature of AIDS to the congregation. This is an indication that nurses have been disseminators of AIDS information in Berekum. There is a very high level of AIDS awareness among the nurses. However, it must be stressed that insect, toilet seats, casual contact and kissing do not spread the AIDS virus.

A fairly accurate description of the methods to prevent the transmission of the AIDS virus points to the fact that the nurses were well-informed. They cited the use of condoms, screened blood, the use of sterilized instruments, having a faithful sexual

relationship, reduction in the number of sexual partners, avoiding casual contact with persons with AIDS and avoiding sex with certain groups as some of the most effective ways to prevent the AIDS infection. While casual contact with persons with AIDS does not spread the AIDS virus, the reduction in the number of sexual partners and avoiding sex with certain groups may not be enough guarantee to prevent the AIDS infection. Most of the protective ways the nurses cited here are related to a change in sexual behaviour. The extent of consensus among the nurses here is also high.

OTHER INFORMANTS' KNOWLEDGE ABOUT AIDS

In the previous sections, I examined the general perceptions of the nature of AIDS and its alleged relationship with the old illnesses. I further assessed how these perceptions of AIDS could influence the AIDS education programme in Ghana. I solicited the views of the informants (patients, healers and nurses) through formal interviews. In this section, I analyse the extent of other informants' (prostitutes and youth gang) knowledge about AIDS and how the HIV is transmitted. I also examine their knowledge about the preventive measures against AIDS. I acquired the information from these informants through informal talks and discussions rather than through interviews. I deem it significant to solicit information about AIDS from some prostitutes and some members of a youth gang for several reasons. Despite the biased sample size covering mainly prostitutes, it is important to note that 63 out of the 72 seropositives in Ghana in September 1986 were prostitutes (Neequaye et al:1986). Prostitution seems to be one of the effective ways in spreading the AIDS virus in Africa. This is important because multiple partner sex may increase the risk of contracting the AIDS virus. The use of intravenous drugs is generally not common in Ghana. However, a youth gang which operates in the Zongo section in Berekum is noted for the use of illicit drugs, especially marijuana. The sharing of needles and

syringes is one of the effective ways by which the AIDS virus is spread. My interest in the members of the youth gang is to examine the extent of intravenous drug use among them. Both the prostitutes and members of the youth gang live in the Zongo. This is a suburb of Berekum mostly populated by non-indigenous inhabitants, who are also non-Akans, and usually affiliated to the Islamic religion. However, all the prostitutes and some members of the youth gang are apostates.

Prostitutes and AIDS

The prostitutes are easily identifiable as they sit in front of their rooms waiting for their clients. They are mostly illiterates, whose ages range between 30 and 45 years. None of them is a Brong; they are affiliated to the Krobo and Banda tribal groups. Prostitution is the only occupation among them since they operate both day and night. Most of them first heard of AIDS on the national radio, while some of them heard of AIDS from some friends practising prostitution in Abidjan who occasionally come to Ghana. The prostitutes heard of AIDS later than the patients, healers and nurses. Most of them heard of AIDS not more than three years ago (that is, not prior to 1987). Physical emaciation (leanness) is the only visible clinical manifestation associated with AIDS these prostitutes recognized.

The prostitutes recognized sexual transmission as the only way AIDS virus could be transmitted. Consequently, they regarded the use of condoms as the only way to prevent the spread of the AIDS virus. The use of condoms is not a new phenomenon to the prostitutes; they have been using condoms to protect themselves against sexually transmitted diseases. However, now they see it as a necessity to protect their lives. Despite the recognition that AIDS has no cure, the the prostitutes feel they have been able to cope with venereal diseases, and they can similarly survive the AIDS epidemic. The greatest threat AIDS poses to these prostitutes is that they have recognized a

decline in the number of their clients when AIDS was publicized in Ghana. This has drastically reduced their incomes.

Youth Gang and AIDS

All the members of the youth gang live in the Zongo. Their ages range between 20 and 37 years. Unlike the prostitutes, they are literates, and have completed elementary school in Ghana. They are affiliated to the Banda, Brong and Moshi tribal groups. The majority of them are Moslems, with a few apostates. Smoking marijuana seems to be the unifying force for this gang. They are mostly unemployed, and engaged in gambling. They intensify their gambling activities on market days (that is, Thursdays). On these days people from different parts of Ghana converge on Berekum. There have been several occasions where they have had violent confrontations with the police. Yet, the group still persists, and now money-trafficking is another lucrative activity for most of them. All these activities make them a very strong and unified force. Like the prostitutes, all of them have heard of AIDS. Most of them first heard of AIDS on the national radio about two years ago. They regard AIDS as a sexually transmitted disease which has no cure, and could be only prevented by a change in sexual behaviour, especially sex with prostitutes. While they admit that they use drugs, they believe none of them uses intravenous drugs.

It is seen that both the prostitutes and the members of the youth gang are less-informed about AIDS. Prostitutes, who are generally regarded as a high risk group, know very little about AIDS. The situation becomes even more grave when AIDS is regarded as a type of venereal disease. Generally, all the informants (patients, healers, nurses, prostitutes and youth) have some knowledge about AIDS. It seems AIDS education in Ghana has raised people's awareness of AIDS. In order to expand the AIDS education programme in Ghana to cover the rural areas, disseminators of AIDS

information should use churches/mosques, schools and other social organizations in these areas. The local radio stations in different parts of Ghana could be helpful in this. Not much use is made of the local radio station in Berekum; during the research period, the programmes of the radio station never included AIDS education.

CHAPTER VII

SUMMARY AND CONCLUSION

In trying to understand how Ghanaians respond to afflictions and misfortunes, medical sociologists tend to emphasize the etiological explanations Ghanaians provide for afflictions. Ironically, this has been the area where divergent research findings have been pervasive. The literature on etiological explanations of illness in Ghana can be broadly divided into two; a body of literature which attests to the primacy of spiritualistic explanations among Ghanaians, and the other which suggests that naturalistic explanations are equally important or even more pronounced among Ghanaians. The former bases its assumption on two basic things. First, it is believed that modern theories of health have not affected the traditional Ghanaian social structures in any significant way. The traditional belief system still predominates, and therefore ideas about disease causation are sought in the realm of supernatural agencies. The second factor is related to the unequal distribution of medical facilities and doctors in Ghana. The majority of the doctors in Ghana are stationed in the cities (Accra, Kumasi and Sekondi-Takoradi). Similarly, the medical facilities are mainly concentrated in the cities.

The premise is that the majority of Ghanaians live in the rural areas, and do not have access to the urban-oriented health care system. The financial constraint on the government makes the extension of the health care facilities to cover the rural population a remote possibility at this stage. The writers who attest to the primacy of spiritualistic explanations of illness among Ghanaians believe the potentiality of traditional medical practice lies in the supernatural assumptions underlying its practice, and the rural populations who patronize, share the same spiritualistic explanations as the healers. In sum, they try to reconstruct a relatively stable and static Ghanaian

traditional society which has not been influenced by the momentous rapid and radical social changes taking place. The writers who suggest that naturalistic explanations are more pronounced among Ghanaians stress that modernization and secularization have significantly eroded spiritualistic etiological explanations of illness.

Thus, the emphasis on etiological explanations of illness, has resulted in giving little attention to some equally important aspects of medical sociology in Ghana; namely, changes taking place in traditional medical practice, how individuals choose and evaluate therapies, the hierarchy of resort and how the traditional healers also respond to their own illnesses. By giving little attention to these key issues inadequate perception of the nature of medical sociology in Ghana is given. The result is that governments give lip-service to the practitioners of traditional medicine, and this impedes the future development of traditional medicine in Ghana. However, the establishment of the Centre for Scientific Research into Plant Medicine in Ghana indicates the government may recognize the development of plant medicine, and may make health care available to the majority of Ghanaians.

The examination of the etiological explanations provided for illnesses by laypersons in Berekum depicts emphasis on natural factors. The emphasis on naturalistic etiological explanations provided for illnesses in general, specific illnesses and experienced illness follows a similar pattern. Our informants believe most illnesses are naturally caused. Some of these naturally caused illnesses are headache, diarrhoea, malaria, stomach pains, waist pains, sore, cut, rheumatism, measles, bodily pains, piles and eye problems. They think these are familiar afflictions which are quickly treated, and their treatment procedures are physically applied.

Despite the emphasis on naturalistic explanations of illness, they believe under certain circumstances some afflictions like epilepsy, typhoid, malaria, barrenness, severe

stomach pains and chicken pox may be spiritually inspired. The social context of illness (especially its mysterious nature) and the invalid's response to treatment are significant in etiological explanations of illness. For illnesses in general the informants do not seem to operate with a fixed system of illness classification.

The emphasis on naturalistic etiological explanations becomes clearly identified with specific illnesses. Here, illnesses like *abunu, ayamtuo, dam, twa, babaso* and *bonini* are explained as naturally caused. Among the naturalistic causal factors of specific illnesses are mosquito bites, hot weather, food related problems, the use of drugs, brain damage, convulsion, worms, sexual intercourse, menstrual problems, abortion and venereal diseases. Some informants believe some spiritual factors like witchcraft, devilish practices, envy, curse, wrongdoing, competition, magic and 'same name' may in some ways influence some of these illnesses. The majority of our informants believe *kotewui/kotekra* is spiritually caused.

One interesting feature of the causal explanations provided for the specific illnesses is that when the informants seem to have exhausted all their explanatory accounts, and are groping for other possibilities, they tend to emphasize spiritualistic factors. Consensus is more evident in the explanations the informants provide for *abunu, ayamtuo, dam, twa,* and *babaso.* The majority of the informants regard mosquito bites as the main cause of *abunu,* while it is believed food related problems are the main cause of *ayamtuo.* The most frequently mentioned cause of *dam* is the use of drugs. Most informants agree that convulsion and sexual intercourse with affected persons are the main causes of *twa* and *babaso* respectively. Consensus is weak for the explanations provided for *bonini* and *kotewui/kotekra,* where the stress is on menstrual problems, abortion and envy/hatred.

