

Ghana Studies

15/16



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Ghana Studies

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15/16

Health and Health Care

Guest Editors:

Sjaak van der Geest, Kristine
Krause & Kodjo A. Senah

2012/2013

SPECIAL ISSUE: *HEALTH AND HEALTH CARE*

CONTENTS

Editors' Note <i>Akosua Adomako Ampofo and Stephan F. Miescher</i>	1
Introduction: Studying Health and Health Care in Ghana <i>Sjaak van der Geest and Kristine Krause</i>	7
<i>Articles on Health and Health Care</i>	
The Perception of Abnormality in Kasena and Nankani Infants: Clarifying Infanticide in Northern Ghana <i>Albert K. Awedoba and Aaron R. Denham</i>	41
Caring for the Seriously Sick in a Ghanaian Society: Glimpses from the Past <i>Deborah Atobrah</i>	69
“No Matter How the Child Is, She Is Hers”: Practical Kinship in the Care of Mental Illness in Kintampo, Ghana <i>Ursula M. Read</i>	103
HIV Disclosure in Ghana: The Underlying Gender Dimension to Trust and Caregiving <i>Fidelia Ohemeng</i>	135
Mobile Technology and HIV/AIDS in Ghana <i>Perpetual Crentsil</i>	159
Dilemmas of Patient Expertise: People Living with HIV as Peer Educators in a Ghanaian Hospital <i>Jonathan Mensah Dapaah and Eileen Moyer</i>	195

Pharmaceutical Potentials: Praying over Medicines in Pentecostal Healing 223
Kristine Krause

Humanitarian Claims and Expert Testimonies: Contestations over Health Care for Ghanaian Migrants in the United Kingdom 251
Benjamin N. Lawrance

Mission Medicine in a Decolonising Health Care System: Agogo Hospital, Ghana, 1945-1980 287
Pascal Schmid

Documentaries on Women's Health

Accra's Women on Screen, 2001: A Documentary Pair about Body, Risks, Tonics, and Health 331
R. Lane Clark, Nancy Rose Hunt, and Takyiwaa Manuh

Other Articles

Managing the Pan-African Workplace: Discipline, Ideology, and the Cultural Politics of the Ghanaian Bureau of African Affairs 337
Jeffrey S. Ahlman

Staging Unity, Performing Subjectivities: Nkrumah, Nation-Building, and the Ghana Dance Ensemble 373
Paul Schauert

Discourses of Love and Newspapers Advice Columns in Ghana 413
Jo Ellen Fair

Reviews

New Wine in Old Wineskins: The Conservative Tradition in Ghana's Historical Surveys <i>David Peterson del Mar</i>	467
Christine Oppong, Delali M. Badasu, and Kari Waerness, eds., <i>Child Care in a Globalizing World: Perspectives from Ghana</i> <i>Cati Coe</i>	497
Notes on Contributors	501

EDITORS' NOTE

We are delighted to present the double issue *Ghana Studies* 15/16 which will be our last as editors. More than four years have passed since we assumed the editorship, and it is time to pass the baton to a new set of editors: Akosua Darkwah of the University of Ghana and Sean Hanretta of Stanford University. They will continue the practice of an editorial team that is based in Ghana and in the global North. We are confident that their next issue will mark the beginning of another fruitful transnational collaboration.

Our journey as *Ghana Studies* editors has been exciting and intellectually stimulating, although the workload at times stretched us beyond what either of us had anticipated. When we were invited to take on the editorship in 2009, the journal had not appeared for several years. In 2010, our predecessors published their last issue, *GS* 10 (2007), a wonderful special issue about Ghana@50; the same year, we brought out our first issue, *GS* 11 (2008). The double issue 12/13 (2009/2010) on Revisiting Modernization followed in 2011, and then issue 14 (2011) in 2012. We are thrilled to report that with the present double issue *Ghana Studies* is again up to date. We trust that our successors, who are already hard at work preparing issue 17, will continue publishing the journal in a timely fashion. More good news needs to be shared: *Ghana Studies*, in addition to its print edition, will appear online as part of Project Muse starting in 2014. At the time of writing, we are still looking for a suitable Internet place to house the back issues yet remain confident that they will become accessible online as well. In the course of our editorship we accumulated numerous debts, including to our reviewers, our authors, and the production staff of the African Studies Program at the University of Wisconsin,

Madison. We are especially thankful to our reviewers for their unflinching support of the journal—some of them turned around articles we sent them in record time. Their names appear at the end of this note, and we hasten to offer apologies to anyone whom we may have omitted. We hope that the support of reviewers will continue under the new editors, as rigorous peer review is at the heart of this scholarly journal.

Ghana Studies 15/16 is an especially rich and diverse issue. It contains a special issue on health and health care in Ghana, skillfully edited by Sjaak van der Geest, Kristine Krause, and Kodjo A. Senah. We are leaving it to two of the guest editors, van der Geest and Krause, to situate their special issue within a larger scholarly context and introduce their contributions. The nine articles on health and health care are followed by R. Lane Clark, Nancy Rose Hunt, and Takyiwaa Manuh's piece that introduces two film documentaries about women's health and medical care: "*Excuse Me to Say*"-- *Notions of Body and Risk in Accra* and "*Where Shall I Go?*"-- *Tonics, Clinics, and Miracles in Accra*.. These two documentaries, directed by Clark and produced by Hunt and Manuh, are accessible online through the *Ghana Studies* website, YouTube, and Vimeo.¹ The documentaries are the culmination of a collaborative training project on women's health in Accra between the University of Ghana and the University of Michigan. In these films, "health" not only refers to the curative sense but also to social health, economic security, and activities related to joy and well-being. While the first film focuses on catering and seamstress apprentices who share their dreams and aspirations about beauty, dating, marriage, and health concerns, the

¹ See <http://youtu.be/h3fcKq6wGGQ> and <http://youtu.be/j4P1CFNOJh0>, <http://ghanastudies.com/ghana-studies-journal/>, and <http://vimeo.com/rlaneclark>

second film shows therapeutic options sought out by girls and women, including hospitals, pharmacies, herbalists, spirit mediums, and healing churches. Both films feature a complexity of voices and spaces, in which women of different ages speak candidly about their health options and challenges. The films incorporate interviews with Ghanaian health experts whose work is cited by other contributors. Thus, the documentaries complement and extend the findings and scope of the special issue by adding a compelling visual dimension.

Two articles deal with two very different institutions founded by Kwame Nkrumah. Jeffrey Ahlman revisits the Bureau of African Affairs, one of the most controversial institutions of Nkrumah's Ghana. While most scholarship has looked at the Bureau in relation to its Pan-African activities seeking to shape governments across the continent, Ahlman examines the Bureau as a workplace. He looks at the development of work regimes that transformed contestations over pay, leave, and technological innovations into debates about national security and ideological discipline. Drawing on the Bureau's neglected archive, he reconstructs cases of talkative staff, perceived abuses of the telephone, and gendered lack of discipline. These workplace tensions triggered challenges to the Bureau's operation, its Pan-African and nation-building agenda. Such inter-office debates, Ahlman argues, reflected anxieties about gender, generational, and class tensions in postcolonial Ghana.

Paul Schauert's contribution tracks the history of the Ghana Dance Ensemble, established at the Institute of African Studies, University of Ghana in 1962. This state-sponsored troupe became instrumental in attempts of nation building and in promoting the ideologies of African Personality and Pan-Africanism, even beyond the duration of Nkrumah's regime. Schauert explores how

Ensemble members have interpreted, embodied, and expressed nationalism through performance. He argues that while the ideals of nationalism pushed individuals into an objectifying unitary identity, drummers and dancers individually engaged with such processes. By performing a variety of Ghanaian dances, they embraced a national identity but still related this identification to their own sense of self. Adopting a national identity did not mean to abandon their own ethnic affiliation. Rather, national unity was experienced subjectively as individuals created their own identity through music and dance.

Jo Ellen Fair brings an interesting popular dimension to this collection by providing us with perspectives on the dilemmas of “modern love” as read from the letters to advice columns in Ghanaian newspapers. Romance, sexual attraction, love proposals, courtship, uncertainties, and heartbreaks are issues that concern people of all ages and cultures. However, Fair shows the particularly *Ghanaian* ways in which “tradition” and “modernity” meet, and sometimes collide. She reveals the theories and (oftentimes very skillful) methods of the columnists as they bring popular, social, and moral discourses to bear on these exciting yet sometimes troubling subjects. Fair’s work is a useful addition to the large body of anthropological and sociological work on love, marriage, and kinship in that she provides insights into *discourses* of love in a contemporary setting where individuals are impacted by global social media and want to be “modern” at the same time that they seem to seek to maintain “traditional” ways of navigating the relationship terrain.

The review essay by David Peterson del Mar examines historical surveys of Ghana’s past published since independence, particularly foregrounding Albert Adu Boahen’s influential work. Historical surveys written since the 1990s, del Mar suggests, have

become more conservative, since they merely present conventional political narratives that ignore the insights of cultural and social history. This conservatism, he argues, serves the needs of the current nation state. The book review by Cati Coe reconnects to the themes of the special issue by discussing an edited collection that documents a childcare crisis in Ghana with a disturbing impact on children's health.

Finally, we are again grateful to Bethany Wilinski for seeing *Ghana Studies* 15/16 through the production process. We wish you happy reading of this splendid special issue on health and healthcare, of the other articles, as well as enjoyment and inspiration when watching the documentaries. While we are now stepping back, handing over to Akosua and Sean, we are already looking forward to receiving their first issue with new work about Ghana, her people, and the worlds they have created.

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INTRODUCTION: STUDYING HEALTH AND HEALTH CARE IN GHANA

Sjaak van der Geest, University of Amsterdam &
Kristine Krause, Max Planck Institute, Göttingen¹

This introduction delineates and discusses the field of social, cultural, and historical studies of health and health care in Ghana. Health and health care are viewed as significant nexuses of social and cultural processes. This overview of studies, mainly from Anglophone medical anthropology, focuses on developments around “traditional” medicine and various themes relating to biomedicine, including hospital ethnography, pharmaceuticals, health insurance, reproductive technology, and HIV/AIDS, while the final topic is about concepts and quality of care. The contributions to this special issue are briefly presented and linked to the above mentioned themes.

Keywords: Traditional medicine, medical pluralism, biomedicine, hospital ethnography, pharmaceuticals, health insurance, reproductive technology, HIV/AIDS, care, Ghana.

Illness and health are major concerns in life. During illness people experience and express their most inner-felt ideas and concerns regarding belonging, belief, trust, kinship, economy, reciprocity, and identity. Sickness reveals what and who really counts, the value of kinship, where economic priorities lie, and what religion means. If illness and health are at the centre of culture and society, it is not surprising that the domains of ill health and wellness, fortune and misfortune, provide some of the most important tools and metaphors that people use to order their existence, attach meaning to it, and communicate with others. The sick body becomes the “topos” of social vulnerability; the body afflicted by chronic illness or AIDS represents the inveterate ailments of society, the ageing

¹ We thank Edward Nanbigne and Kodjo Senah for helping us with the literature search and Zoe Goldstein for final editing.

body becomes a metaphor for a world that has lost its appeal. The able as well as the sick or disabled body is the intimate point of reference from which and through which people explore their world. It is also the most intimate interface between the individual and public institutions. This is one of the reasons why modern nation states define the provision of health care as one of their core duties. The health status of a population is seen as a measure of a nation state's achievements in terms of equality and justice in the distribution of resources. As Kwame Nkrumah declared in 1957:

We shall measure our progress by the improvement in the health of our people ... The welfare of our people is our chief pride and it is by this that my government will ask to be judged. (Quoted in Senah 2001: 85)

Where does Ghana come from and stand now with regard to health and health care? What can we learn about Ghanaian society through the lens of health and health care? The contributions to this special issue are a modest attempt to explore health, illness, and medical treatment in the context of Ghanaian culture and society, through a contemporary as well as a historical perspective. They do so by looking at the relationship between kinship, gender, and care, mission medicine and the colonial and postcolonial state, the intersection of religious practices and the consumption of pharmaceuticals, the legal status of migrants and the quality of health care in Ghana.

In this introduction, we take the opportunity to provide a rough overview of social science studies of health and illness in Ghana since the 1960s. We then sketch how the articles in this issue communicate with the existing literature. Obviously, the overview is a small selection of the hundreds of publications that exist and draws mainly on Anglophone studies from medical anthropology.

Studies of Health, Sickness, Wellbeing, and Healing in Ghana (1960-2013)

In accordance with developments in medical anthropology in general, studies on illness and healing in Ghana started off as studies of “traditional” medicine and local ideas about illness, both among specialist healers and community members. Invariably, the first authors were non-Ghanaians. Research into biomedical practices and institutions only began many decades later, in the twenty-first century. We will look at both periods, and then focus on three special themes: mental health, HIV/AIDS, and care. While doing so, we keep in mind that medical knowledge and practice are transnational phenomena. Although the focus of this special issue is on Ghanaian culture and society via the lens of health, we acknowledge that illness and healing cannot be looked at only within the borders of the nation state. Ghana is widely influenced by globally circulating biomedical knowledge, the traveling of biomedical professionals and traditional healers, the influx of pharmaceuticals from India and China, the outmigration of nurses and doctors, and the remittances of family members to their relatives in Ghana. Thus, what happens elsewhere in the world affects Ghanaian villages, neighbourhoods, and cities, and vice versa.

“Traditional” Medicine and Medical Pluralism

Topics that are considered most relevant in the social and cultural study of health and illness reflect academic trends and what is at stake at the time of writing. This is especially true for contested terminologies such as “tradition” and “modernity.”

The term “traditional” with regard to medicine is not only misleading and naïve, as has been argued by many; it is also a revealing adjective, since it throws together every type of thinking and acting that differs from biomedicine. It reveals the ethnocentrism of the observer – the outsider, but also the insider who has internalised the views of the outsider. The term

was widely accepted during the colonial period and the first post-colonial decades, but still today it is commonly used – sometimes with apologies – because there are no acceptable alternatives. Furthermore, the term has gained a life of its own, as for instance in the establishment of the office of Traditional Medicine, Health System Governance and Service Delivery at the WHO.² The term was further promoted by the policies of international bodies such as UNESCO to protect local practices and intellectual property rights. “Tradition” refers then to the idea of valuable local heritage that needs to be protected against global forces. In the case of Ghana, it goes along with a strong political discourse within the country on national identity, culture, and heritage, which dates back to the time of Nkrumah and his efforts to shape a national identity for the newly independent nation (Hagan 1993; Schramm 2000). Still today, “tradition” is on the agenda of the Commission of Culture and the Ministry of Tourism, and so-called “traditional medicine” is regarded as worth preserving for reasons ranging from the securing of property rights for local pharmaceutical treasures to fostering tourist attractions and maintaining a health resource for local populations.

Following this line of thinking, Ghana’s first prime minister and president, Kwame Nkrumah, promoted the professionalisation of so-called traditional medicine and encouraged the foundation of one of the first African Associations of Traditional Medicine, the Ghana Psychic and Traditional Healers Association.³ For this purpose, he appointed Mensah Dapaah, who had just returned from McGill with an MSc in Medical Anthropology, “to study and organize traditional healers to form Associations for the advancement of

² <http://www.who.int/medicines/areas/traditional/en.html> [accessed 3 July 2013]

³ Authors disagree on the year in which the association was founded; some say 1961 (Twumasi and Warren 1986: 122-23) others 1963 (Fyfe 1987: 1; Mullings 1984: 43).

their art and techniques in the delivery of health care” (quoted in Twumasi and Warren 1986: 122). The emphasis on the heritage of “African medicines” was based on the “conscious quest for an African way of doing things to distinguish the African from the European”, as Twumasi and Warren (1986: 12) wrote.⁴

The first two major studies of traditional medicine were by Margaret Field (1960, 1961), an anthropologist and psychiatrist employed by the colonial government. Field’s first publication was a rebuttal of the widespread view at the time that “mental stress and mental illness are the prerogative of ‘over-civilised’ societies” (13). African minds were believed to be free of the worries that plagued “civilised” people, but in her account of more than 2,500 complaints brought to five shrines in Brong Ahafo, she convincingly showed that Ghanaians – and women in particular – suffered from depression and other forms of mental stress that were also common in the West. Her second study was an ethnography of a Ga community from the perspective of religion and medicine, long before (other) anthropologists realised the central role of medicine in local culture. In her analysis, she stressed the importance of social and economic change, in particular the introduction of wage labour in the cocoa industry.

More studies of traditional medicine followed, some critical (Twumasi 1975), some “neutral” (Osei 1978; Fosu 1981; Fink 1989), and some in its defence (Warren 1974; Appiah-Kubi 1981). In 1975, Patrick Twumasi from the Sociology Department, University of Ghana, Legon published his book *Medical Systems in Ghana*, in which he attempted to provide a comprehensive picture of Ghana’s therapeutic landscape, which included biomedicine as well as the various forms of healing. Although he mainly focused on the Akan, his

⁴ Following these initiatives, in 1975 the Centre for Scientific Research into Plant Medicine was established in Mampong.

conclusion about why traditional healers remain important for people (because they provide “social causation theories” [Twumasi 1975: 108]) has been important for the study of non-biomedical practices – in particular those related to spiritual healing – in and beyond Ghana.

Michael Warren, an American anthropologist, intervened in anthropological debates on more general terms in his study of Bono medicines in Techiman. Warren composed detailed taxonomies of diseases and their treatment, demonstrating that Bono healers based their medical knowledge and treatment on practical experience. He collected nearly 1,500 disease names and organised them into a 12-level taxonomic system. In his voluminous study, he countered the popular belief that “Africans” conceptualise disease only in terms of supernatural causation, a belief he found to be both simplistic and untenable. The vast majority of Bono diseases, he claimed, were defined in terms of natural causation. Spiritual causations of disease did occur, but their incidence was low and they were related to well-defined conditions of social deviance from culturally recognised norms of behaviour (Warren 1974: v).

Warren attempted to provide empirical grounds for the argument that traditional healers should not be seen as religious actors but as medical practitioners working on similar premises as biomedical professionals. The arrival of a “Western” hospital in Techiman was thus not a break with or intrusion into traditional medicine, but a “convenient functional alternative” (ibid: vi). Warren wrote several articles to plead for more recognition of local healers and their greater cooperation with the Techiman hospital (Warren et al. 1982), and was involved in a training programme for local healers to facilitate such cooperation.

Fourteen years later, Peter Ventevogel (1996) carried out a case study in a rural community near Techiman to examine if the local healers who had participated in the above mentioned training programme had taken up the new techniques that they

had learnt. The most remarkable outcome of his study was that the healers still remembered what they had been taught, but preferred to stick to their own methods, which they considered more effective. In correspondence with other writings in the field, such as by Robert Pool (1994), Ventevogel criticised the earlier attempt by Warren to systematise a body of knowledge that was a loose constellation of ideas, orally transmitted and often shrouded in secrecy.

Akan traditional medicine is not a solid and systematised body of knowledge. It differs from town to town, from healer to healer, from day to day. Akan medical knowledge is partially idiosyncratic and embedded in an externalizing medical system. The indigenous medical terms cannot be equated with biomedical disease terms, since they are constructions from two separate discourses. Besides, the meanings of Akan disease terms are not fixed. Akan disease terms are used flexibly by the healers. The knowledge of the healers is of a fragmented and practical kind, guided by clear principles, but not readily available for shackling into a scheme (Ventevogel 1996: 137).

More than thirty years after Warren's dissertation, Kwasi Konadu (2007) interviewed twenty Bono healers and concluded on the basis of their statements and claims that Bono medicine does indeed have a strong religious character and that a so-called 'integration' with biomedicine would be an illusion. He wrote that "At the cultural or ideational level, both the indigenous and the biomedical systems are irreconcilable at their very core" (177). Moreover, the unequal power relations between the two systems would undoubtedly turn co-operation into co-optation, leading to the disappearance of the weaker indigenous party. Van der Geest (1985) referred to this as a "fatal embrace." Ayim-Aboagye's (1993) psychological analysis of experiences of traditional medicine in Akyem and Asante also pointed at the religious dimension of Akan healing.

We mention the above publications in more detail because they have advanced the scholarly debate outside of the study of Ghana. The publications by Warren, Fosu, Fink, and Ventevogel followed a new approach at the time, which looked at traditional medicine in the context of medical pluralism, a term denoting “the coexistence of ideas and practitioners from several traditions occupying the same therapeutic space in society” (Janzen 2002: 234). The attention is therefore more and more focused on the presence of various medical options and on how people choose between or combine them. This trend has remained in recent dissertations by Barimah (2002), Atobrah (2009), and Baataar (2011).

Ama De-Graft Aikins’ work (2005, 2007) shows the importance of these questions for the treatment of non-communicable and chronic health conditions, which have become a major public health issue in Ghana. In a study on diabetes treatment in rural and urban settings, she found that biomedical treatment was the preferred option, thereby proving the widespread opinion incorrect that people with chronic conditions pursue mainly herbal and spiritual healing methods. Among her study participants, herbal treatment was only a secondary option, but became the first choice in cases when it was cheaper than biomedical drugs (see also Sato 2012). In general, De-Graft Aikins found that the goal to tackle high mortality rates related to diabetes is undermined by the high cost of the recommended foodstuffs and prescribed drugs and the unregulated landscape of spiritual healers and most herbal treatments.

The use of traditional medicines by Ghanaians in the Diaspora is another topic of interest (Barimah 2002). Kofi Barimah and Edwin Van Teijlingen (2008) explored whether Ghanaians living in Canada have adopted different views about traditional medicines through the process of migration, predicting that traditional medicine would lose its importance in the migration process to a country where high standards of

biomedical care are available. They found no evidence of a major change in attitude, however, although around 30 percent of the Ghanaians they interviewed had modified their attitudes and opinions somewhat.

Kristine Krause (2010) looked at when and how first generation Ghanaians living in London combine biomedical treatment with other healing methods. She found that people turned to so-called traditional medicine after years of living without it. The reasons for this change were that traditional medicines only became easily available in London during the 1990s. At the same time a shift in the evaluation of community specific practices occurred in the United Kingdom: it became acceptable and fashionable to consume traditional medicine from one's home country. Thus, the validation of "tradition" was not, as Barimah and Teijlingen (2008) argued, a certain "cultural baggage" people carry with them but a new pattern of health behaviour, taken up after years of residence in Britain with full access to biomedical health care. Krause (2008a) further explored the circulation of pharmaceuticals within people's personal networks and found that migrants requested not only herbs and other traditional medical products from Ghana but also pharmaceuticals such as specific antibiotics.

In general, it needs to be noted that the increasing intensification of translocal connections within Ghana and linkages between Ghana and other parts of the world has an ongoing effect on the therapeutic landscape. Kate Hampshire and Samuel Asiedu Owusu (2013), for instance, explore how healers position themselves strategically in a highly pluralistic, contested, and globalised medical arena, in which they draw not only from "grandfathers" but also from Google. The effect of global linkages is particularly visible in the sector of spiritual healing. Thomas McCaskie (2008) describes how at the Medoma shrine in Kumasi the priest does not only react to the dominance of transnational Pentecostal churches but also to the ever growing clientele of African Americans who seek help

from his gods. Already in pre-colonial and colonial times, it was the case that healers who came from far away were considered the most powerful (Goody 1957). Jean Allman and John Parker (2005), in their historical study on the Tognaab, describe how labour migrants from the north brought their gods to the south of Ghana and how pilgrimage networks evolved, which today bring visitors from the United States to Japan to this remote corner of the West African Savannah.

Similarly, the emergence of Christian therapeutics in Ghana should be seen as the result of an ongoing exchange between different Christian denominations, including missionary churches and the various revival movements in the region. The role of new Christian churches in healing has been an ongoing research topic. Hans Debrunner (1959) and C. G. Baeta (1962) were among the first to draw attention to the rise of prophetic movements and their healing activities. Since then, numerous studies have been carried out on healing in Christian churches and prayer camps (e.g. Mullings 1984; Sackey 1989, 2001; Van Dijk 1997; Asamoah-Gyadu 2005; Krause 2008b; Kwansa 2010; Read 2012). Here again, the case of Ghana has stimulated debates of wider relevance for the anthropological discussion in general, such as the relationship between missionary activities and conversion to “modernity” (Meyer 1999), as well as how Pentecostalism has impacted the Ghanaian media industry (De Witte 2008). A contribution by Kristine Krause to this special issue describes how the taking of medicines is embedded in religious practice.

With regard to a systematic exploration of Christian therapeutics, the work of Adam Mohr (2008, 2010, 2011) is particularly important. Most writings on Christianity have been on so-called spiritual or Pentecostal churches. Yet, as Mohr (2008: 6) highlights, demographically speaking the majority of people in Ghana belong to so-called mainline churches. In combining the work of both a historian and an anthropologist, and by looking beyond the boundaries of Ghana to include

branches of the Presbyterian Church in the U.S., Mohr was able in his research to answer in great detail the question of how discourses and practices of healing have changed over time and space in one of the oldest churches in Ghana.

Biomedicine

Although the provision of biomedicine was mentioned as early as Twumasi's 1975 book on the medical various systems in Ghana, it was only toward the end of the twentieth century that biomedical activities, products, and institutions in the country caught the attention of social scientists, as worthy of studying in more depth. This shift was related to the "homecoming" of cultural anthropology: "culture" was not only what "others" thought and practised; Western science too was a cultural phenomenon that deserved to be explored in the anthropological manner. To provide detailed descriptions of biomedicine in its practiced form and as situated knowledge was thereby the innovative contribution of these studies.

A pioneering step in that direction was taken in a study by David Patterson (1981) of the epidemiological situation in the then Gold Coast between 1900 and 1955, from a political and economic perspective. Patterson's study included an assessment of "modern" medical services in the colony. Poverty and ignorance, according to the author, were greater obstacles to good health than a lack of doctors and clinical facilities. Stephen Addae (1996), a medical scientist, wrote an historical account of the development of modern medical services in the colonial and immediate post-independence area, between 1880 and 1960. Kodjo A. Senah (1997) studied the popularity of modern pharmaceuticals in a coastal village and described how these products had been reinterpreted and integrated into local concepts of anatomy and aetiology. Bernhard Bierlich's (2007) study in Dagbon society also focused on modern pharmaceuticals. He showed the liberating effect of these pharmaceuticals in the lives of women who

could simply buy them rather than have to “beg” for them, as they had to do for traditional medicines. Bierlich thus connected the availability of biomedical commodities with changes in gender relations, morality, and “modernity.”

Ethnographic research in hospitals and other clinical settings is another example of the turn to biomedicine. Christine Böhmig (2010) conducted anthropological fieldwork on a ward in Korle Bu Hospital and described the daily routines of nurses. The nurses had been trained in Western concepts of care but were confronted with problems that were never mentioned during their training. In a study on the differential treatment of patients in a hospital in Bolgatanga, Helle Max Andersen (2004) analysed the production and legitimisation of categories of difference from the perspective of the health workers. She showed how the categorisation of patients is linked to the professional attitudes and identities of the health workers, and how this allows room for negotiation and agency under demanding working conditions. Jonathan Dapaah (2011) studied the treatment of HIV/AIDS patients in two hospitals in the Ashanti Region. Faced with stigmatisation in their family and wider society, patients found a new “home” in the hospitals, where they could speak openly about their problems with nurses, doctors, and other patients. Most hospitals in Ghana are linked to mission medicine and ambitious political projects. Pascal Schmid’s contribution to this issue explores the history of one hospital in the context of missionary work and political developments in the country.

Concerns about fertility were and remain common in Ghanaian society, which explains the interest in reproductive technology in Ghanaian research. Field (1960), in her early study of visitors to shrines in Brong Ahafo, found that about one quarter of the complaints was related to problems around pregnancy and childbirth. Christine Oppong has written extensively and edited various volumes on aspects of fertility in relation to gender, class, and politics in Ghanaian society (e.g.

Oppong 1987). Wolf Bleek (1976) studied sexual relationships and birth control practices in a rural town in Southern Ghana and found that contraceptive techniques were hardly available to those who were most in need of them (school-going youths), while those who did have access to them (married couples) were rarely interested. As a result, induced abortion was commonly practiced by young unmarried women, sometimes with serious consequences for their health and future reproduction. Today, with the arrival of HIV, condoms – and other contraceptives – are widely available for sexually active people of all ages.

Recent research by Viola Hörbst and Trudie Gerrits (2013) shows how the latest technologies in reproductive medicine have been brought to Ghana by specialists who have worked abroad, who have built one of the first fertility clinics in the region. While the clients of the clinic are mainly middle class Ghanaians, the clinic also offers sources of income for women who serve as surrogates or egg donors. Aspects of fertility in a broader sense are discussed in this issue by Albert Awedoba and Aaron Denham. By exploring the difficult “management” processes around infants born with a disability or “abnormality” in the Upper East Region of Ghana, they show that fertility is not just about getting any baby, but about continuity of a particular kind.

The introduction of health insurance was a milestone in Ghana’s health policy and has since formed an important topic of research. Daniel Arhinful (2003) explored and critically analysed “the gap between the official rhetoric concerning community health insurance and the reality of people’s views and expectations” (viii). Ten years later, his findings were confirmed by three other researchers: Genevieve Aryeetey (2012) and Caroline Jehu-Appiah (2012) studied the problem of “sub-optimal enrolment” in health insurance, especially among the poor, and proposed solutions to improve enrolment; Agnes Kotoh (2013) wrote a case study of two rural communities,

discussing both the obstacles to health insurance enrolment as well as the enabling factors. Kotoh too focused on the failure to reach the poor, for whom – ironically – the insurance was most urgent. Other critical studies of health insurance in Ghana include F. K. Nyongator et al. (2005), Irene Agyepong and Samuel Adjei (2008), and S. Witter and B. Garshong (2009).

Mental Illness

Among the non-communicable diseases that present an ongoing problem in Ghana, mental illness is one of the most pressing (De Graft Aikins 2007, 2014). In an extensive literature review, Ursula Read and Victor Doku (2012) looked at 66 publications between 1955 and 2009. They found that “much of the research was small in scale and thus largely speculative in its conclusions” (29). Epidemiological quantitative data was virtually absent, as were in-depth qualitative studies, and very few studies focused on clinical practices in mental health. The authors further concluded that claims for the efficacy of traditional healers in mental health “tend to be anecdotal and speculative and are seldom based on rigorous longitudinal data” (35). They traced only one study about the role of the family in providing care for patients during their stay in traditional shrines and churches (35).

Laudable exceptions to the somewhat pessimistic conclusions of Read and Doku include the early study of Field (1960), discussed above, and Leith Mullings’ (1984) monograph on mental illness among Ga people in Labadi, as well as more recent research by Ama De-Graft Aikins and Angela Ofori-Atta (2007), who looked into the interrelated phenomenon of homelessness and mental illness in urban contexts in Ghana, with a special focus on how people cope in their daily life. Mullings (1984), in her study, analysed how healers mediate new arising ideologies and forms of social organisation. She juxtaposed traditional healing by shrine priests with the services offered by Christian spiritualists, and

argued that the former tend to locate the reason for an affliction within the wider social relations of a patient and include the kin network in the therapeutic process. The therapy therefore externalises internal conflicts. In contrast, spiritualists – like biomedical professionals – would rather concentrate on the individual and his/her personal responsibility.

Ursula Read's (2012) dissertation on mental patients in Brong Ahafo focused on the experience and role of the family in the treatment and management of mentally ill patients. She found that many such patients are still brought to healers where they are often kept in chains. In her contribution to this issue, Read focuses on one particular theme in her dissertation: the concern of parents with a mentally disturbed child to keep their child within the family. The combination of biomedical treatment and spiritual healing is not only initiated by patients and their families, however, but also by biomedical practitioners. Krause (2006) found that mental health professionals who are born-again Christians combine biomedical treatment with Christian charismatic healing by providing drugs in the morning, and "anointing prayers" in the afternoon (57).

HIV/AIDS

As almost everywhere in Sub-Saharan Africa, HIV/AIDS has attracted much attention from social scientists and international donor agencies in Ghana, among others. Although the prevalence is low in comparison with countries in Southern and East Africa, the disease raises many questions because of the huge attached stigmatisation and other social complexities. Numerous articles have been published on HIV/AIDS focusing on prevalence, policy, sexual behaviour, secrecy, stigma, social exclusion, and counselling (e.g. Anarfi 2003; Anarfi et al. 2000; Awusabo-Asare 1995; Awusabo-Asare and Anarfi 1997; Kwansa 2011; Mill 2003; Radstake 2000). Phyllis Antwi and Yaa Oppong (2006) provide an overview of attempts to manage

the disease in Ghana plus an extensive list of references. Two recent dissertations looked at the experiences of people living with HIV/AIDS in the context of their family and community (Kwansa 2013) and at two hospitals providing treatment and care for HIV positive people (Dapaah 2012). In his contribution to this issue (co-authored with Eileen Moyer), Dapaah discusses the role of “peer educators” in hospital work for people living with HIV/AIDS. In another paper, Perpetual Crentsil discusses how the use of mobile telephones facilitates confidentiality and the logistics of care for people with HIV/AIDS, but also poses new risks. Fidelia Ohemeng draws attention to a clear preference among HIV positive people to disclose their status to female relatives.

Care

A concept that underlies all themes discussed so far is care. The term “care” has various shades of meaning. Its two basic constituents are emotional and technical/practical. The latter refers to carrying out activities for others who may not be able to do them alone. Parents take care of their children by feeding them, providing shelter, educating and training them, and so forth. Healthy people take care of sick ones and younger people of older ones. This type of care thus has a complementary character. Care also has an emotional meaning: it expresses concern, dedication, and attachment. Ghana differs from European societies in that it is the family that takes on the responsibility for caring for its members who can no longer care for themselves. Whereas older people in Western Europe usually move into institutions or receive professional care at their homes when they grow dependent, Ghanaian families keep their sick and older relatives at home where family members or members of the social network who have agreed to take over this task care for them. The question is, of course, whether families will be able to continue this tradition in the globalising present.

Valentina Mazzucato (2008) conducted extensive work on transnational networks of Ghanaians living in the Netherlands and found that a major portion of remittances are sent to pay for care for the elderly through a network of generalised reciprocity. Migration, in her words, can be seen as an “implicit insurance contract between the migrant and the family back home” (91). One way in which children who live in Europe express their care is by building houses for their elderly parents. But, as Mazzucato shows, a new house alone does not guarantee that the old have their needs met.

This raises the question of the extent to which care in the past was as “perfect” as the older generation claims (cf. van der Geest 2002). Nana Apt (1996), Sjaak van der Geest (2002, 2004), and Isabella Aboderin (2006) have all emphasised the importance of reciprocity in intergenerational support and have written critically about care for older people and the shifting priorities among the younger generation with regards to care. Deborah Atobrah (2009) and Sarah Dsane (2010) studied care for chronically ill and older family members in two Ga communities, while Baataar (2001) focused in his dissertation on care for children in northwest Ghana. Christine Oppong and Kari Waerness directed a large research project for NUFU (the Norwegian Programme for Development, Research, and Education) that produced several publications on care. Two collections of articles dealt with care for the seriously sick and dying (Oppong et al. 2009) and on child care in a globalising world (Oppong et al. 2012).

This issue contains several contributions that focus on aspects of care. Deborah Atobrah attempts to provide clearer insight into the quality of care that Ga families in the past gave to seriously ill relatives; Fidelia Ohemeng, as mentioned above, discusses the preference for female caregivers among people living with HIV/AIDS; Ursula Read details how the burden of care for the mentally ill is mostly left with mothers; while

Benjamin Lawrance describes the plight of Ghanaians seeking medical treatment in London.

Contributions to this Issue

The articles in this special issue tap into the discussions described above. They show the manifold articulations between health and care arrangements on the one hand and socio-cultural developments on the other.

Albert Awedoba and *Aaron Denham* analyse in their article the multi-layered discourses and practices around the phenomenon of the “spirit child” in Kasena and Nankani society in the north of Ghana. The authors present the spirit child both as a form of discourse and as an infanticide practice, arguing that it needs to be seen in terms of its connection with local moral worlds and understandings of personhood. By describing how spirit children are handled in practice, the authors show how these cases emerge from a concern about fertility and growth, as well as continuity of the family. Poverty, food insecurity, and the prioritisation of human and kinship relations therefore play a vital role.

Family relations, and their gendered forms in particular, are at the centre of *Deborah Atobrah*’s, *Ursula Read*’s, and *Fidelia Ohemeng*’s contributions. *Deborah Atobrah* explores the care provided to people suffering from chronic non-communicable diseases in the past. Family care in the past is commonly described as superior to the quality of care today. Closer-knit networks and stronger solidarity within families two and more generations ago are often held up as examples in contrast to the current “disintegration” of families who fail to provide the care that sick and older relatives need. *Atobrah* examines the extent to which this romanticised image of the past is supported by reliable evidence. In-depth conversations with older people in a Ga community enabled her to nuance these romantic stories, but also suggested that these accounts are indeed plausible in their historical context. She concludes

that it is not only the quality of care relations that has contributed to this positive picture of the past, but also the fact that the incidence of chronic disease was lower and biomedical intervention more difficult to access, and therefore people died more quickly and did not require such long term domestic care. Therefore, “These factors rendered the care demands less burdensome than what prevails today”.

Ursula Read found in her study on caregiving for mentally ill persons in Kintampo that it is mainly mothers who take on the burden of care, in particular when the condition turns chronic. Based on case studies from her extended fieldwork, Read analyses the financial stress and social and emotional toll of severe mental illness and the associated disability for families. She explores the tension between the status of a person considered as “mad,” who is unable to contribute financially or in any other way to the family, and the moral obligation not to abandon a family member. The “mad vagrant” roaming about in towns and cities epitomises a national stereotype of madness and its association with the opposite of the domestic ideal. Paradoxically, the mad vagrant embodies both the sanction that “this is what happens to someone who is uncared for” and the moral judgement of the mad person himself, that “this is what happens if you take drugs.” Read argues that neglect of a family member may be morally more shameful than the taint of madness within a family.

Fidelia Ohmeng argues that the people likely to be informed by AIDS patients about their status are those perceived by the patient to be potential caregivers, and that such people are mostly female. She draws her conclusions from interviews with 25 people living with HIV/AIDS receiving treatment at a Ghanaian hospital. Her findings confirm the near universal gender imbalance in practical care giving and provide important insights into the dynamics of HIV disclosure in a context of extreme stigmatisation of people with the disease.

These insights are useful in the struggle against HIV/AIDS and its social recrimination.

Perpetual Crentsil's contribution is also concerned with HIV/AIDS and questions of disclosure and trust, but approaches the topic from a very different angle by bringing together four different themes: the appropriation of mobile phones in Ghana, the potential of mobile phones for counselling, the problem of secrecy related to HIV, and telephones and their association with (extra-marital) sexual relationships. Crentsil argues that mobile phones can be used for counselling patients, helping patients and counsellors to avoid stressful long distance travel. She further points to the ways in which the specific forms of interaction created by the technology can be particularly suitable for discussing sensitive issues around HIV/AIDS.

Jonathan Dapaah and *Eileen Moyer* describe “expert patients” or “peer educators” in two hospitals, who find themselves caught between professionals and HIV/AIDS patients. Some years ago, a donor-funded initiative promoted the use of HIV positive patients as peer educators in treatment and counselling. This programme has subsequently ended, but the “experience-experts” still show up at the clinic, even though they are no longer paid for their services and are not formally recognised by the hospital. In practice, they are called upon not only by patients but also by the nurses on the understaffed wards. Nevertheless, there remains a general lack of recognition for their work by hospital authorities and health workers. By examining the frictions between differently positioned healthcare providers, the authors demonstrate what is at stake for peer educators in their daily work and lives. The study shows the potential for people living with HIV/AIDS to act as credible and effective health workers, as well as their agency and self-management to overcome the social and moral challenges associated with HIV infection.