The informants do not seem to know much about their own illnesses. Those who are able to provide explanations for their illnesses resort only to natural factors. Some of these illnesses are piles, malaria, hernia, burns, asthma, miscarriage, broken leg, hypertension and rheumatism. They believe these illnesses may be caused by insect bites, problems related to food, physical injury and malfunctioning of the body. The treatment of the previous illnesses follows a hierarchy, the first choice is scientific medical treatment, followed by self-treatment, while herbal treatment and faith healing follow in that order. Here also, the emphasis on naturalistic explanations is very marked. Some of their present illnesses are barrenness, madness, impotence, jaundice, poverty, hernia, diabetes, hypertension, abdominal pains and snake bite. Among the explanations provided for these afflictions are hot weather, lorry accident, malfunctioning of the body, family disagreement, bad water, curse and peppery food.

The informants encounter different types of therapies in their effort to find a cure for their afflictions. However, most of them first consult scientific medical practioners, and when all things have been tried and failed, they then consult the practitioners of herbal treatment (comprising herbalists, Moslem healers and priest healers) as the last resort. A shift from one type of therapy to another is mainly due to the dissatisfaction with the services provided. This finding in Berekum about laypersons' emphasis on naturalistic explanations of illness lends support to the literature which stresses that emphasis on naturalistic explanations of illness is more pronounced among Ghanaians.

The healers in Berekum also stress naturalistic etiological explanations of illness. They regard general and specific illnesses as naturally caused. This is significant because the impression is created that traditional healers generally resort to spiritualistic explanations. Some of the illnesses believed to be spiritually inspired under certain circumstances are impotence/sterility, turgidity, barrenness and epilepsy. Among

such situations or circumstances which may cause these illnesses are violation of some taboos, the response to treatment, curse and shirking from responsibility. There have been some occasions where deaths resulting from lorry accidents have been attributed to the activities of witches. In such cases not only the agent involved in the cause of the afflictions are considered, but also the ultimate causes. The healers also do not seem to operate with a fixed system of illness classification, both naturalistic and spiritualistic explanations are complementary, and not mutually exclusive.

Most healers regard malaria, headache, hernia, piles, waist pains, rheumatism and guinea worm as naturally caused. Some of the factors that may cause these illnesses are excessive exposure to heat or cold, food related problems, too much work and insect bites. It is believed that sick persons respond quickly and positively to physical treatment. Another important feature about the healers' explanations of illnesses in Berekum is the influence of the geographical distribution of illnesses. Guinea worm is concentrated in the Koraso and Mpatasie areas. Among the residents of these areas guinea worm is regarded as naturally caused because it is common and familiar there. Illnesses that do not occur under any extraordinary circumstances are regarded as naturally caused.

The emphasis on naturalistic etiological explanations of both *abunu* and *ayamtuo* is very marked. All the healers regard the main causes of *abunu* and *ayamtuo* in natural terms. Some of the main causes of *abunu* and *ayamtuo* are weather, mosquito bites, excessive drinking, food related problems and bad water.

The healers' preference for naturalistic explanations of illness is further reflected in the etiological explantions provided for *twa*, *babaso* and *bonini*. The causal explanations cited for *twa* are convulsion, wrongdoing, 'in person at birth', phlegm in stomach and evil spirit. Most healers believe *babaso* is mainly contracted through sexual

intercourse with an affected person. For *bonini*, they believe it is caused by such factors as menstrual problems, abortion, envy, wrongdoing and witchcraft.

On the contrary, the healers regard *dam* and *kotewui/kotekra* as spiritually-inspired illnesses. The main causal explanations provided for *dam* are the use of drugs, wrongdoing, envy, malaria and evil spirit. It is also believed that *kotewui/kotekra* may be caused by envy/hatred, wrongdoing, weak penis, weak sperms, witchcraft, magic and 'in person at birth'.

Consensus is more evident in the explanations of *abunu, ayamtuo, babaso* and *bonini* by the priest healers. Most of them point to hot weather and food related problems as the main causes of *abunu* and *ayamtuo* respectively. The priest healers point to sexual intercourse with affected person and menstrual problems as the most usual causes of *babaso* and *bonini* respectively. However, consensus on the etiological explanations of *twa, dam* and *kotewui/kotekra* is very weak. The lack of consensus becomes even more pronounced when the healers resort to secondary or less important causes of afflictions.

The extent of consensus among the herbalists is higher than that of the priest healers. Consensus is even more evident in the explanations of *babaso, bonini, twa* and *ayamtuo*. All the herbalists point to sexual intercourse and menstrual problems as the main causes of *babaso* and *bonini* respectively. Convulsion is also the most frequently mentioned main cause of *twa,* while hot weather and mosquitoes constitute the major explanations provided for *abunu*. The herbalists also believe some people have *ayamtuo* at birth. Consensus among the herbalists is weak for the explanations provided for *dam*. Lack of consensus becomes even more pronounced in the explanations provided for *kotewui/kotekra*.

Generally, there is evidence of more consensus among the spiritual healers than the other healers. Consensus is higher for the explanations provided for *abunu, ayamtuo, twa, dam* and *babaso*. However, consensus is less evident in the explanations of *bonini* and *kotewui/kotekra.*

Apart from *bonini* and *babaso* where all the Moslem healers regard menstrual problems and sexual intercourse respectively as the main causes, there is lack of consensus on the etiological explanations provided for the other types of illnesses. Here, each healer cites different causes for these illnesses.

The extent of consensus in the healers' explanations of illness in Berekum is rather surprising. There is generally a low level of professional interaction among them. Some of the healers pursue personal fame, and are therefore preoccupied with their work alone. Despite the existence of Berekum Traditional Healers' Association, the traditional healers in Berekum do not form a cohesive group. However, the high level of consensus among them in their explanations of illness may indicate that the re-organization of the association where it will play a meaningful role, may lead to regaining some lost systemic attributes in future. Conspicuously absent from the etiological explanations of illness in Berekum is the role of ancestors in illness causation. The literature on Ghana is replete with references to ancestors as custodians of morality. The ancestors are believed to be in *asamando* (the world of ancestral spirits), and constantly watching over the living relations, and punishing those who breach customs (Warren:1973). Assimeng (1981) also stressed that ancestors are the principal upholders of the socio-moral order, and the propriety of social conduct is measured in terms of how such behaviour would please or hurt them. While Nukunya et al (1976) stated that ancestors punish victims who have violated accepted kinship or family ideas, Brautigam et al (1979) also stressed that unseemly behaviour towards one's ancestors means a possible visitation by some vindictive spirit to inflict illness.

Having stressed the role of *nananom nsamanfo* (ancestors) in the upkeep of the moral order, Opoku (1982) indicated that Christianity and Islam among the Akan have come to supplement and not to replace Akan traditional beliefs and practices. These studies suggest that immoral behaviour incurs the displeasure of the ancestors, who in turn punish the offenders by inflicting illnesses on them. This conception suggests that wrongdoing is a mechanism in itself which leads to illness.

In Berekum it is recognized that not all types of wrongdoing could cause illness. For example, sex with someone else's partner is regarded as an inappropriate conduct. However, if the affected person does not see it in order to take appropriate action, it is believed that the culprit will not be afflicted. If the ancestors, as custodians of morality, punish those who breach customs, then wrongdoing will be automatically followed by punishment. The aggrieved person normally consults a medium or sorcerer who in turn will use some magical powers to inflict illness on the offender. The same principle works with curse. Wrongdoing accompanied by a curse is believed to cause affliction. It is significant to point out that in Berekum immoral practices may cause illness.

How then do we explain such factors as evil spirit, envy/hatred, disagreement, witchcraft, 'same name', competition and the use of magic as the causes of some illnesses? These factors may not necessarily involve wrongdoing or inappropriate behaviour. A witch may inflict illness on his/her victim because of greed or envy/hatred. It is even believed that the victims of the witches are their close relatives they love much, who may have not necessarily committed any offence. Witchcraft can be used for beneficial purposes, *bayi pa*, as well as injurious purposes, *bayi boro* (Opoku:1982). *Bayi boro* are said to be destructive, and they destroy things and persons very precious. This may explain why they inflict illnesses on loved ones or even kill them. Perhaps it is easier to 'capture the soul' of a loved one than others.

Most healers in Berekum acknowledge that they are witches, but emphasize that they have *bayi pa*. They claim to use their witchery to protect human beings who fall prey to *bayi boro*. Some believe if you propose love to a lady, and she turns it down, it is enough to justify inflicting an illness like gonorrhoea on her. Also, persons of the same name may be equally afflicted by the use of some magical powers.

The explanations provided for illnesses in Berekum also include such natural factors as weather, food, insects, carelessness, heredity and others. These factors are regarded as morally neutral, and not due to morally inappropriate conduct. It is important to stress that in the context of morality in Berekum, individuals have little control over the conditions that may lead to spiritually-caused illness. Appropriate conduct, while preferable, may not be enough since wrongdoing is among a myriad of factors that may cause spiritual illness in Berekum.

Broadly, the treatment of illness in Berekum is divided into three; scientific, herbal and faith healing. The Holy Family Hospital dominates scientific medical treatment in Berekum. The subvention it receives from the government accounts for more than one-half of the hospital's annual income. In addition to offering inpatient/outpatient services, the hospital is also involved in outreach curative and preventive services. The District Health Service comprises Ministry of Health, Catholic Mission, private and community health workers and traditional birth attendants.

The activities of the Holy Family Hospital have overshadowed both the private and public clinics and the homoeopathic clinic in Berekum. These clinics lack the infrastructure to treat serious illnesses, and therefore refer serious cases to the hospital. They continue to function because generally they charge less in treating less serious illnesses than the hospital. They are also time-saving since an individual patient passes through few bureaucratic bottlenecks.