The contributions by Kristine Krause and Benjamin Lawrance both deal with Ghanaians living abroad, although from very different perspectives. *Kristine Krause* describes one specific aspect of Christian charismatic healing – the praying over pills and food – and analyses how pharmaceuticals and foodstuffs can become boundary objects between God's healing power and the believer. Pentecostal healing practices are employed by Ghanaians in London to arbitrate in some situations and deal with the unpredictable nature of biomedical interventions. They thereby secure the deeply insecure position that many Ghanaian migrants inhabit.

Fundamental insecurity and the structural violence of the European migration regime are central to *Benjamin Lawrance's* article. Lawrance analyses the country's policy towards immigrants seeking treatment through the presentation of two cases of Ghanaians who attempted to get permission to remain in the U.K. for medical treatment. For these two Ghanaians, permission depended on whether adequate treatment for their health problem was available in Ghana. An over-positive evaluation of medical services in Ghana fell into the lap of immigration officials, who consequently denied the two migrants the right to treatment in the U.K., despite the fact that the specialised care that they needed was beyond their resources in terms of affordability as well as the specialisation level available in the country.

Finally, the contribution by *Pascal Schmid* provides an historical analysis of biomedical practice in rural Ghana. It is based on the case of Agogo Hospital in the Ashanti Region, which was founded in 1945 by the Basel Mission and is today run by the Presbyterian Church. Until the 1950s, the hospital acted to a great extent autonomously of the colonial health care system and focused strongly on curative medicine and hospital-based care. By the end of the 1970s, the hospital had become integrated into the national health care system and worked in more consonance with the current policies, which aimed for

community focused, preventive, and basic health care. Schmid shows how medical practice in Agogo emerged out of the changing constellations of different interests, ideas, conceptions, and values; a process in which nurses' training in particular played a crucial role.

The influx of missionaries in the past resulted in the building up of a wide network of biomedical facilities. Similarly – and paradoxically – today's outmigration of nurses and doctors also shapes the health system of Ghana, while the outmigration of many other Ghanaians means that families have to rethink care relations and how to cope with the financial burden of disease. Another significant change is that in addition to the well known health threat of infectious diseases, Ghana is now witnessing an increase in chronic health conditions such as hypertension, cardio-vascular diseases, stroke, and cancer. In urban centres, the private health market is flourishing and comprises not only fertility clinics but also genetic testing centres for members of the old African Diaspora in search of their roots in Ghana. Various holistic and spiritual health centres have “gone global,” and traditional priest-healers and Pentecostal pastors post films on YouTube. All in all, there is no doubt that the landscape of health and healing in Ghana is ever changing, but some things have remained the same. In Akyeampong's (2006: 207) words, “disease and health in West Africa's history cannot be removed from the context of political economy.”

The contributions to this special issue illustrate these aspects and show how a social and cultural approach to illness and health illuminates the ways in which people produce culture and society and, in turn, are “products” of social and cultural processes. The editors and authors therefore modestly hope that this special issue will contribute not only to a better understanding of the dynamics of health and health care in Ghana but also to global discussions in the field of social health

sciences. We believe that the articles will have theoretical and ethnographic value for academic researchers, as well as practical relevance for policy makers and people working in the field of health care in its widest sense.

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⁵ Wolf Bleek is a pseudonym that Sjaak van der Geest used to protect the anonymity of his informants.

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Appendix: Ph.D. Dissertations on Health and Health Care in Ghana

This list of – mainly unpublished – Ph.D. dissertations is based on what the editors and some colleagues could assemble, but is far from complete. Additions and corrections can be sent to Sjaak van der Geest: s.vandergeest@uva.nl

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THE PERCEPTION OF ABNORMALITY IN KASENA AND NANKANI INFANTS: CLARIFYING INFANTICIDE IN NORTHERN GHANA

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While the scholarship of health researchers working in the Upper East Region of Ghana concentrates on the epidemiological and demographic factors affecting child health and child rights advocates focus on child labour, sexual abuse, neglect, and forms of abuse, few scholars have explored infanticide practices, such as the spirit child phenomenon, that are reported to occur in the region. This article, based on ethnographic research, addresses this gap by offering a description of the spirit child phenomenon. By presenting the spirit child as a form of discourse and as an infanticide practice, the article demonstrates how the spirit child is ultimately connected to local moral worlds, personhood, and concerns about the family and its perpetual continuity.

Keywords: Spirit child, infanticide, Kassena-Nankana District, infant and maternal health, disability.

Introduction

The Kasena people have a saying: “If you are kin-rich it matters not if you do not have material wealth” (*Tan jegenoon se-n yeimwonnu*). For the Kasena and their culturally similar neighbours the Nankani, real wealth is measured in persons—one’s children, dependents and kin—and it is praise worthy to expend other valuable resources such as subsistence goods, livestock and labour in the accumulation of dependents.¹ However, not all children are seen as a positive addition to the family. Despite the importance of children,

¹There is variation in how communities in the region refer to themselves and are referred to by others. There are also variations in spelling. In this case, we use Nankani, as opposed to Nankana, and Kasena, rather than Kassena. All language references in this article are in Kasem unless otherwise noted.

some are regarded by families as dangerous bush spirits “masquerading in human guise with the ultimate object of subverting man” (Awedoba 2000: 25). These “spirit children” are subject to infanticide through administration of a poisonous concoction or other death hastening behaviours designed to send the child back to the “bush” before it is able to cause further misfortune and distress. Spirit children come into the family to harm to one’s kin and cause illness, infertility and death. They are also implicated in crop failure, loss of livestock, and other misfortunes. They do not fit within the family and are not regarded as human.

This article discusses the spirit child phenomenon among the Kasena and Nankani people of Upper East Region (UER) of Ghana and answers why family members would condone the death of certain infants and children associated with the bush—a wild and untameable space seen as antithetical to the family. Throughout the region, people refer to spirit children in various ways, such as “bush babies,” “dwarfs,” “bush spirits” and “fairies” by earlier anthropologists and as “babies of misfortune” in the media (Fortes 1987; Goody 1972; Rattray 1932). In Kasem they are referred to as “*chuchuru*” and in some Oti-Volta languages spoken in the UER they are known as “*sinsireko*,” “*kyinkyiringa*,” or “*kolkpaare*.” “*Kontome*” is a possible analogous term in Dagaba. For consistency this article uses the term “spirit child,” which is in accordance with the previous scholarship on the topic in this region.

While the writings of health researchers concentrate on the epidemiological and demographic factors affecting child and family health and child rights advocates focus on child labour, sexual abuse, parental neglect, and forms of child abuse, few scholars have examined infanticide practices in the UER. When scholars subject the spirit child phenomenon to scrutiny, it is often misunderstood. Researchers, the media, and community members frequently do not consider the difference between the community discourse on the spirit child—such as folktales and

rumour—and what actually happens in practice when families are confronted with a suspected spirit child. Less frequently do people consider the importance of the sociocultural and contextual influences on the phenomenon, such as local definitions of personhood and normality, the role of poverty and food insecurity, and the prioritization of human and kinship relations—and hence fertility. Examining these interrelated factors, while considering what is at stake for families, offers insight into how suspected infants and children can come to embody characteristics of the bush and its wild, anti-social characteristics that threaten the family.

The Kasena and Nankani people do not regard infanticide as murder but as a practice done in the best interests of the family to ensure its continuity. Some community members also recognize that since spirit children are often disabled or chronically ill, such actions can be in the best interests of the child, particularly in rural and resource poor areas. While it is beyond the scope of this article to present an adequate discussion on the slippery slope of “mercy killing” or euthanasia, it remains important to consider how community members do not necessarily perceive this practice as a callous act.

The Scope of Infanticide

There is abundant evidence of infanticide occurring within most societies at some point throughout their history (Williamson 1978). There is no agreed upon definition of infanticide. In its most narrow conception, it is regarded as the wilful death of a newborn. However, infanticide is also used to describe the death of older children without reference to age. Broadly speaking, it is most often understood as behaviour likely to lead to the death of a dependent (Scrimshaw 1984: 440-42). This includes deliberate killing, placing a child in a dangerous situation, abandonment, and what Susan Scrimshaw

(1984) describes as lowered biological support. That is, passive infanticide through underinvestment or selective neglect. Abortion, euthanasia, accidental death, and death resulting from excessive physical punishment are less often considered infanticide. Regardless of how scholars define infanticide, such practices require the consideration of the local moral complexities associated with the act and an attention towards the larger context in which it occurs.

In a comprehensive literature review, Catherine Hill and Helen Ball (1996: 382) categorize the most common reasons for infanticide as including low likelihood for survival, inadequate resources, twins, gender preference or abnormal births. In her research among the Beng people of the Côte d'Ivoire, Alma Gottlieb (1992) describes how children with developmental or physical disabilities could be regarded as "snake children." Similarly, Jónína Einarsdóttir (2004) describes how among the Papal of Guinea-Bissau children born with physical or functional abnormalities could be regarded as "*iran*" or spirits. *Iran* children are often subject to abandonment.

In her research among the Bariba in Benin, Carolyn Sargent (1988: 80) found that infants displaying unusual biological features such as neonatal teeth, or born prematurely or in a breech position, are considered witch babies and are killed or abandoned. The witch baby practice, which bears several similarities to the spirit child practice, requires an understanding of the role that witch babies play in the causation of misfortune, and the relationship of misfortune to witchcraft, sorcery, ancestors, and taboo violation. In this practice, solitary birth provides the mother flexibility in determining the fate of the child, since she is the primary decision-maker. If necessary, the mother may call a midwife to help with her decision. Calling for help before delivery of the placenta signals to the family that a dangerous child may have been born. After the child has been born, the mother has the power to disclose

information that may lead family members to believe that the child is a witch baby. The male head of the house often makes the final confirmation and, if necessary, infanticide and the subsequent purification ceremony are carried out by a ritual specialist (Sargent 1988: 84). The loss of such children is not to be grieved due to the harm that such a child can cause the family. The increasing numbers of hospital births complicate such decisions, since the birthing process has shifted from a private to a public affair. Although infanticide still occurs, alternatives to the child's death, such as giving the child to missionaries, are described as becoming more common (ibid: 86, 90).

Most infanticide accounts frame practices in terms of evolutionary, sociobiological, or economically oriented paradigms—wherein nonviable children, for example, are subject to infanticide due to inadequate resources. While infanticide data often easily fit within these experience-distant frameworks, they rarely capture or offer detailed descriptions and interpretations of infanticide practices; they do not consider the closer experiences and decision-making processes that families face when confronting these circumstances. Moreover, data supporting these theories are too often cursory, anecdotal, misrepresented and inaccurate (Bechtold and Graves 2006). This oversight is understandable in part because accurate data and accounts of family experiences of infanticide are difficult to obtain. This difficulty has been true for the spirit child scholarship.

Previous work on the spirit child has framed it as an “important risk factor for infant mortality” and that within the Kassena-Nankana District up to 15 percent of infant deaths of under three months could be due to the practice (Allotey and Reidpath 2001: 1010). Demographic data from the Navrongo Health Research Centre estimated that 4.9 percent of neonatal deaths between 1995 and 2002 were a result of infanticide

(Baiden et al. 2006). Newer studies have shown that infanticide is likely less common than thought and accounts of spirit children do not distinguish between discourse and practice. Aaron Denham et al. (2010) demonstrate that describing a child as a “spirit” is not a reliable indication of the cause of death. In some cases, families use it as an explanatory model to describe, for example, the ultimate reasons for why a child died of malaria or another condition—families might say the child was not meant for this world and that it wanted to return to the bush. Hence, how families use the spirit child construct to understand and describe events within the family might differ from the actual cause of death.

Context

This article is based on ethnographic research conducted throughout the Kassena-Nankana District (KND) and in neighbouring communities of the Upper East Region. Albert Awedoba conducted in-depth interviews during the late 1980s, primarily within the Kasem communities of Navrongo, Paga, and Chiana. He is also from the district. Since 2006 Aaron Denham has conducted in-depth ethnographic research on the spirit child phenomenon primarily within the Nankani communities of Sirigu, Yua, and Kandiga. He interviewed and worked closely with families and spirit children, concoction men, diviners, and local NGOs. He continues to work in the region.

While the UER has distinct urban areas that continue to grow, a significant portion of the population lives within rural areas as subsistence farmers. Migration to southern Ghana is also a source of income for many families—the north has traditionally been a source of human labour. There is a substantial north-south political and economic divide. Planners and development organizations have frequently neglected northern development and infrastructure projects in favour of the south. In the north, community members claim that in

comparison to southern Ghana and the rest of the world the gains from “modernity” have been unevenly applied. While much has changed within the region over the past several decades, many dimensions of daily life have remained unchanged. Mixed agriculture combining crop farming, poultry, and livestock husbandry continues to be practiced outside of urban areas. The UER is a semi-arid Guinea savannah with one annual rainy season. Due to the dependence on a single growing season, food insecurity, periods of famine and seasonal malnutrition are persistent threats and offer significant challenges to families.

Families within the UER are patrilineal, virilocal, and organized according to a segmentary lineage pattern. The Kasena and Nankani have always invested in people. Polygyny is practiced, although less common than in the past. Traditionally, children and large families have been a priority, resulting in high fertility rates. Prayers frequently contain requests for prosperity measured by large families, abundant harvests and the survival of children. Kinship and economic imperatives, as well as the prestige of having a large family, drive pronatalist beliefs. However, in recent years the district’s fertility rate has fallen in conjunction with community health and family planning projects and other regional demographic changes (Debpuur et al. 2002).

Between 1995 and 1999 the total fertility rate in the district declined from 5.1 to 4.1 percent (Baiden et al. 2006). In 2004 the Navrongo Health Research Centre indicated that the total fertility rate was 3.9 percent. Infant and child mortality rates have also improved over the past decade with child mortality (1 to <5 years) dropping below the national average of 82.9 deaths per 1000 births. Infant mortality (0 to <1 year) in the KND has also improved by about 34 percent in the past decade with 84.6 deaths per 1000 births (Binka et al. 2007). These improvements are probably due to Ministry of Health and the Navrongo

Health Research Centre's community-based health interventions. Historically, child mortality rates were much higher. Even today, as in the past, a significant burden of infant and maternal mortality remains a result of home-birth complications in rural areas (Ngom et al. 1999). The primary causes of child mortality are malaria, diarrheal diseases and acute respiratory infections (Baiden et al. 2006). Scholars have dubiously claimed that further reductions in child mortality could come with the elimination of infanticide (Baiden et al. 2006: 532).

Maternal and child mortality figures depict only one dimension of the spirit child context. Attempts to understand the spirit child must consider the cultural and social characteristics, such as distinctions between the house and bush and notions of personhood. Community members regard the house (*songo*) and settlements (*sam*) as safe, predictable, and habitable. The bush (*gaao*) is unsafe, unpredictable, and a habitat for predators and various spirits, such as diminutive spirit beings that are antagonistic to humanity. Family members must keep things originating from the bush out of settlements unless they have been captured, killed or otherwise rendered safe to bring into the house. Notions of personhood and entities deemed safe for the family are often understood according to this dichotomy between domesticated and undomesticated spaces.

Personhood is a social fact and social status that cannot be understood as an individual or atomistic phenomenon (Mauss 1985). While personhood in a European sense follows an ideology of individualism that ascribes family membership and personhood by virtue of birth or, within some communities, conception, many communities in the UER do not necessarily follow this pattern of instant and assumed personhood. Families can be initially suspicious of infants and children and their intentions until their status as a "human being" is confirmed. The attribution of personhood is a more gradual and

accumulative process occurring over one's lifespan which involves in part engaging in socially appropriate relationships and exchanges with others.

Personhood is a distinctive part of morality that characterizes who is socially recognized within the community. In this case, families establish an initial foundation of personhood connected culturally to specific notions of normality and an individual's value within the family. Community members consider characteristics associated with the bush—such as selfishness, abnormality, and wild behaviours—as antisocial and not evidence of personhood, regardless of the age at which they appear. A child appearing or behaving abnormally, or an infant associated with a succession of misfortunes, can raise questions within the family concerning what transgressions brought such a child—or the bush-like characteristics—into the family. It is possible that families will identify such infants and children as “spirits” that are not human or persons, since they did not originate from the house of God or be given a life predestined to end with entering the land of the ancestors.

Community members consider the killing of any human being sacrilegious and a crime against the earth. Abortion was also relatively uncommon until recently—it was seen as murderous since it denied the ancestors their right to enter and leave the world of the living, as decreed by God. However, traditionally, family members do not regard causing or hastening the death of a spirit child as a form of abortion or murder because such an entity is not human or a person.

The Spirit Child as Discourse

The discourse—specifically, myth, folklore, personal accounts, and rumour—surrounding spirit children has considerable historical depth and breadth within the UER. This section briefly explores the spirit child discourse, working from the

position that the spirit child myths ultimately contain “truths and issues of explicitly cosmological significance” (Gottlieb 1992: 98). Upon examining this discourse we can begin to develop an understanding of what is at stake for families and the community.

Community members frequently recall dramatic stories about spirit children, either as myths, rumours, or personal encounters. Children and adults are commonly exposed to stories about the antics of spirits. Such stories include spirits attempting to trick humans, nefarious night time gatherings, and infants sneaking out of house at night to roam the bush or frolic with other spirits. Some also offer family-based experiential accounts, whether real, imagined, or exaggerated. For instance, a Nankani man explained:

At my uncle's house there was a child there that could not walk, it could only crawl. In the night while everyone was sleeping the child was able to go across the compound to a different room. The child stood up next to a covered pot with bambara beans, opened the lid and ate the beans in there. An old man walked by and saw the child. The child cannot walk, how is it able to get there? Because of that, they knew immediately, the child was a spirit child. (Interview, Denham 2006)

A widespread concern is that the child will vanish when no one is watching. When describing what a spirit child does, a Nankani man stated, “The child will be sleeping with the mother and all of a sudden, the child will vanish.” Kasem communities discuss how the spirit child is able to fly at night, leaving its mother's side to milk lactating cattle dry. Concerns around uncontrollable consumption of household resources are common. A Nankani man offered the following when asked to describe a spirit child:

My mother gave birth to a child. Just by looking at this child nobody believed that it could survive. Then some strange things started happening in the house. All the fowls in the house disappeared. We went to the soothsayer and discovered that it

was a spirit child and was eating all the fowls in the house.²
(Interview, Denham 2006)

The broad range of factual and seemingly implausible accounts of spirit children emphasize how the spirit child discourse is enmeshed within a complex web of family and community relationships and concerns. Therefore, the unique beliefs and experiences surrounding spirit children are adapted to and are taken from understandings of these social relationships. The spirit child discourse is not only shaped by the cultural system in which it is embedded, it in turn shapes people's perceptions of infants and children and mediates their experiences of normality and abnormality.

Within Kasena folktales, there is coexistence of animals, humans, and an ogre-like category of spirits (*chuchuru*) which include the spirit child. The latter are presented as monstrous beings capable of Herculean feats. Community members depict them as ugly—with an abnormal or disproportionate bodies consisting of a large or multiple heads or unusual genitalia. They are obtuse, wicked and amoral. In their narrow sightedness, however, man is able to take advantage of the spirits in efforts to acquire knowledge and inventions. Community members describe how they discovered improvements in farming techniques or medicines from tricking the spirits. A Nankani elder recalls how a hunter exploring the bush learned how to make *pito*, a local beer, from a spirit child. The story follows:

There was one hunter who went to the bush and climbed to the top of a tree to look around. He saw some spirit children. He could see them physically and they were very short. The hunter was able to watch the spirits making the malt and brewing *pito*; they could not see him. He had never had *pito* before so when the spirits left he got down from the tree and drank the *pito* and

² "Soothsayer" is the local English term for a diviner. Locally, men practice a form of interpretive divination.

found it was very good. He returned to the tree to continue watching. When one spirit came back, he said “Ahh! Who has come here and taken my drink?” This spirit said to himself, “This fellow doesn’t know how to make it!” The spirit explained all the steps involved in preparing *pito* and the hunter was silent as he listened to all the spirit described. It wasn’t hard to hear him, since the spirit was shouting loudly. When the spirit left, the hunter quickly returned to his house and instructed his wife on how to make *pito*. When all the people began to enjoy *pito*, all the spirit children became angry and swore they’d come into people’s houses to attack them because the hunter had taken their knowledge.. (Interview, Denham 2006)

Calling someone a spirit child can refer to an individual who prefers to be alone or a person without a sibling. Community members might remark that such a person has killed his/her siblings or prevented the parents from having another child. In Kasem, *wo-chuchuru* (lit. a *chuchuru* thing) is something that is strange and hard to comprehend. A *non-chichirais* a person who is hard to understand or is eccentric. In one Kasena folktale, a spirit child cultivates eggplant by the roadside and decides to set a trap for unwary humans.

A mother and her spoilt toddler were walking along the road. The toddler demanded to have some of the eggplant by the roadside and began to fret and throw a tantrum. The mother told the child that he could not have just anything he wants; the eggplant crop belongs to someone else. The child continued to protest. The *chuchuru*, hearing this, tells the mother that she can fetch a ripe eggplant for her child, civilly remarking that “a child is not solely for the individual.” As soon as the mother finished plucking it, the *chuchuru* demanded that she re-attach the fruit. It took the intervention of a wiser man to rescue the woman and her child from trouble. (Interview, Awedoba 1970)

A similar Nankani folktale exists. In such matters, if someone gives something then demands it back again the person might be asked, “Are you a spirit child?”

While appearing human-like and having significant power to deceive, the spirit child is, as community members describe, “The enemy of mankind”—bent on harassing people and

causing misfortune and death. The ambivalence surrounding the spirits and the spirit child is in part a result of their position between worlds, human and spirit, house and bush, and the moral and amoral spheres.

Within Kasem thought, the larger category of *chuchuru* has a diminutive analogue the *chichira*, a tiny spirit being living in the bush. This form of bush spirit is said to be invisible to most humans. They frequently spy on people and play pranks on the unwary. Within various communities in the UER there remain individuals that have power to call on these spirits, summoning them to séances to prognosticate the future or entertain. However, these spirits, upon entering a woman and hence the family unit, also have more sinister and destructive intentions. If the family does not detect and carefully manage the spirit child, it will bring calamity as it moves from the undomesticated wilderness into the home. There is also the concept of the “sweet *chuchuru*” that does not harm or benefit the family. Community members recognize these individuals as not able to lead a normal life—they will not marry, become parents, or be depended upon to discharge kin obligations.

Finally, it is important to distinguish between the spirit child in northern Ghana and the Yoruba spirit child, or *abiku*—a child destined to be reborn after its death. While their death and rebirth torments family members, the *abiku* does not have an outright goal of destroying the family. A similar practice exists among Akan communities. An attractive child might be called back to the ancestors. Such children may be given a death prevention name, which was often offensive, and small incisions would be made on the child’s face to make it less attractive to the ancestors or make the child appear as if it came from another ethnic group (Obeng 1998). These children are not *chuchuru*; the practice differs from spirit child practices in northern Ghana. Rather, in Kasem children that die and return are referred to as *chiri-jwoora* (lit. returned spirit). Despite the

linguistic similarities between the *chiri-jwoora* and the *chuchuru*, the beliefs and practices are different.

Detecting a Spirit Child

Community members hold that spirit children are imperfect copies of normal human infants. People are therefore cautious of babies presenting certain physical deformities. However, visible signs alone might not be enough. Children displaying unusual behaviours or are associated with misfortunes could also be revealed as spirits. Family members express concern and focus their attention on the interplay between what the spirit child chooses to reveal to people and what it is able to hide. Consequently, families that suspect a spirit child observe the child's behaviours closely to determine if it is revealing any other clues to its identity.

Visible congenital deformities are the most common suspicion that an infant could be non-human. The most commonly described characteristics are hydrocephalous or a disproportionate head; being born with teeth; having various physical disabilities, such as misshapen or missing limbs or additional fingers and toes; and, possessing secondary sex characteristics when born. Essentially, the greater the degree of abnormality, the more the community is likely to perceive the infant to be non-human. Other characteristics such as dwarfism or individuals with a range of intellectual or developmental disabilities might be considered but are not automatically perceived as spirit children; rather, they could be regarded as harmless non-humans who should be allowed to live. Accordingly, physical impairment is not necessarily a guarantee that a child is a spirit. Families also change their minds regarding the status of a child. Denham encountered one family that suspected their daughter was a spirit child; however, after several weeks and multiple consultations with soothsayers and family elders they determined that she was just disabled;

the problem was not spiritual in origin but physical. The notions of causation are distinct.

In addition to physical manifestations, unusual behaviours are suggestive of a spirit child's presence in the house. Community members described a diverse range of characteristics that a non-human child would manifest. Excessive crying and voracious appetite are commonly described, as is refusal to eat. Refusing to eat but not exhibiting signs of malnourishment indicates the child is obtaining food from an unknown source. A persistent clenching of a fist could mean that the spirit has a dangerous magical object in its grasp to be used against the family. A child walking or talking before age appropriate is also a potential concern. A mother with a spirit child might report her child absent during the night—families believe that such children are out roaming the bush. Elder male family members will consult with soothsayers before and after the birth of an infant to determine its intentions and fate. Occasionally, during these consultations a soothsayer will reveal the presence of a spirit child, even when signs of abnormality are not evident. In these cases, the family will attempt to verify the diagnosis through other means or reject the possibility.

Treatment

In most cases, families require a range of evidence to confirm the existence of a spirit child and to support sending it back to the bush. Some children go on their own, described community members, and do not need the assistance of a concoction man. In Kasem this is the *chuchurikweenu* (lit. the taker of the *chuchuru*), the specialist who conducts the rituals necessary to send the spirit to the bush. These men have the necessary spiritual powers and protection to enable them to confront spirit children and repel their spiritual attacks. When children die of other causes, but the family ultimately identifies them as spirits,

they might still call the concoction man to take the body to the bush. Families do not give spirit children a funeral and do not bury them in the family graves. Families are also discouraged from mourning the death of a spirit child.

When families call the concoction man to the house to treat a suspected spirit child, there is significant variation in the methods used to send the spirit away. Many concoction men use the root of a common herb. They will either boil the root in water or simply mix it within water without boiling. The precise toxicity of the herb is unknown. It is likely mildly poisonous. Community members report that when given to spirit children it causes gastric distress, particularly diarrhoea. Most concoction men add “black medicine”—a mixture of herbs that are lightly burnt and mixed with shea oil. Some concoction men do not use any herbs or teas; rather, they simply touch the child with a symbolic ritual object. These concoction men report that this action is sufficient to send the spirit away. Most of the concoction men and community members claim that it not so much the chemical power of the concoction that is effective as it is the spirit child’s dislike of the ritual object and its desire to return to the bush (Denham et al. 2010). Families consider giving the concoction as the final test to confirm that the infant was indeed non-human—death confirms its spiritual identity. According to community members, in theory, if the child does not die, it is not a spirit. In practice, Denham found that children are frequently tested multiple times until the child dies.

Some rumours describing physically violent acts as the cause of death are present. These are rare. Denham confirmed only one such case occurring two decades ago. Other sources offer a more detailed description of the process, variations in the concoctions used and the community’s perceptions of death (Denham et al. 2010; Denham 2012).

Community discourse describes how some spirit children are dangerous and capable of fighting back, requiring a more

powerful concoction man to battle the spirit. One concoction man claimed that such powerful babies were capable of flying and clinging to the rafters for protection and attacking their adversary with spiritual missiles. In such cases, the concoction man noted, people should remove all stones from the area before he attempts to engage the spirit child. After a spirit child has passed away, the concoction man will take it to the bush. The spirit child is said to “enter the bush” as it is wrapped in a traditional sleeping mat or placed within a pot or basket and disposed of far from any settlement. Some concoction men might dig a shallow grave for the child or otherwise leave it exposed.

The Spirit Child in Practice

While the discourse surrounding spirit children can be dramatic and often fantastic, the actual cases of observed spirit children differ. The spirit children encountered during fieldwork were often physically at risk due to disability, chronic illness or related complications. Families had a clear idea of what ill or disabled children would survive to adulthood and these understandings of child vulnerability closely contributed to informing spirit child suspicions. Children with long-term problems were more likely to be understood as spirit children, whereas children with treatable conditions were less suspect.

This section elaborates on a previously published account of Azuma, a three-year old girl suspected of being a spirit child (Denham 2012). Azuma lived in a rural area with her extended family. Denham’s first visit with the family was in the middle of the dry season; he was shocked by their poverty and the general conditions within the house. All the children under the age of eight had kwashiorkor malnutrition, with distended bellies and irregular hair colour and growth. Everyone had upper respiratory infections with persistent coughs and the children seemed to lack the energy to move. Azuma’s mother,

Abiir, also had a significant filariasis infection in her lower left leg.

Azuma's medical card indicated that she was consistently underweight since birth, never exceeding 5 kg. She was developmentally delayed and could not stand unaided or talk. Azuma's most noticeable feature was a strabismus in her right eye. Wandering eyes are perceived as evidence that a child or adult is "up to something" spiritual and cannot be trusted. She had an ongoing respiratory infection and possibly malaria. Azuma's family were also concerned about her persistent crying, since it was disturbing family members as they slept and was perceived by them as intentional and mischievous. Due to her physical condition and chronic illness, her abnormal behaviours, her mother's condition and the general misfortunes within the family, the family suspected Azuma was a spirit child.

In her exhaustion, the mother expressed ambivalence about the spirit child diagnosis. If Azuma had a medical problem, she remarked, it was just a medical problem. She said that if the family was healthy and Azuma was developing properly, she would have little reason to believe that her daughter was a spirit child. However, Azuma's condition and behaviour were making her suspicious and she was concerned that Azuma might be causing her illness or even trying to kill her.

Azuma came to the attention of a local NGO through a concoction man who notified them that Azuma's family wanted him to test her with a concoction. The NGO made several weekly visits to the family, provided some food assistance and arranged for a community health nurse to treat Azuma and Abiir. The intervention seemed to be effective. Two weeks after the initial visit, Azuma was not as cranky, her eyes seemed brighter, and she was a more active. She could stand without assistance and take a few steps forward before falling. However, despite the progress, her family felt otherwise. Abiir commented on her progress: "From what people are saying,"

she responded, “I agree that the child is a spirit child. The child is hiding some features from you to make it appear as if it is not a spirit child. My friends have given birth already, and their children are walking, and are normal human beings. This child, it cannot do anything. It has even given me sickness; I am sick all the time” (interview, Denham 2006).

Abihiro reported that Azuma has indeed been eating well and that the other family members were healthy, but interpreted these changes as small. She emphasized how her filariasis infection was still bothering her and that Azuma continued to cry at night. The family still suspected she was a spirit child and had frequent conversations about calling a different concoction man. A few days later, in a final effort, the NGO soon took Azuma and Abihiro to a feeding centre in Bolgatanga for malnourished children and their mothers. During their three-month stay at the centre Azuma and her mother received food, a chance to rest and an opportunity to participate in education programs. A month after their return home Denham stopped by their house to visit and asked Abihiro if she still thought Azuma was a spirit child. “That’s not the case,” she replied, glancing toward Azuma. “It was just some sickness. She’s not a spirit child. There’s no need to call the concoction man” (interview, Denham 2007).

Azuma’s case was similar to other cases encountered where suspected spirit children had some form of disability, chronic illness or developmental delay. In the cases observed it was not disability alone that caused the spirit child suspicions; rather, a combination of factors were necessary to confirm a family’s suspicions, including sickness of the child or family members, household misfortune such as limited food or livestock loss and conflict within the family. In some cases, the provision of additional food resources or medical assistance lessened spirit child suspicions or the urgency to find a concoction man. However, this was not always the case—in

some situations, families emphasized that additional resources made no difference. These families were often in crisis and viewed the child as a significant enough threat to their lives and livelihood that action to protect the family was necessary. Despite the urgency of these more serious cases, families still spent a great deal of time considering other causes and were careful in their diagnosis. The decision to send a spirit child to the bush was rarely made in haste. Families often expressed uncertainty when confronted with a potential spirit child and would frequently wait to see if additional evidence arose before giving a concoction. Additionally, families reported that some spirit children “returned on their own,” or died of other causes—several reported that this was preferable to summoning the concoction man. The prolonged decision-making process marks a significant difference between the spirit child practice and other forms of infanticide where the decision is reportedly reached quickly and with minimal deliberation (cf. Sargent 1988; Shostak 1981).

Indeed, parents will engage in a lengthy period of help-seeking before coming to a spirit child diagnosis. We should not interpret families’ speculation or concern that their child could be a spirit as “giving up” or a form of fatalism. Rather, families are working within the pragmatic realities of a larger decision-making framework and cultural system, including specific understandings of risky children, local interpretive and meaning systems and assessments of what is in the best interest of the family. In some circumstances, families have simply run out of options.

It is apparent that the discourse surrounding spirit children influences how families interpret infant and child abnormalities and misfortunes occurring within the household. When a child is born, its embodied status creates an opportunity for meaning making within the family and community. Abnormality, illness or disability—when interpreted through the local moral world—can become a focal point wherein conflict and threats

to the family are manifest. Bodies are made “to speak powerfully about social problems and ultimate values.” One method to manage and defend against social complexities and ambiguity is to express these values and concerns with the body itself or body imagery (Stewart and Strathern 2004: 76). The following section further explores selected interpretations of how the spirit child phenomenon “speaks” about what is important within the family.

Interpreting the Spirit Child Phenomenon

It is important to emphasize that the spirit child phenomenon is a very real, tangible threat to families. It is not a practice without logic. Families clearly articulate reasons for the existence of the spirit child. Similar to E. E. Evans-Pritchard’s (1937) study that identified how Azande witchcraft and sorcery are rational beliefs that explain misfortune, elements of the spirit child phenomenon represent similar attempts to explain unfortunate events and, specifically, to search for the truth and meaning within those events. Spirit child suspicions and accusations function as attempts to control uncertainty and ambiguity—they are enmeshed within local moral systems and are a reflection of a cultural model that expresses a particular experience of crisis (cf. Stroeken 2004: 46).

A child, normal or abnormal, is born into a space of ambiguity within the family. If a child is born under unusual conditions or with a disability, this ambiguity increases and the child’s intentions within the family become increasingly unclear as the family attempts to determine if the child is for the house or for the bush. The moral understandings attached to this ambiguity and the spirit child’s embodied status and behaviour situate the child as the opposite of kin with origins outside of the family.

Examining what can bring a spirit child into this world offers significant insight into what is “at stake” for the family

(Kleinman 1995: 98). Kasena and Nankani communities believe that spirit children are a result of violating taboos, primarily breeches associated with or occurring within the bush. The most common behaviour by which a woman can attract a spirit child is if she eats while walking. If a woman should walk anywhere outside the home while eating, pieces of food may fall to the ground. If spirits are nearby, they will follow her and enter her womb. Community members describe how male spirits are desirous of women, often following them in attempts to have intercourse. Thus, women must not expose themselves or have sexual relations in the bush, since a spirit can easily enter a woman through such activities and be reborn as a spirit child. Seen from another perspective, anyone having sexual relations in the bush would likely be having an inappropriate or adulterous relationship, thus threatening the kinship line. Additionally, community members advise women to avoid places where there are forbidden trees, where they bury spirit children or where spirit children live. A concoction man assured Denham that most women who have given birth to a spirit child have visited to a taboo place. There are occasional accounts of men being liable for bringing spirit children into the family. Awedoba encountered a case where a man's musical skills were responsible. A soothsayer explained that the spirits thought it would be nice to have him as a father so that they might listen to his fine voice.

What is ultimately at stake in the spirit child phenomenon? Despite the complexity of the phenomenon, the answer is simple: the family. A dominant concern of local families centres on managing threats to the integrity, growth and continuity of their family system. This includes the early death of family members, sterility, incestual activities between one's brother and one's wife and any misfortune or hardship that could result in these, such as famine and illness. The spirit child, being a threat from the bush, embodies and is implicated in all of these concerns. Women are a focal point for the

practice and are a symbolic bridge between the house and the bush. Specifically, women's procreative powers and their initial position as an outsider to the patrilineal family system is a door for potential threats, thus the common causes of spirit children focus on women's behaviour and her adherence to taboos that could place the family at risk.

If the family allows the spirit child to live, the masquerader will remain a liability and an unrecognized part of the family system. Community members say that if such persons were to grow up they would never become mature adults capable of assuming expected roles and statuses. They would never have enduring interpersonal relations, engage in exchange relationships, or marry and beget children to perpetuate the lineage. Instead, they are likely to abandon the lineage and disappear forever: metaphorically "returning to the bush." Family members know that it is unwise to invest in those that are unable to uphold the values of society or its moral principles. Since personhood is something one accumulates over one's lifespan and is dependent upon these characteristics, particularly marriage and having children, families consider individuals unable to fulfil these roles as non-persons and in some cases non-human.

Towards Social Change

Community discourse indicates that the spirit child practice was more common historically. In recent years, improvements to basic infant and maternal health services and access to community health services in rural areas have played a significant role in reducing spirit child cases. An elder man recalled the number of spirit child deaths in the past:

I live near the hill where they abandoned the spirit children. When I was a child, we would follow the animals as they grazed, watching over them. In those days, there were so many spirit children abandoned there [without burial]... These days it's no

longer so, because of the medical treatment we have for them... and because the women attend antenatal care, these days when you go to the hill you rarely see any spirit children. (Interview, Denham 2006)

It can be argued that the spirit child practice played an important role in earlier times, particularly in situations where families did not have the resources to care for children with serious disabilities or chronic conditions. In a modern context, however, this position should no longer be tenable. While pre- and post-natal outreach services have made a significant impact throughout the region, some health facilities remain difficult to access, both financially and geographically. Furthermore, care and support programs for infants and children with special needs are rare. While the Upper East Region of Ghana is not as isolated as in the past, it still lags behind in receiving advances in quality education, technology and healthcare more generally available elsewhere.

Despite global medical advances, more can be done in this region to address the associated health factors connected to infanticide practices and offer better support for families and children with disabilities. Calls for addressing the spirit child phenomenon must coincide with calls to improve services for families in crisis and local programs confronting the root causes of the phenomenon. The need to address national as well as global inequities also remains a persistent issue. Since most spirit children are sick or disabled, the spirit child itself comes to exemplify the root public health issues facing the region: poverty, food insecurity, access to high quality medical care, education, and support for disabled children. The incidence of spirit child cases will further decrease with on-going improvements in these areas (Denham et al. 2010: 614).

It is important to note that solutions to the spirit child should not lie in the imposition of foreign programmes; rather, the application of local knowledge, resources, and personnel are effective in tackling sensitive issues. The District

Assembly, which enjoins grassroots participation in community development, provides a means for effecting changes in awareness and building infrastructure. Local NGOs run by community members have also been effective. The Navrongo Health Research Centre has played a significant role in research and developing programs for the Ghanaian Ministry of Health. While there have been significant successes working at the community and grassroots levels, it also remains important, however, to place the onus of responsibility on the national government to assist families and facilitate additional options for the care of children like Azuma.

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CARING FOR THE SERIOUSLY SICK IN A GHANAIAN SOCIETY: GLIMPSES FROM THE PAST

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Since the pre-colonial period, the family in Ghana has been the main provider of care for people with serious illnesses. It is commonly suggested that in the past, family care was well organized, effective, and reliable. However, despite its apparent relevance and endurance, family care in the past has not been given adequate scholarly attention. Using primary ethno-historic data from literary and living sources, this article presents an analysis of responses to the phenomenon of chronic non-communicable illness among the Ga people of Ghana from a historical perspective. The study is important because it provides an overview of past caring practices, which could form the basis for appreciating the extent of socio-cultural transformation in the care of the chronically sick in Ghana today.