There are other purveyors of western medicinal drugs without any formal training. These drug pedlars deal in drugs bought from pharmacy/drug stores. They make drugs accessible to many people in the outlying towns and villages in Berekum every week. Generally, these pedlars treat minor illnesses. Some of them give injections illegally in the remote areas.

Herbal treatment in Berekum is mainly conducted by priest healers, herbalists, Moslem healers and other purveyors of African medicine. Priest healers normally go through a long period of training, and during this period they adhere to strict taboos, and learn the names and uses of herbs. In addition, the priest healers have shrines which are mainly family-owned, and the shrines usually persist for some years. The most distinctive feature about the priest healers is that they use white clay as bodily marking. The herbalists, on the other hand, have a shorter period of training than the priest healers; usually they learn from their parents without going through any formal training. They practise in their own houses, and generally do not have extra spaces to accommodate many patients. The practices of the Moslem healers are similar to the herbalists, except that they claim to derive some spiritual powers from the Koran.

The emphasis on naturalistic explanations of illness reflects the emphasis on naturalistic approaches to the treatment of illnesses in Berekum. The availability of different species of medicinal plants in the immediate environs makes it easier for the healers in Berekum to use roots, barks, stems/twigs and leaves of trees. The same plant species may be used to cure different illnesses. In Berekum some of these medicinal plants are ground, crushed/squeezed or macerated in water. Depending on the type of illness, the preparation may be used for enema, bathing, or taken orally; while others are put in the eyes, ears or nostrils. The healers normally recite some incantations over the preparation before administering it to a patient.

The other purveyors of African medicine in Berekum are the itinerant herbalists, bone-setters and traditional birth attendants. The itinerant herbalists go round and sell the medicines they have prepared themselves. They are normally seen on market days in Berekum. These healers are generally regarded as amateur practitioners, and usually treat less serious illnesses. Some of them get settled down and establish a reputation. Bone-setting is one area where traditional healers in Berekum have had a lot of co-operation from the local hospital. Occasionally, patients from the hospital are referred to some of these bone-setters for treatment. They prepare a herbal concoction and smear it over the the affected part, and bandage it. Traditional birth attendants also use herbs in treating their patients. When an affliction is believed to be spiritually caused the traditional healers usually supplement the herbal preparation with the performance of some rituals.

Faith healing in Berekum is mainly done by the indigenous African Christian churches. The healing is usually done at the premises of these churches. In the process of healing, Florida water, ordinary water, lavender and candles are used to apply to the affected part where appropriate. Some of the spiritual healers also use some arboreal preparations.

In the event of illness the invalids in Berekum have different therapeutic options to choose from. The quality of treatment is important in the individual's choice of therapy. Some patients move from one healer to another in order to get good treatment. Some people also switch from one treatment or healer to another if they are not positively responding to treatment. One healer switched from the Holy Family Hospital to Sunyani General Hospital because he was dissatisfied with the quality of the treatment. In addition, the social and financial cost are influential in the choice of therapy. Depending on the type of illness and the explanation provided, some people may prefer to patronize a specific kind of treatment. It must be stressed that none of

the factors standing alone can adequately explain the choice and evaluation of therapies in Berekum. When all these factors are weighed, scientific medicine usually becomes the first choice, and when that fails they then resort to the other therapies.

All the patients have heard of AIDS. Despite the generally held belief that AIDS is a new kind of illness, some have incorporated AIDS into the old illness knowledge. Another perception of AIDS is that it is contagious, and its patients should be isolated. Some of them also believe AIDS is contracted through sexual intercourse only. Physical emaciation, vomiting, dry cough, continuous diarrhoea and shingles are some signs of a person they believe may have contracted the AIDS virus. Most informants heard of AIDS on the national radio. All the informants cited sexual transmission as the main cause of AIDS, and here, the consensus among the informants is striking. They believe that AIDS may be contracted through the use of unsterilized instruments, blood transfusion, perinatal transmission and the use of contaminated blades. Most informants believe AIDS is incurable. However, some believe Kwaku Firi shrine can treat persons with AIDS. They regard change in sexual behaviour as the best way to prevent the transmission of the AIDS virus.

All the healers have also heard of AIDS, but they are less-informed about AIDS than the patients. Some of them believe physical emaciation, continuous diarrhoea, yellowish urine, and swelling feet are clinical manifestations of AIDS. The majority of the healers regard sexual transmission as the main cause of AIDS. Most of them also believe a change in sexual behaviour is the best way to help prevent the spread of the AIDS virus. Some of the healers believe they can treat persons with AIDS.

All the nurses have heard of AIDS, and they seem to be well-informed about AIDS. The high level of AIDS awareness among them is reflected in the identification of most signs related to AIDS. They regard sexual transmission with an affected

person as the main means by which the AIDS virus is transmitted. All of them regard blood transfusion and the use of unsterilized instruments as some of the ways the AIDS virus may be contracted. There is more evidence of consensus among the nurses in the explanations they provide for the main causes and other causes of AIDS. They point to the use of sterilized instruments as some of the most effective ways to prevent AIDS infection. They also believe AIDS is incurable.

All the prostitutes have heard of AIDS, but do not know much about it. They recognize physical emaciation as the only visible clinical manifestation associated with AIDS. They also regard sexual transmission as the only way the AIDS virus may be transmitted, while the use of condoms helps to prevent the spread of AIDS virus. Members of the youth gang regard AIDS as a sexually transmitted disease which has no cure, and may be prevented by a change in sexual behaviour, especially with prostitutes.

CONCLUSION

The emphasis on naturalistic explanations of illness in Berekum offers a promise of assessing the perceived contribution of traditional medicine towards the implementation of a comprehensive health care system in Ghana. The World Health Organization has given recognition to the role played by traditional medicine in the Primary Health Care programmes in the developing countries. It seems this is advantageous for several reasons.

First, developing a health care system in the rural areas that takes into account the culture of the people seems to be viable. The local manpower and natural resources are tapped. The Centre for Scientific Research into Plant Medicine in Ghana would be responsible for testing the efficacy of plant medicine.

Second, the government's active participation in the development of plant medicine will help reduce quackery and wrong application of plant medicine. In addition, funds may be available to the healers through the healers' associations to expand their practices. This is significant because some traditional healers in Ghana have labelled and put their medicines in bottles.

Third, the healers in Berekum emphasize naturalistic treatment procedures. It may be helpful to design a programme that will augment the knowledge and skills of the healers, and to bring about closer co-operation and understanding between indigenous healers and western-oriented health care workers. One such programme (Warren et al:1982) was designed for 60 healers in Techiman. The pilot training programme covered some topics like hygienic preparation and preservation of medicinal plants, sources of typhoid infection, basic first aid and weaning food. The healers supported the programme from its inception, and some healers who were not included in the programme were asking to be included in future training programmes.

The study examines people's explanations of illnesses and their response to them in Berekum in order to help assess the future role of traditional medicine in Ghana. It is suggested that some areas need further research. First, the attitudes of medical doctors and traditional healers towards such future co-operation need further research. Asuni (1979) objects to the integration of traditional healers into the Nigerian modern health care system because he believes herbalists lack any knowledge of the effects their potions may have on their patients. On the part of the healers, will their power base be eroded? Will the healers be interested in the training programmes? Second, most healers are illiterates, and cannot have written records of patients, their complaints and the effects of the treatment. They are also generally old. Can we get young literates to replace them? How can the young be motivated to practise herbalism? Third, healing is a part-time profession for most healers. In Berekum most

of the healers are also actively engaged in farming. How will they be remunerated to sustain their interest as full-time professionals? Which categories of healers should be included in the programme? Further research in these areas will help delineate some basic problems to be encountered by involving traditional medical practitioners in a comprehensive health care programme in Ghana.

The general perceptions of the nature of AIDS by our informants indicate there is a high level of AIDS awareness among them. The AIDS programme in Ghana seems to be partly responsible for this. AIDS has received more publicity in Ghana than any other types of illness. However, one potential problem in Ghana is the belief by some people that AIDS is curable. The media has sensationalized news about the claim by a traditional healer who believes he can cure persons with AIDS. The local education programme to raise people's awareness of AIDS may be improved if local institutions and groups actively involve themselves in the dissemination of AIDS information in the rural areas. The local radio stations in the districts can include AIDS education in their programmes. Public meetings, where people can exchange ideas about AIDS, may be helpful.