Keywords: Family care, chronically sick, history, Ga, Ghana.

Introduction

Ethnography on sub-Saharan African family systems during the pre-colonial and colonial era is generally typified by the presentation of the norms, values, beliefs, and sanctions that fostered coherence, strong lineage ties, and solidarity among members of the kin group (Fortes 1978; Goody 1982; Oppong 1974). Such considerations are further extended to the description of past normative practices and behaviours towards dependents and vulnerable persons within the kin group, particularly infants,

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children, nursing mothers, and the aged. In post-colonial accounts of changes and crises in African family systems, researchers have described the situation of infants, children, nursing mothers, and the aged by analysing the changes that have occurred in their wellbeing, in relation to relevant past normative practices. In describing the contemporary precarious situation of the aged, Nana Apt (2002:41) refers to the traditional “family” as “the greatest force that gave security to its poor, its children and its older members.” Drawing examples from the Tallensi, Dagomba, Akan, and Ga, Christine Oppong (1974) demonstrates the central role that kinship plays in sustaining infants and nursing mothers, showing a strong linkage between the existence of the corporate descent group and sibling unity, solidarity, filial piety, and responsibility. Although these accounts do not suggest perfection in family organization and practices, they allude to a past when there was organized care and a support system that worked well.

Vulnerable groups like infants, children, the seriously ill, and the aged have always needed support and home care. Many seriously ill patients become vegetative and in need of daily support to maintain decent physical and psychological wellbeing. Although serious illnesses have long existed among so-called “primitive societies,” much of the old literature has focused on illness prevention, treatment, and cure, and the neglect of the support system available to such patients at home (Harley 1944; Field 1961; Read 1966; Middleton 1967). Yet one cannot dismiss the assumption that members of the lineage played specific roles in caring for their sick members, an activity that has long been taken for granted. It is such a gap in the literature that this paper seeks to fill.

Care is not perfunctory and its determinants are dynamic and variable. Emily Abel and Margaret Nelson (1990) present the fact

that certain resources (time, materials, knowledge, and skills) are necessary to render care possible and effective. They use Kari Waerness's (1987) conceptualization of the "rationality of caring" to assert that caring is not only based on emotions, but that carers reflect, reason, and apply judgement to determine their caregiving. Just as Janet Finch (1989) illustrates with examples from the United Kingdom, relevant ethnographies in Ghana show that care utilizes both an individual sense of obligation and reciprocity as well as ongoing social, demographic, political, economic, and cultural occurrences (Van der Geest 2002; Apt 2002; Aboderin 2004).

It is imperative, therefore, to know the principles behind care for the seriously sick, and the factors that enable it, as well as the specific forms of care that were provided in the past for persons with serious illnesses. Persons between the ages of 72 and 93 years in Central Accra were interviewed for this study.

Methodology

This paper focuses on historical accounts of care practices for the seriously sick within Ga families. Twenty-three persons – twelve women and eleven men – were interviewed on historical care practices for the sick.² These interviewees were purposively chosen based on their knowledge of Ga traditions and were found through snowball methods.³ Each respondent was interviewed at least two times. One focus group discussion, made up of six

² Most of these interviews were conducted between January and October 2008, and the rest in April 2013.

³ Some of the research participants in this category include the GaManye, Naa Dedei Omadro I, Paramount Queen mother of the Ga Stool, Naa Norkor Nanobeng, *Gbese Manye* (Queen Mother of Gbese Division), Nii Tetteh Ankamah of Tetteh Ankamah Royal Family of Gbese Division, Nii Ayiku of Asere Royal House, and Mr. E. T. Abbey.

elderly persons, was conducted among residents of the Search for Hope Help Age Centre at Korle Wokon, Ga Mashie. All interviews were conducted in the Ga language, audio recorded, and later transcribed and translated into English.

Respondents discussed the Ga traditions, beliefs, perceptions, and practices of care prevalent in the colonial era over half a century ago. They were asked to share their experiences (what they saw, heard, or did) regarding how seriously sick people were cared for or neglected during the time period when they were growing up.⁴ They were also asked to discuss the specific caring activities that were done for patients, which people performed these activities, and why these activities were performed. They were assured that it was alright for them not to remember vivid experiences. To avoid romanticizing the past, they were asked to recount both weaknesses and strengths of the traditional systems of caring, in order to solicit a balanced view on the subject. Deliberate efforts were therefore made to probe for cases of dysfunctional care or care crises for seriously ill patients as well as effective care. Again, to guard against confusion, respondents were requested and guided to restrict their discussions to serious illnesses, and not to discuss care for the elderly or for people with mild illnesses and physical disabilities. Although research participants mainly gave accounts of different cases, dominant themes and patterns of care were found in virtually all narratives, and a high level of uniformity in narratives was realized.

⁴ Patients who have been sick for more than a month, with little or no progress or recovery; in their productive years (18-60 years); not suffering from infectious or mental illness; and in need of assistance in performing basic and practical activities.

Respondents supported their assertions with popular proverbs and maxims.⁵

The Ga People 1930-1950: Relevant Context for the Study

The Ga are the indigenous people of Accra, and they form about 12 percent of the Ghanaian population (Ghana Statistical Service 2010). Traditionally, a Ga person is known to belong to his *weku* kin group, and is expected to be an active participant in the lineage events and ceremonies (Robertson 1984; Kilson 1974; Field 1961). Long before the 1930s, the Ga had extensive contact with other Ghanaians, Africans, and Europeans because they lived along the trade route to the coast (Robertson 1984). Nevertheless, they held on to their traditional beliefs and practices very intensely in those periods.

Kinship ties and communal bonding were historically stronger than they are today, and kin members did many things communally (Robertson 1984; Azu 1967; Fayorsey 1993). Christine Oppong and Katharine Abu (1984: 74) draw analogies between the past kin relations of the Dagomba and the Ga thus:

Both the Tamale Dagomba and Accra Ga are to a large extent urban, typically with ramifying ties of kinship with rural as well as urban dwellers. Kin ties continue to be the loci of important material and social transactions. ... Kin ties, especially filial and sibling bonds are customarily solidarity and an important potential source of present help and future security...for care or socialization of children.

In the 1930s, “men’s and women’s economic functions were separate but complementary” and the corporate kin mode of production, segmented by sex, was a common characteristic of the

⁵ Although oral sources of tradition are usually idealistic, they reflect dominant norms, values, and practices in a society (Yankah 1989).

Ga (Robertson 1984:13). The women wielded a high level of productive autonomy, accumulated much capital, and acquired property and wealth mainly through their trading activities. Nypan (1960) notes that although by 1960 the Ga comprised only 39 percent of the total population of Accra, Ga women formed 52 percent of the market stallholders. Many women flourished in trading at the Makola market and financially supported their relatives.

Men, on the other hand, enjoyed western education (Robertson 1984: 2), whilst few Ga girls attended school (Colonial Annual Reports 1890-1938, cited in Robertson 1984). Many girls dropped out of school, despite the Education Ordinance of 1852, which sought to encourage the education of girls. Claire Robertson (1984) attributes this to the failure of the poll tax,⁶ inadequate public schools, the fear of girls becoming “uncultured,” and the fact that “girls were needed at home for domestic duties and trading” (139). Generally, household children were available for errands and support in performing household chores, thereby easing the chore burden of adults.

At the time, marked changes in residential arrangements had begun and some elite Ga men in Ga Mashie had started moving from the traditional area to settle in the Accra suburbs (Fayorsey 1993; Sanjek 1982). This was attributed to poor sanitation, overcrowding, and the earthquake of 1939. Those who moved from central Accra, however, maintained strong links with their families.⁷

Despite the fact that the Korle Bu Teaching Hospital was opened in Accra in 1923, biomedicine still experienced low usage and acceptability within this period. The hospital facility was

⁶ Part of the tax revenue would have supported the ordinance.

⁷ This is discussed below under the sub-heading “Visiting.”

shunned by many Ga people and they adhered to their usage of herbs *shikpɔŋ tsofa* (“ground medicine”) (Senah 2003; Twumasi 1975). There were minimal developments in the treatment of chronic illness during this period. Chemotherapy did not commence in Korle Bu until the 1970s and was initially restricted to lymphodemas (Ankrah-Badu 1988). The diabetic clinic and dialysis treatment of renal diseases commenced in the mid 2000s, and generally persons with chronic diseases were likely to die earlier and so would not require prolonged periods of care.

The socio-economic and socio-cultural context of the era has been noted to have greatly influenced care norms and practices. The onset of a chronic illness evoked varied reactions to the provision of care, some of which are discussed below.

Traditional Responses to Illness

Herbert Blumer’s symbolic interactionism is useful in analysing and understanding the traditional responses of the Ga to the onset of chronic illness. Blumer (1980) suggests that people react to events based on the meaning that those events have for them, and these meanings are derived from social interactions and modified through interpretation.

The traditional responses of the Ga to chronic illness are generally based on the interpretations and meanings ascribed to concepts such as personhood, illness, disease causality, and wellness, much of which is documented by Margaret Field (1961). Field noted that every Ga person is composed of three elements: *susuma*, *kla*, and *gbomotso*. The *susuma*⁸ is the soul of the person and the *kla* maintains his breath and life. The *kla* is invisible and is perceived to have organs which correspond to the organs of the physical body such as head, legs, and eyes. Thus when an organ of

⁸ The word also means “shadow.”

the *kla* is affected, it manifests in the physical body as a disease, deformity, or defect. The *gbomotso* is the physically visible constituent (the body), believed to carry or house the *susuma* and the *kla*. Often, when the *susuma* and the *kla* are affected by an activity, there is a manifestation of various forms of weakness in the *gbomotso*, which usually implies illness or death.

The Ga prioritize disease prevention over treatment, and promote certain traditional measures to ward off illness. The commonest and most applied illness prevention strategy is to abstain from mentioning the name of an illness and rather to use metaphors, since “names are always powerful to attract their namesakes” (Field 1961:120).

Another form of illness prevention was to know what one’s *kla* abhors in order to know what to avoid – this could be norms and taboos on food as well as refraining from particular activities. One should observe such restrictions and endeavour not to violate them. It was also believed that moral uprightness shielded one from diseases caused by angry *kla*, curses, and *sisai* (ghosts).

Special forms of protection were also acquired from medicine men⁹ (*tsofatse*) to help ward off the negative influences of malevolent forces, the powers of witches, and to provide protection against specific illnesses and other afflictions. Medicine men immunized people against the activities of witchcraft by preparing special concoctions for them to smear or wear on their bodies (Field 1961). In the event that traditional means of disease prevention failed and a person was afflicted by a serious illness, the family responded with a variety of possible traditional care options, which are discussed below.

⁹ The medicine man cures sicknesses using the *won* (fetish) and/or herbs. Field (1961) presents details of the activities of medicine men among the Ga.

Home Remedies

The usage of herbs among the Ga and Ghanaians in general has been documented by researchers including Field (1961), Patrick Twumasi(1975),and Kodjo Senah (2003). Generally, medicine is referred to in Ga as *tsofa* (tree root), which depicts the acceptance and wide use of herbs. Field, for instance, indicates that most adults, particularly women, had ample knowledge of medicinal herbs and products to treat minor ailments. This is one of the reasons why the moment a person feels that he is ill, he should first tell an adult member of the household. The patient is only accorded the “sick role” and sent to a traditional healer when the condition is deemed serious (Twumasi 2005: 38).

At the focus group discussion held with elderly respondents, they related that the application of home remedies was the initial intervention in the care of the seriously sick. Ayorkor Quaye (81 years) indicated:

In those days, people knew a lot about ground medicine [herbs] and the diseases they cured... If you did not know, your sibling would teach you...So many houses had been built so the ground medicine grew in the neighbourhoods, backyards, and compounds... You only had to ask the people in the house that you wanted some, then when you take them, you drop a shilling or quarter pence on the ground where you took the medicine.

The focus group participants explained how it was expected that people who had medicinal plants in their backyards would show care by allowing others to take some when needed. In this way, the community participated in caring for the sick. Unlike herbs provided by “professional” healers (as Kilson [1974] refers to them), such herbs were rarely sold and it was believed that selling them would render them impotent.

Other forms of home therapy named by respondents included steam baths, emetics, enemas, and the smearing of herbs. Food therapies, such as corn dough (for skin infections), light soup and *agidi*¹⁰ (for convalescence), and *otinshi nu*,¹¹ were also named as home remedies. The spice range included pepper and ginger, which were particularly used for respiratory infections.

There was much sharing of traditional knowledge on food therapies among women in particular. Ninety-three year old Naomi Dede Quaye recounted:

Naomi: In those days, every household had an earthen pot [*kukue*], which was used to prepare the *odidoo* [a popular herbal and spice preparation]. If someone is sick, you give him *odidoo* first and if he does not recover then you send him elsewhere...

Interviewer: How did you know which herbs to give the patient?

Naomi: Usually someone would have experienced a similar illness, a household member or a neighbour, then he would share his experience with you. That is how we learnt about the herbs. ...sometimes people deliberately planted them or when you bought the land the medicine was already on the land...

People would often talk to each other about their latest medicinal discoveries, telling about how it ought to be prepared, its potency and efficacy, and any significant rules or conditions for its preparation and maintenance. This also constituted care and communality in fighting illness.

Interrogation

Interrogation is noted as a critical part of illness diagnosis and treatment. Traditionally, “health and illness are means for detecting

¹⁰ A staple food made of peeled maize, light enough to ensure easy digestion and absorption, since it is believed that the digestive system of a sick person ought not to be wearied with the consumption of foods that are difficult to digest.

¹¹ *Otinshinu* is the stock that remains from boiling *kenkey*, a maize staple of the Ga people.

threats to social unity and for re-establishing the harmony of social relationships essential to life” (Twumasi 2005:41). Twumasi writes that the explanations for many illnesses include the antisocial behaviour of victims, and as such are means for detecting threats to the social unity of the family. It thus became imperative for family members to interrogate the patient if home remedies have failed to have any noticeable effect. At this stage, the illness was termed *helani mli wa* (illness that is strong), making it necessary to seek treatment from a medicine man (*tsofatse*). Prior to visiting the *tsofatse*, the patient would be subjected to interrogation by his parents or close relatives: “Have you touched somebody’s thing?” or “Have you taken anything that does not belong to you?” The narrative of a 73 year old man points to how interrogation was an important component of family care:

Respondent: No good family will sit down and watch when they see that their child or sibling has been sick for a long time. They have to do something to show that the matter is worrying them. If curing does not work, maybe the sick person has done something to someone. Excuse me to say that some people will forgive you when offended, but others will curse you then you start falling sick, then the sickness will get worse and worse until something is done.

Interviewer: So what does the family have to do?

Respondent: One or two people in the family who the patient respects very much or fears must call him at dawn and ask him to think deep if he has wronged someone....because the patient may be suffering, he would usually say it.

If the answer was “yes,” the relatives would quickly take steps to make peace with the offended person to have him reverse the curse by the performance of the appropriate propitiation.¹² If the sick person failed to confess any act of violation of social norms, it

¹² The process of reversing a curse is called *daiamo*.

would be impossible to reverse the curse and the alleged offender would have to bear the consequences of serious illness and death.¹³

Gbeɓimɔ (“*Euthanasia*”)

If the patient’s condition lingered on for a long time or worsened, a number of options were available to the family. They could explore other healers who were acclaimed to be more powerful, or resort to modern medicine. Patients and their families oscillated from one health provider to the other; this is illustrated by the fact that 22 percent of the 131 patients in Kilson’s (1974) study of Ga healers were former patrons of western medicine. Alternatively, some traditional healers did refer patients to the hospital if they deemed it necessary.¹⁴ But if a patient experienced prolonged undue pain and agony, and signals from family experience and the medicine man’s findings pointed to death, there was the traditional provision of *gbeɓimɔ* to hasten death.¹⁵

Gbeɓimɔ, literally translated as “way asking,” is used in this sense to mean “asking for permission.” This is a traditional provision of the Ga for “opening the way” for death in order for a suffering person to die in peace. In the past, when some people had grown very old and had to endure much physical discomfort and suffering, *gbeɓimɔ* was performed to seek permission from the ancestors to enable the patient to have his suffering eased through death. It was also used as the last resort for a chronically sick person with a debilitating condition, as described below.

¹³ See Field (1961: 117) for modalities on how to reverse such curses.

¹⁴ See Nana Afua’s portrait in Robertson (1984: 164).

¹⁵ Although all of the respondents knew about *gbeɓimɔ*, it never emerged naturally in the interviews until I mentioned it. My father had told me about *gbeɓimɔ* a couple of years before I conducted this research, intimating that his own mother had died this way.

Gbeɓimɔ is the literal act of prayer through libation, which involves the pouring of gin,¹⁶ associated with the verbal request to the ancestral shades (*sisai*) “to open the way,” to facilitate the death of a suffering patient. Marion Kilson (1969:164) notes that “although gods are the most important mediators between God and living men, ancestral shades may act as intermediaries between their descendants and divine beings.” Kilson further indicates that “Ga believe that ancestral shades continue to be involved and concerned with the affairs of living men. ...and their spiritual presence may be invoked to assist the living” (ibid).

According to E. T. Abbey (personal communication), a renowned social historian on Ga customs and traditions, when there was the need for *gbeɓimɔ*, the primary caregivers of the sick person drew the attention of the family head (*weku nukpa*) by speaking in a circumspective manner, such as:

As you will be aware, [Nii Lante] has been ill for a very long time. We [the family] have done all there is to be done but he is not getting well. What is difficult about it is that he is suffering a great deal. The way the illness is, we do not think he will get well, so we came to see you so that we know what can be done about it.

When this had been said, it was very likely that the *weku nukpa* would inquire into the various treatment options that had already been undertaken. He might then recommend further options. In the case of the seriously sick – rather than the extremely old – *gbeɓimɔ* was never carried out hastily. The sick person was given ample room for recovery, and the *weku nukpa* might ask the caregiver to go and try further treatment options. These recommended treatment options then had to be executed by the caregiver.

¹⁶ Kilson (1969: 176) indicates that although water is the appropriate medium through which the Ga connect with immortal beings, gin is considered “more efficacious in achieving the aims of libation.”

If after several months the patient was still in pain and agony, the caregiver would return to the family head and indicate that although she had tried all the suggested treatments, the patient was still wasting away. Abbey again:

The family head usually knows what is being driven at but he will not pre-empt anything.he is an elderly man, he is wise and does not do things by heart.

It was then likely that the family head would ask the caregiver what she thought could be done. The caregiver would usually say “*Ke ebaa hiε, ni obi gbεoha le mɔ*” (If it would be good, ask for permission for him). The family head would usually ask the caregiver for time to ponder the request. He might seek the opinion of other elderly persons on the matter, but would still allow time and would visit the patient several times within this waiting period to observe how the patient was faring. If he thought *gbehimɔ* was necessary, he would invite the caregiver and fix a date for its performance; this was usually in the following month. On the said date, the *weku nukpa* would go to the house where the patient lived and pour libation to the gods and ancestors, explaining the facts of the matter to these spiritual beings, asking them to open the way for death to the patient in question, to enable him to die in peace.

After this, my informants assured, the patient would usually die within two days. It was believed that gods and ancestors opened the way for death for the patient to die in peace. Responding to my questions about the efficacy of the prayer, 93 year old Dede Borley Quaye retorted that “It worked very well, there were many surprising things in the past.” Reliable information on the “efficacy” of the ritual was, however, difficult to obtain.

Tradition demands that *gbeɓimɔ* had to be in the ultimate interest of the patient, with the sole aim of mitigating his suffering. Caregivers and other family members, particularly the *weku nukpa*, had to be extremely careful not to abuse it; otherwise they would incur the wrath and subsequent punishment of the ancestors. This was the reason why so much time (between six months to a year) was allowed between the point at which the request was first made and when the intervention would take place. Mary Saaku Nettey (72 years) of Korle Wokon intimated:

The libation was made to the patient's parents, if they were already dead, and then the ancestors of the lineage [*shiasisai*], to come for the patient because he is suffering. So if it was not so, the patient might die but his parents will be very hurt and would do something bad to the family head. He may become confused [*ebaa fee basabasa*] or he will also fall sick and die.

As a traditional provision, *gbeɓimɔ* was optional and some families did not apply it, irrespective of how long the sick person suffered.

This kind of assisted death did not include the administering of poisonous or herbal substances to the patient, a practice that prevailed among the Dagaaba of the Upper West region of Ghana (Nanbigne and Baataar 2009). Unlike euthanasia as practiced in the Netherlands, for example (Van der Geest 2009), the patient was never informed about the arrangement. He was considered to have no knowledge of it. One informant, however, indicated the possibility that some elderly patients anticipated the practice, suspecting it when they saw certain signs in the household:

When they saw the family head and other key persons come to the house intermittently, hold private discussions, and speak undertone, they could possibly suspect that something was going on. Some people are intuitive and discern some of these events.

It is uncertain if all patients would have consented to *gbɛbimɔ*. The notion of the patient tiring from serious illness was taken from the perspective of the caregiver and it is possible that the patient would maintain hope of recovery and vehemently reject any forms of assisted death.

Caring Activities for the Seriously Sick in the Past

During the historical period under consideration, most people worked in the informal sector and were likely to have had more time within their daily lives to respond to kin and social expectations, including caring for the chronically sick. Care expectations were defined in accordance with enduring bonds among the Ga (Accra City Handbook 1977: 7, cited in Robertson 1984: 2).

Robertson (1984) insists that “caring for the old and infirm is by far the lesser of the two major dependency burdens; attrition makes them less numerous than the young, and habitat, as well as necessity, enjoin that they work as long as possible” (207). In line with this, the majority of men in her study indicated that they received help firstly from their daughters, and then from their sons and other relatives.¹⁷ Women received help from a far wider range of relatives than men (ibid: 208). Typically, caring activities for the chronically ill were both feminized and communal, involving relatives, friends, neighbours, and friends of the patient’s relatives. Since most Ga women at the time were busily engaged in economic activities, they leveraged support from their networks of matrikin when needed. Similar to the Asante market traders who relied on female relatives and non-relatives for support in their reproductive and productive roles (Clark 1994), the Ga women were also noted to have used slaves, pawns, and unrelated foster

¹⁷ This was mainly financial and material support.

children in domestic tasks. It was observed by Robertson (1984: 13) that:

Men's and women's economic functions were separate but complementary... Women more often had to rely on purchased labour for help. Not only in Accra but in most of sub Saharan Africa, most slaves were women. Whether they were legally owned by women or not, their labour was chiefly used by other women because of the sexual division of labour.

Women's domestic work, however, was likely to have taken pre-eminence over their productive work in times of role conflict. According to Oppong (1977), although Africans wield economic autonomy, their family obligations come before the growth of business.

Care was further facilitated by the high fertility levels of the Ga people in the past. An individual was likely to have had several siblings, children, nieces, and nephews to support and help when the need arose. Traditionally, high fertility was valorised to the extent that a woman who bore ten children or more was celebrated and rewarded.¹⁸ In the 1970s, on average men bore 14.1 children and women 6.8 (Robertson 1984: 209). Kin groups and households were thus large and strategized about how to carry out practical caring activities for the seriously ill. When a patient became moribund, an initial family meeting was held among the patient's siblings, his parents' siblings, and his own children to discuss how to provide adequate care. This was illustrated by Mary Ansong, a 73 year old respondent, thus:

When my mother's sickness became strong, she left my father and came to her family house... her siblings, my grandmother's sister, and us [her children] met to discuss how we would look after my mother.

¹⁸ She is given a *nyomga too* (tenth ram) and a big feast is held in her honour.

I said I will stop work and look after her. I was working at UAC¹⁹ at the time. Then my mother's sister [Auntie Kuma] started weeping. I was the eldest child of my mother, and my siblings were in school. My mother's brother gave me money every weekend to cook for my mother. Auntie Kuma also stopped selling at the market to help me care for my mother.

While various members of the kin group and the household could show care in various ways, usually some specific members were appointed as primary caregivers. Twumasi (1975: 40) notes of the Akan that relatives usually appointed an *okyigyinafo* (patient supporter) who would remain with the patient during treatment. The bond and solidarity among kin, and support from paid maids, slaves, and pawns, facilitated the provision of care, as illustrated below.

Feeding the Sick

One fact that constantly emerged in initial discussions with older informants was that in the past, a sick person was never allowed to be hungry and was thus adequately fed. In traditional households, which usually accommodated several domestic units, cooking was done in turns (Robertson 1984). The *Ga Mannye*²⁰ (queen mother) disclosed that in large households, even when people did not eat together, they shared food among themselves, and hence it was almost impossible for sick persons not to be given food by members of their household. In describing how she helped care for her mother's sick sister when she was young, 77 year old Sanku Netey indicated:

It was my duty to prepare *koko*²¹ for her each morning. If I had to go to town in the course of the day, I would prepare her lunch in the morning. My mother's sisters who also lived in the house gave her food in the evening. She was very sick and did not eat much but we

¹⁹ United Africa Company, a British colonial trading company.

²⁰ Naa Dedei Omadro II.

²¹ Porridge made of corn dough.

still had to make sure she ate something every time otherwise people will say “Go and see how their mother goes hungry.” They will insult you and the whole town will hear.

Although participants did not mention food in relation to feeding the *kla*, the narratives suggest that the proper feeding of a patient was more for the *kla* of the patient, so that its healing would manifest as healing in the patient’s *gbɔmɔtso* (body). Adoley Papoe (78 years old) articulated the role of feeding in care thus:

The patient becomes weak because of the sickness and his body becomes worn out. He has to eat well so that his body will have strength to make the medicine work. His mouth may be dead so soups are good for him...

In the focus group discussions, participants unanimously indicated that the traditional food of the Ga, *kenkey*,²² served with fried fish and pepper sauce, was considered too dry for a sick person. Light soup,²³ porridge, fruits, and lighter foods were mostly recommended and given to them. *Kenkey* mashed in water with sugar (*agege nu*), *agidi*, and *otinshi nu* were also commonly served to patients. It was very important that the chronically sick person was not given oily stews and foods, and meat was substituted with fish. Sometimes, the patient could also make specific food requests, which were likely to be granted, and some carers attached certain importance to the request as it could be either a sign of recovery or of the patient’s last request before death, as illustrated in an interview with 73 year old Auntie Mary:²⁴

²² A meal prepared with fermented corn dough.

²³ Light soup is a common Ghanaian soup prepared with tomatoes, onions, pepper, and fish or meat.

²⁴ She is also the caretaker of the Help Age Centre at KorleWokon.

My mother was 52 years when that illness attacked her. ...one day she asked me to prepare plantain *fufu* and chicken soup for her. In fact I got alarmed because I had been told that in their family people usually requested for *fufu* and chicken soup when they are about to die. ...I prepared the meal and sent it to her at the hospital. She thanked me intensely. The next day we got the message that my mother had passed away.

A patient's continual inability to eat was construed as a poor prognosis. This information was readily mentioned to visitors who inquired about the patient's recovery progress.

Visiting

The importance of family members visiting each other was observed by Robertson (1984) as critical, even in the ordinary daily relations of the Ga. In her study of the nature of the support that 65 Ga residents in Kaneshie²⁵ gave to their relatives in Central Accra, 34 percent visited and supported them financially, 2.3 percent only provided financial support, and 45.4 percent only visited. It is very likely that infirmity evoked a greater need for help and visits.

It was considered extremely important for the seriously sick to be visited by members of their kin group, as well as by friends, neighbours, and well-wishers. The illness condition was rarely kept secret and it was necessary that people got to know about the patient's condition and visited him; an exception to this rule was for conditions which attracted stigma, such as mental illness (Mullings 1984). Having many visitors was an indication of a patient's social standing. People would comment thus: "This person is liked. When he was sick so many people visited him."

²⁵ This suburb of Accra was newly developed to accommodate victims of the 1939 earthquake in Central Accra. The inhabitants at the time had moved from Central Accra.

Visits were also a form of showing appreciation or reciprocating the patient's good deeds. A sick patient was deemed to be in his "dark hours," and this was an appropriate time to show kind gestures. As the saying goes, "*Aleee mɔ shwane ni gbɛɛ ake kane akwe ehiɛ*" (You do not know a person in the afternoon, then in the evening, you use light to view him). This proverb implies that a friend should not turn his back on another in a time of need. Many people invested much in building up their social capital, such as by participating in funerals, naming ceremonies, and marriage ceremonies, and expected that kin members and friends would reciprocate by visiting them when they were sick and/or needed such courtesies in return.

Visiting the sick was one essential way of showing care and concern, not only for the patient but also his immediate family. Hence all visitors did not necessarily have to see the sick person. If the patient was asleep, the visitor could sit and talk to his caregivers, enquire how the patient was doing, encourage the caregivers, and then leave without seeing the sick person. He would, however, ask that the patient be told that he had come to visit. Visiting was so important that many would even visit a patient whom they did not know personally. In this case they would be friends of relatives of the sick person, and the care was thus indirectly meant for the caregivers.

Visits could also be made in groups, such as a group of work colleagues, school mates, or church members. Many groups had a tradition of visiting. When church members visited a sick parishioner, they sang choruses, prayed, and presented gifts such as fruits and groceries. Community associations within Ga traditional settings, as noted by Kenneth Little (1971), all had their caring traditions for their sick members, which included visits and the presentation of gifts and material support to the patient.

The patient was grateful for these gestures, and might go to thank the people who had visited him individually when he recovered, or send a relative to do so. Conversely, the patient might resent and begrudge those friends and relatives who knew about his serious illness but did not visit him; they could be suspected of having caused the illness through a curse, charm, or witchcraft.

Presentation of Gifts to the Patient and his Caregivers

Linked to the act of visitation is gift giving. Gifts of all kinds were given to the seriously sick as a sign of concern, and it did not matter whether the particular gift had direct bearing on the condition of ill health. While the most common gifts were food items such as maize, millet, fish, vegetables, fruits, and provisions, others such as fabrics for clothes, talcum powder, and slippers could also be given. Men mostly gave money. On certain occasions, gifts by a group of persons, such as sisters, brothers, a conjugal unit, or household members, were also presented.

The main purpose of gifts was to show off. Patients who did not receive gifts could be viewed as having little social standing. The period of ill health was thus a suitable time for friends and relatives to reciprocate all the good the patient had done for them. Gifts were given “freely and unresentfully” (Robertson 1984: 222).

Emotional Support

Emotional care is the support given to enhance the mental wellbeing of a patient. Respondents expressed this form of care as *tsui hamɔ* (giving of heart). Ga people believe that when one is worried, one’s heart is “wearing off” or “eating away,” commonly put as *etsui miye* (his heart is eating away or eroding). It becomes necessary, therefore, that when one has “eaten one’s heart” one

should be “given heart” through encouragement. A patient with a serious illness will worry intensely about pain and physiological changes. Patients also worry about loss of livelihood, loss of prestige, the cost of treatment, and the interruption of personal ambitions.

Patients also suffered much emotional stress over what various people would think or say about them, their illness, and its resultant changes in their physiology. They also worried about lifestyle changes and restrictions, particularly those pertaining to diet and mobility. Many became depressed and frustrated and sometimes felt guilty for having brought the disease upon themselves. Family and friends of sick people usually lavished *tsui hamɔ* (giving of heart), *miɲshɛdzemɔ* (comfort), empathy, concern, affection, and love on the sick person. Sick people, the respondents emphasized, were rarely alone; they usually had company that gave them encouragement and emotional care.

Domestic Caring Activities

In the personal domain, the seriously ill patient usually had to be bathed, cleaned, and his surroundings tidied to avoid embarrassments when being visited. It was indicated that self-contained houses²⁶ were rare during the period under discussion; instead, many had their bathrooms and toilets detached from the main apartment, or household members used public bathrooms and places of convenience. Improvisation was thus common in ensuring convenience and comfort for both the patient and his caregivers. In the event that a patient was unable to walk to the bathroom, they would be bathed or cleaned in the room.

²⁶ This is a term used to refer to apartments with enclosed facilities such as toilets, bathrooms, and kitchen.

There were some strict rules guiding the performance of intimate activities for a patient. For instance, a patient's own children were not allowed to bathe him or her, irrespective of the children's age. It was considered embarrassing for children to see their parents' nakedness, as made explicit in the popular Ga saying "*Bi enaa enye yayaimli*" (A child does not see its mother's nakedness). Thus, the patient's female siblings, mother, or elderly female kin were traditionally designated to attend to the intimate needs of the patient. The patient ought to be shown due respect by having personal care needs attended to by older females in the kin group. Alternatively, servants, pawns, and foster children were engaged for domestic activities, which emerged in some narratives thus:

Some rich families bought people to help them at home and in their work. My grandmother's illness made her blind. She had one slave girl who was grown at the time. She helped to wash her things, cook for her, and to clean her room. The girl helped a great deal. (Josephine Niikoi, 77 years)

Although care was highly feminised, individual women were hardly overburdened with caring for their sick relatives. There was much sharing and kin support in the performance of caring activities.

Division of Labour in Caring for the Sick

In times of sickness, elderly women could go and live with the sick person to provide extensive care, while the men brought material items and money to care for the sick. Children and young people were also involved, as they were regularly sent by adult relatives, especially parents, to visit patients with food and provisions. Ataa Laryea, an 82 year old participant, related how his mother used to

cook on a daily basis for his sick maternal uncle when he was about thirteen years old:

[At] the time we had moved [from Ga Mashie] to Adabraka, and I was still in school. Every evening, around four o'clock my mother would send me with food, I carried it in a basket [*kenten*] on my head and walked about a mile from Adabraka to Swalaba for her brother. I did that every day until he died. ...other family members did other things for my sick uncle, and my mother took it upon herself to give him food every evening.

In regard to the enormity of care demands, it was important that virtually every member of the kin group participated in caring for seriously sick family member.

Extension of Care to Caregivers

Lineage members and friends did not lose sight of the difficulties of caring for a seriously sick person, and thus extended much care to the patient's caregivers as well. The social system made the following arrangements for caring for the caregivers.

Friends and affiliates of the caregiver would visit the caregiver to express their sympathy, because the caregiver would have been wearied and distressed by caring activities. It was common for people to say "*Mike le yaa ye nkɔmɔ*" (I am going to eat worry with her). As a show of solidarity, friends and well-wishers of the caregiver would go to sit with her to deliberate and share ideas on the illness, caring activities, and how things could be improved.

Another way by which care was extended to the caregiver was that a significant proportion of the gifts presented to the patient was actually meant for consumption and use by the caregivers. It was believed that "the caregiver too must eat to gain strength to care effectively for the sick," as one older respondent put it. The caregiver might have abandoned her economic activities to care for

the patient and would thus find such gifts extremely beneficial, as expressed by Nii Ayiku (85 years):

My father's maternal relatives could not come to look after... their visits were not frequent but they contributed money towards our father's upkeep. They did that three times before he died.

It was also a traditional practice to show appreciation and motivate the caregiver to care for the patient. Such appreciation was called *ayekoo hamɔ* (congratulations giving). When people visited the patient, they would say *ayekoo* (well done) to the caregiver, or donate cash or material things for her good work. Sometimes a caregiver would jokingly ask for *ayekoo* from a visiting male family member, by saying "*Esa ni ohawɔ ayekoo*" (You have to give us congratulations). Most men would honour this request.

Deficits in Care Practices

Ga traditional society was definitely not "perfect" and so some care deficits in the past could be cited. Respondents were asked first of all to describe the situation of a patient who lacked care. The responses mainly described situations where a patient had no one to provide him with meals, clean his room, wash his clothes, visit him, and help him find treatment, which were the dominant components of care. Respondents were then asked to recount any such event that they had witnessed, but most could barely remember such situations. One 74 year old participant in the focus group discussion gave an account of a female relative who, he thought, had lacked care:

[My] aunt's sickness became strong and she could not do anything. She was in bed for a long time and I was young but I heard my mother and her sisters complain that her father's relatives did not visit her, and did not care whether she got treated or not. I was related to her on her mother's side. That is all I know...

Kinship networks were generally strong (Oppong 1997; Nukunya 1969; Azu 1967), and the culture of care demonstrated above shows the importance attached to caring for all members of the Ga community. It should be noted that the concept of deficits in care is dependent upon the care needs and expectations of the era. While it is possible to speculate about respondents' presentation of the ideal rather than the practice, the fact that respondents could hardly remember cases of care deficit suggests that it was not a common phenomenon.

Respondents rather talked about what it meant to lack proper care (*enaaa kwemɔ kpakpa*) when they were asked questions on care deficit. They emphasized that in earlier times, when boundaries between private affairs and kinship matters were blurred, the ill health of one person concerned members of the entire (larger) kin group. "Private" matters were discussed and mediated by all. It was thus almost impossible for the chronically sick to be left without any care at all. If a sick person lived alone and it was not possible for some of his family members to go and live with him and provide care, he would be relocated to the family house, where several people belonging to the same lineage lived. Virtually everyone had a family, and those who were childless usually received care from nieces and nephews who they had fostered.

Weaknesses of Past Caring Practices

It is important to note that patients' voices have not been captured in this study of past responses to and care practices for patients suffering chronic illness. Certain weaknesses and adverse effects of these care practices for patients' wellbeing and comfort did, however, emerge in the data analysis process.

Chronically sick patients might be sombre and need some quiet time to be reflective, but according to the descriptions they seemed to have had virtually no privacy due to frequent visits. Visits could become intrusive, creating discomfort for patients. Patients could also be embarrassed when visitors saw their changing physiological state. Moreover, frequent visits potentially denied a patient of much needed sleep during the day.

The decision over the usage of *gbɛbimɔ* (euthanasia) did not involve the patient; caregivers executed it on the patient's behalf. This constituted a breach of the patient's rights and the laws of Ghana. If patients were not involved in this exercise, how certain could one be that *gbɛbimɔ* was always in the interest of the patient? Furthermore, in an era where Christianity had gained roots in Ghana, it was also possible that *gbɛbimɔ* contravened the religious convictions of Christian patients, who believed that only God gives and takes away life.

Chronic diseases were usually associated with supernatural causation (Twumasi 2005), thus health seeking practices were overly focused on traditional and spiritual therapies (Atobrah 2009). According to Nii Gyease Ayiku of Asere, many Ga at the time did not patronize Korle Bu Teaching Hospital in Accra because it was perceived to be a means of extorting money from them. They chastised children who played too vigorously in order to stop them from getting hurt, because "Korle Bu *ntao shika*" (literally, KorleBu wants money). This had a number of implications. First, there was an over reliance on traditional medicine, which did not always provide cure and relief to patients. Second, the traditional search for disease causality consisted merely of an interrogation to find fault and pass judgement of guilt. This is likely to have heightened the distress of the sick and lead to witchcraft accusations.

Conclusion

In this paper, I have described older Ga people's memories of past caring practices for chronically sick people in their productive years, a condition that evoked sympathy and care from family and friends. My attempt to analyse and visualize these past practices in contemporary situations is problematic because the contexts are very different.

While the care practices outlined in this article may seem idealized, it is important to note that the socio-cultural context of the early to mid-twentieth century made their actual occurrence plausible. The incidence of chronic diseases was much lower (Ankrah-Badu 1988) than today, biomedical care was limited, and people died more quickly from chronic diseases, thus they did not require long term domestic care. These factors rendered the care demands less burdensome than what prevails today.