APPENDIX A

FREQUENCY TABLES

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF INFORMANTS

LAYPERSONS

TABLE 1: SEX

SEX	NO.	%
Male	24	54.6
Female	20	45.4
TOTAL	44	100.0

TABLE 2: AGE

AGE	MALE	FEMALE	TOTAL	%
15-25	1	1	2	4.6
26-36	12	15	27	61.3
37-47	6	4	10	22.7
48-58	3	0	3	6.8
59-69	2	0	2	4.6
TOTAL	24	20	44	100.0

TABLE 3: LEVEL OF EDUCATION

LEVEL	MALE	FEMALE	TOT.	%
Illiterate	7	5	12	27.2
Elementary	10	7	17	38.6
Commercial	1	1	2	4.6
Technical	1	1	2	4.6
School Certificate	2	2	4	9.0
'A'4-year	0	3	3	6.8
'A' Post-Secondary	1	0	1	2.3
Diploma	1	0	1	2.3
University	1	1	2	4.6
TOTAL	24	20	44	100.0

TABLE 4: RELIGIOUS AFFILIATION

RELIGION	MALE	FEMALE	TOTAL	%
Orthodox	11	13	24	54.5
Traditional	5	2	7	15.9
Spiritual	4	2	6	13.6
Pentecostal	2	3	5	11.4
Islam	2	0	2	4.6
TOTAL	24	20	44	100.0

TABLE 5: TRIBAL AFFILIATION

TRIBE	MALE	FEMALE	TOTAL	%
Brong	15	16	31	70.45
Ashanti	4	2	6	13.64
Moshi	1	0	1	2.27
Kusasi	0	1	1	2.27
Fanti	1	0	1	2.27
Akim	1	0	1	2.27
Dagarti	1	0	1	2.27
Ga	0	1	1	2.27
Dagomba	1	0	1	2.27
TOTAL	24	20	44	100.00

TABLE 6: MARITAL STATUS

STATUS	MALE	FEMALE	TOTAL	%
Married	21	16	37	84.1
Single	3	3	6	13.6
Divorced	0	1	1	2.3
TOTAL	24	20	44	100.0

TABLE 7: REGION OF BIRTH

REGION	MALE	FEMALE	TOTAL	%
Brong Ahafo	16	18	34	77.2
Ashanti	4	0	4	9.1
Northern	2	1	3	6.8
Eastern	1	0	1	2.3
Central	1	0	1	2.3
Greater Accra	0	1	1	2.3
TOTAL	24	20	44	100.0

TABLE 8: PREVIOUS OCCUPATION

OCCUPATION	MALE	FEMALE	TOTAL	%
Unemployed	8	7	15	34.1
Farming	2	5	7	15.9
Labourer	4	3	7	15.9
Teaching	2	2	4	9.0
Trading	0	2	2	4.5
Driving	2	0	2	4.5
Steel Bender	1	0	1	2.3
Masonry	1	0	1	2.3
Sewing	0	1	1	2.3
Storekeeping	1	0	1	2.3
Farming/Driving	1	0	1	2.3
Purchasing Clerk	1	0	1	2.3
Druggist	1	0	1	2.3
TOTAL	24	20	44	100.0

TABLE 9: PRESENT OCCUPATION

OCCUPATION	MALE	FEMALE	TOTAL	%
Farming	8	4	12	27.1
Teaching	2	5	7	15.9
Trading	0	7	7	15.9
Sewing	1	1	2	4.5
Typing	1	1	2	4.5
Labourer	1	1	2	4.5
Student	1	0	1	2.3
Steel Bender	1	0	1	2.3
Masonry	1	0	1	2.3
Police	1	0	1	2.3
Lottery Agent	1	0	1	2.3
Export Manager	1	0	1	2.3
Watchman	1	0	1	2.3
Fitting	1	0	1	2.3
Civil Defence	1	0	1	2.3
Electrician	1	0	1	2.3
Accountancy	1	0	1	2.3
Unemployed	0	1	1	2.3
TOTAL	24	20	44	100.0

NURSES

TABLE 10: SEX

SEX	NO.	%
Female	4	80.0
Male	1	20.0
TOTAL	5	100.0

TABLE 11: AGE

AGE	MALE	FEMALE	TOTAL	%
26-36	1	2	3	60.0
37-47	0	2	2	40.0
TOTAL	1	4	5	100.0

TABLE 12: LEVEL OF EDUCATION

LEVEL	MALE	FEMALE	TOTAL	%
S.R.N *	1	1	2	40.0
Nursing College	0	1	1	20.0
S.R.N/Midwifery	0	2	2	40.0
TOTAL	1	4	5	100.0

(S.R.N *) State Registered Nurse

TABLE 13: RELIGIOUS AFFILIATION

RELIGION	MALE	FEMALE	TOTAL	%
Orthodox	0	4	4	80.0
Pentecostal	1	0	1	20.0
TOTAL	1	4	5	100.0

TABLE 14: TRIBAL AFFILIATION

TRIBE	MALE	FEMALE	TOTAL	%
Brong	0	3	3	60.0

Ashanti	0	1	1	20.0
Ewe	1	0	1	20.0
TOTAL	1	4	5	100.0

TABLE 15: MARITAL STATUS

STATUS	MALE	FEMALE	TOTAL	%
Married	1	1	2	40.0
Single	0	2	2	40.0
Widowed	0	1	1	20.0
TOTAL	1	4	5	100.0

TABLE 16: REGION OF BIRTH

REGION	MALE	FEMALE	TOTAL	%
Brong Ahafo	0	3	3	60.0
Ashanti	0	1	1	20.0
Volta	1	0	1	20.0
TOTAL	1	4	5	100.0

TABLE 17: PREVIOUS OCCUPATION

OCCUPATION	MALE	FEMALE	TOTAL	%
Trading	0	2	2	40.0
Unemployed	1	1	2	40.0
Teaching	0	1	1	20.0
TOTAL	1	4	5	100.0

TABLE 18: PRESENT OCCUPATION

OCCUPATION	MALE	FEMALE	TOTAL	%
Nursing	1	1	2	40.0
Nursing/Midwifery	0	2	2	40.0
Student	0	1	1	20.0
TOTAL	1	4	5	100.0

HEALERS

TABLE 19: SEX

HEALER	MALE	FEMALE	TOTAL	%
Priest Healers	6	3	9	47.3
Herbalists	2	2	4	21.1
Spiritual Healers	2	2	4	21.1
Moslem Healers	1	1	2	10.5
TOTAL	11	8	19	100.0

TABLE 20: AGE

AGE	MALE	FEMALE	TOTAL	%
13-34	1	0	1	5.3
35-56	3	4	7	36.8
57-78	4	3	7	36.8
79-100	3	1	4	21.1
TOTAL	11	8	19	100.0

TABLE 21: LEVEL OF EDUCATION

LEVEL	MALE	FEMALE	TOTAL	%
Illiterate	6	7	13	68.4
Primary School	2	0	2	10.5
Elementary School	3	1	4	21.1
TOTAL	11	8	19	100.0

TABLE 22: RELIGIOUS AFFILIATION

RELIGION	MALE	FEMALE	TOTAL	%
Traditional	7	4	11	57.9
Spiritual	2	2	4	21.1
Islam	1	1	2	10.5
Orthodox	1	1	2	10.5
TOTAL	11	8	19	100.0

TABLE 23: TRIBAL AFFILIATION

TRIBE	MALE	FEMALE	TOTAL	%
Brong	11	7	18	94.7
Fanti	0	1	1	5.3
TOTAL	11	8	19	100.0

TABLE 24: MARITAL STATUS

STATUS	MALE	FEMALE	TOTAL	%
Married	9	2	11	57.8
Divorced	2	2	4	21.1
Widowed	0	4	4	21.1
TOTAL	11	8	19	100.0

TABLE 25: REGION OF BIRTH

REGION	MALE	FEMALE	TOTAL	%
Brong Ahafo	11	7	18	94.7
Central	0	1	1	5.3
TOTAL	11	8	19	100.0

TABLE 26: PREVIOUS OCCUPATION

OCCUPATION	MALE	FEMALE	TOTAL	%
Farming	7	6	13	68.3
Nil	1	1	2	10.5
Driving	1	0	1	5.3
Pottery	0	1	1	5.3
Forestry	1	0	1	5.3
Teaching	1	0	1	5.3
TOTAL	11	8	19	100.0

TABLE 27: OTHER OCCUPATION

OCCUPATION	MALE	FEMALE	TOTAL	%
Farming	8	6	14	73.6
Nil	3	1	4	21.1
Pottery	0	1	1	5.3
TOTAL	11	8	19	100.0

TABLE 28: WHERE CAREER STARTED

PLACE	MALE	FEMALE	TOTAL	%
Brong Ahafo	9	7	16	84.2
Cote d'Ivoire	2	0	2	10.5
Central Region	0	1	1	5.3
TOTAL	11	8	19	100.0

TABLE 29: YEARS OF PRACTICE

YEARS	MALE	FEMALE	TOTAL	%
1-20	3	5	8	42.1
21-40	5	2	7	36.9
41-60	2	0	2	10.5
61-80	1	1	2	10.5
TOTAL	11	8	19	100.0

EXPLANATIONS OF ILLNESS IN GENERAL

LAYPERSONS

TABLE 30: SPIRITUAL CAUSATION

SPIRITUAL	MALE	FEMALE	TOTAL	%
Yes	4	3	7	15.9
No	20	17	37	84.1
TOTAL	24	20	44	100.0

TABLE 31: NATURAL CAUSATION

NATURAL	MALE	FEMALE	TOTAL	%
Yes	21	16	37	84.1
No	3	4	7	15.9
TOTAL	24	20	44	100.0

HEALERS

TABLE 32: SPIRITUAL CAUSATION

SPIRITUAL	MALE	FEMALE	TOTAL	%
Yes	6	2	8	42.1%
No	5	6	11	57.9%
TOTAL	11	8	19	100.0%

TABLE 33: NATURAL CAUSATION

NATURAL	MALE	FEMALE	TOTAL	%
Yes	10	7	17	89.5
No	1	1	2	10.5
TOTAL	11	8	19	100.0

EXPLANATIONS OF SPECIFIC ILLNESSES

PATIENTS (LAYPERSONS)

TABLE 34: MALARIA

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Mosquitoes	12	12	24	51.1
Hot Weather	7	5	12	25.5
Food Related Problems	5	1	6	12.8
Bad Water	1	1	2	4.3
Witchcraft	0	1	1	2.1
Anaemia	0	1	1	2.1
Constipation	0	1	1	2.1
TOTAL *	25	22	47	100.0
OTHER CAUSES				
Hot Weather	6	8	14	41.1
Mosquitoes	4	5	9	26.5
Food Related Problems	1	1	2	5.8
Bad Water	1	1	2	5.8
Witchcraft	1	1	2	5.8
Constipation	1	0	1	3.0
Lack of Fresh Air	1	0	1	3.0
High Body Temperature	0	1	1	3.0
Sorcery	0	1	1	3.0
The Devil	0	1	1	3.0
TOTAL *	15	19	34	100.0

* (The number of responses, and not the number of informants).

TABLE 35: DIARRHOEA

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Food Related Problems	13	14	27	58.7
Bad Water	10	6	16	34.8
Excessive Drinking	1	1	2	4.3
No Idea	1	0	1	2.2
TOTAL *	25	21	46	100.0
OTHER CAUSES				
Food Related Problems	9	9	18	47.4
Bad Water	3	3	6	15.8
Excessive Drinking	3	1	4	10.6
Sorcery	2	1	3	7.9
Witchcraft	2	1	3	7.9
Compilation of Illness	0	1	1	2.6
Curse	0	1	1	2.6
Stomach Pains	0	1	1	2.6
Wrongdoing	1	0	1	2.6
TOTAL *	20	18	38	100.0

TABLE 36: MADNESS

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Drugs	17	17	34	73.9
Brain Damage	2	2	4	8.7
Witchcraft	1	2	3	6.5
Worrying	1	1	2	4.4
Devilish Practices	2	0	2	4.4
No Idea	1	0	1	2.1
TOTAL *	24	22	46	100.0
OTHER CAUSES				
Drugs	9	2	11	31.4
Worrying	4	3	7	20.0
Brain Damage	4	1	5	14.2
Curse	1	3	4	11.4
Witchcraft	0	3	3	8.5
Competition	1	0	1	2.9
Disappointment	0	1	1	2.9
Disagreement	1	0	1	2.9
Heredity	1	0	1	2.9
Magic	1	0	1	2.9
TOTAL *	22	13	35	100.0

TABLE 37: EPILEPSY

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Convulsion	10	12	22	46.8
No Idea	7	4	11	23.4
Envy	3	0	3	6.4
Wrongdoing	3	0	3	6.4
Witchcraft	1	1	2	4.3
Curse	0	2	2	4.3
In Person at Birth	1	0	1	2.1
Worms	0	1	1	2.1
Starchy Food	0	1	1	2.1
Heredity	1	0	1	2.1
TOTAL *	26	21	47	100.0
OTHER CAUSES				
Wrongdoing	11	10	21	47.7
Envy	11	9	20	45.5
Witchcraft	0	2	2	4.5
Worms	1	0	1	2.3
TOTAL *	23	21	44	100.0

TABLE 38: GONORRHOEA

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Sexual Intercourse	24	19	43	97.7
No Idea	0	1	1	2.3
TOTAL	24	20	44	100.0
OTHER CAUSES				
Sex With Someone's Partner	6	3	9	33.4
Wrongdoing	1	3	4	14.8
Penis Related Problems	3	0	3	11.1
Magic	1	2	3	11.1
Envy	1	1	2	7.4
Same Name	0	2	2	7.4
Rivalry	1	1	2	7.4
Witchcraft	1	0	1	3.7
Sleeping With Pants On	0	1	1	3.7
TOTAL *	14	13	27	100.0

TABLE 39: BARRENNESS

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Menstrual Problems	8	8	16	34.7
Abortion	8	8	16	34.7
In Person at Birth	3	1	4	8.7
Complications In Fertilization	2	0	2	4.3
Damaged Womb	1	0	1	2.2
Contraceptives	0	1	1	2.2
Witchcraft	0	1	1	2.2
Early Sex Life	1	0	1	2.2
Venereal Diseases	0	1	1	2.2
Envy	0	1	1	2.2
Wrongdoing	0	1	1	2.2
No Idea	1	0	1	2.2
TOTAL *	24	22	46	100.0
OTHER CAUSES				
Envy	18	11	29	28.7
Wrongdoing	14	8	22	21.8
Abortion	8	10	18	17.8
Witchcraft	2	5	7	6.9
Menstrual Problems	3	3	6	5.9
In Person at Birth	2	2	4	4.0
Venereal Diseases	2	2	4	4.0
Curse	1	3	4	4.0
Complications in Fertilization	1	2	3	2.9

Piles	0	2	2	2.0
Family Disagreement	1	0	1	1.0
Affection	0	1	1	1.0
TOTAL *	52	49	101	100.0

TABLE 40: IMPOTENCE/STERILITY

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Envy/Hatred	11	10	21	33.3
Wrongdoing	7	5	12	19.0
Venereal Diseases	4	1	5	8.0
Affection	2	3	5	8.0
Weak Sperms	2	2	4	6.3
In Person at Birth	2	2	4	6.3
No Idea	3	1	4	6.3
Penis Related Problems	1	1	2	3.2
Witchcraft	0	2	2	3.2
Magic	1	0	1	1.6
Different Blood Group	1	0	1	1.6
Hernia	0	1	1	1.6
Sex With Someone's Wife	0	1	1	1.6
TOTAL *	34	29	63	100.0
OTHER CAUSES				
Envy/Hatred	6	3	9	22.5
Wrongdoing	4	4	8	20.0
Weak Sperms	5	2	7	17.5
Witchcraft	3	1	4	10.0
Affection	2	1	3	7.5
Sex With Someone's Wife	2	1	3	7.5
Magic	2	0	2	5.0
Venereal Diseases	1	0	1	2.5

In Person at Birth	1	0	1	2.5
Penis Related Problems	1	0	1	2.5
Excessive Drinking	0	1	1	2.5
TOTAL *	27	13	40	100.0

HEALERS

TABLE 41: MALARIA

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Hot Weather	4	6	10	47.6
Mosquitoes	2	2	4	19.0
Food Related Problems	2	1	3	14.2
Low Blood Pressure	1	0	1	4.8
Tiredness	1	0	1	4.8
Bad Water	1	0	1	4.8
In Person at Birth	1	0	1	4.8
TOTAL *	12	9	21	100.0
OTHER CAUSES				
Hot Weather	2	2	4	21.1
Food Related Problems	2	2	4	21.1
Envy/Hatred	2	2	4	21.1
Mosquitoes	2	0	2	10.4
Witchcraft	1	1	2	10.4
Excessive Drinking	0	1	1	5.3
General Weakness	1	0	1	5.3
Curse	1	0	1	5.3
TOTAL	11	8	19	100.0

TABLE 42: DIARRHOEA

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Food Related Problems	4	5	9	47.3
Contamination In Stomach	2	0	2	10.5
Bad Water	2	0	2	10.5
In Person at Birth	1	1	2	10.5
Worms In Stomach	1	0	1	5.3
Change In Drinking Water	0	1	1	5.3
Excessive Drinking	1	0	1	5.3
Contaminated Blood	0	1	1	5.3
TOTAL	11	8	19	19
OTHER CAUSES				
Food Related Problems	6	2	8	29.7
Envy/Hatred	3	1	4	14.8
Wrongdoing	2	1	3	11.1
Witchcraft	2	1	3	11.1
Bad Water	1	1	2	7.4
Contamination In Stomach	0	1	1	3.7
Worms In Stomach	0	1	1	3.7
In Person at Birth	1	0	1	3.7
Excessive Drinking	1	0	1	3.7
Malaria	1	0	1	3.7
Sore In Stomach	0	1	1	3.7
Flies	1	0	1	3.7
TOTAL *	18	9	27	100.0

TABLE 43: MADNESS

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Drugs	3	4	7	29.1
Wrongdoing	4	2	6	25.0
Envy	3	1	4	16.7
Curse	2	1	3	12.5
Damaged Brain	2	0	2	8.3
Malaria	0	1	1	4.2
Evil Spirit	1	0	1	4.2
TOTAL *	15	9	24	100.0
OTHER CAUSES				
Wrongdoing	4	5	9	34.7
Drugs	5	2	7	26.9
Envy	1	4	5	19.3
Excessive Drinking	2	0	2	7.7
In Person at Birth	1	0	1	3.8
Witchcraft	1	0	1	3.8
Worrying	1	0	1	3.8
TOTAL *	15	11	26	100.0

TABLE 44: EPILEPSY

MAIN	MALE	FEMALE	TOTAL	%
Convulsion	4	4	8	38.1
Wrongdoing	2	1	3	14.3
In Person at Birth	2	0	2	9.5
Phlegm In Stomach	0	2	2	9.5
Stomach Pains	1	1	2	9.5
Envy/Hatred	1	1	2	9.5
Worms In Stomach	1	0	1	4.8
Evil Spirit	1	0	1	4.8
TOTAL *	12	9	21	100.0
OTHER CAUSES				
Envy/Hatred	5	5	10	38.5
Wrongdoing	5	5	10	38.5
Worms In Stomach	1	1	2	7.7
Witchcraft	2	0	2	7.7
Convulsion	1	0	1	3.8
Disagreement	1	0	1	3.8
TOTAL *	15	11	26	100.0

TABLE 45: GONORRHOEA

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Sexual Intercourse	10	8	18	94.7
Witchcraft	1	0	1	5.3
TOTAL	11	8	19	100.0
OTHER CAUSES				
Sex With Someone's Partner	4	1	5	27.8
Envy	2	1	3	16.6
Wrongdoing	2	0	2	11.1
Competition	1	1	2	11.1
Magic	1	1	2	11.1
Penis Related Problems	2	0	2	11.1
Witchcraft	1	0	1	5.6
Sexual Intercourse	1	0	1	5.6
TOTAL *	14	4	18	100.0

TABLE 46: BARRENNESS

MAIN CAUSES	MALE	FEMALE	TOTAL	%
Menstrual Problems	7	6	13	59.1
Envy	2	1	3	13.6
Wrongdoing	2	1	3	13.6
Abortion	1	1	2	9.1
Witchcraft	1	0	1	4.6
TOTAL *	13	9	22	100.0
OTHER CAUSES				
Envy	5	5	10	26.3
Wrongdoing	5	5	10	26.3
In Person at Birth	3	2	5	13.1
Abortion	3	0	3	7.9
Witchcraft	2	1	3	7.9
Menstrual Problems	1	1	2	5.3
Piles	1	1	2	5.3
Contraceptives	2	0	2	5.3
Complications In Fertilization	1	0	1	2.6
TOTAL *	23	15	38	100.0