The historical context of the period within which these care practices prevailed, coupled with popular adherence to Ga philosophies on care of the sick, culminated in the provision of ample care for the chronically sick; yet this was not without its weaknesses. Families deemed it their responsibility to care for their sick dependants, and they took much pride in doing so. Caring activities for the sick were mainly based on solidarity and communality, sympathy for the sick, beliefs in general vulnerability to illness, and the notion of care for the sick as a sacred activity. Caring activities which included interrogation, home remedy, appropriate feeding, and celebration of victory over death were judiciously dispensed by the members of the kin group and some community members. Instances of care crises were said to have been present but extremely rare. As such, the need for

governmental social support systems and provisions for such dependents was somewhat unnecessary.

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“NO MATTER HOW THE CHILD IS, SHE IS HERS”: PRACTICAL KINSHIP IN THE CARE OF MENTAL ILLNESS IN KINTAMPO, GHANA

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Few studies have explored in detail family responses to mental illness in sub-Saharan Africa and the impact on the household. This article draws on ethnographic research in Kintampo, Ghana, to illustrate the social, emotional, and practical consequences of prolonged mental illness. Drawing on Bourdieu's notion of "practical kinship" this article suggests that the affective and moral force of the family ideal inspires a concern to maintain care for a relative with mental illness against the threat of social exclusion. However such care can stretch family resources to breaking point. The impact on families and their important role in maintaining the social personhood of those with mental illness suggests the need to foreground initiatives to enhance family support in mental health services.

Key words: Mental illness, family care, stigma, kinship, chronic illness, Ghana.

Introduction: Idealisation and Stigma

Discourse surrounding family care of the mentally ill in Ghana as elsewhere in sub-Saharan Africa has historically rotated around two poles – either an idealised view of the “traditional” extended family as a haven of care (Bass 1997; Sow 1990 [1978]), or the demonization of the family as neglectful, throwing mentally ill relatives out of the home or “dumping” them at the doors of the asylum (Rosenberg 2002: 310). There is no doubt that some families do leave their relatives in the psychiatric hospitals and never return. However, this represents only a small proportion of those with serious mental illness, the vast majority of whom, despite making periodic use of the psychiatric hospitals, remain

in the care of the family, either at home, or in healing churches and shrines. Over the last two decades researchers have challenged notions of traditional African life as a protective utopia of tolerant family care. Stigma and discrimination along with emotional stresses, loss of earnings, and the costs of caring for a relative with serious mental illness such as psychosis can strain even the most supportive family networks (Martyns-Yellow 1992; Ohaeri 1998; Quinn 2007; Ukpogong 2006). Researchers in Africa have reported that psychotic illness has a significant impact on employment, marriage, social and leisure activities, domestic routine and household income for the person affected and family members (Shibre et al. 2003; Gureje and Bamidele 1999). Limited provision of state-funded welfare and services and close day-to-day contact with the mentally ill relative may increase the burden of care (Jenkins and Schumacher 1999). Indeed measurements of “family burden” in Nigeria have exceeded those of similar studies in the United Kingdom (Ohaeri 2001).

However, assumptions on the role of the extended family in the care of mental illness have largely taken place in an “ethnographic vacuum” (Hopper 1992: 95) and there has been little detailed examination of the impact of mental illness on family life in Africa. Few studies of stigma and family burden have involved prolonged contact with families; rather they have relied on one-off interviews, community surveys, and the opinions of “stakeholders.” Research often remains trapped in the tradition/modernity dualism, contrasting urban (“modern”) rejection of the mentally ill, with rural (“traditional”) acceptance. A recent study of family carers in Ghana, for example, reported more tolerance towards the mentally ill in the rural north compared to urban locations in the south (Quinn 2007). However the researcher relied on single interviews with carers rather than prolonged observation and there were potentially confounding factors in the reliance on male interviewees in northern regions who were unlikely to have

been involved in day-to-day domestic care, usually the role of women (Bierlich 2007: 129-51) .

Such studies highlight stigma as an “unreliable signifier” (Hopper et al. 2007: 272) and the limitations of surveys of self-reported attitudes towards the mentally ill. As Roland Littlewood and colleagues argue, “We cannot presume in advance a causal sequence from concept to attitude and thence to practical stigmatization” (2007: 181). In a study of people with disability in Botswana, Benedicte Ingstad (1995) contrasts the stereotype, repeated by government officials, that they were “hidden within the home,” with ethnographic observations which revealed a great deal of family care and concern. She argues that beliefs or attitudes expressed in general terms are modified relative to the particular relationship with the disabled person. A similar negotiation with societal attitudes may operate in the case of family encounters with mental illness which, like physical disability or chronic illness, can disrupt expected norms of social development and interaction. Such negotiations may not involve a refutation of the dominant discourse *per se*. Rather, as Kim Hopper and colleagues (2007: 274) argue in their review of marital prospects among Indians treated for psychosis, families did not “dispute the cultural judgment” on the undesirability of marriage to a person with psychosis. Indeed these families strongly feared that psychosis would discourage suitors in seeking a marriage partner for their own family member. This reflects Pierre Bourdieu’s (1990) approach to culture as “practice,” a process of negotiation with “official” ideals; as much improvisation as reproduction. Rather than a “black box” view of culture (Craig et al. 1997) as a unified and static frame which constrains and shapes the experience of mental illness, families improvise with socio-moral ideals and mores to wrestle with the puzzle of mental illness and adapt to its intrusion into daily life.

As a profoundly social experience (Good and Subandi 2004), mental illness calls into question notions of

responsibility, morality and obligation. In Ghana, an “ethic of responsibility” (Gyekye 1996) places care for others as a central obligation of social personhood. Thus neglect of a family member may be more morally shameful than the family taint of madness. The vagrant madman may be ignored as a stranger, but if a person known to the community is observed wandering around untreated and uncared for this brings disgrace to the family who allowed the person to descend to such a state. The moral order, as Hopper and colleagues (2007: 273) argue, provides a powerful motivation “to set right, to redress and repair, the moral rupture of psychosis.” Thus “resistance to the cultural opprobrium attached to madness is not a strategic assault on a structured source of shame and discrimination, but a tactical manoeuvre in the name of a higher cultural good - family, the lineage, and the social order” (ibid.).

This paper draws on ethnographic research with people with mental illness and their families in homes, shrines and healing churches (Read 2011) to explore the impact of mental illness on family life).¹ Based on extended contact with families living in Kintampo and surrounding communities, this paper highlights the intimate domestic experience of mental illness within the context of limited resources and the aspirations and ideals of wider society. Drawing on Bourdieu’s (1990) notion of “practical kinship” as process in action, this paper illustrates the struggle to maintain the social personhood of the family member with mental illness against the threat of dehumanisation and exile. In doing so it highlights the financial, emotional and social cost of such efforts at “cultural repair” (Hopper et al. 2007: 270). In 2007 and 2008, data were

¹ Pentecostal healing churches and “prayer camps” have become popular resources for the treatment of illness and other misfortunes. As with the shrines, in the case of severe illness these often require the person to stay in the prayer camp for some months with a family member who provides day-to-day care. Families in this study frequently made use of psychiatric hospitals, traditional shrines and prayer camps in the search for a cure.

collected during repeated visits to over forty people with mental illness in household compounds, three healing churches, and a shrine. The focus of the study was on those with longstanding mental illness resulting in severe disruption of social functioning, predominantly those with psychiatric symptoms of psychosis or schizophrenia. The majority of those studied had been ill for periods of at least five years, some for much longer. Frequently described behaviours included talking nonsensically, acting aggressively, roaming around, and dressing in dirty clothing. Alongside observation and informal conversations, seventy semi-structured interviews and six focus group discussions (FGDs) were held with people with mental illness, family members, traditional healers, pastors, and imams.²

Keeping it in the Family

This response by a focus group participant: “In Ghanaian society, if you are mentally ill, nobody cares about you. Because they see you to be a useless person” accords with other research from Ghana which reports that madness, like leprosy, is *animguaseyadee* or *yadeɛfo*, a disgracing or shameful disease

² Research was conducted by the author between October 2007 and December 2008, working with a Twi-speaking research assistant. In addition to visits, informal conversation and observation, a total of 67 informants participated in semi-structured interviews. These included 25 people with mental illness, 31 family members, three traditional healers, four pastors, one Muslim healer and three imams. Three interviews were in English, the rest in Twi. Wherever possible we interviewed the person with mental illness, however, some were too unwell to provide consent or to participate in the interview, in which case we interviewed the main carer, usually the mother, father, or sibling. In eight of the interviews the carer and the person with mental illness were interviewed together. To obtain contextual information relevant to mental health seven focus group discussions (FGDs) were held with a total of 47 participants including registered mental nurses, young people, Muslims, cannabis users, church members, and parents. Five FGDs were conducted in Twi; two in English. Interviews and FGDs were digitally recorded, transcribed into Twi and translated into English. Ethical approval for the study was granted by Kintampo Health Research Centre and University College London.

to the afflicted individual and the family. The mad person, Helga Fink (1989: 279) was told by healers, is unable to marry or have children and thus “worthless for the community.” As *fie yadee*, “family/household illness” (Fink 1989), madness is said to taint all family members, as in Erving Goffman’s (1963) concept of a “spoiled identity.” Echoing this view, I was commonly told that if a family were investigating a potential marriage partner a family history of mental illness would render the proposed spouse unsuitable. As one psychiatric nurse told me: “They would say: ‘That house is not good.’” However, during the course of fieldwork it became evident that this view was not universally enacted in practice. Even those who suffered from longstanding mental illness had brothers and sisters who had married, apparently without difficulty. Yusuf,³ who had an eight-year history of severe mental illness, had a sister who had married a young man from a respectable and relatively wealthy family, given birth to a son, and established a food store without any apparent taint from her brother’s madness. Contrary to reports that family members with mental illness may be hidden from view (Fink 1989; Obeng 2004), I usually met family members with mental illness living openly within the compound, even if they had been restrained with shackles or chains (Read et al. 2009).

Yet “keeping it in the family” could stretch family resources to the limit, and exert a high toll on family life. The story of Alice’s mother clearly demonstrates the day-to-day difficulties faced by families in seeking to meet the responsibilities of caring for a relative with severe mental illness and exemplifies the ways in which the extended family as a source of support can fail due to a combination of factors - in this case youth unemployment, marital breakdown, an irresponsible father, and disappointing maternal uncles.

³ All names are pseudonyms to protect the identity of informants.

“Because of Alice it is All Gone”

I first met Alice at a Christian healing crusade held in Kintampo in July 2007 where she was running wildly around the grassy arena.⁴ Her mother explained that Alice had suddenly gone mad ten years before - talking, singing, and running around in the main street of the town. Since then she had suffered recurrent breakdowns, as her mother described:

She will sing and cry so much. She will start from the morning. When you cook and give her some she says: “Go away! I have said I don’t want any food, I won’t eat!” She will then cry so much. That time this house had no fence so she will get out to Sawaba [the centre of Kintampo]. When she goes to Sawaba she spoils people’s things.

Alongside refusing to eat Alice did not sleep for several days at a time, and talked constantly, often shouting insults at her mother and other family members. Sometimes Alice physically attacked her mother, once hitting her with a chair requiring her to have stitches to a gash on her leg.

As she put it, Alice’s mother had “roamed around a lot” in search of treatment for her daughter visiting a number of shrines and churches reputed to treat mental illness, often requiring considerable travel and expense. When the illness began, she took Alice to a prayer camp recommended by a local church where Alice stayed for over a year. When her father visited, he saw that there was little improvement and suggested they take Alice to a well-known shrine to the north of Kintampo. At first Alice seemed to improve but this did not last, and her mother became increasingly worried. Alice’s father was also angry when he discovered that Alice had been severely beaten there. After five months they decided to try the “mental” [hospital] where Alice was treated with antipsychotic medication and electro-convulsive therapy. Alice stayed several months at the hospital and recovered enough to be discharged

⁴ I met Alice prior to beginning formal fieldwork.

home where she was told to continue taking medication to prevent a relapse. However, when she got home Alice soon stopped taking medication complaining that it made her feel “lazy,” and before long she once again became aggressive, abusive, and disruptive to the household. Alice’s mother took her to another succession of prayer camps and shrines before she sent her back to the psychiatric hospital. This pattern continued with Alice being admitted to hospital four times between 2002 and 2007.

The impact of Alice’s illness on the family finances had been catastrophic. Alice’s mother, a catering assistant in a government institution, had struggled to bring up her five children on her small salary, saving what she could. However, she had exhausted all her savings on Alice’s treatment, including transport expenses, “anointing oil” at the churches, and offerings at the shrine:

So when she wasn’t sick I saved a lot [...] I was employed in 1979 and I’ve saved since to this time. This 1st May I had 27 years [working]. So I had money. I’ve spent it. It’s not something small. I was doing that so that when I go for my pension I will use the little money I’ve got to build a house here. So my money was quite a lot. Because of Alice it is all gone.

Alice’s mother was her primary source of financial support. She was divorced from her husband who had taken another wife before Alice was born. Although he had initially been involved in Alice’s treatment at the shrine, contributing schnapps, chickens and cash for the offerings, by the time I met her he was no longer providing any support for the family. Of the extended family Alice’s mother said that aside from her sister, a midwife who gave occasional cash donations, “they won’t give me anything.” This included Alice’s maternal uncles, one of whom was apparently a wealthy man. Alice’s mother told us:

We are all from the one family and if your niece is sick or your child is sick at least if you can't manage to come and see her, you can send someone or send a gift. Maybe every two or three months you can send 200 or 400 [GHS]⁵ with her sister to be given to me to buy something for the child. No, I didn't get anything like that. It is left to me and my God and my work.

Alice and three of her siblings had completed secondary school, yet none were contributing to the family income. Alice's brother had been unable to find any substantial work since leaving school and her sister was completing an apprenticeship as a hairdresser and not yet earning an income. Although her siblings had little to contribute in cash, they accompanied their mother to take Alice to shrines and churches and one or the other stayed to look after her while Alice's mother returned to work. As for Alice, she had dropped out of secondary school and after starting correspondence with a “white man,” a friend of her brother's, had hoped they would marry. However, after a year or so Alice became unwell, and the expected marriage never materialised. After Alice recovered from her first illness episode, her mother sent her to live with her older sister and learn to make soap which she sold in the market. The business went well until one market day when Alice suddenly “dashed” the money she had made to strangers in the transport yard, signalling her relapse into illness. Alice never worked again.

At the crusade, Alice's mother received a cash donation from the church which she used to pay for the fare to send Alice back to the psychiatric hospital. With help from his peers, her younger brother escorted her on public transport and returned regularly to visit, taking food and money from his

⁵ Ghana cedi (GHS) is the unit of currency. It was redenominated from approximately 10,000 cedi to US\$1, to 1 GHS to US\$1 in July 2007. However, people continued to use the old values in common speech, which I refer to as “old cedi.”

mother. By the time I left Kintampo over a year later, Alice had still not returned home.

“All the Burden Was on Me”

The struggles of Alice’s family were not unusual. Most of those I met with mental illness were living with their mothers as the primary carers. Eleven of the sixteen mothers interviewed were divorced, separated, or widowed and claimed they had little financial support from the child’s father or other family members including, as in Alice’s case, the *wɔfa*, maternal uncle who, according to the matrilineal structure of Akan families, has an important role as provider for his sister’s children.⁶ Some were advanced in years, some had married an older man, perhaps as a second or third wife, and the husband was also unwell and no longer working. Therefore mothers could find themselves bearing not only the day-to-day domestic care of their child, but also the costs of daily living and treatment. As one mother put it: “I have no man, except God.” As with Alice, stays at healing centres could be lengthy from several months to a year or more. During this time a relative is obliged to stay with the patient to care for his or her personal and domestic needs – toileting, bathing, fetching water, washing clothes, cooking, and administering medicine. Although occasionally fathers, uncles, or sisters took on this role, it was most commonly mothers whom we met at the shrine and churches.

As Julie Livingston (2005) has pointed out in her study of disability and chronic illness in Botswana, social, political, and economic changes have challenged ideals of family care-giving, as represented in the “therapy management group” (Janzen 1987), and resulted in a “shrinkage” of the family willing or available to provide care. The influence of Christianity, urban and international migration, and changing patterns of employment have altered the structure of the

⁶ In patrilineal families from Northern groups the father’s brother is a classificatory father and fulfils a similar role as the biological father.

extended family, with many family members living away from their natal village or town and in nuclear family units (Nukunya 2003), and increasing emphasis on the role of the father as provider (Allman 1997). Combined with such changes, the complexity of access to resources within the lineage and extended family (Clark 1994: 333) can lead to conflict and responsibilities become blurred or sidestepped. Furthermore, the nature of chronic or recurring illness can strain family resources, with generosity and support eroding over time, as with Alice's father. In these cases it is often the mother as the person with both the strongest emotional attachment and the highest moral obligation who is left to bear the burden and is the last to give up. Female-headed households were common in Kintampo due to divorce, separation, or widowhood. Men also migrated to the cities, Libya, or Europe in search of work. The absence of fathers from the household and the practice of actual or de-facto polygyny could compromise the role of fathers as providers for their children (Agadjanian and Ezeh 2000) and the loss of such support was acutely felt when a child fell ill.

Most mothers in this study were in their fifties or sixties and, like Alice's mother who suffered from painful arthritis, were also unwell. At one point during the rainy season, when malaria was at its peak, there were several mothers at the shrine who seemed at the point of emotional and physical exhaustion. Older women complained of aches and pains, the bodily toll of long years of bending in the fields, headloading water and farm produce, and carrying babies on their backs. Mothers also complained of “thinking a lot” (*dwendwene*) about their child. This combination of bodily pains and excessive thinking has been interpreted in African settings as indicating clinical depression (Patel 1995). It was clear that many carers were under severe emotional strain, and during interviews and conversations many broke down in tears. Martha was extremely mentally and physically unwell when we met her at the shrine, emaciated with diarrhoea and pressure sores, staring wildly and

talking and singing incomprehensibly. Sometimes she screamed or wailed loudly. Her mother, a widowed cocoa farmer from Asante, washed and dressed Martha like a baby, cleaning her several times a day when she soiled herself, and rising frequently in the night to tend to her needs. When we met she seemed frazzled, hopeless, and drained, and as she recounted her story she wept. Over the ten years of Martha's illness her mother had taken her to all three psychiatric hospitals only for Martha to repeatedly discontinue treatment and relapse. Martha's mother had exhausted all her resources and relatives were no longer responsive. Finally she had left her farm to bring her daughter on the long journey to the shrine to try *abibiduro* (African medicine).

Mothers also frequently took the brunt of a child's hostility when unwell. Several, like Alice's mother, were insulted, threatened with violence, and sometimes physically assaulted, occasionally at risk of their lives. Such hostility was also enacted within accusations of witchcraft which could intensify the risk of violence (Andinkrah 2004). Yakub's frail elderly mother described his accusations and murderous threats: "When he sees me, he is angry with me [...] he says if I joke, he will stab me with a knife. When he sees me, he says I am a witch." Yakub ceased all contact with his mother, refusing to eat in her house. In our conversation, his mother repeatedly expressed her sorrow at his accusations which had ostracised her from her son.

"Now My Life has Become *Basa*"

Above all there was a strong sense of a person becoming *see*, meaning "spoiled," "destroyed," or "wasted" by mental illness, as Alice's story makes clear.⁷ As observed among carers of people with mental illness in India, measured against the

⁷ The Twi word *see* is a polyvalent term applied to wasted money, rotten food, something broken, or malfunctioning, in some cases implying the possible influence of witchcraft in such destruction.

standard of the responsible adult, there was “a keen sense of failure on behalf of patients and prolonged grieving on behalf of parents” (Corin et al. 2004: 136). Most of those with mental illness were in their twenties and thirties yet far behind their peers. Few had married (32 out of the 42 case studies had never married) and of the rest most had experienced marital breakdown with only two remaining married.⁸ Although 13 had children, often they were unable to care for them, and certainly unable to provide for them financially. As Comfort put it, “Now my life has become *basa*”, meaning disrupted, out of order, messed up. Samuel, a once promising young man from a farming family of modest means, remained in the prayer camp where he had been treated, dependent on the pastor’s support and occasional farm work. He had been unable to finish secondary school and was all too aware that he had exhausted his family’s investment in his future:

I lost my schooling, the work which I would have studied, I don’t have any work again. So now even the way I will take to feed myself is a problem. If it had not been for the Prophet, or someone will meet me by God’s grace and give me some money to go and buy something to eat, it means I won’t get help from anywhere since my relatives have wasted their work and wasted their money on me, so now they have to give up.

This sense of “spoiling” or “blocking” was accentuated when, like Samuel, a child was felt to show particular promise, especially at school. Sending a child to secondary school represents an advantage within the reach of only a small portion of Kintampo society and can involve considerable family sacrifice from which they expect a return. Parents invest in a child’s education or apprenticeship with the hope that they

⁸ Separation and divorce in any case is high where in practice conjugal relationships are to a large extent processual and polygynous despite ideals of Christian monogamy propagated by the churches. However, some claimed that marital breakdown was specifically due to the impact of mental illness.

will thereby access higher paid work so as to support them in old age, comparable to investing in a pension scheme (Bierlich 2007: 149). Such expenditure and the student's effort are "wasted" if they become unwell.

Yakub's mother was divorced and had worked hard as a trader of farm crops, earning enough to send Yakub to school. After he had completed school, she then used her connections to find him a job as a mechanic. Yet despite her sacrifices her son's illness meant she faced old age alone. As a member of a patrilineal Sisala family her married daughters had moved to their in-laws. Her oldest son had died. The lack of return on her investment in Yakub's and therefore her own future was not solely a question of financial loss, but the loss of his affection and company, as she poignantly explained:

But me, a woman who has struggled to take care of children, taken them to school, and found them work. Don't they say I have done well? And when it is time for the child to say: "Mother take this," God has suddenly taken him with an illness. And you are alone . . . is it not sad? If it were money, I wouldn't be sad. As for money, God gives. But human sadness has touched me. [...] I am in great sorrow.

It has been suggested that in an informal rural economy there may be more opportunity for those with mental illness to be reintegrated into work, particularly farming and petty trading (Warner 1994: 159). However, none of those interviewed with long-standing mental illness was doing any work which could provide a consistent livelihood, and many were not working at all. Regular employment was hard to come by in Kintampo, even for healthy young people such as Alice's brother. Six of the mentally ill informants were doing a little farming on family land, and those at the shrines or churches who became fit enough helped farm the healer's land in return for a share of the crops or, like Samuel, their maintenance. However, mental illness was experienced as weakening, removing the bodily

strength and motivation needed for physical labour, particularly farm work which was the primary source of informal employment. Even those who recovered struggled to regain their productivity. Kwaku had stayed with his mother in a prayer camp for three years. When he recovered sufficiently to return to his village he tried to resume work on the family land. He had previously helped construct the mounds in which yams are planted, heavy labour which his mother could not do herself. However, now Kwaku was unable to complete a full morning's work. He became easily tired and would often sit down to rest whilst she continued. He also had chronic pains in his legs from being chained at the prayer camp. Of his three siblings, one had died, another was living and working elsewhere, and his sister had fits and was unable to farm. With Kwaku unable to work as hard as he used to, his mother had to meet the cost of hiring labourers.

Sikasem: Money Matters

Unsurprisingly therefore, families repeatedly referred to *sikasem*, “money matters.” As Alice's mother's story illustrates, the financial consequences of mental illness could be devastating, particularly when the sickness persisted. Alice's mother commented: “As for a human being, if he becomes sick and it doesn't go, he thinks a lot about money matters.” Alice's mother was fortunate in that her government post meant that her salary, however meagre, continued to be paid when she took time off to care for her daughter or was sick herself. However, this was an exception. The flip-side to the flexibility of the informal economy is its inherent insecurity (UNDP 2007). Most carers were self-employed in trading or farming and when unable to work lost their income and their businesses suffered. Those who left work to accompany a relative to shrines or churches often remained for months and even years in which case their trading or farming enterprises could fold completely. Kwaku's mother told us: “I lost everything, I don't

even have one pesewa. You see someone who has stayed at one place for three years without doing any work -- any money you have will finish.” Some left their farms in the care of relatives, others managed to pay someone to tend their land. However, workers, even family members, could not always be trusted to look after the crops well and carers could not often, if ever, make the long journey back to the farms to check. More common was the situation Gifty’s mother described: “If I am not there, it is lost. If you make a farm and you are not there nobody takes care of it.”

Aside from the loss of earnings, the costs of treatment could be high from whatever source. As with Alice’s mother, Mary’s mother had depleted all her savings on a prolonged search for healing: “The amount I’ve spent on her, if I say it, you will think I’m telling lies. Because I was having money in the bank, but if you go to the church, give collection, bring this, help in this, after all these....” Treatment at a healing church, as Mary’s mother explained, involved “collection,” thanks to the pastor in money or gifts, and perhaps, as in Alice’s case, payment for “anointing oil.” This could be costly. As James’ father said: “The collection you will give is more than paying money.” Contrary to the perception that traditional healers are more “affordable” (Tabi et al. 2006), treatment at shrines was reported to be the most expensive with large sums of money for the *ntoasee* (down payment) and for the post-treatment *aseda* (thanksgiving).⁹ Families at the shrine visited for this study reported paying around GHS200¹⁰ (then the equivalent of about US\$200), as well as gifts such as cloth and palm oil, alcohol for libation, and animals for sacrifice. All too often such outlay was to no avail as Mariam’s father explained:

⁹ It has been suggested that cash payment to African healers, as opposed to gifts, was introduced with the cash economy and has increased over time (Tsey 1997: 169).

¹⁰ At the time of research GHS1 (Ghana cedi) was equivalent to roughly US\$1. The currency has since devalued to approximately GHS1 to US\$0.5.

It's not a joke. If you go here they say pay 700,000 [old cedi] and a cockerel. You go here they say buy a sheep and pay 500 [500,000 old cedi]. [...] You go to the medicine man there he will also tell you to take money, he says: "Put cash there before I start." He will do all that, you will see nothing. And you go to a different place and there too pay money, buy a cockerel, yet you will see nothing.

Even psychiatric treatment, which is officially free,¹¹ could incur costs. Drug supplies are often depleted at the psychiatric hospitals in which case families have to purchase medication privately. On top of this, patients and doctors commonly expect to give or receive a donation, in keeping with the practice of *aseda*.¹²

To meet this outlay people drew on a variety of resources: the extended family, particularly uncles, remittances from relatives abroad, and selling assets such as cows, and stored crops such as yam or maize. Some received small contributions in cash or kind, such as food, from family and friends. Others borrowed money from relatives or acquaintances or bought food on credit, running up considerable debts. Gifty's mother had used her farming profits to accumulate the materials she needed to build a house. She also had a freezer ('fridge') from which she sold frozen food. After three years at the shrine all her assets had gone to fund her daughter's treatment as she described: "Now all my work is spoiled [...] Even now my fridge and all the property that I had I have sold it all." From being a fairly prosperous farmer Gifty's mother struggled to feed herself and her daughter. Often she had to resort to buying

¹¹ Psychiatric treatment has historically been provided free of charge within psychiatric facilities (though not necessarily within general health care) (Appiah-Kubi Undated).

¹² See Andersen (2004); Van der Geest and Sarkodie (1998). Newton (2008) describes the relatively low pay and long hours of public sector doctors, and their gratitude for "gifts" from patients.

food on credit, or, in season, selling the mangoes they picked in the forest.

“No Matter How the Child is, She is Hers”: **Family Devotion**

As cited in the introduction the literature has made much of the caring role of the extended family in times of illness, however, as in Alice’s case, expectations of support were often disappointed. Mary’s mother reported:

When the sickness came, none of my friends or family members has ever said maybe you are sick or the child is also sick, so we are giving this to help you cure the sickness. Nobody has done that for me since the sickness started.

Furthermore if the illness was little improved despite years of treatment, resources or generosity could run dry. As with Alice, early on in the illness family members would consult on the choice of treatment, however, as time passed and treatment proved fruitless, the mother could find herself left to her own devices in seeking treatment, following recommendations from friends or acquaintances. The popular perception of madness as incurable, reinforced by frequent relapses, meant that several carers reported that relatives perceived spending money on healers as throwing money to waste. Yaw, for example, had been ill for six years. His brother, who was living in Europe, paid the *aseda* and also met the expenses of Yaw and his sister during their year at the shrine. However, Yaw’s sister complained that their *wɔfa*, who was also overseas, had declined to spend money on Yaw’s treatment, seeing his case as beyond help. Members of the matrilineage, she said, had told her she was “struggling in vain.” “When I go back they don’t even ask how he is. They think he is spoiled so we are struggling in vain. When I go there, some even tell me to leave him.” This resulted in a “spoiling” of relations between Yaw’s mother and her brother and the loss of his support. Yaw’s sister speculated: “Perhaps they wanted us to leave him because it

was too late. But my mother said she couldn't leave him to go to waste like that.”

This reluctance to give up, to let a child “spoil,” was demonstrated in extraordinarily prolonged efforts to seek treatment as Alice's case illustrates. Though Yakub had rejected his mother as a witch, she told us she would go to any expense to cure him: “Wherever I can go for my child to get healed, I will go [...] if ten million [old cedi] can stop the sickness, and I even have ten million in my hand I will give [it] to you so that my child could be well.” Despite the waning support of some family members, the moral imperative of family responsibility could lead to accusations of neglect against those who failed to provide adequate care or treatment. One informant explained:

When the person is roaming about and they know the actual family the person is coming from, when you are passing by they will be looking at you and be saying all sorts of things [...] people will be talking against you, maybe you are not trying your best.

Though the finger might point at the wider family, the burden of responsibility and the shame of public neglect appeared to fall most heavily on mothers. The ideal of the mother is a potent one in Ghana, even whilst there exists a vivid imaginary of the perversion of maternal nurture in the figure of the witch. As the visible embodiment of such paradoxical idealisation and demonization, mothers had most to fear from public judgement in Kintampo and the surrounding villages, where life is lived under the eye of family, neighbours, and friends, as well as potential enemies. Whilst fathers might also be judged for evading their responsibilities, in cases where they were living elsewhere their physical absence enabled them to escape the consequences of such judgement. Kwabena's mother described how people had accused her of “neglecting” her child by not seeking treatment. However, she argued: “It isn't like I have

neglected him. It is a money issue. I don't have money." Since no help was forthcoming from her family, she had searched for a large loan (GHS200) so that she could bring Kwabena to the shrine. After using this to pay for a taxi and the *ntoasee*, she was forced to find a further loan to complete his treatment.

Such efforts to prevent a mentally ill child from "spoiling" were not only directed to seeking a cure, but also to caring for the child within the household, extending the parental role well past its expected lifespan. Mothers in their late fifties and early sixties were entering a period of life when it was hoped the child would begin to take on the responsibility of caring for them, particularly as their own health and strength failed. However, many informants with mental illness did not participate in household chores such as fetching water, washing clothes, and preparing food. Some needed coaxing and chiding to take a bath and change into clean clothes, and help to manage intimate tasks during menstruation or using the toilet. There were also difficult challenges in managing agitation and bizarre behaviour. One day at the shrine we found Kwasi pouring water into his mouth from a cup, dribbling it slowly over his clothes and on the floor. He then put his fingers in his mouth and attempted to vomit. Seeing this strange behaviour, the shrine attendants summoned his father, who leant over his son, patiently soothing him. Kwasi's father had left his farm untended and given over years of his life to care for his son – he had already spent two-and-a-half years in a prayer camp – and planned to spend another year at the shrine. In effect his caring role had become a full-time job:

Since the illness came, all my work as broken down. I don't work as I'm staying with him, washing his things, I fetch firewood, I cook food for him to eat. How can you go and work in addition to this?

Yet despite this "burden of care," I was often struck by the patience and affection which parents extended to their

dependent child. As Susan Whyte (1991: 13) notes, through their prolonged dependence, the child could become a “special source of companionship,” even when social capacity was impaired. Gifty’s mother displayed a great deal of affection to her “useless” daughter, patiently chiding her to greet or thank us, reinforcing basic social mores which should have long been internalised. Similarly, Akosua’s sister explained how her aunt had “devoted herself” to caring for Akosua whom she refused to disown despite her years of sickness: “She said no matter how the child is, she is hers.” Through maintaining familial intimacy, such caring challenged popular stereotypes of the mad as less than human, creating novel ways of being and relating despite the inability of many of those with severe mental illness to fulfil the responsibilities of adulthood. As Livingston (2008) observes, the act of caring works to draw people who are considered compromised as human beings through impairments or illness, back into the social universe. This young person illustrated how treating her mentally ill grandmother as “still a family member” not only met the moral obligation to care for her, but actively maintained her humanity:

She’s still in the house with the whole family. She’s not neglected. Every time they collect food for her. So when you even go and see her, if not once a while that she will talk and you’ll see there’s something wrong with the old lady, you will never know that there’s something wrong with her, and that way she will not go out to do things that is not proper. But if you leave her, she will end up by going naked and all those things.

The alternative to such family care was the “neglected” homeless mad vagrant – “naked and all those things.” The fear of losing a “roaming” child to vagrancy seemed to haunt some families who went to great lengths to prevent this fate, even to the extent of chaining the person at home. When Mariam, a young woman of 16, wandered from home her father expended

considerable time and energy searching for her. He vividly described the moment he finally found her in a lorry park in Tamale, three hours from Kintampo:

When I saw her tears fell from my eyes and I cried. So those who were around asked me why and I said: "She is my daughter, I searched for her but couldn't find her." [...] Mariam saw me and straight away she came and held me. And from Tamale I brought her home.

Conclusion

The story of Mariam's father poignantly illustrates the active restoration of family relationships against the social and moral disintegration threatened by mental illness. As a vagrant stranger in a lorry park far from home, Mariam conforms completely to the popular stereotype of madness, however, as a child of her father in the family home Mariam's humanity is restored despite her evident and ongoing symptoms. Ida Nicolaisen (1995) notes of family members with mental illness in Borneo, "While their illness prevents them from taking full part in social life in practice, the community will generally try to cope with their situation so as not to deprive them of the social relationships that define adult personhood" (ibid: 45-46). She illustrates how the longhouse with its communal veranda facilitates the incorporation of the person with mental illness into the kin group, as one could argue for the compound house in Ghana – "It creates an environment in which the individual, disabled or not, experiences himself as embedded in society" (ibid: 47). In Bourdieu's (1990) theory of practical kinship such cultural and social embedding is an active process of nurture and repair. Family relationships are realised in action through "maintenance work," they are "something that people make, and with which they do something" (ibid: 167), rather than simply the expression of a shared blood line. Through the practical enactment of kinship in the care of everyday needs and a search for a cure families seek to nurture the humanity of

the person with mental illness to meet the social ideal, publicly restating the person as a family member against the threat of social disintegration through madness.

Nonetheless such maintenance work is arduous and came at great cost – exacting an emotional, financial, and physical toll on those who provide care. In a society where aspiration, wealth, and status are often associated with moral worth, those with mental illness and their relatives keenly felt their social and moral failure and the burden of care could stretch family ties to breaking point. Whyte (1991) highlights the challenges of caring for a relative with mental illness in Tanzania - help with daily activities, treatment expenses, worry, and unhappiness, and coping with aggressive or destructive behaviour - all of which equally applied in Ghana. However, while Whyte cites Tomov who claims that “the shattered mother of a schizophrenic young man or the worn-out wife of a chronic psychotic with their subdued bitterness are definitely absent from the mental health clinics of rural Tanzania” (ibid: 100), the same could not be said of Kintampo. We met several “shattered mothers” and heard of spouses so “worn-out” they were no longer around. As we have shown, prolonged mental illness could exhaust sympathies and material assistance in the wider extended family, leaving key family members, often the mothers, as the sole providers of care. For many such carers the difficulties arising from the care of a disabled child are often in the context of the wider vulnerability of the household due to poverty and limited access to resources (Ingstad 1995: 260; Mhina 2009: 151). For those struggling to get by, severe illness can push families from poverty to destitution.

There is some evidence that church networks can act as alternative sources of social capital, as with the donation to Alice’s mother, but family support from health and social services is virtually absent. There is much international emphasis on “scaling up” mental health services to increase access to treatment in low-income settings such as Ghana

(WHO 2008). However, in the context of limited resources and trained workers such treatment can become reduced to the dispensing of medication rather than addressing the social needs of families (Hanlon et al. 2010). As with Alice, psychotropic medication may certainly be valued by families in helping to alleviate symptoms such as aggression and disruptive behaviour (Read 2012), but to provide such treatment without education and support for those who provide day-to-day care risks wasting resources, since, as this study shows, it is they who ensure that the person with mental illness takes medication and who struggle to meet their daily needs (Van der Geest 2011). Furthermore, the contributions of family members are invaluable not as a poor substitute for institutionalised models of care, but as active participants in the nurture and restoration of social personhood and functioning. Despite this, in low-income settings the majority of research and investment remains focused on drug treatments rather than social interventions (Patel 2007).¹³ However, a number of family interventions trialled in low-income settings suggest their potential to reduce carer burden, improve family functioning, and support adherence to treatment.¹⁴ These include education on mental disorders and treatment, enhancing coping skills and resilience, and improving interfamily communication through peer support groups and home visits to affected families. There are fewer reports on interventions to address the financial impact of mental illness so evident in this study. The NGO BasicNeeds that operates in Ghana and other low-income settings has established micro-credit and work placements to enable people with mental illness to engage in

¹³ In a review of research on treatment for schizophrenia in low- and middle-income countries only 8.5 percent of the studies were conducted on family and community interventions, compared to 57.7 percent on drug treatments (Patel et al. 2007).

¹⁴ See Chien et al. (2005); Gutierrez-Maldonado and CaqueoUrizar (2007); Ran et al. (2003); Murthy et al. (2005); Van der Geest (2011).

“sustainable livelihoods” (BasicNeeds 2010), though their impact has not been formally evaluated. The suffering of families encountered in this study, as well as their potential to support social recovery, suggests they must form the priority for interventions and resources in addressing the challenges facing mental health in Ghana and elsewhere. Learning how best to live with mental illness is a question that faces all of us. Yet those who know most about how to do so are often those to whom we listen least.

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HIV DISCLOSURE IN GHANA: THE UNDERLYING GENDER DIMENSION TO TRUST AND CAREGIVING

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Missing in the debate of HIV/AIDS-positive disclosures is its gender dimension in terms of those likely to disclose their status, as well as the people in whom they are likely to confide this personal and socially perilous news. This article explores the gender dimension of HIV-positive disclosures through in-depth interviews of 25 AIDS patients receiving treatment at a hospital in Ghana. It argues that the people likely to be informed by AIDS patients of their status are those perceived by the patient to be potential care-givers and more often than not these are females. In other words, unlike in most “Western” countries, gender role expectations do shape HIV-positive disclosures in Ghana.

Keywords: HIV/AIDS, disclosure, women, gender, trust, care, Ghana.

The HIV/AIDS pandemic continues to be a major health problem around the world three decades after its emergence. Globally, nearly 65 million people have been infected with HIV, and more than 20 million have lost their lives to AIDS. In 2009 alone, HIV/AIDS claimed more than 2.1 million lives (UNAIDS 2010). In 2010, the global estimate regarding the number of people living with the disease was about 33.3 million, of which about 22.5 million (70 percent) lived in sub-Saharan Africa alone (UNAIDS 2010). In Ghana, the first HIV/AIDS cases were reported in 1986; by the end of 1996, about 21,000 cases had

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been reported (Oppong 1998), a number that increased to about 76,139 cases by 2003 (NACP 2004). Between 2000 and 2003, the percentage of the population diagnosed with HIV/AIDS steadily increased from 2.3 percent to 3.6 percent. In 2006, HIV prevalence had decreased to 3.2 percent and further declined to 2.6 percent by 2007. A marginal increase to 2.9 percent in 2009 put the number of people living with HIV/AIDS at 267,069, of which 3,354 were children (NACP 2010). The HIV prevalence for 2011 was estimated at 1.5 percent with approximately 225,478 cases consisting of 100,336 men and 125,141 women living with HIV/AIDS (NACP 2011). It is estimated that new infections of HIV will further decrease in accordance with global trends.