TABLE 47: IMPOTENCE/STERILITY

MAIN CAUSE	MALE	FEMALE	TOTAL	%
In Person at Birth	3	3	6	23.0
Envy/Hatred	4	2	6	23.0
Wrongdoing	4	2	6	23.0
Weak Sperms	0	2	2	7.7
Witchcraft	2	0	2	7.7
Weak Penis	1	0	1	3.9
Piles	0	1	1	3.9
Magic	0	1	1	3.9
No Idea	0	1	1	3.9
TOTAL *	14	12	26	100.0
OTHER CAUSES				
Envy/Hatred	2	3	5	27.7
Wrongdoing	2	3	5	27.7
Witchcraft	1	2	3	16.7
Evil Spirit	2	0	2	11.1
Curse	1	0	1	5.6
Weak Sperms	0	1	1	5.6
Venereal Diseases	1	0	1	5.6
TOTAL *	9	9	18	100.0

TABLE 48: PREVIOUS ILLNESS

CAUSE	MALE	FEMALE	TOTAL	%
Natural	13	8	21	47.7
No Idea	8	11	19	43.2
Don't Remember	3	1	4	9.1
TOTAL	24	20	44	100.0

TABLE 49: PRESENT ILLNESS

CAUSE	MALE	FEMALE	TOTAL	%
No Idea	17	14	31	70.5
Natural	6	4	10	22.7
Spiritual	1	2	3	6.8
TOTAL	24	20	44	100.0

PATIENTS' CHOICES OF TREATMENTS**

TABLE 50: FIRST CHOICE OF TREATMENT

TYPE OF TREATMENT	MALE	FEMALE	TOTAL	%
Scientific	18	16	34	77.2
Herbal	4	3	7	15.9
Self-Treatment	1	1	2	4.6
Spiritual Healing	1	0	1	2.3
TOTAL	24	20	44	100.0

TABLE 51: TREATMENT OF LAST RESORT

TYPE OF TREATMENT	MALE	FEMALE	TOTAL	%
Herbal	6	5	11	36.7
Scientific	3	7	10	33.3
Spiritual Healing	4	5	9	30.0
TOTAL***	13	17	30	100.0

**Choices of treatment for present illness.

***Those who had more than one level of treatment

PERCEPTIONS OF AIDS AMONG INFORMANTS

LAYPERSONS (PATIENTS)

TABLE 52: GENERAL DESCRIPTION OF AIDS

DESCRIPTION	MALE	FEMALE	TOTAL	%
New Illness	21	12	33	33.7
Sexually Contracted	9	4	13	13.3
Incurable Illness	8	4	12	12.3
Can't Describe	4	8	12	12.3
Killer Disease	3	6	9	9.2
Deadly/Dangerous	2	2	4	4.1
Venereal Disease	2	1	3	3.1
Isolates Patients	0	2	2	2.0
Prostitutes' Illness	2	0	2	2.0
Kills Gradually	2	0	2	2.0
Slim Disease	0	1	1	1.0
Kind of Fever/Measles	0	1	1	1.0
Kills After 5 Years	0	1	1	1.0
Dormant for Years	0	1	1	1.0
Infectious Disease	0	1	1	1.0
Suppresses Immune System	0	1	1	1.0
TOTAL *	53	45	98	100.0

TABLE 53: MEANS OF IDENTIFYING AN AIDS PATIENT

IDENTIFICATION	MALE	FEMALE	TOTAL	%
No Means/Idea	13	9	22	45.8
Leanness	11	10	21	43.7
Vomiting	1	1	2	4.2
Coughing	1	0	1	2.1
Continuous Diarrhoea	0	1	1	2.1
Rashes On Body	0	1	1	2.1
TOTAL *	26	22	48	100.0

TABLE 54: SOURCES OF AIDS KNOWLEDGE

SOURCES	MALE	FEMALE	TOTAL	%
Radio	19	12	31	63.3
Church	3	5	8	16.3
Friends	3	2	5	10.2
Newspapers	2	2	4	8.1
Magazine/Books	0	1	1	2.1
TOTAL *	27	22	49	100.0

TABLE 55: PERIOD OF AIDS KNOWLEDGE

PERIOD (IN YEARS)	MALE	FEMALE	TOTAL	%
1	10	8	18	40.9
2	6	5	11	25.0
3	3	4	7	15.9
4	4	0	4	9.1
5	1	3	4	9.1
TOTAL	24	20	44	100.0

TABLE 56: KNOWLEDGE OF AIDS TRANSMISSION

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Sexual Intercourse	24	20	44	100.0
TOTAL	24	20	44	100.0
OTHER CAUSES				
No Idea	13	10	23	39.7
Unsterilized Instruments	6	5	11	19.0
Blood Transfusion	5	6	11	19.0
Perinatal	3	1	4	6.9
Insect Bites	2	1	3	5.2
Kissing	2	0	2	3.4
Gonorrhoea	1	0	1	1.7
Contaminated Blades	0	1	1	1.7
Handshake	0	1	1	1.7
Eating/Drinking With Patients	0	1	1	1.7
TOTAL *	32	26	58	100.0

TABLE 57: IS AIDS CURABLE?

RESPONSE	MALE	FEMALE	TOTAL	%
No	18	18	36	81.8
Yes	6	2	8	18.2
TOTAL *	24	20	44	100.0

TABLE 58: METHODS TO PREVENT THE TRANSMISSION OF AIDS

METHODS	MALE	FEMALE	TOTAL	%
Stop Indiscriminate Sex	12	10	22	36.1
Faithful Sexual Partner	10	8	18	29.5
Screened Blood	5	2	7	11.6
Sterilized Instruments	4	3	7	11.6
Sex With Someone Tested	0	1	1	1.6
Good Food	0	1	1	1.6
Uncontaminated Blades	0	1	1	1.6
Avoid Quack Doctors	1	0	1	1.6
Use Condoms	1	0	1	1.6
Stop Kissing	1	0	1	1.6
Prevent Insect Bites	1	0	1	1.6
TOTAL *	35	26	61	100.0

HEALERS

TABLE 59: MEANS OF IDENTIFYING AN AIDS PATIENT

MEANS	MALE	FEMALE	TOTAL	%
No Means	4	4	8	38.0
Leanness	3	4	7	33.3
Consult Koran/Dwarfs/Shrine	2	0	2	9.5
Yellowish Urine	0	1	1	4.8
Swelling Feet	1	0	1	4.8
Continuous Diarrhoea	1	0	1	4.8
Holy Spirit's Guidance	1	0	1	4.8
TOTAL *	12	9	21	100.0

TABLE 60: GENERAL IDEA ABOUT AIDS

GENERAL IDEA	MALE	FEMALE	TOTAL	%
New Illness	4	6	10	52.6
Old Illness	3	1	4	21.0
No Idea	2	1	3	15.8
Typhoid Fever	1	0	1	5.3
Gonorrhoea	1	0	1	5.3
TOTAL	11	8	19	100.0

TABLE 61: KNOWLEDGE OF AIDS TRANSMISSION

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Sexual Intercourse	7	6	13	68.4
No Idea	2	0	2	10.5
Gonorrhoea	1	1	2	10.5
Febrile Conditions	1	0	1	5.3
Indiscriminate Sex	0	1	1	5.3
TOTAL	11	8	19	100.0
OTHER CAUSES				
No Idea	7	5	12	54.6
Mosquito Bites	1	1	2	9.2
Wrongdoing	2	0	2	9.2
Blood Transfusion	0	1	1	4.5
Envy	1	0	1	4.5
Sexual Intercourse	1	0	1	4.5
Witchcraft	0	1	1	4.5
Eat With Patients	0	1	1	4.5
Share Towel	0	1	1	4.5
TOTAL *	12	10	22	100.0

TABLE 62: CAN AIDS BE SPIRITUALLY CAUSED?

SPIRITUAL	MALE	FEMALE	TOTAL	%
No	6	7	13	68.4
Yes	4	1	5	26.3
No Idea	1	0	1	5.3
TOTAL	11	8	19	100.0

TABLE 63: CAN YOU SUCCESSFULLY TREAT AIDS PATIENTS?

RESPONSE	MALE	FEMALE	TOTAL	%
No	8	7	15	78.9
Yes	3	1	4	21.1
TOTAL	11	8	19	100.0

TABLE 64: METHODS TO PREVENT THE TRANSMISSION OF AIDS

METHODS	MALE	FEMALE	TOTAL	%
Faithful Sexual Partner	4	3	7	33.3
Stop Indiscriminate Sex	3	3	6	28.5
No Idea	2	2	4	19.0
Moral Goodness	1	0	1	4.8
Prohibit Prostitution	1	0	1	4.8
Avoid Eating With Patients	0	1	1	4.8
Avoid Sharing Towel	0	1	1	4.8
TOTAL *	11	10	21	100.0

NURSES

TABLE 65: GENERAL DESCRIPTION OF AIDS

DESCRIPTION	MALE	FEMALE	TOTAL	%
Destroys Body's Immune System	1	2	3	60.0
Kills its Victims	0	2	2	40.0
TOTAL	1	4	5	100.0

TABLE 66: MEANS OF IDENTIFYING AN AIDS PATIENT

MEANS	MALE	FEMALE	TOTAL	%
Weight Loss	1	4	5	23.8
Severe Headache	1	4	5	23.8
Tiredness	0	3	3	14.2
Continuous Diarrhoea	0	2	2	9.5
Shingles	0	2	2	9.5
Continuous Fever	1	0	1	4.8
Vomiting	1	0	1	4.8
Dry Cough	0	1	1	4.8
Painless Swellings	0	1	1	4.8
TOTAL *	4	17	21	100.0

TABLE 67: SOURCES OF AIDS KNOWLEDGE

SOURCES	MALE	FEMALE	TOTAL	%
Radio	1	3	4	57.1
Magazine	2	0	2	28.6
Television	0	1	1	14.3
TOTAL *	3	4	7	100.0

TABLE 68: PERIOD OF AIDS KNOWLEDGE

PERIOD (IN YEARS)	MALE	FEMALE	TOTAL	%
3	0	2	2	40.0
4	1	2	3	60.0
TOTAL	1	4	5	100.0

TABLE 69: KNOWLEDGE OF AIDS TRANSMISSION

MAIN CAUSE	MALE	FEMALE	TOTAL	%
Sexual Intercourse	1	4	5	100.0
TOTAL	1	4	5	100.0
OTHER CAUSES				
Blood Transfusion	1	4	5	22.7
Unsterilized Instruments	1	4	5	22.7
Insect Bites	1	3	4	18.2
Toilet Seats	0	3	3	13.6
Casual Contact	1	1	2	9.1
Kissing	0	2	2	9.1
Perinatal	0	1	1	4.6
TOTAL *	4	18	22	100.0

TABLE 70: IS AIDS CURABLE?