Since a cure has yet to be found for HIV/AIDS, prevention has been a major concern for governments. To this end, disclosure of HIV-positive status is recognised as essential for reducing the incidence of HIV/AIDS and increasing the well-being of those infected (Shehan et al. 2005; Bairan et al. 2007). Christine De Rosa and Gary Marks (1998) have shown that the disclosure of one's HIV-positive status in sexual relationships positively correlates with safer sexual practices, while non-disclosure may lead to unsafe sexual practices.

Furthermore, HIV/AIDS disclosure to family and friends is found to be essential in garnering social support and providing strategies critical to coping with the disease (Greeff et al. 2008). The benefits of HIV disclosures cannot be overemphasised; however, many people living with HIV/AIDS (PLWHAs) do not disclose their status for fear of stigmatisation (Greeff et al. 2008). Ervin Goffman (1963:3) defines "stigma" as a deeply discrediting attribute which reduces a whole person to a tainted and discounted one. According to Goffman, the stigma felt by individuals could reduce their life chances and spoil their identity. Stigmatised

individuals could face discrimination, isolation, status loss, and loss of employment. Although HIV was not yet present when Goffman was writing, the disease fits Goffman's three types of stigma in that it is associated with bodily imperfections, character flaws, and negatively regarded groups.

Studies on disclosure patterns in Africa in general (Shehan et al. 2005; Bairan et al. 2007; Greeff et al. 2008; De Rosa and Marks 1998), and Ghana in particular (Mill, 2003; Dapaah 2012; Kwansa 2013) have looked at the various aspects of HIV/AIDS disclosures. However, the bulk of these studies have largely explored reasons for disclosure, non-disclosure, and possible consequences (Shehan et al. 2005; Bairan et al. 2007; Greeff et al. 2008; De Rosa and Marks 1998) and overlooked the gender dimension of disclosures.

In most cultures, the burden of care falls directly on women, who are perceived as natural carers (MacNeil 1996). Statistics available in the United States indicate that three out of four caregivers are women (Wootton 1998). Likewise in Ghana, the burden of AIDS patients' emotional and physical falls to women, especially to mothers, sisters, and daughters (Radstake 1997; Anarfi 1995). Men on the other hand offer care by providing financial resources and, occasionally, visiting (Sackey 2009). There is the need, therefore, to explore the possible relationship between gendered expectations of care and disclosure by AIDS patients. Consequently, this article explores the role of gender in HIV-positive disclosures through in-depth interviews of 25 AIDS patients receiving treatment at the Koforidua Regional Hospital in Ghana. It argues that those likely to be informed by an HIV seropositive patient of their status are usually women, largely perceived by the patient to be potential care-givers. The article therefore explores the role gender plays in patterns of HIV-positive

disclosures in Ghana, as well as to whom and why HIV-positive disclosures are made.

HIV-Positive Status: To Disclose Status or Not?

The decision to disclose an HIV-seropositive status is a daunting one in a culture that stigmatizes disease and a healthcare delivery system that often blames victims. This socio-cultural milieu is further complicated by the question of to whom, why and how one discloses a positive HIV status. Ann Miller and Donald Rubin (2007) argue that HIV-positive disclosures may differ per culture. Several studies (Marks et al. 1992; Green and Seronovich 1996; Miller and Rubin 2007; Greeff et al. 2008) show that the people to whom AIDS patients in Africa disclose their status differ from other parts of the world. The most remarkable difference is that sexual partners in African societies are much less likely to be informed about an HIV infection than in the United States of America and Europe.

Evidence from African countries shows that the majority of people living with HIV/AIDS (PLWHAs) disclosed their HIV-positive status to family members, but only a few disclosed the information to sexual partners and friends (Lie and Biswalo 1996; Antelman et al. 2001; MacNeil et al. 1999; Miller and Rubin 2007; Moemeka 1996). For instance, Gro Lie and Peles Biswalo (1996), in a study in Tanzania, asked HIV-positive people to indicate their choice of significant others to whom their HIV-positive status would be disclosed. They noted that about 90 percent of their respondents chose close family members of the same sex and generation as their confidants. Similarly, Gretchen Antelman and colleagues (2001) studied pregnant HIV-positive women attending an antenatal clinic in Dar es Salaam, Tanzania, and found that while the majority of the respondents had disclosed their HIV-

positive status to a female family member, only a few had disclosed it to their sexual partners.

Similarly, Joan MacNeil and colleagues (1999) examined the differences in sexual risk behaviours among newly-diagnosed people with HIV in rural Tanzania. They reported that the majority of HIV-positive disclosures were made to parents, followed by spouses and sexual partners. In yet another study on the factors leading to HIV-positive disclosures in Kenya, Miller and Rubin (2007) found that men who are HIV-positive are more likely to disclose their status to their wives, while HIV-positive women disclosed their status to their relatives and not their spouses. In their study, many of the participants did not disclose status to their friends because of fears of rejection and gossip.² Likewise, women living with AIDS did not disclose their illness to their husbands for the same reason, and many wives claimed there was no open discussion on sexual issues with their partners (Miller and Rubin 2007). Similar studies in India also point to a higher rate of disclosure to members of the family than to friends. That HIV-positive status disclosure in Africa and India seems to be most frequently made to the family probably indicates the family's primary support role (Moemeka 1996; Gyekye 1997). In Africa, unlike in most European countries, a support system is provided almost solely by the family. In much of Europe, the state provides welfare for its citizens; in such a case, individuals are also likely to turn to the state's welfare system.

² Friendship can be defined as a relationship with another person that is intimate, close and private, but not sexual (Turner 2006). This can be contrasted with acquaintanceship—a relationship that is not intimate. The authors did not indicate whether those referred to above are close friends or acquaintances.

Method

This article draws on a wider study of the perception of death of AIDS in the New Juaben Traditional Area of Ghana. The setting for this study is the largest hospital in the Koforidua Municipality, the Koforidua Regional Hospital. Most people of New Juaben belong to the largest ethnic group in Ghana, the Akan, who share a similar culture in terms of language, descent, and inheritance practices. Among the Akan, descent, inheritance and succession are traced through the female line.

The HIV clinic at the Koforidua Regional Hospital (est. 2005) was the first of its kind in the municipality and serves the adjoining conurbations. The clinic has four units: the Data Centre, where data on HIV/AIDS in the Koforidua area are collated and processed; the voluntary counselling and testing unit; the prevention of mother-to-child transmission unit; and the sexually transmitted diseases unit.

The benefits of a qualitative approach to healthcare research are becoming increasingly recognized. After gaining approval from the National AIDS Control Programme (NACP) and the hospital administration, we utilized in-depth interviews as a method to conduct our study of 25 PLWHAs. Participants were obtained with the help of the staff at the HIV clinic. Though the clinic days at the hospital are Tuesdays and Wednesdays, most PLWHAs come to the clinic once a month. The “convenience sampling” method was used; thus, participants who met the study criteria and were willing to participate were screened and introduced to the researcher. All interviews took place in one of the rooms at the centre.

The purpose of the study was explained to the participants and their consent sought before the interviews began. The interviews took place on different days and were conducted, recorded and transcribed in the Akan language, Twi, before being translated into

English. The transcribed data were subjected to content analysis with close attention paid to emerging themes from the narratives, such as care, trust and fear of stigmatization. For anonymity and confidentiality purposes, pseudonyms were used to protect the identity of participants. In all, 19 females and six male participants ranging from 26 to 58 years of age were involved in the study.³ Participants had very low levels of education: two had a secondary school level education, fourteen had a primary/middle school education, and nine had no education at all. Of the 25 participants, five were married, seven were divorced, six were single, one was separated, and six were widowed. Twenty-one interviewees had between one and seven children, while four interviewees had none. The participants were engaged in petty trading, farming, volunteer work, barbering, hairdressing, dressmaking, and some were unemployed.

The Role and Impact of the “Monitor”

In this study, all participants had disclosed their HIV-positive status to at least one person who was also their monitor. A “monitor” is a person who AIDS patients are required to bring with them before they are put on anti-retroviral therapy (ART). The main purpose of a monitor is to supervise the patient and ensure that the ART regimen is adhered to; this regimen must be strictly followed for it to be effective. The health care providers at the HIV clinic explained that invariably, some of the patients are suicidal after their diagnosis and may need someone around them. They also explained that patients need a caregiver, especially at the start of the ART regimen, because of the potentially severe side effects.

³ This gender breakdown seems to reflect the higher number of women reported with HIV in Ghana. In 2009 the estimated persons living with HIV and AIDS were 267,069, made up of 154, 612 females and 112, 457 males (NACP 2010).

In cases where patients are very weak and require help, a monitor who knows the illness and the drugs being taken can assist the patient when the need arises. Obviously, finding a monitor requires disclosure. Healthcare providers do not see this as a violation of patients' rights; rather they believe it is in the interest of the patients that somebody knows their status.

Patients undergo counselling before and after testing and are encouraged to self-inform their monitors. In some cases, hospital workers inform both the monitor and the patient at the same time. This was the case for most of the participants, because the majority of them reported to the hospital when they were already in the advanced stages of the disease—that is, with full-blown AIDS. Most of them remembered being very sick, and some said they were in a coma for several weeks.⁴ Additionally, many of the monitors were already providing care for the patients; indeed, in several cases it was the monitors who suggested that the participants take an HIV test. As indicated above, the implication of the monitor system is that PLWHAs are forced to disclose their HIV-positive status to someone.⁵

To Whom is HIV-Positive Status Disclosed?

Analysis of the narratives revealed that the majority of the participants disclosed their status to family members. In this study, 19 out of 25 participants had disclosed their status to close

⁴ As already indicated above, some of the participants said that they had been gravely ill before their AIDS diagnosis. Some reported being paralysed and others reported being blind. Two of the participants reported being in a coma for several weeks.

⁵ Inspired by the proverb *Se wotɔn wo yadɛe a na wonya ano aduro* (It is only when you sell your sickness that you get medicine), Kwansa (2013: 75-102) describes in detail the strategies that PLWHAs in two Ashanti communities employ to disclose or withhold disclosure of their disease. He extensively discusses trust and mistrust but does not take into account the gender factor.

relatives; five did so to spouses and one made no disclosure to anyone. She was asymptomatic and was not on an ART at the time of the interview. This finding is consistent with studies in other parts of Africa (Lie and Biswalo 1996; Miller and Rubin 2007) where the majority of status disclosures are made to relatives. The rationale for disclosing information to close relatives was the enduring function of the family as the basic support system in Ghana (Gyekye 1997); indeed, the majority of AIDS patients in Africa are cared for by their families as the health care system is inadequate (Crentsil 2007; Kikule 2003).

Gender is a significant factor in deciding to whom to disclose a diagnosis. Of the nineteen participants who had disclosed this information to relatives, only seven did so to male relatives—two discussed it with their sons and five with their brothers. Twelve respondents reported disclosing HIV status to their mothers, making this group the largest in which informants confided. Six of the participants disclosed their illness only to their mothers, and another six to their mothers plus additional relatives. For instance, some married women divulged their status to both their mothers and their husbands. Other informants similarly confided in their sisters in addition to their mothers. The reason for their choice, they said, was the care they hoped to receive from these relatives. It is noteworthy that some of the mothers were already involved in seeking treatment for their children before they were ultimately diagnosed with HIV. For instance, on the care she received from her mother both before and after her diagnosis, a respondent we named Harriet explained:

Had it not been for my mother, I would have been dead by now. No one understands me as much as my mother. She has been with me and has comforted me since I had this virus. She has been my pillar of strength. She took all my children upon herself and catered for them. She said I didn't have enough strength to do so.

Other participants also indicated that they were grateful for the care they had received from their mothers thus far. For example, Gina intimated that her mother ate with her from the same bowl (a common and significant practice in Ghana symbolising belonging and acceptance) as they did before she was diagnosed. Liza, an informant who said she had left her husband for infecting her, is currently living with her mother. She indicated that her mother pays her medical bills and other expenses. Mavis, a participant who has informed her mother but not her father, said of her mother:

She encourages me to take the medicine. Sometimes at dawn she will come and wake me up to take my medicine. She comes to check whether I am taking the medicine.

Nevertheless, some participants reported being isolated and discriminated against after they disclosed their HIV status to their mothers. Stella, who sells vegetables at the local market, explained that her mother would rather buy from others and would not even accept Stella's vegetables as a gift. Likewise her siblings would not eat from the same bowl with her and refused to enter her room. Another woman, Ophelia, indicated that she experienced stigmatisation and discrimination after informing her mother of her HIV status. She explained that her mother would tell the children in the family not to eat her food because she was HIV positive and would insult her at the least provocation. Unlike Stella, Ophelia has moved out of her mother's home and rents her own place. Similar findings were made by Phyllis Antwi and Deborah Atobrah (2009) in a study that compared stigma in the care of cancer and AIDS patients in Ghana. In their study, some participants reported that they were stigmatised and discriminated against by their mothers and other family members.

Other female relatives to whom the participants had disclosed their status were sisters, daughters, and wives. While six of the participants had disclosed their status to their daughters, another four had confided in their sisters as well as other relatives. Three of the participants disclosed their illness to their daughters alone and another three to both their daughters and their mothers.

Significantly, most participants did not disclose their HIV positive status to male relatives; only two of the participants, neither of which had daughters, disclosed their status to their sons, although both described the tremendous care they have thus far received from their children. One participant also disclosed her status to a brother, who became her primary caregiver and has been instrumental in providing financial care. The other four who disclosed their status to their brothers had also disclosed it to their mothers.

More significantly, several of the participants chose to disclose their status to close female relatives but not to close male relatives. Some participants had confided in their mothers but not their fathers. Only Harriet reported that she had disclosed her status to both parents; neither Akuanor Mavis had done the same. Similarly, three participants had only disclosed their status to their daughters while withholding the information from their sons. Auntie Bea, for example, had disclosed her status to her three daughters, but her four sons were only aware that she was sick. She said:

I have seven children—four boys and three girls. Two of them (daughters) were initially by my bedside. In our house [family], only three people apart from me know about my condition. No other person knows.

In addition to the prospect of care as the main motivating factor in disclosing HIV status to female relatives, our study also revealed

that trust and confidentiality played a significant role in the decision. It is noteworthy that some of the participants chose not to disclose their status to male relatives but did so to female relatives. These participants were sure that their relatives would not reveal their status to others. For instance, Akua, who trusted her mother and sister to keep her diagnosis secret, explained:

My sister and mother are the only people who know about my condition [HIV status]; it is very dangerous to inform my father because I suspect he has cursed me with this disease; he will easily spread the news. He will never hear about my condition till the day I die.

Similarly, Mark was of the view that if he disclosed his HIV-positive status to his brothers, they might spread the news. Mark, who is 37 years old, had only disclosed the information to his mother and one of his five brothers. He said:

Hmm. Maybe they have wives. And you telling them about such things [HIV status], maybe they will tell their wives, and they [the wives] may tell others about it. And before you know it, everybody knows that you have this disease. So when you're passing by, people will be saying that this person, he even has some of the disease.

Another reason given by participants for revealing their status to female relatives was the desire to keep the men in their lives from worrying. Some of the parents who had disclosed their status to their daughters but not their sons seemingly believed their daughters could better handle such news and intimated that they did not want their sons to worry or be disturbed. Ama, a 40-year-old woman, explained her reasoning for disclosing her status to her daughter as follows: "It is only my daughter who is aware but the boy is not, because I don't want him to be worried." Mary and Adwoa made similar comments. Indeed, Mary indicated that although she initially told her son about her status, he cried so

much that on the advice of Mary's mother, she lied and said she was only testing him to find out whether he loved her. Her son was 19 years old.

The few respondents who disclosed their status to extended family members did so in accordance with cultural prescription because their own parents were deceased. In Ghanaian culture, the family decides who will take care of the children in the event of the death of their biological parents. A mother's sister, for example, is considered to be one's own mother among the matrilineal Akan and has therefore the same responsibilities as one's biological mother. Two respondents whose parents were deceased disclosed their status to their mother's sisters. One reported that in addition to her maternal aunt (who was incidentally already a caregiver pre-diagnosis), she had also informed her brother, who provides her with her financial needs.

In some cases, participants withheld their HIV status from their relatives out of fear that it would impact their funerals. For instance, 32-year-old Abena only disclosed her status to her husband because she felt that informing her relatives might preclude her from a befitting burial. Because funerals are great social events among the Akan people (Gilbert 1988), their performance is the responsibility of the deceased's family (Arhin 1994; De Witte 2000; Van der Geest 2000). Some of the participants, like Abena, were concerned about how their funerals would be performed when they died.

The study also revealed that disclosure of HIV status to people outside the family, especially to friends, was minimal. One woman informed her pastor, another woman a nurse at the hospital who later became her monitor. Only one participant, Kwaku, reported disclosing his status to a female friend whom he—interestingly—chose to call “sister.” This friend was also Kwaku's monitor, and

he related that he would have died without her care. When asked why he disclosed his illness to a friend instead of to his brothers, Kwaku replied: "I share my secrets only with those who can help me." He went on to describe the tremendous help he had received from this friend since testing positive. In this, however, Kwaku was the exception, not the rule: many of the participants indicated that they had either left their friends or their friends had left them. Some cited confidentiality issues, and others were afraid of stigmatization and discrimination. Kwaku explained that even though he had not informed most of his friends of his illness, those friends who suspected had shunned him. He said:

All my friends who used to hang out with me no longer associate with me. Before then, they used to visit and we would eat *fufu* each morning.... After sometime, some of them said I was infected, others said I was not. Others also said it was my sister who was bringing me medicine. I heard about it, but did not confront them. Nobody also personally asked me about it.

Incidentally, some of the participants opined that they did not have friends because it is not good to have many of them. Mark, when asked about his friends, remarked: "I don't like friends anyway. My friends are only two." Mary expressed similar sentiments:

I don't like friends. So it has become part of me. It has always been my sisters and me. I am afraid of friends. They are not good. They can even spread false information about you.

In effect, HIV/AIDS disclosure is dynamic, where notions of care intersect with gender, friends, and even funerals.

Discussion and Conclusion

In this study, the underlying gender dimension of HIV disclosures is remarkable. Most disclosures of status were made to women in their capacity as mothers, wives, daughters, sisters, or female

friends. Only two disclosures were made to men only. The high number of HIV disclosures to females is linked to the expected culturally-dictated caregiving roles of these female relatives. Ghanaian cultural norms regulate who cares for whom during periods of sickness; among the Akan, for instance, wives are expected to care for their sick husbands but not vice versa (Sackey 2009; Van der Geest 2002).

The normative cultural expectation is that children, especially daughters, take care of their aged parents (Van der Geest 2002). While men provide money for care and occasionally visit, women are responsible for the physical care of the sick (Sackey 2009). It is not uncommon for married women to leave their husbands to take care of their ailing parents. In a study of care of the aged in Kwahu, Sjaak van der Geest (2002) relayed the story of a woman who asked permission from her husband to go and tend to her aging parents. Brigid Sackey (2009) recounted the dilemma of a woman torn between caring for her ailing husband and her aged parents. In this particular case, the husband allowed the woman to spend more time with her parents while a nurse was hired to care for the husband (Sackey 2009). Thus, when people living with HIV choose female relatives as “monitors” and confidants, they conform in a way to cultural norms. Invariably, older participants informed their daughters about their HIV status, knowing that they could count on being cared for by their daughters. Even in the case where the participants’ mothers were not alive, other female relatives (and one female friend) were informed. Likewise, when married men informed their wives about their disease and chose them as “monitors,” they did so as a result of the gendered division and ethics of labour that delegates care to females.

Furthermore, the choice of women as the people to whom status can be disclosed indicates the participants’ view that women

can be better trusted to keep their secret from others. Ironically, women are popularly perceived to be gossipers in many cultures (Chrisler and McCreary 2010), and Ghana is no exception. A proverb confirms this stereotype: *ɔbaa tenten so abɛ a, onwam di* (If a tall woman carries palm nuts, the hornbill [a bird] eats them), which according to Akrofi (n.d.: 5) means, “A talkative woman divulges domestic secrets.” In spite of this, participants perceived that women, more than men, would keep their HIV-positive status hidden. Though trust is not explicitly mentioned as a predictor of HIV disclosures in other studies (Shehan et al. 2005; Miller and Rubin 2007), its importance cannot be underestimated. It has been amply proven that the fear of stigmatization and discrimination act as a barrier to HIV-positive status disclosures (Shehan et al. 2005; Mill 2003). The participants thus needed somebody in whom they could trust to keep their HIV status undisclosed. We have seen, however, that not all the women to whom status disclosures were made kept the secret or refrained from stigmatizing the participants. Women as a potential source of stigmatization in Ghana have also been reported by Antwi and Atobrah (2009).

Additionally, the study suggests that participants are more comfortable disclosing their status to their mothers. In traditional Ghanaian societies, “the relationship between the child and the mother ... is very warm and intimate. The mother is in fact the child’s most important and first social contact, and this is regardless of the sex of the child” (Assimeng 1999: 106). According to Max Assimeng, this applies to all ethnic groups in Ghana. The bonds that are created between mothers and their children seem to make it easier for children to confide in their mothers as opposed to fathers. Individuals are also closer to their female relatives in matrilineal societies, which may account for the high disclosure rates to sisters and daughters.

Concerns about confidentiality may also explain why disclosures made to friends were infrequent. Though friends may be trusted when sending remittances from abroad (Smith 2007), the same cannot be said of the disclosure of an HIV status. Since HIV/AIDS is a “metaphor” for moral breakdown (Dilger 2008), its disclosure to friends may be tantamount to washing one’s dirty linen in public. In fact, as noted by Van der Geest (2002), it is possible to keep an illness in the family secret until the death of the patient. An Akan proverb *Ayɔnko goro nti na ɔkɔtɔ anya ti* (The crab does not have a head because of friends) indicates friends are dangerous, as do slogans on public transport vehicles: *Suro wo yɔnko* (Fear your friend) or “Some friends...” It should be noted, however, that similar slogans and proverbs are directed at relatives (Van der Geest 2009b). The underlying thought is that the people closest to you are also the most dangerous because they know your secrets and your vulnerabilities. Witchcraft (*bayie*) therefore thrives among close relatives. This paradox of trust and distrust, closeness and danger, characterises the dilemma of the HIV patient. For instance, in Kwaku’s case we see someone who has both disclosed his HIV status to, and received immense help from, a friend he called “sister.” On the other hand, he later indicates that his other friends have left him because they suspected his illness. How can one person describe how good a friend has been and in the same breath complain that all his friends have left him because they suspected that he was HIV-positive? The problem may be the multiple meanings of “friend” in the Twi language. *Adamfo* or *yɔnko* mean both “friend” and “acquaintance.” Friends are defined as people that can be trusted (Van der Geest 2009a), but at the same time, as the proverbs above show, people that one should also be wary of. As previously stated, closeness-among relatives as well as among friends—engenders both trust and fear. Apparently,

when HIV/AIDS is involved, that trust is strongest in the case of relatives.

This study is exploratory and intends to open up the phenomenon of gender-related HIV disclosures for further research. One limitation we encountered was that the participants were AIDS patients receiving treatment at an AIDS clinic. They had reported to the hospital with advanced stages of AIDS and, as discussed above, were required to bring a monitor before they were given the drugs. The disclosure pattern of those not on an ART is therefore not included in this analysis. Further investigation could include participants who are not undergoing treatment and have consequently not been requested to produce a monitor. Further investigations need to be done on the issue of trust in caregiving. A larger sample size could be useful in eliciting more information on how PLWHAs and patients in general choose people to disclose their sickness to.

In conclusion, identifying people trusted by HIV/AIDS patients and who are willing to provide care is crucial in helping newly-diagnosed PLWHAs cope with the disease. The challenge in identifying people who can be trusted and are willing to provide care could possibly be addressed with an as-yet undeveloped model on how to identify trustworthy people. More importantly, families should be equipped to care for relatives infected with HIV as the burden of care falls on them in the Ghanaian context. Additionally, more needs to be done to reduce HIV-related stigma and discrimination, since this is a disease whose impact goes far beyond the infected. Awareness and education of HIV should be intensified to reduce HIV-related stigmatisation.

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MOBILE TECHNOLOGY AND HIV/AIDS IN GHANA

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The opportunities for using mobile technologies in Ghana to improve health services, particularly to support initiatives in the HIV/AIDS sector, are enormous. HIV/AIDS counsellors and health institutions are relying on mobile phones to retrieve and disseminate information to patients faster and without transport costs. This article discusses the appropriation of mobile telephones in HIV/AIDS initiatives, relates telephone usage to other health communication patterns, and argues that mobile technology amplifies ongoing processes of cultural change and continuity. Mobile telephones have great potential as a mass medium for HIV/AIDS education; however, their association with sex could threaten HIV prevention. The data presented here is based on ethnographic research about mobile telephones and healthcare delivery services conducted in rural Ghana during 2010-2011.

Keywords: HIV/AIDS counselling, health information, mobile telephones, Ghana.

Introduction

The mobile telephone has become a common and important channel of communication in Ghana.¹ The ability of the mobile phone to connect to various places on the globe and foster relationships with absent others is a central facet of modernity's globalizing dynamism (Tenhunen 2008). In Africa, the device has become a very useful tool to link people in towns with their relatives in villages. Mobile phones allow person-to-person communication and are used in very private ways, making them an ideal means of granting

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personal control over communication (Hahn and Kibora 2008: 90, 98). Mobile phones have now attained a leading role in local communications contexts; their flexibility of use enables their wide-scale application (Phippard 2012: 12).

Ghana's deregulation of the telephone market in 1994 fuelled the exponential growth of mobile usage in the country (Overå 2006). These devices are no longer the privilege of the wealthy, as high- and low-end mobile phones are being accessed, used, and considered increasingly indispensable by people from all walks of life (Sey 2011: 384). Ghanaians have adopted the mobile telephone and moulded it to their local context. Today mobile phones enable small business owners to better communicate with their customers; village entrepreneurs make a living by charging community members a fee to use their mobile telephones. Indeed, the use of mobile phones has a direct bearing on social relations and distinctions (Whyte et al. 2004), as they allow people to rapidly communicate with each other, irrespective of distance, and thus saving time and money for travels (Elegbeleye 2005: 197).

There is a growing interest in using mobile phone communication for development (Han 2012). In Africa, studies have focused on how mobile phones are valuable for economic (business) purposes (see Overå 2006; Donner 2006, 2008; Frempong 2009), in social relations (Elegbeleye 2005; Hahn and Kibora 2008), and in addressing issues of gender and poverty (Scott et al. 2004). The application of mobile phones to the public health sector is also gaining increased attention (Kaplan 2006); the proliferation of mobile phones has made them a compelling tool for health communication insofar as they engage in mass education and outreach as a result of their capacity to contact remote areas (Phippard 2012: 144).

In Ghana, biomedical services in the sense of hospital care are severely limited, and there are considerable lapses in the provision of health care (Bonsi 2000). When there is medical service, medicines and other basic supplies are often lacking or

inadequate, although the uneven distribution of care means that many rural areas completely lack any form of medical services (ibid). For access to medical care, patients in villages without a hospital or clinic are forced to travel by car or walk long distances to towns offering medical facilities (Crentsil 2007). HIV/AIDS counsellors and health institutions hope that mobile phones can be used to quickly retrieve and disseminate information to patients without transport costs.

In 2009, around 260,000 people were living with HIV in Ghana, 140,000 of whom were women aged 15 and above. The rate of HIV in women is higher than in men of the same age group. The major mode of HIV transmission in Ghana, as in much of sub-Saharan Africa, is heterosexual contact and mother to child infection (UNAIDS/WHO 2009). While knowledge and awareness of HIV/AIDS and its proven modes of transmission has increased over the past few years, this knowledge is often intertwined with ideas about witchcraft and curses. For instance, some people believe that the virus is only transmitted when someone has been bewitched. Witchcraft, sorcery, and curses are seen as being the real cause of the sickness (Radstake 1997; Crentsil 2007). In many cases these beliefs can influence risky sexual lifestyles, when people feel protected spiritually and therefore do not see the necessity to undertake preventive measures.

In order to examine the potential of mobile phone use for HIV/AIDS measures in Ghana, I looked at the specific communicative ecology related to HIV in the country. Communicative ecology can be defined as the dynamics between human communication and the effective environment, and is primarily understood as the link between human communicative processes, structures and meanings, social networks, and communication technology (Foth and Hearn 2007). People interact with others through communicative structures that are mediated, informational, situational, and contextual in their respective environments (Matthias 2011:

31). An examination of the communicative ecology of Ghanaian HIV/AIDS patients and other stakeholders helps in understanding how and why communication thrives in their everyday lives. AIDS patients and the HIV-positive usually rely on either face-to-face communication with their doctor and HIV counsellor at the hospital or home-based visits for key health information, although there also exists a countrywide, media-driven education and awareness campaign disseminating information via radio, television, and posters. Most HIV/AIDS patients live in rural areas and must travel to hospitals for counselling. With the availability of mobile phones, they can now call distant health experts for information concerning their status without having to travel.

Communication-centric approaches are regarded as essential in HIV/AIDS intervention (UNAIDS 2004), and as Trisha Phippard (2012: 128) has pointed out, new ICTs—particularly mobile phones—present considerable opportunities in this regard, particularly in Africa (DeTolly and Alexander 2009; Lester et al. 2006). For example, the South African Cell-Life project uses mobile phones as a mass information channel for HIV/AIDS interventions (www.celllife.org; De Tolly and Alexander 2009). Cell-Life is also developing solutions that support the management and monitoring of HIV/AIDS in partnership with the University of Cape Town, the U.S. President's Emergency Plan for AIDS Relief, the United States Agency for International Development (USAID), Vodacom, and other international organizations. Solutions include the intelligent Dispensing of Antiretroviral Treatment for adherence improvement, the data collection tool Aftercare, and the use of SMS texts to expand the uptake of HIV testing and follow-ups in treatment.² It is into this body of research on mobile phones in HIV/AIDS responses that this study falls.

² Source <http://www.mhealthinfo.org/project/cellphones4hiv> (Accessed 18 August 2012).

This article examines the role of mobile telephones in the HIV/AIDS sector in Ghana. I use mobile technology as a window into the social values embedded in relationships (De Souza e Silva et al. 2011), and explore the new initiatives that the mobile telephone enables in HIV/AIDS measures, and how the mobile phone may enhance the risks of HIV and threaten HIV prevention in Ghana. This article both draws from and contributes to the understanding of the role of cultural meanings in technology studies, as well as social aspects of HIV/AIDS in Africa. I begin with a discussion of my research methods and mobile phone use in Ghana, examining the latter in the context of the HIV/AIDS sector. Then I discuss my main findings within the context of the current body of literature. The article concludes by suggesting that studies on mobile technology in Africa should focus on the great promise of mobile phones, including their potential for mass education and the alleviation of health-related problems, but also on the ills associated with their use and the dangers to society regarding the threat to HIV prevention.

Methods

This article is based on an ethnographic study of mobile phones and healthcare communication in the HIV/AIDS sector in Ghana. The data were collected in over five months from 2010-2011 through qualitative methods of observation and unstructured, face-to-face interviews with health personnel, HIV/AIDS counsellors, HIV-positive people, and mobile phone users in four towns and villages (two urban and two rural) across southern Ghana. The study collected detailed material on people's everyday lives and narratives about mobile phones. I was particularly interested in patients' case histories. Of the four locations in which I conducted my research, one urban and one rural area each had a hospital with an HIV unit where I could observe and interview HIV/AIDS patients and health personnel on mobile phone use for health care communication.

Most of the interview sessions lasted from thirty minutes to two hours, while conversations were short and conducted over a few minutes. I interacted with 101 respondents consisting of 49 women and 52 men ranging in age from 15 to 81. These were mostly students, nurses, teachers, and traders—Ninety of them were mobile phone users, including both those people with a tertiary education, Senior High School or Junior High School levels, and illiterate people without any formal schooling. Seven respondents—three women and four men—were engaged in two separate focal group discussions in which participants were intentionally selected based on their gender and knowledge of mobile phones. There were also 11 people among my respondents who did not use mobile phones. Most of my respondents were encountered through six local residents who served as contacts and key informants. These were two HIV counsellors,³ my brother, my distant cousin, a man belonging to the church of a Christian clergyman known to my family, and a taxi driver introduced to me by an old elementary school classmate.

During the second phase of my study, I further interviewed 15 mobile phone users (nine females and six males) whom I had interviewed previously. Additionally, 72 survey questionnaires (completed by 42 men and 30 women) were administered to gain a broader picture of mobile phone usage. The questionnaire covered issues such as the respondents' demographic information, the frequency with which they used mobile phones, expenditure on services, and patterns of communication with others. For example, respondents were asked about their income levels, the categories of people with whom they communicated (such as family members, friends, and health officials), and how often they shared their phone with family members, friends, or neighbours. The four research

³ One of the counselors was my contact and key informant during my doctoral fieldwork in 2003.

sites were selected so that the study would incorporate data from different social environments in southern Ghana and thus ensure that the data were as representative as possible of the situation.

Mobile technology has been studied through “the appropriation of technology” or “domestication” approach, which demonstrates cultural underpinnings in social studies of technology. Appropriation generally refers to not only how artefacts are used, but also how they are adapted in use and subsequently interpreted (Mackay and Gillespie 1992). The domestication paradigm centres on questions of how technology is adapted to everyday life and how everyday life, in turn, is adapted to technology (Tenhunen 2008). There is at present a huge interest in the cultural appropriation and domestication of mobile phone technology in everyday life. Heather Horst and Daniel Miller (2005) focus on social aspects of mobile phone communication in kinship and social relations in Jamaica, while Hans Hahn and Ludovic Kibora (2008) studied the domestication of mobile phones and the impact of phone use on oral and social relational aspects of life in Burkina Faso. My approach here in outlining the appropriation of mobile phones for the dissemination of healthcare and HIV/AIDS information in Ghana is similar to the two studies above in that I also prefer to frame my discussion using the domestication paradigm. This paradigm makes it possible to grasp how society shapes technology and how technologies can conversely affect the organization of society (Tenhunen 2008: 516). The discussion also relies on anthropological understandings of culture and social structure as well as hierarchy and power relations (e.g., men and women, service providers, policy makers and HIV/AIDS stakeholders as against AIDS patients and the less privileged).

Concerning mobile phones for health communication, much of the current body of literature has emphasized the need to integrate *mobile* communications technologies with health

intervention (mHealth), a subsection of electronic health (eHealth), because they offer some particularly promising solutions (Phippard 2012: 13). Phippard (ibid), examining the promise of mobile phones for HIV/AIDS intervention in sub-Saharan Africa, concludes that mHealth shows great promise as a means of enriching health communication across the entire AIDS continuum by “strengthening both the scale-up of prevention, outreach, and awareness programs and the access to treatment, care, and support for people living with HIV” (178). Wouter van Beek (2009: 133) focuses more on the ways an indigenous healer used his mobile phone in his traditional medical practice among the Kapsiki/Higi in Cameroon. He noted that through the use of his mobile phone, the healer found new clients (patients) and many appointments and treatment sessions were held by phone, enabling the healer to reach and treat patients over a far wider geographical range than was possible in the past. In Ghana, Rowena Luk et al. (2009) have researched information, communication and technology for development (ICTD) for healthcare and examined two projects addressing the need for improved medical communication by remote consultations through the internet and mobile phones among doctors. Of these two projects, the Ghana Consultation Network runs a web-based application on a network of servers, while One Touch Medicare Line provides doctors with free mobile phone calls and text messages to other members of the medical community. The authors point out the great promise in ICT for health communication (consultation), but noted that implementation and problems at the institutional, societal, and individual levels, such as lack of logistics, poverty and other socio-economic crises must be addressed.

In addition to looking at how mobile phones enable communication about HIV, I also explore how they are associated with sexual behaviours that could raise the user’s risk of contracting HIV. Recent studies focusing on the negative use of mobile telephones include Adriana de Souza e

Silva and colleagues' (2011) discussion of mobile telephone appropriation in the *favelas* (slums) of Brazil and the practice of *directão*, whereby a phone illegally supplied by service provider employees with a special SIM card allows the user to call anyone in the world for three months at no cost; drug traffickers in prison use this mechanism to stay in touch with the outside world and continue managing gang affairs (ibid: 8). The authors introduce the concept of "cannibalistic appropriation," taken from François Bar and colleagues (2007, cited in De Souza e Silva et al. 2011: 3), as a creative and subversive process driven by users. In Mozambique, Julie Archambault (2011) explores ambiguous experiences with and discourses of mobile phones and mobile communication. She found instances of conflict and break-ups in relationships caused by mobile phones.

This article is also based on a review of the literature on mobile phone technologies. Sources include published and unpublished academic articles, media reports, personal and institutional blogs on the internet and other information from Web sites. In addition to these materials, I draw from my prior research in Ghana. As a Ghanaian, and having conducted several periods of fieldwork in the country since 1999 (see Crentsil 2001, 2007), I am familiar with healthcare forms, the social impacts of HIV/AIDS, and the place of mobile phone technologies in the communicative ecology.

The HIV/AIDS Scene in Ghana

Ghana recorded its first HIV/AIDS case in 1986. Today, Ghana's prevalence rate of about 1.9 percent is not as grave as in other African countries—sub-Saharan Africa bears the brunt of the epidemic and is said to be home to about 67 percent of the 33 million people infected with the virus globally. Moreover, in 2008 the region accounted for 68 percent of the 2.7 million new infections among adults worldwide (UNAIDS/WHO 2009).

Women are particularly vulnerable to becoming infected, a fact that is associated with both the physiological make up of the vaginal tract, as well as low condom use in Ghana (UNAIDS 2012). Further polygyny is legal, and so-called casual sex, pre- and extra-marital relationships under conditions referred to as “unsafe sex,” are not uncommon (Ampofo 2001; Anarfi and Antwi 1995; Bochow 2012; cf. Bleek 1976; Dodoo and Adomako Ampofo 2001). While men may be unfaithful or have multiple partners all over the world, in Africa this is associated with “unsafe sex” (Adomako Ampofo 1998; Dodoo and Adomako Ampofo 2001; Smith and Watkins 2005). Women often cannot negotiate the use of condoms by their male partners, feeling this is their only option if they want to keep their husbands and boyfriends (cf. Adomako Ampofo 1998; Anarfi and Antwi 1995; Radstake 1997). Not using condoms also favours some women, despite the danger of HIV infection, because having unprotected sex may result in pregnancy and a possible marriage for the unmarried woman (Radstake 1997).

HIV/AIDS is stretching Ghana’s yearly health budget and encouraging an over-reliance on foreign financial aid. In 2005 alone, the purchase of anti-retroviral drugs (ARVs) and medications for opportunistic infections cost over eight million U.S. dollars in foreign donor-provided funding (Crentsil 2007). Educational campaigns about HIV/AIDS emphasize prevention; those already infected receive counselling and ARV therapy which is highly subsidised—currently GhC 10 per month. Most HIV prevention programmes have been built on a paradigm of individual behaviour change; people are advised to lead healthy sexual lifestyles by practising “safe” sex grounded in the widely-known ABC method—Abstain from sex, *Be* mutually faithful to partners, or Condomize (i.e., use condoms consistently). In the early years the most at-risk groups were identified as sex workers and long distance drivers (the Lagos-Abidjan transport corridor is a project aimed at

educating drivers who travel across Côte d'Ivoire, Ghana, Togo, Benin, and Nigeria) and youth (Ghana AIDS Commission 2002). Today the position of the Ghana AIDS Control Programme is that "everyone is at risk."

Despite recent declines in incidence, HIV/AIDS remains a serious threat and new infections do occur in Ghana. An epidemic of global proportions, HIV is a lived process entangled in a web of existential, individual, social, national, and international implications. International and national policies have been in place for prevention; a joint project developed by the UNAIDS, USAID, WHO, and the POLICY recommended the AIDS Programme Effort Index as a tool for monitoring the 2001 Declaration of Commitment to HIV/AIDS by measuring high-level programme inputs in the worldwide fight against the disease (Bor 2007: 1587). HIV/AIDS responses everywhere emphasize universal access to treatment and vigorous preventive measures through face-to-face counselling and education. Agencies involved in HIV prevention strategies on the African continent have made considerable use of mass media (Benefo 2004), including radio, television/cinema, newspapers, billboards, and posters as means of exposure and education that have also been one of the most important predictors of awareness and behaviour change. In an article on mass media and HIV prevention in Ghana, Kofi Benefo (2004: 2) points out that government and non-governmental organisations (NGOs) alike have utilized mass media as a component of information, education and communication, as well as in social networking campaigns to disseminate information about HIV/AIDS, reduce misinformation and induce behavioural changes against risks of HIV infection.

Despite widespread awareness and education, HIV/AIDS in Ghana remains a stigmatised illness. AIDS patients are often seen as having been sexually promiscuous and as a result they are viewed as being punished for their "sins" (Crentsil 2007).

HIV/AIDS is seen as a social problem resulting from sexual (mis)behaviour; secrecy, denial, and shame usually characterise the disease (Radstake 1997; Crentsil 2007). One problem acknowledged by researchers and stakeholders in the HIV/AIDS sector is that for many HIV-positive people, AIDS patients, and others affected by the disease, there is an unmet need for information on structures of support (De Tolly and Alexander 2009: 1). There is widespread consensus that ICTs present the best solution to this problem, with mobile phones showing particular promise in HIV/AIDS initiatives (Phippard 2012). My data on mobile phone user practices seem to support this view.

Mobile Telephone Use in Ghana

In Ghana many people have two or three mobile phones to reach contacts on different networks (Overå 2006: 1305). As in many parts of Africa, there is a flexible informal context surrounding the mobile phone; they are common gifts from relatives in Europe and North America, demonstrating Ghanaians' engagement with international migration and the global economy. The mobile phone ensures a more direct interrelationship between family members and friends and allows negotiation of important ambivalences about kinship obligations; it intensifies access and "allows the mediation and management of obligation" in the family (Slater and Kwami 2005: 11). Through mobile phones, users can speedily make requests for money from family members, romantic partners, and friends. As aptly described by Horst and Miller (2005) on Jamaica, mobile phones in Ghana are important in social relationships and kinship networks by helping to maintain links with family, friends, neighbours, business customers, and health personnel (see Fig. 1).

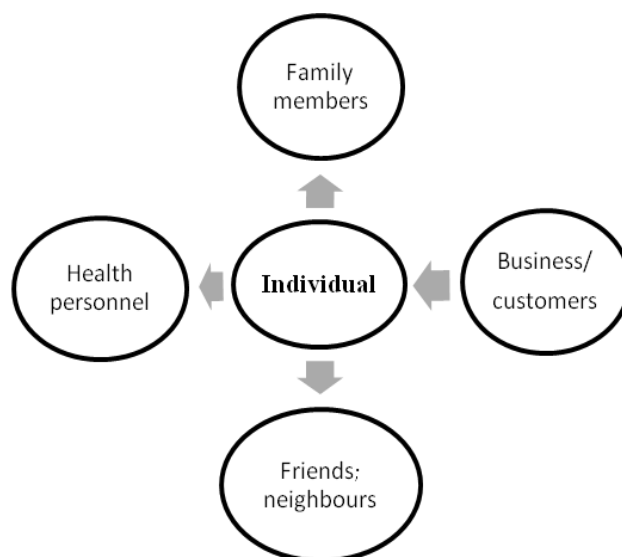


Figure 1: Communication with significant others

Many towns in Ghana have post offices and daily mail delivery services. In the past, literate people used to exchange crucial news and information concerning such things as serious illnesses, death, and funeral arrangements through letter writing and telegrams. Romantic relationships were almost entirely the preserve of letters to loved ones. While post offices are still operational, mobile phones are fast emerging as a popular means of communicating with friends and relatives.

In Ghana, as in other countries, mobile phones are used in very private (personal) ways but are also shared equipment (Fantaw 2012). A pre-paid card allows a user to make calls until the budget has been depleted, after which the phone can only be used for receiving incoming calls until the card's expiry date (cf. Kaplan 2006). Not having a mobile phone does not always mean not using one since, as described by De Bruijn et al. on Sudan (2012), those who do not have their own phones can rely on friends and relatives to make calls on their behalf. Those who cannot arrange to share with relatives or friends can

easily rent a phone from roadside operators in kiosks, booths, or under trees and large umbrellas (see Fig. 2).



Figure 2: A roadside “umbrella” sales point

Oral communication by phone does not require literacy, and in many societies where large numbers are not literate the use of mobile telephones is high (see Hahn and Kibora 2008 on Ghana and Burkina Faso). Short Messaging Services (SMS or text messaging) has become a popular means of communication in Ghana as in other parts of the world, although this is limited to literate people.

Mobile Phones for Consulting HIV Counsellors in Ghana

In Ghana, mobile phones are emerging as an important device in the treatment of AIDS patients through counselling by HIV experts, although there are also serious challenges associated with them. Calling costs are usually borne by either the patients themselves or the HIV counsellors. The counsellors did not seem to mind being forced to bear the costs for calling patients. Rather, it became apparent that they felt obligated to contact patients when patients failed to contact them or attend counselling sessions. It is part of counsellors' jobs to keep in touch with patients as much as possible and be ready to help and show compassion. This seems to encourage them to contact patients despite the costs involved.

The process of using mobile phones in HIV initiatives in Ghana does not seem to be systematically organized, and policy infrastructure coordinating and guiding the sustainable adoption of mHealth services is under-developed. Nevertheless, mobile phones are seen by my respondents as helping immensely. According to most of my respondents, the use of mobile phones reduces problems of transportation costs and the risk of travelling. Counsellors in particular see the mobile phone as a better option than visiting patients in their homes for counselling. While the hospitals provide and pay for transportation costs for HIV counsellors to visit patients, logistical problems, like securing a vehicle and fuel for the journey, abound (see Crentsil 2007). One of the counsellors in my study explained:

The mobile phone makes the job easier for us. It saves time, energy, fuel and transportation. It reduces the transportation cost [borne by the hospitals where the counsellors work] for contacting patients as well as the risk of travelling. Those who do not have phones contact relatives and friends (mostly fellow patients) to use their phones to enquire about counselling days. (Male, ca. 42 years old)

Mobile phones make it possible for HIV patients to phone their counsellors to discuss their immune load (CD4 count) and ask, among others, about their next counselling date and treatment regimens. During a visit to a hospital in Ghana's Eastern Region, the HIV counsellor received a call on his mobile phone from an HIV-positive person. I reproduce below only what the HIV Counsellor (H. C.) said, as I could not hear what the caller was saying:

Caller.....

H. C.: Hello... Oh, hi. Yes, today is counselling day.

Caller.....

H. C.: You are not coming... Oh, you want to know if you need to come today?

Caller.....

H.C.: Ok, what was your CD4 load count from the last session [two weeks ago]?
 Caller.....
 H.C.: Ok, that is quite good. Do you still have some medication?
 Caller.....
 H.C.: Ok, if the CD4 is above 380 and you still have some of the medication from the last supplies, then you don't need to travel all the way to this place.
 Caller.....
 H.C.: Ok, thank you too and see you at the next session. Bye-bye.
 (Male, ca. 42 years old)

After he finished talking with the patient, the counsellor turned to me and said: "Do you see what I was just telling you about? Mobile phones help us to communicate easily with the clients on key information about their health."⁴

According to the HIV counsellors in my study, mobile telephones enable appointment dates to be scheduled and rescheduled in order to keep people attending counselling and treatment sessions. Patients usually call or send messages to the counsellors and the counsellors likewise call or send messages to patients. The counsellors saw calling as a means by which to make things as easy as possible for patients. Such a situation allows health workers to know patients' clinical health, psychological, moral, and financial conditions at any point in time. One of the HIV counsellors said patients' adherence to medication can be monitored through reminders, and those who do not attend counselling can be tracked down in order to reduce absenteeism.

The financing of mHealth is a key point to consider. Currently there seems to be no funding system in place, leaving local health workers to face the major challenge of having to bear the costs of calling themselves. An HIV counsellor explained:

⁴ HIV-positive persons and AIDS patients are referred to at this hospital as "clients," ostensibly to avoid stigmatization. In this article, I use "clients" when I am quoting the hospital official; otherwise, I generally refer to them as patients.

Many of the patients call to ask for information about counselling dates or medications. However, they mostly only “flash” (generated missed calls) you [the counsellor]. When a patient flashes three times, we know they want you to call back. It is obvious that they flash because they do not have money to pay for their calls. The problem this creates is that all the call costs are borne by me. The hospital gives each patient ten Ghana cedis [about six Euros] at the end of every counselling session but still most of them would never use part of it to pay for any call costs.⁵ (Female, ca. 48 years old)

For patients, the mobile phone is an important tool for receiving information about their treatment regimens. A middle-aged, HIV-positive female mobile phone user I interviewed at a hospital said it would be beneficial for patients and others in society to have access to channels of communication, especially mobile phones and computers, for information on HIV/AIDS:

Author (P.C.): How do you get health information?

Woman: We have very good counselling and support from the officials here [at the hospital]. Some of us can call to Mr. ... [HIV counsellor] and ask for some information. What about the others who do not have phones? However, the problem is about when we go back home. We do not have any other source of information. If all of us here [patients] had mobile phones, we could even exchange information about how we are faring.

P.C.: So, what do you think needs to be done?

Woman: We need more mobile phones for other patients who do not have them. In this way, they can call Mr. ... too and ask for key information. You see, I just heard that one woman came all the way from ... [name of village about 50 kilometres away] only to be told that the herbal medicine she takes in addition to the hospital drugs to boost her immune system is not available. If only she had a mobile phone, she would not have travelled all the way to this place. Also, we need computers at the hospitals, in schools and other places where we can read more about the

⁵ This suggests that the patients wanted to keep the credits for themselves, for their own use. Unfortunately, I failed to ask this interviewee the amount of she incurs on telephone calls in a month. I also did not find out whether her phone is used privately or whether it is possible for the hospital she works at to bear her telephone costs.

disease; also the youth, especially young women, will learn and avoid becoming infected.

A middle-aged, HIV-positive woman (ca. 42 years) whose husband died in 2010 told me about the benefits of having a mobile phone:

My phone allows me to contact my customers and business partners easily. It is also useful because it allows me to receive vital information from Mr.... [HIV counsellor] whenever I cannot attend sessions at the hospital on the appointed dates.

As with the HIV counsellors who said calling patients on mobile phones was cheaper than visiting them at home, many patients told me that the use of mobile phones reduced the transportation costs and risks they would have faced had they had to waste time, energy, and money travelling over long distances to hospitals. For AIDS patients, this is highly relevant, since many of them in the advanced stages of their ailment also become lethargic and have little strength to travel.

As in Kenya (Lester et al. 2006), many HIV patients said in interviews that they would be comfortable receiving HIV-related information through their mobile telephones. Secrecy is simply understandable discretion, as Susan Whyte et al. (2004: 22) point out. Mobile phones create new kinds of sociality, making them valuable for communication about AIDS. It was obvious that the patients in my study had quickly built trust with counsellors. Due to the stigma and shame surrounding HIV diagnoses, mobile phones' flexibility, particularly the ability of making calls unobtrusively, is undoubtedly appealing for communication about the disease. Mobile phones can be used in very private ways with high anonymity, as well as with personalised access to sensitive information (Phippard 2012: 144). Talking about personal health on the phone may be easier for patients than doing so in face-to-face encounters. For example, I was told about an HIV-positive married woman who

gave her mobile phone number to the HIV counsellor at the hospital where she was an out-patient with strict instructions that she should be contacted directly when she failed to attend counselling sessions and collect her medication. It was obvious that the cost of the call would have to be borne by the counsellor and yet the patient insisted on being called on the phone rather than being visited at home for fear of making her mother-in-law aware of her HIV-positive status, which she worried would lead to a divorce from her husband. The counsellor told me there had not yet been an occasion to call that patient; however, should the situation arise, there would be no option for her other than to adhere to the patient's wishes. According to the counsellor, on many occasions patients "flash" her three times. In such a situation, the counsellor only knows that patients wants her to call back and she responds according to their wishes.

Table 1: Mobile phone users among HIV patients on antiretroviral therapy (N= 584).

Males	148
Females	436
Employed	525
Unemployed	63
Have mobile phones	150
No mobile phones	434
Over 40 years	254
Under 40 years	330

Table 1 reflects a study that I carried out at an urban hospital in 2010-2011. Of the 584 patients on anti-retroviral drugs, only 150 (25.8 percent) used mobile telephones. At a rural hospital with an HIV unit, of the 170 female HIV/AIDS patients, 45 (26.5 percent) had mobile phones, 123 (72.4 percent) did not, and two (1.1 percent) did not provide this information.⁶ There

⁶ The hospital's list of male patients was not yet fully compiled at the time of my fieldwork.

were immense benefits for those with phones. Patients, who wanted information could directly call health counsellors, send SMS messages, or “flash” the personnel and wait to be called back. As with the health experts, some patients told me that a major challenge for them are the calling costs, which they get around by “flashing” the HIV counsellor who in turn absorbs the cost of the call.

Mobile Communication and Dealing with Stigma and Shame

Mobile technology has many advantages in combating the shame and stigma associated with being HIV-positive in Ghana. Mobile phones have become highly personalized devices that users keep on them all day long, although they sometimes allow family and friends to use their phones. HIV is not changing the habit of phone sharing—people remain generous in sharing phones and phone sharing is also prevalent among HIV patients, although there is the danger of sensitive or compromising texts being detected. I was told that patients can easily make calls on behalf of fellow patients or allow them to use their phones. A key advantage of the phone is that listening to calls can be accomplished silently if the phone’s loudspeaker setting is not on. In Ghana, being HIV-positive usually results in shame, secrecy, and stigmatization by others in the community. HIV counsellors acknowledge that many patients who test positive do not attend follow-up treatment, and in most cases cannot even be traced to their homes because they have given false addresses (Crentsil 2007):

Because of stigma, some of the patients hide their identity by changing their names from what they usually use in the communities where they reside. This makes tracing them and communicating with them very difficult, but if they have phones then it is easier to communicate with them. (Female, HIV counsellor)

Another female HIV counsellor I interviewed told me that the mobile phone affords numerous advantages in their work, especially in regard to anonymity:

It prevents the public from knowing about the patients and the patients from feeling ashamed. You know there is so much shame about the disease. For example, right now there is a woman here who is HIV-positive and wants to take her folder but her in-law is around and she [the patient] does not want her [in-law] to know. It [use of mobile phones] therefore ensures that her [the patient's] identity is not known to others.

For patients, talking about personal health via mobile phones appears from my data to be easier than face-to-face encounters, because phones ensure secrecy, freedom from others' intrusion, and protection from stigmatization and shame. The story of the woman who gave her mobile phone number to prevent her status from becoming known and protect her marriage is an example indicating the importance of mobile phones for privacy, confidentiality, and the avoidance of shame. This account also reveals a key gender aspect of HIV/AIDS, as women appear to suffer worse repercussions than men. Overall, mobile phones can make it more likely that a patient's health status is protected from becoming public.

With respect to HIV healthcare counselling, some patients may prefer text messaging. SMS messaging is silent, which means that a message can be sent and received in places where it may not be practical to have a conversation. Moreover, text messaging costs less than voice messaging and can reach people whose phones are switched off, once they switch their phones back on (Kaplan 2006). On the other hand, this mode does not ensure the same level of privacy as personal calls. A text message could be accidentally opened and viewed by the wrong person, in which case the information found there might result in shame and stigmatization. Consequently, confidentiality issues should be of utmost importance in any

strategy using mobile telephones in healthcare (Lester et al. 2006).

In sum, the advantages of mobile communication for HIV measures in Ghana far outweigh the disadvantages such as the burden of telephone costs on patients and health workers since the mobile platform is cheaper compared to travelling costs and risks. This major advantage should be considered within the context of the poverty and vulnerability experienced by patients. Challenges facing health workers are associated with home-based visits, including the costs, logistical problems, and risks of travelling amidst a sense of duty and a strong need to demonstrate compassion for patients. Where health services are inaccessible, it is important that mobile phones are available for people to get health information without incurring high transportation costs or losing time travelling over long distances at great risk.

Mobile Phones: Sex, Gender, and HIV Risks

Mobile telephones are fast becoming objects associated with sex and the “price” for sex. This association must be understood in the context of the practice of giving gifts in exchange for casual sex, and in which women engaging in transactional sex with men for economic gain is understood as a “necessary evil” (Nabila and Fayorsey 1996). Women have long used their sexual and reproductive capacities to create desirable economic and kin relationships. Girls’ reliance on rich, older male lovers and for gifts and money is a widely known phenomenon referred to as “sugar daddies.” As Astrid Bochow (2012: 21) has pointed out, even if young women are judged for possessing luxury goods given to them by lovers, they are also secretly admired since such materials represent prestigious symbols of a modern lifestyle. Young women and girls are said to give sex in exchange for mobile phones, and men use mobile phones to lure women into such relationships.

The gift of a phone is thereby perceived as displaying affection (Slater and Kwami 2005). In marital relationships it can increase trust in the relationship, as the example of an HIV-positive woman shows; she was happy when her late husband bought her a mobile phone. She proudly told me:

My phone was bought for me by my late husband. I used to communicate regularly with him. Unfortunately, he died about six months ago. (Female ca. 40 years old)

However, the woman suspected that her late husband, a long distance driver, was also the one who had infected her with HIV. The man had had relationships with several women, which his wife only learned about when he tested HIV-positive. She subsequently thought that the man outwitted her by buying the phone to falsely assure her of his fidelity. This example shows the ambiguity around mobile phones in regard to sexuality: they are seen as tokens of affection, but are also associated with extramarital affairs. These aspects are confirmed by studies that have shown how mobile phones aid in the concealment of sexual behaviour by offering users access to a wide range of new sexual contacts and maintaining relationships with people outside one's immediate neighbourhood (Archambault 2011; Stark 2013: 28).

Acquiring and using mobile phones fuels certain gender stereotypes concerning both reputable and disreputable behaviours (Sey 2011). Some husbands, boyfriends, and "sugar daddies" give their wives or girlfriends mobile phones so they can be directly and regularly contacted at will, to show affection and maybe control. The phone can become a tool for keeping others under surveillance (Slater and Kwami 2005: 12). In times past a man might buy a piece of cloth, a pair of earrings, or even a bottle of beer for a woman in order to start a romantic relationship with her. Today, additionally, women can be pursued with gifts of the newest mobile phone models from

their romantic partners. Justifiably or not, this new gift-giving phenomenon sometimes creates the stereotype of young, unemployed women who own mobile phones as disreputable (Sey 2011; Slater and Kwami 2005). Such women, it is often believed in popular imagination, must have a lover (or several lovers) who either bought the phone(s) for her or gave her money to buy it herself. A young woman's possession of a phone can therefore be associated with her sexual status and issues of sexual danger. This is apparent in the following interaction: A 45-year-old seamstress observed a teenage girl talking on a mobile phone. After she had finished talking on the phone, the girl turned to her three friends. Suspecting that the girl was talking to her friends about a male lover who had just called her, the seamstress commented with disapproval: "From where would a young girl get the money to buy a phone? It surely comes from a man in exchange for sex. Oh, modern-day Ghana...May God himself forgive us for such immorality." The notion that girls who have phones may have received them from male lovers is yet to be proven.

Another association between mobile phones and sex concerns the possibility to use the phone as a camera. Reports about men having sex with young women and recording the act on mobile phones for circulation among friends have led to the suspicion that such men are part of the growing pornographic industry in Ghana and abroad (see ECPAT International Report 2008).⁷ Following the circulation of sex videos featuring some junior high school students, the Ghana Education Service was forced to ban the use of mobile phones by non-tertiary students to protect vulnerable young women.

The examples discussed show that phones are ambivalently associated with sex. Although these associations often concern sexual misbehaviour, it is clear that mobile phones still have

⁷ ECPAT is the acronym for End Child Prostitution, Child Pornography, and the Trafficking of Children for Sexual Practices.

the potential to better address HIV issues, since they ensure privacy and anonymity needed by patients in order to avoid shame and stigmatization. Furthermore, counsellors like to use phones, even if it means that they have to bear the calling cost, because they consider communication by phone as faster, reducing the costs and risk of travelling to visit patients at home.

Looking to the Future:

Mobile Technology for HIV Prevention

The course of mobile phone usage for healthcare communication is still unpredictable, since phones are interpretatively flexible and may be put to different usages (Crentsil 2013b). With each new technology emerging from the developed world, new hope arises as to how it can transform the fortunes of people in developing countries (Sey 2011: 376). While one can only speculate about future mobile phone applications that will support HIV/AIDS interventions in Africa, one can hope, for example, that graphics on HIV/AIDS and texts in local languages will soon evolve to help in the campaign against HIV. There is a need for services and software in local languages and dialects in Ghana; the barrier of illiteracy can be addressed through the help that illiterate people may receive from others to send text messages or punch in numbers to make a phone call.

Mobile telephones have great potential to be used as a medium of mass HIV prevention and education. The mass media have been one of the best channels for responding to the AIDS pandemic, as they reach large audiences quickly, make people aware of the risks for HIV infection, as well as break the silence and influence behaviour changes more effectively (UNAIDS 2004: 15). Today, as mobile phones networks reach most areas of Ghana, they can promote HIV education on a wide scale. The growing ubiquity and penetration of phones has helped fuel mHealth in integrating mobile telecommunication

into mobile and wireless health care delivery systems (Tamrat and Kachnowski 2011).

In Uganda, the Text-to-Change project by a Dutch non-profit organization partnered with the AIDS Information Centre uses text messaging in behavior change initiatives (Phippard 2012). Similarly, Project Masiluleke in South Africa is structured around the use of mass HIV/AIDS awareness-raising and educational messages that are inserted into the unused space at the bottom of a specialized text message, "Please Call Me." MTN, South Africa's mobile phone provider, donates 5 percent of the space for use by Project Masiluleke, and one million Please Call Me messages are sent every day to South African mobile subscribers (Phippard 2012; Pop Tech 2012). Mobile technology thus has the potential to open up new spaces for more interactive forms of health communication that would be impossible with print and broadcast media, although it can also work alongside more traditional one-way health information dissemination channels (Phippard 2012: 131).

In Ghana, phones are used to deliver information to other areas of healthcare services. There is currently one mechanism in place to solve the problem of fake medicines by sending a free SMS text to a central number to check the authenticity of a drug. Another example is the One Touch Medicare line, which provides doctors with free mobile phone calls and text messages to other members of the medical community nationwide (Luk et al. 2009).

Poor network coverage and the lack of electricity in remote areas to recharge batteries may be some of the challenges in the use of mobile phones for mass education in HIV initiatives. Of course, using mobile phones in HIV/AIDS measures will also involve huge costs. For example, in 2010 Ghana's Ministry of Health estimated that it will require a total of 115 million U.S. dollars over the next five years to implement a strategy introducing eHealth to harness ICT's potential to improve the health status of Ghanaians (Ghana E-Health Strategy, n.d.).

Even so, there is hope for alternatives, as financing could be borne by donor agencies and other stakeholders as exemplified by Project Masiluleke in South Africa. Moreover, international non-governmental organisations and the United Nations have been supporting the implementation of mHealth and other HIV intervention programs in cooperation with government agencies. The health system can also negotiate financial input with mobile phone service providers, government bureaus, international and local donors, as well as with mobile phone users in a way that will be beneficial to all. Further, that many users try to stay connected by finding places with better network coverage or using car batteries to recharge their phone batteries makes mobile phones easier to handle as a communication device. One area with potential for HIV/AIDS information and education is SMS messaging, since it reaches people with switched off phones as soon as they are turned on.

Conclusion

Given the low and inconsistent condom use in Ghana, we need to bear in mind the ways in which mobile phones are entangled in sexual exchange relationships and are therefore not “neutral” devices. This also demonstrates the ambiguity of the mobile phone. Mobile phones not only help disseminate key information, especially to HIV-positive people and AIDS patients, but also ensure privacy and help patients avoid stigmatisation and shame. Many patients prefer talking about personal health on the phone rather than in face-to-face encounters. It may be a blessing that HIV-positive married women insist on being called on the phone rather than being visited at home to keep their status hidden. This gender aspect reveals how HIV infections are perceived in Ghana: women suffer worse repercussions than men. Consequently, women also stand to gain more than men from the privacy and chance to avoid shame provided by mobile phones. Nevertheless, concealing their status may be dangerous to their partners.

Mobile phone usage can empower HIV patients but, at the same time, is read as something sexual. The ease of making new and potentially lucrative sexual contacts via mobile communication increases people's ability to hide or conceal other relationships from their regular partners. Yet it can also increase levels of distrust and risks of HIV infections (Stark 2013). Hence, a dual focus on both mobile phones' potential to alleviate health-related problems, as well as the ills associated with them and the threat to HIV prevention in society becomes salient.

Scholars have rarely addressed the gender aspects of mobile phone appropriation (Tenhunen 2013: 6), and even less the gender-mobile phones-sex-HIV/AIDS nexus. The few existing studies on women's mobile phone use in Ghana and other African countries indicate both the potential for change, as well as the persistence of dominant discourses and gendered patterns of behaviour (see Archambault 2011).

Mobile phones' benefits, such as the ability to disseminate health information more quickly, thus saving time and reducing shame and stigma, also call forth the capacity of the devices to blur spatial boundaries by acting as a catalyst for reorganisation and new interpretations of culturally constructed spheres and boundaries (Tenhunen 2013: 6). Mobile technology tends to amplify existing structures, but by helping to blur cultural boundaries it also creates spaces for agency and critical discourses: the same technology can empower women, especially HIV-positive ones, as well as amplify gender disparities and vulnerabilities.

This article has illustrated how mobile technology mediates social and cultural processes in the context of illness (HIV/AIDS) and health information. Attempts to deliver health and other developmental services via mobile phone applications with the help of service providers have been successful in Ghana and other parts of Africa. Some of these pilot cases have proven that it is possible to use mobile

technology to deliver information on health issues. At the same time, it is becoming clear that many phone-based health communication, information, and developmental services are consigned to be small-scale pilot projects only as long as they are funded by international organisations (Tenhunen 2013: 5). In this sense, I am in agreement with SirpaTenhunen's view that mobile technology has arrived in Ghana. Yet the problem remains of how various stakeholders in the mobile phone service providers, government agencies, NGOs, and other industries can co-operate to provide applications in affordable and sustainable ways. Successful large-scale mHealth systems will require investments by the state, NGOs, private companies, and others.

In sum, the social world has an impact on the world of mobile phones, which in turn influences the social world. Warren Kaplan's (2006) observation that living in resource poor conditions is not a barrier to the use of mobile phones applies to Ghana because of several cultural and economic reasons. This article emphasises how technologies tend to reinforce existing cultural patterns, while also taking both cultural continuity and change into consideration. Innovative ways of using mobile phones in HIV/AIDS initiatives are evolving from old practices, and there are promising benefits associated with such methods. They come, however, with disadvantages, such as facilitating risky sexual contacts and concealing them. Using mobile phones may have its own restrictions that include the costs to health workers and poor vulnerable patients, phone sharing, and the danger of private or sensitive information getting into the wrong hands. Nevertheless, as suggested elsewhere (Crentsil 2013a), mobile phones possess a great potential as a mass media channel for HIV/AIDS strategies in Ghana.

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DILEMMAS OF PATIENT EXPERTISE: PEOPLE LIVING WITH HIV AS PEER EDUCATORS IN A GHANAIAN HOSPITAL

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This article examines the work lives of HIV positive peer educators at the Komfo Anokye Teaching Hospital in Kumasi, Ghana, who have been trained to complement the work of health workers. Drawing on fifteen months of ethnographic research in the voluntary counselling and testing centre and the antiretroviral treatment clinic, we found that, despite the wide range of services offered by peer educators, there was a general lack of recognition for their work by hospital authorities or health workers. By examining the frictions between differently positioned healthcare providers we demonstrate what is at stake for peer educators and attempt to understand why they continue to work in the clinic despite lack of collegial recognition or remuneration.

Key words: Patient expertise, HIV, peer educators, hospital ethnography, Ghana.

Following the increased availability of antiretroviral drugs in Ghana and a national commitment to increase access to treatment in 2004 (GHS 2005), it became clear that the limited number of health workers would not be able to meet the demand of the many HIV positive persons needing care and treatment. At the time, only 2,000 of an estimated 52,000 adults who required immediate antiretroviral treatment (ART) were receiving drugs (Grimbergen and Thönissen 2007). The fact that Ghana was classified as among the high burden countries in the WHO “3-by-5” initiative helped to persuade the state to create treatment targets (WHO 2005).¹ A

¹ The “3 by 5” initiative, launched by UNAIDS and WHO in 2003, was a global target to provide 3 million people with HIV/AIDS in low-and middle

key partner in the state's effort was the USAID-funded Family Health International (FHI) programme, Support Treatment for Antiretroviral Therapy (START). In collaboration with the Komfo Anokye Teaching Hospital authorities, the START programme selected and trained people living with HIV (PLHIV) to work as peer educators in 2005. The goal of this project was to offer formal training to a select group of HIV positive individuals who would then work in treatment centres to help with the growing workload that came with treatment scale-up.

Similar programmes were launched across Africa, whereby PLHIV were trained in a multitude of projects to serve in a range of capacities (Crigler et al. 2011; Kielmann and Cataldo 2010; Kyakuwa 2010). This new cadre of health workers have been variously termed peer mentors, peer counsellors, peer educators, expert patients, and expert clients, depending on the specificity of local needs and donor perceptions regarding the roles best filled by HIV positive people. The model for the expert patient, based on the early experiences of HIV positive homosexual men in North America at a time when patients often knew more than their doctors about AIDS, emerged from highly organized community-based activist organizations that had the explicit aim of challenging biomedical hierarchies. This is a vastly different context from the one in which most African expert patients operate.

In the case of Ghana, although there have long been community-based organizations geared toward meeting the needs of HIV positive people, there was no history of patient activism, and certainly no thought of AIDS patients challenging biomedical authority. From the outset, the START programme was donor driven and donor funded, even if formally

income countries with life prolonging antiretroviral treatment (ART) by the end of 2005. It was a step towards the goal of making universal access of HIV and AIDS prevention and treatment accessibility for all who need them as a human right.

undertaken in partnership with the hospital. The welfare of the peer educators as volunteers in the clinic was the sole responsibility of the START project. When the programme was running, those who had undergone formal training were paid for their services by FHI. It was the assumption of FHI and the peer educators that upon completion of the project, the status of the peer educators would be regularized and they would be paid as government employees. When the project ended, hospital authorities did not have a financial plan to sustain their activities. As Menka, a 33-year-old peer mentor put it:

The START project, which brought the idea of training us to complement the work of nurses in the clinic here, had very good plans for us. ... I believe the project expected the hospital authorities to continue supporting us after it ended. But the authorities have refused to do that. We have been working here for almost two years now without any support, even in kind. ... In fact, we are disappointed in the hospital management for their lack of interest in the work we are doing here.

Of the nine PLHIV who were trained as peer educators in this program, seven continued working without pay in the clinic after 2006 when the START project, which had provided their salaries, ended. According to Kwaa, a peer educator, the only benefit they got from the clinic was the fact that they did not join queues to access care and treatment. Likewise, their spouses and children did not join queues whenever they visited the clinic for treatment. He said that as volunteers in the clinic, they expected they would be re-supplied with medicines every month free-of-charge (cf. Crigler et al. 2011). In practice, they were expected to pay for their drug rations like other clients. At the time of research and publication they were working on a volunteer basis. Our research elsewhere in Africa suggests that many peer projects initiated between 2005 and 2009, the heydays of treatment scale-up, met similar ends. When the project money dried-up, peer mentors were expected to continue their work without formal employment for minimal, if

any, compensation (Simbaya and Moyer 2013; Moyer 2012). Although seemingly highly valued by donors, patients, and even fellow healthcare workers, peer healthcare workers have rarely been integrated into public healthcare systems.

Our research shows that PLHIV peer educators provide valuable services in the context of HIV testing, counselling, and service provision, filling both quantitative and qualitative gaps in health care. The services they offer vary greatly depending on need and other contextual circumstances, including power struggles between them and other medical personnel. By examining the shifts in the roles they fulfil over time and the power struggles between them and others, we highlight the frictions caused by introducing a form of non-biomedical expertise into institutions where it is generally neither appreciated nor welcome.

We argue that being trained and working as volunteers in the clinic offers peer mentors an important avenue to claim respectability even if the institution where they work does not directly offer them respect. Working as a peer educator contributes to increased self-esteem in spite of a continued lack of recognition of the value of peer-related work from hospital management and some health workers. Although not paid by the clinic for their services, peer educators are able to make a decent living through the contacts they access through their work. Along with the satisfaction they feel working with fellow PLHIV, this too helps to reinforce their self-esteem. Interestingly, it also seems that finding ways to manage workplace challenges related to their lack of recognition may also have helped them transform their stigmatized status into a relatively respectable one.

Setting and Approaches

The study on which this article is based is part of a larger project on the provision and use of voluntary counselling and testing (VCT) and ART in Ghana that has investigated the

social and cultural factors discouraging or inhibiting HIV-positive persons and other people from using VCT and ART services (Dapaah 2012; Kwansa 2013). The data presented here draws on research conducted at Komfo Anokye Teaching Hospital, established in 1954 in Kumasi, Ghana's second largest city. The hospital was upgraded to a teaching hospital in 1975 and is affiliated with the Kwame Nkrumah University of Science and Technology. The hospital was among the few health facilities in the Ashanti Region that benefited from the initial scale-up of VCT and ART in Ghana from 2004-2009. The region is the most heavily populated region of Ghana with 4,725,046 people (GSS 2010). The HIV prevalence rate of 3.9 percent is higher than the national rate of 1.9 percent and is the second highest among Ghana's ten regions (NACP/GHS 2009).

Data was compiled using qualitative research methods including participant observation in the diverse clinical and community settings where the peer mentors worked, informal conversations, and in-depth interviews. These were complemented with a review of hospital records and socio-demographic characteristics of clients. During field research, the lead author participated in daily activities in the clinic and observed interactions between health workers, clients, and peer educators, asking questions when necessary for clarification. He also participated in counselling sessions and observed interactions between counsellors and clients. More than 40 health workers in the VCT centres and ART clinics were observed. He engaged in conversations with health workers and clients to gain insight into his observations about provision and use of services in the clinic. Unlike interviews, which are often formal, the researcher did not guide informal conversations with health workers and clients to reduce desirability bias. In-depth interviews were conducted with health workers and clients on service provision and use. In all, 24 health workers who provided counselling, testing, and treatment were selected and interviewed, including six nurses, five medical doctors, one

pharmacist, one pharmacist technologist, two laboratory technicians, one disease control officer, five counsellors, one health assistant, and two cleaners. In addition, seven peer educators were interviewed. Twenty-two clients were also interviewed, twelve women and ten men.

Ethical clearance was granted from the Ethics Committees of Ghana Health Service and the study hospital. Consent was received from health workers and clients of the VCT centres and ART clinics. Research was carried out over fifteen months divided into two periods: from August 2007 to July 2008 and from November 2009 to January 2010. We assured study participants of anonymity in publications though they were only seven and can be easily identified in the clinic. All names used in this text are pseudonyms.

Findings

Peer Educator Training

Peer educators were formally trained in adherence counselling skills and basic health knowledge through the START project to prepare them for work in the clinic. To qualify for training, they were required to be clients of the clinic successfully adhering to treatment and visibly healthy. They also had to agree to work as volunteers.

The peer educators were trained with the explicit aim of complementing the work of health care providers. They were supposed to help health workers counsel new clients and counsel others already on treatment, and to assist seriously sick and weak patients unable to reach the admission wards or services in other parts of the hospital. They were also supposed to give health talks to clients on nutrition and personal hygiene in the clinic's waiting room. As part of the counseling process, peer educators were obliged to disclose their status to fellow peers to encourage them to access treatment. Finally, they were expected to pursue and maintain contact with patients who

stopped treatment, following up on them in community settings, and to counsel them to restart treatment. In these many ways, they served as a vital link between health workers and PLHIV requiring treatment and to those who had stopped treatment. In many cases, peer educators were the primarily “clinical” contact for those not yet or no longer on treatment.

The Daily work of Peer Educators

Immediately following their two weeks of training the peer educators began carrying out a wide range of activities. Dressed in project t-shirts inscribed on the back with the words Peer Mentor, they were extremely busy from the outset. These daily activities, however, usually differed from what they had been trained to do. Routine tasks included taking clients’ files from the shelves for health workers to attend to them. The files were kept in the records unit of the clinic and contained the treatment records of each client. On every clinic day, nurses must access these folders before they start attending to clients. They relied on peer educators to get the folders of all clients who reported to the clinic for treatment. That they were trusted with confidential patient material may suggest either a great deal of trust on behalf of more permanent staff, but could also indicate that ensuring patient confidentiality was not a high priority within the confines of the clinic.

Peer educators also distributed various laboratory tests results, including CD4 count, haemoglobin, and Hepatitis B, to clients before health workers attended to them, which gave them an opportunity to interact more informally with clients. They also sometimes helped pharmacy staff to dispense drug prescriptions to clients after the nurses and the doctors attended to them. In these contexts, peer educators reinforced messages about how drugs were to be taken, underlining the link between strict adherence and possibilities for regaining health. In terms of counselling tasks, clients who were exceptionally traumatised upon receiving unexpected HIV positive test

results were generally referred to the peer mentors for further counselling, and established clients approached them for advice on treatment and other social and economic problems.

The work of peer educators took place in the clinic, as well as in the community, clients' homes, and other places. They commonly accompanied health workers for outreach programmes in churches or schools where they shared personal experiences about the possibilities of living with HIV that were meant to encourage people to take an HIV test.

Once work was completed at the clinic, peer educators, many of whom were connected to positive persons' associations, sometimes visited fellow members in their homes when the clinic lacked funds or personnel to carry out home visits. From this we see that seemingly discreet social fields overlapped in practice. During these visits they would often enquire how members were doing on treatment and discuss any other issues of interest to the association. While in the house of the client, the peer educator would be introduced to neighbours as a friend and the two would engage in general conversation without reference to HIV infection. After the visit, the peer educator would ask the client to see him/her off at the outskirts of the house. It was at this stage that the two would feel safe to talk about HIV treatment and issues related to treatment. This ensured that the clients' HIV-positive status would not be revealed to neighbours through the peer educator's visit. Such exchanges highlighted the ways peer educators carefully navigated diverse social domains to succeed in their work. In the clinic or when doing community outreach they were often required to disclose their HIV status, whereas during home visits required careful and considerate silences to protect clients' privacy.