RESPONSE	MALE	FEMALE	TOTAL	%
No	1	4	5	100.0
Yes	0	0	0	0.0
TOTAL	1	4	5	100.0

TABLE 71: METHODS TO PREVENT THE TRANSMISSION OF AIDS

METHODS	MALE	FEMALE	TOTAL	%
Use of Condoms	1	4	5	26.3
Sterilized Instruments	1	3	4	21.0
Reduction In Number of Sexual Partners	1	3	4	21.0
Avoid Casual Contact	0	3	3	15.8
Avoid Sex With Certain Groups	0	1	1	5.3
Screened Blood	1	0	1	5.3
Faithful Sexual Partner	0	1	1	5.3
TOTAL *	4	15	19	100.0

APPENDIX B

INTERVIEW SCHEDULE

INTERVIEWS WITH PATIENTS INFNO.....

I'd like to begin by asking you some questions about your present illness.

01 01) What is it that you are suffering from?.....

02) How do you know that this is your illness?.....

.....

03) Have you been getting treatment from other healers besides this one?.....

If YES, give details of sequence and explanations for first choice, second choice, etc. as well as reasons for abandoning one form of treatment for another.....

.....

.....

04) Are you getting treatment for this illness from some other healer at the same time as this one?.....

05) Why do you think you became ill?.....

06) What explanations (if any) of your illness were provided by the healer(s) who have treated/ are treating you?.....

07) What do you think of these explanations?.....

.....

08) How is your treatment progressing at present?.....

Now I want to ask you about your previous experience of illness.

02 01) How many times have you been ill during the past 12 months?.....

02) What kinds of illnesses did you have during that time?. .....

.....

03) What about the last time (before the present) you were ill:

a) When was that?. .....

b) What was the illness?.....

c) What did you think had caused you to become ill?.....

d) What treatment did you seek? (Give details of sequence of choice of treatments, if applicable, and reasons for particular choice etc.

.....

.....

e) Did any of the healers you consulted provide explanations of the illness? (Give details). .....

.....

f) What did you think of these explanations?.....

.....

This community as you know has many healers. So I would like to ask you for your views on them.

03 01) We have herbalists, priest-healers, spiritual healers and western medical doctors in the community. What do you see as the main differences between them?. .....

.....

.....

02) Do you think that these various healers have anything in common, apart from an interest in curing people?. .....

.....

03) In your experience, do all healers offer the same treatments, or are there differences among them?.....

Herbalists. .....

Priest-healers. .....

Spiritual healers. .....

Western medical doctors. .....

04) In your experience, are all healers equally effective/ineffective, or are some better/worse than others?. .....

Herbalists. .....

Priest-healers. .....

Spiritual healers. .....

Western medical doctors. .....

I am interested in what people in Berekum think about some of the illnesses one comes across in this community. So I would like to ask you a few questions about particular illnesses.

04 01) Firstly, MALARIA. In your opinion, what is it that (usually, most commonly, most frequently) causes a person to get MALARIA?. .....

02) Are there any other things that will cause a person to get it?. .....

03) Is it possible for a person to get MALARIA through spiritual means?. .....

If YES, give details. .....

04) What do you think is the most effective treatment for MALARIA?. .....

.....

05 Is there a healer in this community you would recommend to someone suffering from this illness?. .....

05 01) Next DIARRHOEA. In your opinion, what is it that (usually, most commonly, most frequently) causes a person to get DIARRHOEA?. .....

02) Are there any other things that will cause a person to get it?. .....

03) Is it possible for a person to get DIARRHOEA through spiritual means?. .....

If YES, give details. .....

04) What do you think is the most effective treatment for DIARRHOEA?. .....

.....

05) Is there a healer in this community you would recommend to someone suffering from this illness?.....

06 01) In your opinion, what is that (usually, most commonly, most frequently) causes a person to to become MAD?.....

02) Are there any other things that will cause a person to be MAD?. .....

03) Is it possible for a person to be MAD through spiritual means?.....

If YES, give details. .....

04) What do you think is the most effective treatment for MADNESS?.....

.....

05) Is there a healer in this community you would recommend to someone suffering from this illness?.....

07 01) EPILEPSY. In your opinion, what is it that (usually, most commonly, most frequently) causes a person to get EPILEPSY?.....

02) Are there any other things that will cause a person to get it?. .....

03) Is it possible for a person to get EPILEPSY through spiritual means?. .....

If YES, give details. .....

04) What do you think is the most effective treatment for EPILEPSY?. .....

.....

05) Is there a healer in this community you would recommend to someone sufering from this illness?.....

08 01) GONORRHOEA. In your opinion, what is it that (usually, most commonly, most frequently) causes a person to get GONORRHOEA?.....

02) Are there any other things that will cause a person to get it?. .....

03) Is it possible for a person to get GONORRHOEA through spiritual means?.....

If YES, give details. .....

04) What do you think is the most effective treatment for GONORRHOEA?. .....

.....

05 Is there a healer in this community you would recommend to someone suffering from this illness?.....

09 01) BARRENNESS. In your opinion, what is it that (usually, most commonly, most frequently) causes a person to be BARREN?.....

02) Are there any other things that will cause a person to be BARREN?. .....

03) Is it possible for a person to be BARREN through spiritual means?. .....

If YES, give details. .....

04) What do you think is the most effective treatment for BARRENNESS?. .....

.....

05) Is there a healer in this community you would recommend to someone suffering from this illness?.....

10 01) IMPOTENCE. In your opinion, what is it that (usually, most commonly, most frequently causes a person to be IMPOTENT?.....

02) Are there any other things that will cause a person to be IMPOTENT?. .....

03) Is it possible for a person to be IMPOTENT through spiritual means?. .....

If YES, give details. .....

04) What do you think is the most effective treatment for IMPOTENCE? .....

.....

05) Is there a healer in this community you would recommend to someone suffering from this illness?.....

11 01) Have you heard of AIDS?.....

If YES, tell what you heard about AIDS generally.....

.....

.....

02) When did you first hear about AIDS and what were the circumstances (e.g. from whom, at what place, in what situation)?.....

.....

.....

03) Are there any ways in which one can tell if a person has AIDS?.....

.....

.....

04) What is it that (usually, most commonly, most frequently) causes a person to get AIDS?.....

.....

.....

05) Are there any other things that will cause a person to get AIDS?.....

.....

06) Can a person be cured of AIDS?.....

If YES, give details of treatment and appropriate healer.....

.....

If NO, give reasons for difficulty.....

.....

07) Is there any way in which a person can be protected from AIDS?.....

.....

If YES, give details of protective measures.....

.....

If NO, give reasons for difficulty.....

.....

08) Why do you think we have only heard about AIDS recently when we have

heard of venereal diseases for a very long time?. .....

.....

Now I'd like to ask you a few questions about illnesses in general.

12 Do you think there are some illnesses which are:

01) **always** due to spiritual causes?. .....

If YES, give names and explanation as to why these illnesses are so caused.....

.....

02) **very often** due to spiritual causes?.....

If YES, give names and explanation as to why these illnesses are so caused.....

.....

03) **always** due to natural causes?.....

If YES, give names and explanation, etc. .....

.....

04) **very often** due to natural causes?. .....

If YES, give names and explanation etc. .....

13 We noticed that, when they go for treatment, patients don't ask many questions of those who are treating them. Why do you think this is so?. .....

.....

14 Some people seem to think that, in some instances, a person may be ill because (s)he has done wrong. What do you think about this?. .....

.....

15 Finally I want to ask you for some personal details. Naturally, the information you give will be treated confidentially and your anonymity is guaranteed.

SOCIO-DEMOGRAPHIC CHARACTERISTICS

01) Age. .....

02) Sex. .....

03) Level of Education. .....

04) Religious Denomination. .....

05) Tribal Affiliation. .....

06) Marital Status. .....

07) Birthplace. .....

08) Previous Occupation. .....

09) Present Occupation. .....

INTERVIEWS WITH PROFESSIONAL CURERS INFNO. .....

I want to begin by asking you about some illnesses you might have come across in your work as. .....

16 01) Firstly, MALARIA. How do you usually know when a patient has MALARIA? .....

.....

02) In your experience, what is it that (usually, most commonly, most frequently) causes a person to get MALARIA? .....

.....

03) Are there any other things that will cause a person to get it? .....

04) Is it possible for a person to get MALARIA through spiritual means? .....

If YES, give details. .....

05) Can you successfully cure someone who has MALARIA? .....

If YES, give details of treatment. .....

.....

If NO, give reasons of difficulty.....

.....

17 01) Next, DIARRHOEA. In your experience, what is it that (usually, most commonly, most frequently) causes a person to get DIARRHOEA?.....

02) Are there any other things that will cause a person to get it?.....