Their work as peer educators resulted in them being invited to participate in other community outreach programmes not organized by the clinic, where they would similarly offer public testimonies about their experiences with HIV. Such

opportunities were considered fair compensation for their volunteer work at the clinic as they were usually given allowances or appearance fees for participating. In mid-2008, peer educators were stopped from doing adherence counselling and health talks. The reasons given for this shift depended on who we asked as we discuss in the following sections.

Change of Duties: Views of Peer Educators

Health workers claimed that peer educators were carrying out duties meant for care providers and that adherence counselling was not part of peer educators' official duties. They insisted the peer educators had only been trained to counsel their peers when referred to them by health workers in the clinic. The decision to stop them from doing counselling and health talks meant that the peer educators could now only offer counselling and health talks unofficially. The peer educators did not take these actions lightly and, in response, asked health workers not to use their treatment success stories as examples in counselling sessions and health talks in which they were not involved. This illustrates how aware the peer educators were of their added value in clinical settings, whereby their personal stories become a commodity in health promotion activities (Moyer and Burchardt 2012).

When we interviewed peer educators about the reason for the shift in their duties, they claimed they were informed that the decision to exclude them from counselling and health talks was based on allegations that some of them were doing tasks reserved for health workers. They denied this and said that at least health workers should have given them the opportunity to tell their side of the story. Misaa, a peer educator, argued that the health workers' decision was motivated by the fear that they were becoming too popular with the clients. According to her, health workers thought their involvement in these activities brought the clients closer to them and, most of the clients preferred to deal with them instead of with health workers. In

this respect we see how peer educators position themselves as more preferable than health care workers to clients in regards to some tasks, such as providing counselling. Not coincidentally, these were precisely the tasks most likely to require them to make use of their personal experiences and stories to motivate and assist fellow PLHIV. Given that health workers could not rely on such means when they carried out these tasks, it is not surprising that the provision of these services would create friction between health workers and peer educators, or that health workers would invoke claims of expertise and official qualification to justify their actions. The peer educators pointed out that although health workers stopped them from doing the two core duties, they had not been discouraged from coming to the clinic. They said that their role in the clinic was mainly for the benefit of their peers and their absence would negatively affect clients' use of services. In the interest of their peers, they were prepared to continue working in the clinic by carrying out any tasks assigned to them.

Boafo, a peer educator, contended that the health workers' decision was influenced by the perception that their training as peer educators has not changed their status as clients of the clinic. They should therefore be seen as clients and not as peer educators with special skills. He also thought this helped explain why hospital authorities did not compensate them for their work. To Pokua, also a peer educator, the decision of health workers to sideline them in adherence counselling had not changed her determination to continue helping her fellow patients. Pokua said that before she was trained as a peer educator, she had been unemployed for more than two years. She indicated that staying at home without work had been a boring and frustrating experience. By contrast, the work she did in the clinic, which allowed her to meet and chat with her peers, gave her satisfaction. She said that when she saw the patients she had counselled doing well on treatment, she felt she had helped save their lives. Despite not being paid,

Pokuawas dedicated and even borrowed money when she did not have enough to pay for transport to and from the clinic.

Nimo, another peer educator, said that the work had enabled him to acquire some skills to manage the PLHIV support association he ran because it provided him with the opportunity to attend various training programmes and workshops. The Ghana AIDS Commission and other non-governmental organizations, which often support HIV positive persons associations financially, organized some of these programmes. He added that the peer educator work had exposed him to politicians, policy makers, and influential people in the fight against the spread of the disease, locally and internationally. These were important reasons for him to continue to work in the clinic despite a lack of collegial recognition for his work.

Our observations of how peer educators responded to their change in duties at the clinic suggest that although they were not happy with the action, they continued to come to work anyway because the work provided some structure and meaning to their lives. The fact that peer educators felt morally compelled to continue their duties even though they were not being paid and did not receive collegial recognition from clinic staff is similar to what Marian Burchardt (2009) observed in a study of religion and HIV counselling in South Africa, where religious organizations saw themselves as morally obligated to help the needy, in this case PLHIV. Although neither the hospital nor the peer educator programme was a Christian organization, the Ashanti Region, as with much of Ghana, is a fairly Christian area. As such, the Christian ethics of charity and compassion shaped the ways peer mentors carried out their work and they reasons they gave for doing it (cf. Simbaya and Moyer 2013).

Health Workers' Perspectives on Peer Educators' Work

Health workers maintained that they, rather than the peer educators, were responsible for adherence counselling and health talks. Although they often allowed peer educators to join them in the counselling sessions to share their experiences of the treatment with clients, they began to notice that some of the peer educators were not counselling according to procedure. Every new client must attend three weeks of adherence counselling before starting treatment. They “pass” this class to qualify for treatment by recalling what they were taught upon completion of the training. Peer educators were accused of allowing some clients to pass despite being unable to recall what they had learned, running the risk that those clients would not be adherent. Another complaint lodged by health workers was that some peer educators had filled in laboratory test request forms for clients, which they were not permitted to do, and others had reportedly driven away clients who reported late for treatment on clinic days. Health workers were concerned about maintaining institutional protocols and power structures as some peer educators seemed all too willing to flaunt these. Moreover the former felt justified in defining peer educators work more clearly and in stopping them from providing adherence counselling and giving health talks. One health worker remarked:

We are in charge here and we have to tell them what they can do and what they cannot do in the clinic. They cannot do whatever they want. ... They are volunteers and they are here to help us ... but not to take over our professional duties as some of them are trying to do.

Statements such as these illustrate that issues of hospital hierarchy and professional expertise were at stake in the decision to demote peer educators. Yet some health workers also acknowledged that peer educators fulfilled a useful role in the clinic. In spite of the few problems they had caused, they

willingly did any work given to them. Nurse Vera mentioned their role in the records unit, which, she said, helped them to attend to clients without much delay on clinic days. Likewise, when health workers were busy, they referred clients to peer educators for counselling, which reduced their workload.

In fact, to a large extent peer educators were appreciated in the workplace. As long as they did not overstep their roles as volunteer assistants, most nurses were grateful for the help. Nurses tended to see a peer educator's personal experience of living with HIV as one of the most important things they had to offer. Nurses believed these stories had the power to encourage otherwise recalcitrant or difficult clients to adhere to treatment protocols, even when all else seemed to fail. However, it did not seem that the nurses thought there was much they could learn about HIV from peer educators. This contrasts to what Molly Cooke (2011), a physician who had provided services to expert HIV patients in San Francisco observes. She claims that patient expertise was based on knowledge that health professionals simply could not possess, and that this enabled them to manage, mitigate, or prevent problems related to their disease that health workers might easily overlook.

Clients' Perspectives on Peer Educators' Work

Some clients reported that the counselling they received from peer educators on their first visit to the clinic helped them to realize that the disease was not as deadly as it has been portrayed in the media. Attawa, a client, said that before she was diagnosed, she never thought that somebody with the disease could live a "normal life." When she first reported to the clinic she was in tears because she feared she was near to death. The nurses tried to console her by assuring her that treatment would allow her to live, but she was not convinced because she thought that it was normal for doctors and nurses to try to lessen the fears. Her viewpoint changed when she was referred to a peer educator who offered details of her personal

experience of living with the disease for many years. At first she did not understand what a peer educator was and did not realize she was also HIV positive, so, despite the peer educator's assurances, she was still not convinced. It was only when the peer educator mentioned that she was also living with the disease (which took some time for Atta to accept) that she began to regain hope. She said that when the peer educator shared her personal experiences:

I adjusted my seat and sat well to listen to her because the sister was looking very healthy and well dressed. ... I was really touched by her story about the disease and based on what she told me I became convinced that it was possible for me to also live longer with the disease. Since that time, I have taken the sister as my relative because through her advice I started treatment and survived this disease.

On a day when all seven peer educators were absent, another client was prompted to observe that when peer educators were not present to help with the patient files, work slowed down in the clinic and clients often spent more time in long queues before getting treatment. The client said she heard that the peer educators were not paid for their work and thought this might be the reason for their absence from the clinic. She thought the doctors should do something for them financially, so they would continue to work and help clients in the clinic.

An eighty year-old woman who accompanied her daughter to the clinic was also full of praise for a peer educator who gave them hope that a positive diagnosis was not the end of her daughter's life. She reported that when they first got the diagnosis they considered going home to look for herbal treatment rather than going to the clinic because she had heard that doctors did not have a cure for the "bad disease" (*yare ebone*). The clinic nurse who registered her daughter observed that she and her daughter were looking sad and asked them to talk to a peer educator. The old woman said

they did not regret talking to the peer educator, whom she referred to as a health worker (like Atta, they did not initially realize that the “peer” in peer educator indicated shared HIV status). She emphasized that the peer educator took his time to convince them that her daughter would not die of the disease if she went for treatment and their surprise at learning the peer educator was also living with HIV and had been taking medicines from the clinic for many years.

From these accounts we can see several things. First, many clients do not really differentiate between peer educator volunteers and clinical workers, because both offer them critical services in a clinical settings and the concept of a “peer” educator is not readily understood. Second, the factors most valued from the client perspective were that volunteers were often willing to spend more time with them than were other clinical workers, specifically during traumatic periods. Finally, volunteers gave hope as breathing examples of the possibility of living positively with HIV.

Discussion

The comments and remarks by health workers, clients and their relatives presented above show the significant but contradictory role peer educators play in the clinic. In the remainder of this section, we examine four issues: peer educators’ frustrations and challenges in the clinic; the benefits of their training and work in spite of these frustrations and challenges; the concept of “experience experts” in relation to the work of peer educators; and lastly, the peer educators’ status as role models to other PLHIV.

Our ethnographic data show that peer educators definitely faced frustrations and challenges in the clinic. Prominent among these was a lack of recognition for their work from the hospital management and, to a lesser extent, the clinic staff. We argue that this can be partly explained by the fact that it was not hospital or clinic management who decided to train peer

educators to provide services in the clinic. This most likely was influenced by hospital hierarchy that positioned volunteers at the bottom, and the fact that the volunteers who had received only minimal training were not really considered health workers. The peer mentors' main claim to expertise was their experience, which is not easily accommodated in bureaucratic procedure.

Helen Schneider et al. (2008) made similar observations in their study on community health workers in South Africa. They found that health workers often looked down on community health workers who served as volunteers. Neither did the community health workers receive adequate financial support for their voluntary work in the facility. Another study by Katharina Hermann et al. (2009) on community health workers in some sub-Saharan Africa countries observed that health authorities in Uganda failed to recognize the role played by community health workers (some of whom were HIV positive) in ART provision, despite the fact that they had been working in government health facilities for years. The Ugandan Ministry of Health did not even recognize them as a component in the nation's formal occupational structure. From these other studies, we may conclude that regardless of their skill level, it would be unusual for health authorities or health workers to recognise the value of the contributions made by peer educators in the clinic for the simple reason that there was no place for them in the institutional structure and that there were contestations, about the tasks they were carrying out.

The challenges peer educators faced therefore mainly resulted from a lack of clarity of their duties. Both health workers and peer educators are sometimes uncertain about what exactly it is that they should be doing, which made it difficult for peer educators to consistently stay within the shifting boundaries of their professionally defined roles (see Shiner 1999). While peer educators thought their training meant their core tasks in the clinic should have been adherence

counselling and giving of health talks, health workers thought otherwise. This confusion contributed to ongoing latent tension between health workers and peer educators. As medical professionals, health workers sought to assert their authority over peer educators, who they saw as clients of the clinic, as PLHIV, and as volunteers, none of which qualified them to take up tasks that required professional training. For this reason, they restricted peer educators to peripheral activities such as collecting clients' files, which required no particular skill or training.

Margaret Kyakuwa (2010: 156-57) reports similar tensions between PLHIV expert patients in a small rural clinic in Uganda. She attributes these tensions to a struggle over the desire to control knowledge and expertise in the context of providing care in clinical settings, demonstrating that the tension is inevitable because in fact there are some issues, such as nutrition and how to deal with ARV side-effects, about which expert patients do have more knowledge. Similarly, Yakam Tantchou and Marc-Eric Gruénais (2009), working in a Cameroonian hospital, attributed tensions and confusion between health professionals and new actors like HIV-positive volunteers to the absence of precise role redefinitions and task-shifting procedures. Cindy Patton (1999) contends that there is often a natural tension between the roles of professionals and volunteers who are becoming experts in their own right. In the present study, some peer educators indicated that health workers felt that through adherence counselling, they were becoming "experts" and more prominent to clients, which led to their exclusion from adherence counselling sessions and health talks.

Notwithstanding these frustrations and challenges, the training of peer educators and the work they have done has brought them important benefits. Their work inside and outside the clinic enabled them to regain respect, which they had lost following their positive diagnosis. This regained respect and

their healthy and engaged presence in the community also, perhaps, helped to fight HIV stigma.

Peer educators are formally recognised as stakeholders in the fight against the spread of the disease. The recognition is mostly outside the clinic at the district, regional, and national level. This has connected them to influential and powerful people in policy-making circles and in society. Their engagement in HIV-related activities outside the clinic has also helped them learn how to advocate on issues related to the disease and the use of services. They feel confident to talk openly about the disease at public forums, about their status and how the treatment has changed their bleak destinies for the better. All of these activities are examples of the type of “therapeutic citizenship” that Vinh-Kim Nguyen (2010) identified based on research in Burkina Faso and Côte d’Ivoire. While Nguyen’s arguments are based on the way PLHIV embraced particular HIV positive subjectivities to gain access to treatment before it became readily available, our research shows that if PLHIV want to work in health care settings, in the community or with policy makers, they are still expected to conform to certain expectations: to be willing to disclose publicly on demand; to have the capacity to tell a convincingly good redemptive story to restore hope; to embrace their role as natural advocates for other PLHIV; and to respond well to treatment because of their (presumed) exceptional adherence (cf., Moyer 2012).

Working as peer educators has also helped them develop leadership capacities. Those who are leaders of positive persons’ associations have attended workshops and training programmes to acquire managerial and entrepreneurial skills to efficiently manage their associations. Some of them know how to write project proposals to look for funding from governmental and non-governmental organizations to support members of their associations. Furthermore, peer educators have become consultants in their own right to both

governmental and non-governmental organizations (NGOs) following their association with the clinic. Peer educators are often invited by various organizations to serve as resource persons for the training of HIV-related care providers or educational campaigns on the disease. They are sometimes hired by NGOs to work in health facilities that have started providing treatment. In such cases, they help to train new peer educators on the job by sharing their working experiences in the clinic with them. During the follow-up fieldwork, two peer educators were hired by ESTHER, a French NGO, to work in another facility that had started treatment.² In all these instances, peer educators were often paid appearance fees, allowances, or given incentives in kind.

Peer educators also derived psychological benefits from the work they did in the clinic. Prior to their training, most peer educators had been unemployed because they had been too weak to engage in hard work before they were on treatment. Some had also lost their jobs due to many hours spent accessing care and treatment. They had to endure the challenges of unemployment such as lack of money, idleness, and boredom alongside stigmatisation by relatives. Working as peer educators alleviated these problems. The daily visits to the clinic kept them busy throughout the week and helped to reduce the stress of unemployment. They also got satisfaction from working in the clinic to help their peers adhere to treatment and live longer with the disease. Working with clients helped them to feel useful, which was usually enough to encourage them to report to duty in the clinic even when they were not being paid. In line with this observation, Lauren

² ESTHER stands for Network for Therapeutic Solidarity in Hospitals (*Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau*). Besides working in the new ART clinic, the NGO also sponsored the training of the peer educators in psychosocial counselling.

Crigler et al. (2011: iv) noted in their Uganda study that financial incentives did not seem to be the main motivator for expert patients. However, they were highly engaged and said the most satisfying part of the job was helping others who suffered from the same disease. Also, in their Cameroon study, Tantchou and Gruénais (2009) reported that some HIV positive persons explained that they could not stop working in the counselling and testing centre as volunteers after their contract ended because they had become attached to patients.

From our observations and interactions with clients in the clinic, the positive status of peer educators combined with their training in counselling skills made them more effective in the work they did in the clinic. Peer educators have been receiving treatment for many years and have personal experience of how the ARV medicines work. Moreover, the training they received has equipped them with counselling skills and basic medical knowledge to effectively educate others on the disease and its treatment. Their long association with the clinic as clients, volunteers, and peer educators has also given them the opportunity to get on-the-job training on some basic aspects of the treatment. This puts them in a better position to counsel or educate clients and others on the disease and its treatment compared with non-positive health workers. It is in this context that Maria de Bruyn and Susan Paxton (2005: 148) suggest that people living with HIV as peer educators can be seen as “experience experts.” They empathise with clients and may be more effective, trustworthy and able to protect and promote the rights of positive persons. Elsewhere, experience experts are referred to as “expert patients” (Kober and Damme 2006). These authors advocate for the inclusion of positive persons as “expert patients” in HIV/AIDS prevention and treatment programmes, particularly in resource-poor settings where there is lack of health care providers. According to them, the concept of expert patient is based on the premise that if trained, their first-hand knowledge as people directly affected by the disease

is enhanced by physiological and medical background knowledge. These people are therefore able to understand the patients under their care medically, emotionally and socially. They observe that the concept of expert patient has worked well in some developed countries for chronic diseases such as diabetes, and suggest a similar model could be adopted in sub-Saharan Africa, which has high HIV prevalence rate but lacks adequate numbers of health staff to provide services. Further, they suggest that expert patients could potentially improve outcomes for positive persons in terms of adherence to treatment and reduce the workload of the limited health workers providing services.

Patients and health workers alike agreed that peer educators helped to reduce the workload of care providers in the clinic. Most clients approached them first with problems related to care and treatment. They believed that peer educators faced similar challenges and difficulties as HIV positive persons and thus were more likely to provide support and needed counselling (Kyakuwa 2010). Peer educators also showed more sympathy and compassion towards their fellow patients by taking time to address their problems and challenges in the clinic and sometimes in their homes. Peer educators as experience experts put a human face to the disease, which encouraged many people to accept their positive status and access treatment services. Their ability to clearly explain issues about the disease and its treatment might have led some clients and others to think that they were health workers. On the whole, peer educator's recognition as informal health workers had a positive effect on the use of services by clients.

Peer educators have become role models for others by living openly with HIV while responding well to treatment. Like G. Turner and J. Shepherd (1999), we argue that, "the role of peer educator is to serve as a positive role model and to provide social information rather than merely providing

facts...peer leaders enhance the programme's applicability by modelling appropriate behaviours" (328).

Before the scale-up of ARV treatment in sub-Saharan Africa, HIV was generally considered untreatable and its sufferers faced eminent death. Some people continued to doubt the efficacy of ARVs when they were first introduced. This perception has slowly changed as peer educators became healthy and started living "normal lives" in the public domain. The significant improvement in their health through treatment helped to underscore the testimonies they routinely gave in the context of their work in the clinic and in their communities and helped to build public confidence in the efficacy of ARV medicines. It is not surprising that health workers in this study always refer to the peer educators as success stories of treatment to encourage clients to adhere to treatment during adherence training sessions. The information they give to their peers in such interactions was in most cases valued as coming from someone who has been successful in terms of HIV treatment. Most clients were therefore motivated to act upon what they told them to become healthy and survive the disease. Their status as role models in the clinic inspired many clients to take their treatment seriously and not to default on treatment. Peer educators modelled appropriate behaviour by accessing services like any other clients on scheduled dates. Indeed, peer educators were found practising what they counselled to their peers. Their lives were exemplary for clients to emulate and live longer on treatment. It is for this reason that Karina Kielman and Fabian Cataldo (2010: 24) contend that an expert client (or patient) is someone who is a role model to the community (in the case of this study it is clients). Such a person should demonstrate that indeed there is life after being infected with HIV. They must be clean and show progress in their lives.

Their willingness to disclose their HIV status routinely and publicly was the critical act that allowed them to serve as role models for other PLHIV. Given how healthy they looked, they

could have chosen to hide their status, a fact that made their openness all the more appreciated in a context where it was common knowledge that many clients did not want to inform other people about their status due to the fear of stigma. Maud Radstake (2000) reported that Ghanaian HIV-positive persons routinely used secrecy about their status as a strategy to minimize stigma (Hardon and Posel 2012). The non-disclosure of status to others thus helped them to maximize their ability to receive care and support (Crentsil 2007). However, peer educators have defied the persistent stigma associated with the disease and gone public about their status. This bold decision has contributed to the national campaign to de-stigmatise HIV and encourage more people to use counselling and testing services. It is possible that their open disclosure might have encouraged some of their peers to disclose their status to others like their spouses.

Conclusion

In spite of the lack of recognition from hospital authorities and some health workers, peer educators managed to negotiate an unusually positive position for themselves in society, something of a rare occurrence in relation to ill health and biomedical treatment in Ghana. Ill health, and HIV/AIDS in particular, is generally seen as a misfortune, which people often attribute to spiritual causes (Kwansa 2013). Peer educators, by contrast, transformed their ill health into an asset, both financially and morally, and helped encourage people to seek out HIV counselling, testing, and treatment services.

Rather than simply seeking treatment to regain their own health, they seized the opportunity when presented to make a living. Unlike other ill people, some very influential people in society and most clients of the clinic respect peer educators. Rather than seeing themselves as patients to be treated, they position themselves as stakeholders in the effort to fight the HIV/AIDS pandemic. Unlike other persons with HIV/AIDS,

they are able to interact freely with people who do not have the disease without fear of being discriminated against. This openness makes them ideal counsellors and advisors to fellow PLHIV and broader society in matters related to HIV, including VCT and ART services. Finally, the training and work of peer educators in this study shows the greater agency of PLHIV and self-management by clients to overcome the challenges associated with HIV infection.

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PHARMACEUTICAL POTENTIALS: PRAYING OVER MEDICINES IN PENTECOSTAL HEALING

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As shown by research on “the social life of medicines,” pharmaceuticals can be used in a number of ways. Based on research with Ghanaian Pentecostal practitioners and patients in Ghana and Europe, I examine how pills and substances can become points of contact for God. By being prayed upon, pills move from being a medical commodity to becoming a boundary object in the connection created between a sickness, biomedical practices, and the Holy Spirit. It is the unmarked position of the Holy Spirit in the plethora of spirits that makes this possible. Unlike in Catholicism or other religious traditions that work with spirits through objects, the Holy Spirit is not carried in the pills but only amplifies their pharmaceutical potential.

Key words: Pentecostalism, pharmaceuticals, material religion, praying, healing, spirits and objects, Ghana, Diaspora.

Introduction

For several years I had been studying healing through the Holy Spirit in Ghana and among the Ghanaian Diaspora in Britain and Germany.¹ I had attended numerous prayer

¹ This article, although mainly based on fieldwork conducted in London with first-generation migrants from Ghana (12 months between 2004 and 2006, and subsequent visits till 2010), also draws on research conducted in Ghana (seven months between 1998 and 1999, and three months in 2009) and in Germany (six months in 2006). I would like to acknowledge funding from the Friedrich-Ebert-Foundation, the Economic and Social Research Council (ESRC Centre linked scholarship PTA – 042-2003-00032 with COMPAS, Oxford), The German Research Foundation (within the project “Transnational Networks, Religion and

meetings and deliverance sessions, but still felt unsatisfied about my own attempts to understand the phenomenon. As so often, it was a small incident that changed my way of thinking about this research topic. I visited my good friend Nana during my fieldwork with migrants from Ghana in London and we had a meal together. She prayed over our plates, expressing the wish that the ingredients in the food should employ their full nutritional potentials in our bodies, and that God should take anything harmful out. When she had finished her portion, she took a little box containing her assorted medicines (against hypertension, pain, depression), raised her hand above it, and murmured a prayer before she swallowed the medicine with water. When I asked her about it, she explained to me that she had prayed that God should take the medicine as a point of contact and make the medicine work well in her body (Fieldnotes, London, August 2005).

This experience led me to think about Pentecostal healing not so much in terms of dramatic events of deliverance, but more in terms of how people bring about the presence of God in the routines of their daily lives.² Although I was familiar with the Christian habit of praying over food, as a way of giving thanks, which is commonly found in Europe, in particular among Catholics, the idea that God could amplify the nutritional quality of the food and the healing powers of pills was new to me. In my

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² The “tension between the mundane and the transcendental order” (Robbins 2003: 196) is an important theme in the anthropology of Christianity; see Keane (2007); Engelke (2005). Thanks to Girish Daswani for pointing this out to me.

subsequent research I therefore paid more attention to these kinds of practices. Based on observations as well as conversations with individuals, interviews with pastors, prayer warriors,³ and other Ghanaians, I have concluded that the practice of praying over pills and food entails two significant interrelated aspects: how things are done with words in Pentecostal practice, and how the Holy Spirit is mediated through objects and practices of believers. Furthermore, my observance of the praying over medicines was coupled with my interest in what kind of therapeutic objects people circulate within their personal transnational networks. I learned that medicines are sent between Ghana and Europe, within Europe, and from Europe to Ghana (Krause 2008a: 242-245), and that these therapeutic objects consolidate and renew social relations (Van der Geest et al. 1996: 168). Taking these two aspects together, I became interested in how pills can serve as bridging objects, not only between people, but also between humans and God, by becoming “points of contact.” At another level, the instances of praying over food and medicines can be seen as examples of what Thomas Csordas (1997: 109) and Joel Robbins (2009: 59) have called ritualization of social life in Pentecostalism.

In this article I attempt to think about these aspects in more detail. In order to do so, I will draw on several bodies of literature: the social lives perspective in the study of pharmaceuticals and the literature on medical pluralism and Pentecostalism. In the following, I will first outline how I situate the argumentation of the article in the literature on medical pluralism and Christian healing in Ghana, before I give some background information on migration from Ghana to London, to discuss then how the Holy Spirit is

³ Prayer Warriors train to be able to pray for several hours. They view their prayers as weapons in a global spiritual battle. In many churches they are organized in a specific department.

believed to work as an amplifier of pharmaceutical potentials, based on a particular relationship between Pentecostal healing and biomedical treatment.

Medical Pluralism and the Study of Pharmaceuticals in Ghana

Numerous books and articles have documented the coexistence of different therapeutic traditions in Ghana, including biomedicine, spiritual healing, and herbal treatment. Studies have focused on different therapeutic specialists, including diviners, possession priests, traditional birth attendants, bonesetters, herbalists, and biomedical professionals.⁴ Research has been conducted on how people navigate this landscape of healing, how they combine different treatments with each other, and how healers are trained and professionalized.⁵ The recourse to spiritual healing has been interpreted as coming to terms with insecurities and social change (Mohr 2011). In comparison to this rich literature, there is a dearth in the study of biomedical pharmaceuticals. The seminal study by Kodjo Senah entitled *Money be Man* has not been matched by any further work on this topic, at least to my knowledge. In his book, Senah (1997) explores what ordinary people in a Ga-speaking village near Accra do with medications, in particular with biomedical pharmaceuticals, *blofo tshofa* (154). He shows how pharmaceuticals have “been so integrated into the local therapeutic regimen that they have become cultural products” (209). According to Senah, as “a medium of communication, [pharmaceuticals demonstrate] the individual’s claim to control his

⁴ Practices termed “traditional” should not be seen as static or belonging to the past, but as being dialectically related to other forms of healing that proclaim themselves as modern.

⁵ There is not enough space to cite all the relevant literature but classics include: Field (1960); Twumasi (1975); Twumasi and Warren (1986); Mullings (1984); Fink (1989).

or her health” (213). It is the idea of the pharmaceutical as a medium of communication in its final “biographical stage,” that I will take up in this article.⁶

The idea of “life stages” or “biographies” of pharmaceuticals was developed by Sjaak van der Geest, Susan Whyte, and Anita Hardon (1996) as a heuristic tool to study medicines as ethnographic objects (Wythe et al. 2002). The authors name three life stages that determine the biography of pharmaceuticals: the production, distribution, and finally the consumption of medicine. The question of efficacy in this ideal typical model is regarded as the fulfilment of the “social life” of medicines (Van der Geest et al. 1996: 156). The topic of this article, praying over medication, is concerned with this last stage of the biography of pharmaceutical objects, as described in the example of Nana.

Most biomedical medication is prescribed based on average statistical results of pharmaceutical trials. However, in the experience of patients, the probability whether the drug will work for them remains unpredictable: who can assure you at which end of the statistical probability scale your body’s reaction can be placed? Praying over medicines is a way of coping with this unpredictability of efficacy. This results in the ironic effect that what Susan Whyte, Sjaak van der Geest, and Anita Hardon (2002: 14) call “the lives after death” of the pharmaceuticals, is in this

⁶ In his later writings, Senah has pointed to the public health hazard caused by wrong combinations and wrong dosages of medicines. He warns of following a “false sense of security” (Senah 2001: 89), when trusting the availability of pharmaceuticals as a solution to the enormous challenges Ghana still faces in regard to providing equal health care distribution. I am aware that this article does not contribute much to fill the research gap on pharmaceuticals, since it evolved rather as a by-product through my research on Pentecostalism. However I relate this article to Senah’s work, since the research question – “What do people do with medicines?” – he tackled in his book (Senah 1997) has been a great inspiration to me.

practice handed over to the power of God, as in the case of the death of human believers as well.

Pentecostalism and Other Healing Methods

The practice of praying over medicines is one specific aspect of the manifold and partly conflicting ways in which charismatic Christianity relates to other therapies. Although healing through the Holy Spirit has been a constant feature of the history of Christianity in Ghana, the various Christian traditions and renewal movements differentiated themselves from each other partly through the ways in which they objected or approved of biomedicine and/or herbal treatment and other forms of spiritual healing. Historian Adam Mohr (2009) reports how Presbyterian missionaries in Akuapim first not only endorsed but actually used traditional medicine. This attitude changed, however, when missionaries began undergoing basic medical training in their country of origin before their departure. Thus, among most mission churches there was the tendency to neglect healing with the Holy Spirit and to object to most traditional medicine, in line with the politics of the Native Customs Regulation Ordinance of 1878, which banned traditional healing.⁷

In response to the negative view on healing but also to counter discriminatory practices among the missionary churches, so-called *sunsum asɔre* in Twi, or “spiritual churches” in Ghanaian English, founded by local Africans, evolved very quickly as early as the late nineteenth century (Field 1960; Mullings 1984; Sackey 1989;

⁷ The mission churches included the Roman Catholic, Presbyterian, Methodist, and Anglican Churches, as well as other Protestant churches stemming from mission societies; see Omenyo (2006: 41).

Asamoah-Gyadu 2005).⁸ With their emphasis on protection against malevolent forces, they took over the role of local healing cults, which offered protection against witchcraft.⁹ The *sunsum asɔre* came under pressure in the late 1980s when the charismatic renewal took root among the educated elites and on university campuses throughout West Africa (Ojo 1988; Gifford 2004: 23-26), and spread from there into the different strands of Christianity, including the missionary churches (Omenyo 2006; Asamoah-Gyadu 2005). A similar development could be observed during the 1990s in London (Harris 2006: 218-23).¹⁰ The idea of “renewal” expresses the zeal to get rid of practices perceived as belonging to a past that should be left behind, and to uncover the true message under the ballast of wrong teachings and ritual practices.

Although the Holy Spirit has been central to spiritual churches as well, as mentioned above, in the view of the charismatic churches, the spiritual churches infuse too many elements of so-called “traditional religion” into their healing practices, for instance by using herbs and by relying on other spirits aside from the Holy Spirit. The charismatic churches therefore draw strict boundaries between their own practices and those of spiritual churches, which they regard as “not following the Bible.” But

⁸ Although mission churches provided new possibilities for young men to gain status independently from their families, there was a tendency to exclude Africans from leading positions, see Omenyo (2006: 67-73).

⁹ See Goody (1957); Field (1960); Mullings (1984).

¹⁰ The “new,” neo-Pentecostal or charismatic churches are so called to differentiate them from the classical Pentecostal churches, which emerged as early as the 1930s, often as splinter groups from Pentecostal mission societies; see Omenyo (2006); Daswani (2007, 2010). Although churches grouped under the umbrella term “charismatic renewal” differ considerably, they share common elements, such as the emphasis on a personal relationship with God, a conduct of life according to strict ethical rules, and a belief in the gifts of the Holy Spirit, which include speaking in tongues, the achievement of success and wealth, and miraculous healing.

some strands of charismatic churches particularly differ from spiritual churches in their interest in scientific medicine.¹¹ This is central for the argumentation of this article, because the construction of a close relationship with biomedicine explains why pills can become boundary objects between a born-again Christian and God.¹² Yet, before going deeper into this, I want to first give a few more background information on Ghanaians in London.

**From Been-to to Burger to Born-again:
Migrants from Ghana in London**

Ghana, (pre-independence, the Gold Coast) and London have been closely connected through colonial and postcolonial links, of which migration for educational, economic, and political reasons has formed an important part (Akyeampong 2000; Anarfi and Kwankye 2003; Nieswand 2011). The different migration periods can be described with the help of three ideal-types: the Been-to, the Burger, and the Born-again, although all three figures have been present to some extent across all periods. The Been-tos are those elites who went abroad for education between the 1920s and 1960s and intended to return to the Gold Coast/Ghana to become lawyers, doctors, and civil servants (Martin 2005: 11-13). Due to political turmoil at home, many of them had to remain in London and could not realize their ambitions of building up the first independent African nation. In London Been-tos founded associations that have looked after their members in times of need, assisted them with funeral costs, and are still active today.

¹¹ Among these earlier strands of African Christianity, in particular those led by “prophets of rebellion” (Adas 1979, quoted in Sarró and Blanes 2009: 53), some explicitly rejected biomedicine, as a way of resisting colonial oppression.

¹² The term “born-again” is used to indicate that somebody lives his life in accordance with Jesus.

The contrasting figure of the Burger evolved in the second emigration wave, when many Ghanaians left the country due to economic and political instability. The etymology of the word is often traced to the name of the German city of Hamburg, a popular destination among Ghanaians during the late 1970s and 1980s due to its relaxed immigration rules (Nieswand 2011: 135; Martin 2005: 11-12). Most Burgers did not strive for education, but rather for the improvement of their economic status. Thus, according to Boris Nieswand (2011: 135-49), the distinction between Been-tos and Burgers marks a class difference among migrants. Burgers show up with big cars and other prestigious goods back home but hide their experiences of downward mobility in Europe (Martin 2005: 12).

When European immigration laws were tightened in the 1990s, the Born-again entered the scene, founding churches and building up transnational connections via their religious organizations (Van Dijk 1997). Living life as Christians helped them to acquire a respected status within in a context characterized by menial jobs and conditions of illegal residency (Fumanti 2010). The 1990s and 2000s saw an intensification of transnational linkages (Mazzucato 2008), particularly in regard to student migration comprised of individuals who frequently move back and forth between London and Accra or Kumasi on working holiday visas. These recent wave also included the emigration of health professionals (Buchan 2004), onward migration from EU countries and undocumented migration in its various forms.

Nana, who made me aware of the importance of praying over food and medicines, falls between the categories of Burger and Born-again. She followed her husband in the 1970s to London after he had been recruited to work as a boxer in the British capital. She can recall a time when it was difficult to buy Ghanaian

foodstuffs and when Ghanaians joined churches founded by black Caribbeans because they felt unwelcome in white mainline churches and had not yet founded their own. Today Nana can buy fresh pepper and yam around the corner and is the Church Mother of a lively Pentecostal church in which parts of the sermons are preached in Twi. Nana is highly respected, not only among Ghanaians living in her neighbourhood, who patronize the same hair salons, shops and restaurants as her, but also across London, because she is active in several associations and functions as a queen mother in her home town. People respectfully refer to her as “mother” and consult her on important issues such as marriage problems and sickness. So did for instance Ama, a woman in her early forties who was diagnosed with late-stage breast cancer and died in 2007. Before her death, Nana visited her regularly, helped her with paper work, organized her home-based care, and also prayed with her over medication and for “good people,” meaning understanding and skilful doctors and nurses.

When I came for a visit during Ama’s sickness, I phoned her beforehand to inquire what I could bring along. She asked me to get her a yam from her favourite Nigerian shop, whose owner kept the best pieces for her. When I came to her house, Nana was there and prepared the yam. Ama asked me to join them in praying over the food. We raised our hands and Ama said: “Lord, let this food stay in my stomach, take this as a point of contact to make me strong again.” She was on chemotherapy and had to take an array of pills and capsules every day, which made her vomit. She could not keep any food down and had become terribly thin and fragile. After eating she collected the differently shaped capsules in the palm of her hand and she and Nana started to pray: “I pray over this medication that it becomes a point of contact for your healing power, God... Amen... Let the medicine kill the cancer cells... Yes Lord... Use the tablets to heal me, Lord ... In Jesus’ name ... Use them to destroy what the enemy has sent to kill me! ... I know you can do it Lord, let the medicine do only good things and no bad things, oh God, let the food stay in my body to make me strong again.” At a later stage in her

sickness, when she felt too weak to pray forcefully, Ama asked Nana and other friends to pray over her medication for her. (Fieldnotes, May-December 2007)

In regard to their health profiles, Ama and Nana are typical examples of black Londoners, who for years worked in several low-paid jobs under unfavourable working conditions. Rates of diabetes and hypertension are found to be much higher among Black Ethnic Minority groups (BEMs) than among white British, and although statistically-speaking black African women are found to have lower rates of breast cancer, those who do have it seek medical attention significantly later and frequently have more aggressive tumours. They therefore have lower survival rates (Nazroo 1997). As ordinary residents, Ama and Nana have full access to free treatment through the National Health Service (NHS) and are registered with a General Practitioner (GP) in their area. Nana, through her work as a community nurse assistant, feels very comfortable navigating the NHS system. She has established a personal relationship with her GP and her local pharmacist, the latter of which sometimes gives out her tablets even if she has not yet procured the prescription for them. Nana often assists friends, like Ama, claim the services they are entitled to. Ama, however, expressed deep feelings of powerlessness and mistrust in regard to her cancer treatment; she felt poorly taken care of and “written off” by the consultants. “They don’t want to spend any money on me,” she bitterly remarked. Her praying over her medicines and food as well as the prayers Nana initiated for “good people” can be seen as elements of the wider practice with which to manipulate the arbitrariness experienced in encountering the NHS as a black Londoner. But it is also a significant instance of the wider tendency among Pentecostal Christians to use anything available as point of contact to God’s healing power. In the following section, I

will take a closer look at the elective affinities (Johannessen 2006: 7-8) constructed between biomedical treatment and the healing power of the Holy Spirit in Pentecostal practice.

The Holy Spirit as Unmarked Other and Biomedicine as Godly Medicine

Although there exist to my knowledge no institutionalized links between churches founded by Ghanaians and hospitals in London, anecdotal evidence from my research points to a high percentage of Ghanaians working in health related jobs, as nurses, nurse assistants, and medical doctors, who are very active members of Pentecostal churches.¹³ This might be partly explained by the fact, that biomedicine and Pentecostalism are both social and discursive realms, which foster aspirations, and seem to attract urban middle classes. But it also points to the historical linkages between Christianity and medicine. Thus the combination of biomedical treatment and Pentecostal healing of which the praying over medicines is part of, is a practice found among a specific clientele who does not see any antagonism between the workings of the Holy Spirit and the workings of a biomedical doctor, only between Christian healing and other spiritual practices. This view is also reflected in Ama's and Nana's attempts to manipulate food, tablets and the encounter with NHS staff through their prayers. When Ama's state of health deteriorated under chemotherapy, some of her friends spent a considerable sum ordering herbal medicine from Ghana. Even though it meant refusing a gift and risking offending friends, who were very dear to her, she refused to take it, since she was aware of the possibility that spiritual forces had

¹³ Elsewhere I have written on a Pentecostal fellowship consisting of psychiatric nurses, who prayed for patients in an institutional setting in Ghana (Krause 2006, 2008b).

become attached to the herbs in the course of their preparation. In contrast, she perceived biomedical pharmaceuticals to be spiritually “neutral” objects, which only needed to unfold their effects in the right way in her body.