03) Is it possible for a person to get DIARRHOEA through spiritual means?.....

If YES, give details.....

04) Can you successfully cure someone who has DIARRHOEA?.....

If YES, give details of treatment.....

.....

If NO, give reasons for difficulty.....

.....

18 01) Next, MADNESS. How do you know when a patient is suffering from MADNESS?.....

02) In your experience, what is it that (usually, most commonly, most frequently) causes a person to suffer from MADNESS?.....

.....

03) Are there any other things that will cause a person to suffer from it?

.....

04) Is it possible for a person to become MAD through spiritual means?.....

05) Can you successfully cure someone who is suffering from MADNESS?.....

If YES, give details of treatment.....

.....

If NO, give reasons for difficulty.....

.....

19 01) Next, EPILEPSY. In your experience, what is it that (usually, most

commonly, most frequently) causes a person to have EPILEPSY?.....

02) Are there any other things that will cause a person to have it?. .....

03) Is it possible for a person to get EPILEPSY through spiritual means?. .....

If YES, give details. .....

04) Can you successfully cure someone suffering from EPILEPSY?.....

If YES, give details of treatment. .....

.....

If NO, give reasons for difficulty. .....

.....

20 01) Next, GONORRHOEA. How do you usually know when a patient has GONORRHOEA?

.....

02) In your experience, what is it that (usually, most commonly, most frequently) causes a person to get GONORRHOEA?. .....

.....

03) Are there any other things that will cause a person to get it?

.....

04) Is it possible for a person to get GONORRHOEA through spiritual means?. .....

If YES, give details. .....

.....

05) Can you successfully cure someone who has GONORRHOEA?. .....

If YES, give details of treatment. .....

.....

If NO, give reasons for difficulty. .....

.....

21 01) Next, BARRENNESS. In your experience, what is it that (usually, most

commonly, most frequently causes a person to suffer from BARRENNESS?.....

02) Are there any other things that will cause a person to suffer from it?.....

03) Is it possible for a person to become BARREN through spiritual means?. .....

If YES, give deatils. .....

.....

04) Can you successfully cure someone who is suffering from BARRENNESS?.....

If YES, give deatils of treatment. .....

.....

If NO, give reasons for difficulty. .....

.....

22 01) Next, IMPOTENCE. In your experience, what is it that (usually, most commonly, most frequently) causes a person to suffer from IMPOTENCE?.....

.....

02) Are there any other things that will cause a person to become IMPOTENT?.....

03) Is it possible for a person to become IMPOTENT through spiritual means?. .....

If YES, give details of treatment. .....

.....

04) Can you successfully cure someone who suffers from IMPOTENCE?.....

If YES, give details. .....

.....

.....

If NO, give reason for difficulty.....

.....

We have been hearing a lot about AIDS and I wanted to ask you some questions about this.

23 01) Have you personally encountered any cases of AIDS among your patients?.....

If YES, give information regarding numbers, circumstances, etc. .....

.....

02) How can you tell if a person is suffering from AIDS?.....

.....

03) What is it that (usually, most commonly, most frequently)

causes a person to get AIDS?.....

.....

04) Are there any other things that will cause a person to get it?.....

.....

.....

05) Is it possible for a person to get AIDS through spiritual means?.....

If YES, give details. .....

06) Can you successfully cure someone who has AIDS?.....

If YES, give details of treatment.....

.....

If NO, give reasons for difficulty. .....

.....

07) Is there any way in which a person can be protected fom AIDS?.....

If YES, give details of protective measures. .....

.....

If NO, give reasons for difficulty. .....

.....

08) Why do you think we have only heard about AIDS quite recently when we have heard of venereal diseases for a very long time?. .....

.....

Now I'd like to ask a few questions about illnesses in general.

24 Are there some illnesses which are:

01) **always** due to spiritual causes?. .....

If YES, give names and explanation as to why these illnesses are so caused.....

.....

02) **very often** due to spiritual causes?.....

If YES, give names and explanation as to why these illnesses are so caused.....

.....

03) **always** due to natural causes?.....

If YES, give names and explanations etc.....

.....

04) **very often** due to natural causes?. .....

If YES, give names and explanation etc. .....

.....

25 We noticed that your patients don't ask questions about the reasons why they are ill. Why do you think this is so?.....

26 Some people seem to think that. in some instances, a person may be ill because (s)he has done wrong. What do think about this?.....

.....

As you well know, this community has many healers. I'd like to ask you a few questions these healers in Berekum.

27 What do you think are the main differences between what you do as a..... and what is done by (then, each of the other healer-types in Berekum)?.....

.....

.....

.....

28 What do you think are the main similarities between what you as a..... and what is done by.....?

.....

.....

29 Have you ever sought help when you yourself were ill from: (then, each of the other healer-types in Berekum)?.....

.....

30 Among healers of your own kind, are there some who are better than others?.....

If YES, give details. .....

.....

31 Among healers of your own kind, is information about your work and knowledge shared and exchanged?. .....

If YES, explain why. .....

If NO, explain why.....

32 01) We see that many people in Berekum, when they are ill, don't rely exclusively on one kind of healer. Can you give me your own impressions about this?.....

.....

02) Are your patients usually people who come to you first, before

going to another kind of healer?.....

03) Or are they usually people who have failed to get successful treatment by other kinds of healers before they come to you?.....

How much depends on the kind of illness the patient has?.....

.....

33 Finally, I want to ask you some personal details. Naturally, the information you give will be treated confidentially and (unless you wish your name to be mentioned in my report) your anonymity is guaranteed.

SOCIO-DEMOGRAPHIC CHARACTERISTICS

01) Age.....

02) Sex.....

03) Level of Education.....

04) Religious denomination.....

05) Tribal Affiliation.....

06) Marital Status.....

07) Birthplace.....

08) Previous Occupation.....

09) Other Occupation.....

34 Basic information on career development.

01) When.....

02) Where.....

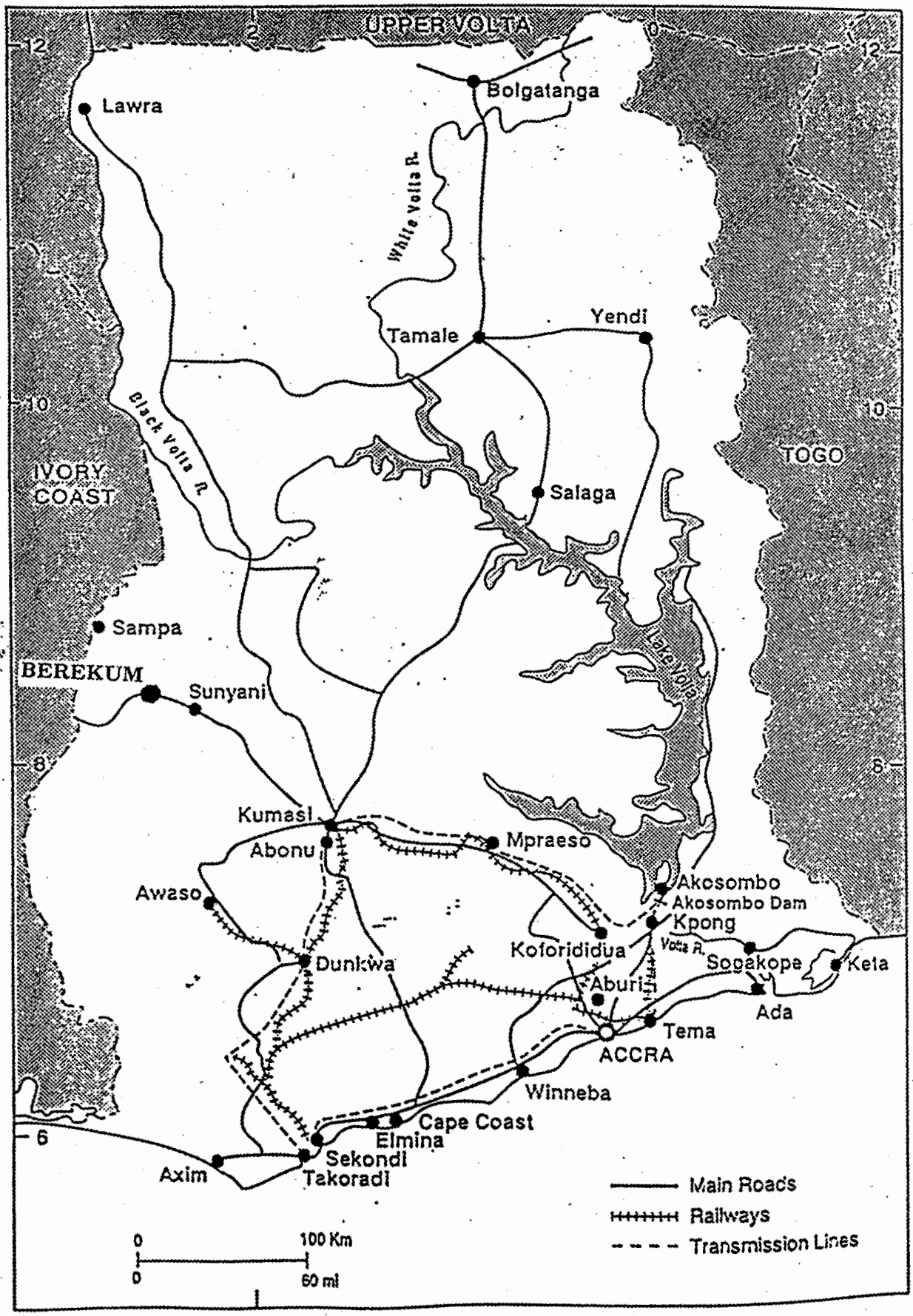
03) How.....

04) Why.....

of embarking on healing career?

APPENDIX C

GHANA : Roads, Railways and Major Towns



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