The perceived spiritual “neutralness” of the pills seems to resonate with what I like to call the “unmarked position” of the Holy Spirit within Pentecostal ideology.¹⁴ In linguistic theory the “unmarked” is that part in an asymmetrical relation, which defines the terms of interaction (Waugh 1982: 299). In Pentecostal ideology (and in most literature about it) the Holy Spirit is constructed as unspecified, but as superior to any other spirit. This is reflected in the positioning of Christian knowledge as superior to other beliefs. Historical studies on missionary work, like Birgit Meyer’s book *Translating the Devil* (1999), show how the introduction of Christianity drew on existing idioms of spirits and translated them into the Christian framework, transforming their relational logic into a dualistic one. Local deities became disembedded from a practice in which they were neither evil nor good, but depending on the context, helpful or not helpful. The “innovation” work of Christian missionaries rendered these relational and situational distinctions into the dualism of “good” and “evil.” Furthermore, spirits and gods became positioned within a hierarchy of spirits, in which the Holy Spirit occupies the unmarked position as part of an antagonistic power relationship: everything but the Holy Spirit is seen as particular, idiosyncratic, local, specific, whereas the Holy Spirit itself is associated with the universal, the global, the unspecific (Hüwelmeier and Krause 2010: 2; Krause and Van Dijk 2010; Coleman 2010).¹⁵

¹⁴ Pharmaceuticals, according to Engelke (2005: 129), are non-problematic objects for Christians, because they embody no “immaterial pretensions.”

¹⁵ There is a striking parallel with how biomedicine is treated by medical anthropology. For decades, anthropologists produced ethnographies about

This unmarked position of the Holy Spirit forms the basis for presenting biomedical knowledge as part of “true Christian knowledge,” which similarly is the unmarked knowledge in relation to the marked so called “traditional knowledge” of healing. The “true” knowledge needs to be uncovered from underneath wrong ritual practices. Biomedicine is viewed as “Godly” medicine (Ranger 1981) and placed next to Pentecostal knowledge as a “modern” achievement, given by God (Krause 2006: 59-60, 2008b: 196-97). In subsuming biomedicine under this “true knowledge,” Pentecostalism places itself close to the superior ontological status of biomedicine: Pentecostal practice is thus not represented as being based on beliefs, but on knowledge. Along this line of thought, being a born-again Christian does not mean adhering to a religion but following the truth. Belief is assigned to other “religions” and is viewed as distorting compliance with biomedical treatment.¹⁶

Being a Christian, in contrast, makes people appreciate the achievements of medical treatment, which is based on scientific research. Kwadwo, a prayer warrior in one of the churches in London where I did research, used the following words to explain this to me:

biomedicine’s “Other,” the plethora of healing practices and herbal medicine around the world. Only since the 1980s have medical anthropologists discovered that it is equally important to provide detailed ethnographies about biomedicine; the unmarked “Other” of medical pluralism has received a culture (Lindenbaum and Lock 1993). More recently, scholars have produced detailed analyses of knowledge productions; see Mol (2002); the overview by Mol and Berg (1998). Similarly, the Holy Spirit remains the unmarked “Other” of the demons and evil spirits in Pentecostal healing.

¹⁶ This line of argument contradicts the common understanding according to which spiritual healing would be grouped among “health beliefs,” resulting in “illness experience,” and not among “knowledge of disease.” For a critical reading of belief in medical anthropology, see Good (1994: 1-24).

Once you have the Holy Spirit in your life, you are on the right track. If you follow God, he will lead you. That is why as Christians, we are not against science; we do not say: sit at home and don't see a doctor. It is only through being a Christian that you will be able to appreciate the wonderful things scientific medicine can achieve. After all, it was God who has given the wisdom of science to humankind.¹⁷

In saying "it is only through being a Christian that you will be able to appreciate the wonderful things scientific medicine can achieve," Kwadwo points to the assumed affinity between knowledge, education, and being a Christian.¹⁸ In his view, only a true Christian, who follows the Pentecostal doctrine, is able to appreciate the value of scientific knowledge as embodied in biomedicine (see Mohr 2009: 449). His statement resonates with the close historical connection between the introduction of biomedicine in Africa and missionary activities. Missionaries brought not only Christian teaching, but also European goods, a specific life style, and eventually biomedicine (Mohr 2009; Ranger 1981; Vaughan 1991: 55-76). As Pascal Schmid argues in his contribution to this special issue, the building of hospitals was of high symbolic meaning and conceived of as an ideal opportunity to convert individual patients (cf. Vaughan 1991: 57).

In line with the idea that Pentecostal and biomedical knowledge are of the same kind, biomedical pharmaceuticals are not necessarily used to convert, but to provide a channel for God's healing power. The omnipresence of the Holy Spirit is assumed, but it is not discernible for the ordinary human being. It is a potentiality that can only come into effect if the born-again Christian creates points of contact with God through intensive ritual practices such as deliverance and speaking in tongues, but also through short prayers when riding on a bus, upon entering

¹⁷ Interview with Kwadwo, London, 27 November 2005.

¹⁸ For similar statements from fieldwork in Ghana, see Krause (2006).

one's workplace, or before taking medicines. In the life of a born-again Christian, there seem to be multiple events that can become points of contact for God.¹⁹ In order to turn activities into points of contact, it is necessary to be an active agent of one's destiny and to "not sit at home and be idle." Related to the case of sickness, this means: being unwell is not an excuse for doing nothing. If a Christian asks God to perform miracles in her life, she needs to be prepared to open up as many points of contact for God as possible, including biomedical treatment. This idea of pro-activeness in regard to biomedical treatment is also apparent in the following statement by Ama's pastor, with whom I spoke:²⁰

In Christian healing, we don't preach, "stay at home, and don't consult your GP [General practitioner in the UK health system]." On the contrary: we believe that God is supporting what we are struggling for. This is why I preach that "God will move your life, if you are ready to move." This means, if you are sick, try to get the best doctors, try to get the best medicine, and God will make it work for you. If you pray, Jesus will transform the medicine to healing, as he transformed water to wine in Canaan.²¹

The idea voiced by Nana and Ama that God is able to amplify the nutritional qualities of food and the pharmaceutical potentials in their tablets, is related here to the story of the wedding in Canaan, where Jesus transformed water into wine. In Ama's case, the prayers also included the request for a reduction of the side effects of the chemotherapy.

While Pastor Solomon relates the creation of points of contact to a specific pro-active ethos, ordinary believers often rely on all

¹⁹ Robbins (2009) has argued that it is precisely the ritualisation of social life which has contributed to the global success of Pentecostalism.

²⁰ Van Dijk (2010: 102) has shown how, far from providing only consolation, Pentecostal practice "catapults" the believer into new challenges.

²¹ Interview with Pastor Solomon, London, 5 May 2007.

kinds of objects to experience the presence of the Holy Spirit. They keep handkerchiefs in their pockets which have been blessed by a Pentecostal prophet, and use anointed olive oil for protection to achieve God's intervention in situations which lay beyond their control and in which save navigation is needed, as in the case of severe sickness.²²

But there is a tendency among Pentecostal leaders to disregard these practices, since it is suspected that evil spirits can easily be allured to reside in objects. However, pharmaceuticals are perceived as spiritually neutral, unmarked, or "empty," since they represent biomedical knowledge. Thus the two moments described in this section, the understanding of Pentecostal knowledge as being of the same kind as biomedical knowledge, namely God given, and the specific nature of the Holy Spirit as the unmarked Other of a multitude of idiosyncratic deities, forms the basis for praying over medicines as a request to amplify their pharmaceutical potentials.

Amplification of Pharmaceutical Potentials

As Senah (1997) and others have shown, medical objects such as tablets and capsules can be used in a number of ways. Sjaak van der Geest and Susan Whyte (1989: 346) have argued that it is the "thingness" of pharmaceuticals that makes them significant objects in exchanges. They suggest that pharmaceuticals are easily divorced from their social embeddedness (ibid: 348-49), but that they can also serve as objects that sustain and revitalize relationships. This is particularly true in situations of crisis. Within Pentecostal practice, the connecting and communicative aspect of pharmaceuticals gains another dimension. Tablets and substances

²² For the significance of material objects in Pentecostal practice, see Meyer (2011).

can become points of contact for God and facilitate the experience of God's influence in one's life. They move from being a medical commodity to becoming a boundary object in the relationships between biomedical practices, born-again Christians, and the Holy Spirit.²³

In anthropological writings on Protestant Christianity, it is common to assume that Pentecostal practice is about unmediated and inspired access to the divine to which objects are a hindrance (Martin 1990: 163-84; Harding 1987: 169). According to Simon Coleman, this view is a "powerful contemporary echo of the iconoclasm of original Protestant reformers" (Coleman 1996: 108; 2006: 164-65). It obscures the ways in which objects and sensational formats (Meyer 2006) mediate the presence of the divine, even in iconoclastic traditions. Abstinence from objects, as Matthew Engelke (2010: 812) argues, is always a "fantasy about immediacy." It is about abstaining from certain things but considering others as direct routes to God. A striking example from Engelke's (2005: 123) own work is the practice among Masowe we Chishanu Christians to use honey as mediating substance but regard the Bible as an object that hinders direct access to God. They regard the spoken word as more powerful than the written. Along a similar line, Coleman (2006: 165) argues that Pentecostal practice converts words into physical forms, permeating the total fabric of religious life. Hence, by praying over food and medication, Ama and Nana were "doing things with words" (Marshall 2009: 4; Austin 1975), and imbuing the physicality of the substances with the presence of the Holy Spirit. According to them, the prayer transformed the food and the tablets

²³ Boundary objects, according to Star and Griesemer (1989: 393), have different meanings in different social worlds but can be used across different contexts and disciplines as a means of translation; cf. Kirsch (2008: 26).

into points of contact for the Holy Spirit, which then amplified the substances.

In Pentecostal teachings and in conversations I had with my interlocutors, the ideas that objects can be charged with spiritual powers, that spiritual entities can be transferred via material things, and that spirits can be kept in containers were all prevalent. Such powers were usually conceived of as negative: objects can become points of contact for witches who extract money from their victims by inhabiting their purses and their bank cards (Parish 2000), or cause sickness. Ama's cancer, for instance, was viewed as having been caused by one of her relatives during a visit to Ghana, where the relative imbued her underwear with sickness-bringing spiritual forces. Objects as locations of spirits were furthermore associated with "shrines" – a popular word in Ghanaian English, referring to a "particular object in which it [a spirit] is said to dwell or through which it may be contacted" (Kirby 1986: 66). Thus, to include objects as points of contact with God is highly contested among Pentecostal pastors and leaders. Yet pharmaceuticals are seen as particular kind of objects, since they represent biomedical knowledge. They are conceived as being different from religious objects, such as talismans, pictures of saints, statuettes, and other carriers of spiritual powers.

In the many varieties of Christianity, worldwide, there are numerous examples of how material objects mediate the presence of the divine. Fenella Cannell (1995) describes how people in the Philippines create figurines of the dead Jesus taken from the cross and incorporate them into healing rituals. Colleen McDannell (1995: 25-26) explored the power of material objects among American Catholics. She argues that objects achieve power through the blessing of a religious authority. The idea of intercession is central here and is also at the core of cults of saints

(Brown 1981). McDannell (1995: 148-49) describes how water is sent from Lourdes to America for healing at the request of Catholics. In the believers' perception, Holy Mary works through the water and intercedes with her son on behalf of the sick person. In contrast, as emphasized by the Ghanaian Christians I talked to, the Holy Spirit is not perceived as being attached to, contained in, or transferred through objects. This resonates with Thomas Kirsch's writings on *Zambian Pentecostals*:

Whereas it was repeatedly claimed that the "physical" keeping of non-Christian spirits was possible, this possibility was rejected as far as the Holy Spirit was concerned. It was unthinkable to my interlocutors that anyone could succeed in keeping the Holy Spirit in some type of material vessel. Instead, the Holy Spirit was conceived as an inevitably unbound and evanescent entity, which human beings could not control in its movements. Against this background, the Holy Spirit was presumed never to reside permanently at any particular material location, whether in the Bible or in any other object of Christian practice. (Kirsch 2008: 141)

The perception that the Holy Spirit cannot be kept in any material vessel is different from practices in Catholicism, in which the healing power of a relic stems from the fact that it was once part of the clothing or the body of the holy person. Healing results from partaking in the power of a saint through her physical remains. The relics or talismans are carriers of a power that is different from the properties of the object itself. In contrast, the words of prayer of Ama and Nana have power that is transmitted into the tablet but does not inhabit it. The Holy Spirit itself is not transported through the tablets or the food, as it would be the case with witchcraft spirits. The tablet does not carry the Holy Spirit; instead, the Holy Spirit amplifies the healing powers of the pharmaceutical. This act of amplifying efficacy is similar to what Van der Geest, Whyte, Hardon (1996: 167) have described about "pharmaceuticals,

[which are] believed to be more effective if given by a good hand or accompanied by the right words.” It is in this regard that pharmaceuticals become particular objects in acts of communication between God and people.

Conclusion

Central to the practice of praying over medicines is the idea of creating points of contact for God. As I have shown in this article, in Pentecostal teaching the source of scientific knowledge is viewed as ultimately being God himself. Interestingly, though, in this discourse the boundaries between spiritual and scientific practice are maintained in order to endow each with the authority of the other. Thus, the idea of creating points of contact rests on the understanding that the Holy Spirit amplifies whatever positive is at hand for the believer.

Van der Geest, Whyte, and Hardon (1996: 154) point to the fact that anthropologists have studied material medicine, when they explored magic objects and talismans. This article has pointed to the process by which pills and other medicines become similar objects, although in a different way. In Pentecostal practice, unlike in a Catholic setting or in contexts of Ghanaian diviners and possession priests, the pharmaceutical objects do not contain the spiritual power but create connections to Godly powers. The Holy Spirit is amplifying the helpful substances and reducing the harmful side effects that can potentially unfold during the treatment. Through prayer then, a drug becomes a different object – a connection to God and an avenue of communication. Pharmaceuticals thereby are not only meaningful because they alter the state of the body. Rather, they are objects that help the born-again Christian to incorporate God into her daily life.

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HUMANITARIAN CLAIMS AND EXPERT TESTIMONIES: CONTESTATION OVER HEALTH CARE FOR GHANAIAN MIGRANTS IN THE UNITED KINGDOM

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Ghanaian migrants seeking to remain within the United Kingdom for medical treatment employ various strategies to navigate health and humanitarian assistance law. U.K. immigration officers police immigration controls and assess humanitarian claims often without requisite medical knowledge. Drawing on ethnographic case studies, this article examines the expert country conditions report, and its capacity to document medical provision and supply in Ghana in response to the diagnoses and prescription of physicians. Whereas immigration officers attempt to detach individual claimants from their biomedical narratives by arguing that medical care is available and improving in Ghana, expert testimony re-tethers claimants to the specificities of their conditions by documenting the incapacity of the Ghanaian state to provide adequate treatment and therapy.

Keywords: Migration, health, expertise, expert testimony, medicine, ethnography, Ghana, United Kingdom.

Ama Sumani's Death

On 19 March 2008, Ama Sumani died in Korle Bu Teaching Hospital, Accra, Ghana, from complications caused from bone cancer. She was 42 years old. Although only one of innumerable cancer patients, her death proffered a moment of reflection among many Ghanaians and Britons. Sumani, a mother of two, first came to the United Kingdom in 2003 with a visitor's visa with hopes of obtaining a degree in economics. She soon applied for change of status to a student visa and attempted to stay in the U.K. by enrolling in a banking course in Cardiff, Wales. Her poor English and low educational level prevented her from enrolling. Sumani,

returning from a brief trip to Ghana in 2005 to attend a memorial for her late husband, soon learned that her student visa had been revoked because she had violated reporting requirements.

In January 2006, Sumani was diagnosed with myeloma, an aggressive cancer affecting the bone marrow. By January 2008, the cancer replicated and led to serious health problems, including kidney failure. After she forewent a medically recommended transplant, doctors began kidney dialysis in order to prolong her life. At the same time, however, efforts were untaken to remove her to Ghana. Despite the pleas of lawyers and doctors, the Borders and Immigration Agency (BIA), a division of the U.K. Home Office, ruled that because Sumani had knowingly overstayed her visa, she was to be removed from the country.¹ Although Sumani and her advocates pleaded for humanitarian consideration and noted that she could not afford dialysis treatment in Ghana, Lin Homer, the BIA Chief Executive, told British parliamentarians that numerous judicial rulings had found that deporting those undergoing medical care did not amount to inhumane treatment. Drawing non-specifically on the language of these rulings, Homer observed that Sumani's case was "not exceptional" (Ford 2008). Homer stated the courts had affirmed that deportation could be halted only in "very rare and extreme cases" under Article 3 of the European Convention on Human Rights (ECHR), which bars degrading or inhumane treatment. On 9 January 2008, Sumani was removed from University Hospital of Wales in Cardiff and transported to Accra. She died about two months later.

Although people die of cancer every day in Ghana, Sumani's peculiarly sorrowful story drew considerable

¹ Alan Travis, "Immigration chief defends deportation of cancer patient," *The Guardian*, Tuesday, 15 January 2008.
<http://www.guardian.co.uk/uk/2008/jan/16/immigration.politics>
[accessed 7 August 2013].

attention. *The Guardian* covered her passing with dramatic irony, describing how she died “two hours before friends rang with the news that they had found a U.K. doctor willing to treat her condition, ...and were about to apply for an emergency visa to allow her to return.”² Earlier, before her deportation, an editorial in a leading U.K. medical journal, *The Lancet*, sharply criticized the decision to deport Sumani, describing it as “atrocious barbarism” (N. A. 2008). A petition, signed by hundreds of doctors, called on the government to reject proposed regulations which would abolish the right of failed asylum seekers to seek medical help from the National Health Service (NHS); the debate continues to rage among medical practitioners today (Jackson 2008).³

“Health Tourism,” Humanitarianism, and Expertise

To some U.K. politicians, Sumani’s case may appear to be a classic example of “health tourism,” a loaded term in British anti-immigration discourse expressing the fear that people enter the country with the purpose of exploiting the tax-funded British health system. Opponents of so-called “health tourists” argue that it is not the U.K.’s problem if healthcare is inadequate elsewhere, but as the NHS is free to everybody considered “ordinarily resident,” politicians and the public at large struggle to define ordinary residency. This debate notwithstanding, I am not particularly interested in debating a potential “right to health” so much as disentangling what

² Sadie Gray, “Deported Ghanaian dies of cancer,” *The Guardian*, Thursday, 20 March 2008.
<http://www.guardian.co.uk/uk/2008/mar/20/immigration.immigrationandpublicservices> [accessed 7 August 2013].

³ Editorial, “Treating failed asylum seekers in the NHS,” *BMJ* (2009) 338:b1614; and letters received in response; BMA Ethics Department. “Access to health care for asylum seekers and refused asylum seekers.” (September 2008): 1-2.
http://www.bma.org.uk/images/asylumhealthcare2008_tcm41-175519.pdf [accessed 29 March 2013].

appears to be a conflict of interest on the part of immigration officials, who both police immigration policy and assess humanitarian claims. And without going more into detail about the controversy over the existence of health tourism (Stevens 2010), I want to state that like Sumani, the two individuals discussed below fell ill while in the U.K.: they did not arrive seeking treatment.

Attempts to “remove” or deport sick Ghanaians from the U.K. constitute part of a broader national effort to delimit the capacity of migrants to trump rapidly unfolding immigration law by claiming access to medical treatment. Thus, in a statist counterpoint to what Miriam Ticktin (2006: 33) has described as the “trade in biological integrity” among “sans papiers” for political recognition, the decision to deport Sumani flowed directly from the knowledge that dialysis was available in Ghana. Dialysis is available in Accra, but it is not free of charge. A BIA spokesperson reportedly claimed that “part of our consideration when a person is removed is their fitness to travel and whether the necessary medical treatment is available in the country to which they are returning.”⁴ Sumani checked into Korle Bu the day after her arrival in Ghana, but the hospital declined to treat her without pre-payment for dialysis. Although British officials reportedly claimed they would provide funding for treatment for three months, the hospital had not received payment. As Dallal Stevens (2010: 375) argues, “human rights arguments” can “rarely reverse” negative BIA determinations and tribunal decisions. A carefully composed healthcare provision report by a country conditions expert, however, may have provided a legal basis for reconsidering Sumani’s claim.

⁴ Barry Mason, “Britain: Terminally ill Ghanaian woman deported and denied medical care,” World Socialist Website, 18 January 2008, <http://www.wsws.org/en/articles/2008/01/depo-j18.html> [accessed 29 March 2013].

This article explores how Ghanaian humanitarian claimants become *detached* from the biomedical narration of their own deteriorating conditions as they seek to remain in the U.K. and how the dynamic role of expert testimony *re-tethers* specific claims. I employ the term “detachment” to explain a process whereby, in the context of the adversarial nature of the humanitarian claim adjudication process, claimants are separated from the biomedical specificities of their bodily experience by efforts of the BIA to demonstrate the availability of care as it pertains to their illness. Claimants and their legal counsel counteract this with multiple strategies, among the most of important of which is a country conditions report examining the nature of medical treatments and the actual capacity of the origin state to provide the requisite care. The concept of “re-tethering” thus describes the dynamic role of expertise and conveys a sense of how the personal claimant’s narrative, rendered abstract by BIA action, is once again connected to the bodily-lived reality of the claimant.

My focus on the relationship of the expert with the humanitarian claim has two objectives. The first is empirical; building on Ticktin’s (2006, 2008) observation that humanitarian claims may provide agency to traumatized individuals navigating transnational politics, I seek to make sense of how, why, and within what legal, social, and medical contexts such claims are made. While the health needs of specific claimants may be documented in meticulous detail, many of the decisions emanating from the BIA are based on speculative future projections about generalized medical and psychiatric provisions and accessibility in Ghana. Immigration officers’ contestation of medical claims and clinicians’ medical reports contributes to a process of detachment on the part of migrants from the individuated biomedical narrative. Part one thus narrates the detachment processes of claims, including the legal basis and the evidentiary burden, via the case histories of

two real individuals for which I provided expert country conditions expertise.

The second objective is theoretical. It might well appear that the status of Ama Sumani is a classic exemplar of what Giorgio Agamben (2003) describes as a “state of exception,” where the capacities of citizenship and individual rights are forfeited, and the government holds ultimate power over life and death. Indeed, Charles Watters (2001: 1712) correctly predicted in 2001 that U.K. asylum seekers would continue to have “less and less control over their own lives” as a direct consequence of immigration policies. Building on these observations, however, I wish to turn the focus to the dynamic processes whereby people access resources and gain legal rights, specifically the expert country conditions report, through their bodily condition. My experience as an expert witness has alerted me to some aspects of the structural violence embedded within European immigration policy. I suggest that expert testimony constitutes a dynamic mechanism for re-tethering, whereby specific challenges to humanitarian claims may be undercut by addressing the realities of healthcare provision in Ghana.

Whereas the U.K. may have a legitimate goal in enforcing immigration policy, the BIA adjudicates each application on a case-by-case basis. The complexity of the human rights basis of claimants invoking medical or psychiatric issues is significant and may be beyond the comprehension of immigration officials with no medical training. Indeed, the case histories described here suggest that balancing immigration policy enforcement and the human rights of gravely ill patients is incommensurable. A key tension is revealed, namely that there exist two targets in constant flux: the health status of the individual in question and the health provision in the receiving country. As part of a wider project of the legitimate enforcement of an immigration policy, current adjudication of humanitarian claims requires that these two fluctuating issues

be balanced and evaluated as if they were static at one particular moment in time.

By way of conclusion, I consider two possible avenues for further research. The legal threshold created by U.K. and European rulings provides little useful guidance for adjudicating cases from source countries, such as Ghana, that have rapidly changing public medical provision.⁵ One possible solution to this predicament involves separating the immigration enforcement component from medicine and healthcare entirely. A second possible resolution involves removing BIA administrators from the decision-making process and replacing the current adjudication team with an appointed panel composed of medical and psychiatric professionals and country conditions experts, the determinations of which would continue to be subject to judicial review.

Detachment of Humanitarian Claims

Ghanaian migrants who become ill while in the U.K. and subsequently pursue humanitarian protection in the U.K. under Article 3 of the European Convention of Human Rights (ECHR) are increasingly invoking the poor quality and limited accessibility of medical and psychiatric treatments in Ghana as grounds for refugee status. Whereas both the right to treatments and protection from deportation causing serious physical harm and/or death have been the subject of important U.K. and E.U. case law, the BIA consistently invokes the very high standard of “exceptional circumstances” in asylum/refugee claims and “withholding from removal” petitions (i.e. lawsuits attempted to quash deportation orders), thereby utilizing medical and

⁵ *N (FC) v. SSHD* (2005) UKHL 31.

<http://www.bailii.org/uk/cases/UKHL/2005/31.html> [accessed 7 August 2013].

psychiatric issues to detach claimants from the bio-medical materiality of their condition.⁶

The BIA describes its goal in effectively enforcing an immigration policy as legitimate, and several U.K. and European rulings provide the authority to adjudicate applications case-by-case.⁷ At the same time, maintaining and enforcing an immigration policy has been determined as an illegal basis for adjudicating a claim.⁸ Indeed, evidence demonstrates that the BIA struggles to weigh information about the health status of the individual and the health provision in Ghana against its legal responsibilities. In adjudicating the “exceptional circumstances” of claims made under Article 3, the BIA may base its decisions on a variety of sources, including information about known conditions and facilities in Ghana and reports from medical, psychiatric, and country conditions experts. Notwithstanding these observations, medical and psychiatric facilities are rapidly changing and improving in Ghana, among the most important developments being the 2003 launch of the National Health Insurance Scheme (NHIS). When a Ghanaian petitions to remain for humanitarian reasons (an Article 3 claim) by arguing for the necessity of medical or psychiatric care currently untaken in the U.K., the

⁶ Ibid. at §53 and 54.

⁷ The role of the BIA in the adjudication of immigration cases involving evaluating the private life of the applicant versus the national objectives of an immigration policy was upheld as compatible with the ECHR in *Nyanzi v. United Kingdom*, Appl. No. 21878/06, Council of Europe: European Court of Human Rights, 8 April 2008, available at: <http://www.refworld.org/docid/4805cd722.html> [accessed 7 August 2013]. Beginning with *N (FC) v. SSHD* (2005) UKHL 31, cited above in 5.

⁸ *Regina v. Secretary of State for the Home Department (Appellant), ex parte Adam (FC) (Respondent)*; *Regina v. Secretary of State for the Home Department (Appellant), ex parte Limbuela (FC) (Respondent)*; *Regina v. Secretary of State for the Home Department (Appellant), ex parte Tesema (FC) (Respondent) (Conjoined Appeals)*, [2005] UKHL 66, United Kingdom: House of Lords (Judicial Committee), 3 November 2005, available at: <http://www.refworld.org/docid/43fc2d1a0.html> [accessed 7 August 2013] at 55.

burden falls on the claimant to establish the danger encumbered by deportation.

The Legal Basis of Humanitarian Claimants' Right to Treatment

Ghanaians in the U.K. who make humanitarian claims involving "removal against withholding" may often argue that their physiological and/or psychiatric conditions require the continuing treatment they are presently receiving and that such treatment can only be received properly in the U.K. When claimants advance an argument about the necessity for medical or mental healthcare, they are immediately subjected to a series of tests established by legislation and legal precedent emerging from domestic and European contexts.

The main document determining humanitarian claims pertaining to health is Article 3 of the ECHR, which reads, "No one shall be subjected to torture or to inhuman or degrading treatment or punishment." Since 1978 the distinction between torture and inhuman or degrading treatment has been interpreted to "derive ... principally from a difference in the intensity of the suffering inflicted."⁹ Thus to advance an Article 3 claim, Ghanaians must make a strong case about the severity of the suffering caused by deportation.

To engage the U.K.'s obligations under Article 3, on the basis of medical treatment, Ghanaians must meet three conditions. The individual must demonstrate that there is a complete absence of the appropriate medical treatment for the illness in Ghana. Credible medical evidence must demonstrate that return to Ghana would significantly reduce life expectancy and lead to acute physical or mental suffering and/or a painful death. The individual must additionally demonstrate that the

⁹ *Ireland v. UK* (1978) 2 EHRR 25 at §167. See [1978] 2 EHRR 25, 2 EHRR 25, (1980) 2 EHRR 25, [1978] ECHR 1, (1978) 2 EHRR 25. <http://www.bailii.org/eu/cases/ECHR/1978/1.html> [accessed 7 August 2013].

U.K. has provided the individual with appropriate medical or psychiatric treatment for an appreciable amount of time to the extent that the U.K. can be regarded as having *assumed the responsibility for care*. The burden on migrants making Article 3 claims about the withdrawal of access to care became significantly higher after 1997, when a ruling established the general principle that persons cannot avoid deportation based on the fact that they should continue to benefit from state-provided assistance. Only in “very exceptional circumstances” may humanitarian considerations be invoked. In 2005 this principle was entrenched when the House of Lords stated that what must be considered is “whether the applicant’s illness has reached such a critical stage” that it would be “inhuman treatment to deprive him of care” and send “him home to an early death” unless similar care is available “to meet that fate with dignity.”¹⁰ While medical and psychiatric cases are constantly litigated, these rulings are withstanding scrutiny.¹¹ Today asylum seekers are not considered “ordinarily resident” for the purpose of access to healthcare; discretion is the order of the day.¹²

For a Ghanaian seeking humanitarian protection for medical or psychiatric reasons based on Article 3, the key issue is the “severity” of “treatment” experienced when forcibly returned to Ghana. The European Court ruled that “actual bodily injury or intense physical or mental suffering” could involve issues “flowing from conditions of detention, expulsion or other measures, for which the authorities can be held

¹⁰ *N (FC) v. SSHD* (2005) UKHL 31, at §18.

<http://www.bailii.org/uk/cases/UKHL/2005/31.html> [accessed 7 August 2013].

¹¹ For discussion of *N (FC) v. SSHD* (2005) UKHL 31, see Sawyer (2004); Chalmers (2010); Bettinson and Jones (2009); Mantouvalou (2009).

¹² *R (on Application of YA) v Secretary of State for the Home Department* [2009] EWCA Civ 225.
<http://www.bailii.org/ew/cases/EWCA/Civ/2012/1383.html> [accessed 7 August 2013].

responsible.”¹³ The U.K.’s interpretation of “severity caused by ill-treatment” has since extended to mental health.¹⁴ Whereas the assessment of severity is relative and includes many variables, being abandoned on the streets of Accra without the capacity to afford care may conceivably reach the threshold of severity.¹⁵ Article 3 applies principally to prevent deportation where the risk of ill-treatment in Ghana emanates from *intentionally* inflicted acts by public authorities who are unable to afford the applicant appropriate protection or treatment. Where there is *no intentional* ill-treatment, the suffering which flows from naturally occurring physical or mental illness may still be covered. Where an individual’s condition is, or risks being, exacerbated by actions for which authorities may be responsible in very exceptional cases, humanitarian grounds against deportation may exist.¹⁶

It is within this context, then, that Ghanaian claimants must make their case. They must be able to establish the complete absence of appropriate medical treatments in Ghana. They must demonstrate with credible medical expertise that return to Ghana would reduce life expectancy and/or lead to acute physical or mental suffering or a painful death. Finally, they must demonstrate that the U.K. has effectively assumed the responsibility for care. Each aspect of the three-part test is subject to scrutiny according to U.K. and E.U. law. In order to

¹³ *Pretty v United Kingdom* 35 EHRR 1, 33, §52.

<http://www.bailii.org/eu/cases/ECHR/2002/427.html> [accessed 7 August 2013].

¹⁴ *N. v. UK* – 26565/05 [2008] ECHR 453; [2009] EWCA Civ 1354, Court of Appeal, 14 December 2009.

<http://www.bailii.org/eu/cases/ECHR/2008/453.html> [accessed 7 August 2013].

¹⁵ *Jalloh v Germany*, no. 54810/00, §67, ECHR 2006.

<https://wcd.coe.int/ViewDoc.jsp?id=1018815&Site=COE> [accessed 7 August 2013].

¹⁶ *N. v. UK* – 26565/05 [2008] ECHR 453 [see note 14 above]; *Pretty v the United Kingdom*, 2346/02, § 52, ECHR 2002-III.

<http://www.bailii.org/eu/cases/ECHR/2002/427.html> [accessed 7 August 2013].

be considered “very exceptional,” the Ghanaian must demonstrate that the U.K. is causing severe ill-treatment by forcibly returning the individual to Ghana where s/he will be deliberately inflicted harm insofar as the Ghanaian government cannot or will not provide the care necessary to avoid a significant reduction in life expectancy, acute physical or mental suffering, and/or a painful death.

Treatment Sought by Ghanaian Migrants

Ama Sumani’s miserable narrative, while illustrative of the structural violence obstructing humanitarian claims, was not considered exceptional. That the BIA took such a view – and in the absence of any solid data on the socio-demographic profile of humanitarian claimants (McColl and Johnson 2006) in the U.K. specifically (or asylum seekers generally) – is curious to say the least. Because so little is known about the actual numbers of individuals, let alone a demographic profile against which a claim of exceptionality might be leveled, U.K. media outlets routinely resort to sensationalism (Stevens 2010: 369).

In order to make sense of how adjudication operates on a case-by-case basis, I consider two Ghanaian petitioners, a man and a woman, with a spectrum of pressing medical and psychiatric conditions. The two individuals, whom I refer to pseudonymously as Kwame and Akua, are based on two cases for which I personally provided expert testimony. I have changed small details about the case histories to protect the informants’ identities. I restrict my analysis to two Article 3 claimants because the only medical cases I have evaluated were framed primarily by Article 3, although at times additional humanitarian bases are invoked. I have provided written testimony in over two hundred asylum petitions and refugee status claims from West Africans in the U.S., the U.K., and elsewhere, a number of which involved physiological and psychiatric health considerations. This also informs my narration of Kwame’s and Akua’s experiences.

The Ghanaian state's public health agenda remains incommensurate with the specific needs of many humanitarian claimants subjected to forcible return. Significant advances have been made in the public provision of physiological and mental healthcare and pharmaceutical availability in Ghana since 1992 and the establishment of the Fourth Republic. Notwithstanding these changes, the materiality of Ghanaian migrants' claims demonstrates the disjuncture between the highly specialized mental and physical health requirements and the objectives of the constitutional and legislative expansion of public healthcare. The public health agenda of the Ghanaian state provides no indication of a shift toward providing specialized care at the public expense beyond diagnostics, nor is this likely to change any time in the foreseeable future.¹⁷

Kwame and Akua

Kwame is a 54-year old male who entered the U.K. on a temporary business visa in 2008 to place orders and develop relationships with clients and suppliers in the plastics industry. After one month in the country he collapsed during a meeting, was rushed to hospital, and was diagnosed with an acute pulmonary embolism. He began treatment and was advised that he had a serious condition from which death was likely if he did not adhere to a specific treatment regimen under medical supervision. He immediately sought permission to remain in the U.K. for humanitarian reasons but was refused, with no right of appeal. While his case was re-filed in 2008, he developed several additional complications, some related to his condition, including hypertension, and diabetes, and some previously undocumented chronic conditions, including

¹⁷ See NHIS Benefits Package, <http://www.nhis.gov.gh/?CategoryID=158&ArticleID=120> [accessed 29 March 2013]. Thanks to Daniel Kojo Arhinful for this information.

hepatitis B, malaria, sickle cell anemia, and a stage-three subungual nodular melanoma.

Akua is a 24 year-old woman from rural Ghana with no formal education. She arrived in the U.K. in approximately 2003, although precisely when is unclear. Akua was trafficked into the country for the purpose of working in prostitution; she contributed some money to the initiation of the illegal migration but was under the impression she would be working as a domestic servant. After three years imprisonment (ostensibly to pay off the debts incurred from her smuggling contract), she became pregnant and gave birth to a boy in the building where she was held. A year later, she became pregnant a second time and escaped from the house with her child. She was discovered on the street, destitute, and admitted to hospital, where she was and discovered to have an ectopic pregnancy and advanced HIV/AIDS disease complications, including cytomegalovirus and other opportunistic infections. During a medically necessary termination, complications caused her to fall into a coma. Her son was placed in foster care. A year later, she emerged from the coma with diminished speech and hearing capacity. She claimed asylum as a victim of human trafficking and sought protection against deportation based on humanitarian grounds.

Lawyers for Kwame submitted expertise from medical doctors demonstrating the severity of his conditions, in particular his complete inability to fly while undergoing treatment for a pulmonary embolism. Medical and country conditions reports attested to the nature of his ailments and the type of medical care available in Ghana for a number of the conditions, as well as the complete absence of care for several in particular. The case was again rejected, but right to appeal was allowed on the basis of the fact that the judge had not considered the complexity of the medical evidence submitted. New country conditions reports provided additional data about

the availability or absence of specific medications, the cost of medicines, and the prevalence and regularity of supply.

Lawyers for Akua developed multiple arguments for why she should be allowed to remain within the U.K. Expert reports about the severity of her medical condition, and the post-traumatic conditions resulting from her trafficking and imprisonment, formed the basis for these claims. Whereas her claim of trafficking was accepted, it was determined that protections for victims of trafficking existed in Ghana. Additional appeals were filed on humanitarian grounds and rejected based on information about the availability of treatment for HIV/AIDS sufferers in Ghana. A third round of appeals focused on the deprivation her now six-year-old son would face if, as was highly likely, his mother died impoverished and destitute on the streets in Accra. Additional country conditions reports attested to the nature of poverty and destitution, the lack of child protection programs; medical reports substantiated and reiterated earlier claims about the absence of medical care.

Affirmation of Necessity of Treatment by Experts/Physicians

Credible medical expertise is essential to support arguments about the necessity of treatment and the proposition that the U.K. has become the primary caregiver. Humanitarian claimants seek to provide extensive documentation from qualified medical and psychiatric personnel, who may be physicians of record or specifically contracted experts. Experts usually do not discuss the possibilities for continuing care were the individual removed to Ghana. If exhibiting “the stigmas of indigence” may operate as “a last resort” (Fassin and d’Halluin 2005: 597) in other contexts, knowledge about on-the-ground conditions is usually beyond the expertise of U.K.-based physicians. Instead, reports constitute fact-based accounts of current medical and psychiatric conditions and care, accompanied by supporting documentation, or “the evidence of

truth” (ibid: 598). Any speculation is confined to the implications of withdrawing treatment or failing to adhere to a specific regimen.

Physicians of record document the diagnosis; the nature of treatments, including prescribed pharmaceuticals; the treatments undertaken; the prognosis; and the necessity of future treatment. They may address specific effects of deportation, such as the impact of high altitude in an airplane. Physicians may be general practitioners (family doctors) or specialist consultants. Where the claimants have physical signs of trauma, including torture, specialized technical reports are required; consultant psychiatrists and practicing psychologists focus on the psychiatric diagnosis (e.g. post-traumatic stress disorder [PTSD] complex). And as Watters (2001) observes, this increasingly involves a dialogue between the individual and clinician in relation to refugees’ own perceptions of their need. Reports include many of the same details as physicians’ reports. In many instances, trauma survivors, such as victims of human trafficking, are referred to dedicated care facilities, such as the Poppy Project in London. Notwithstanding advancement in provision, the Western biomedical approach circumscribes the refugee experience by only documenting clinically significant data (Woodcock 1995; Eastmond 1998).

In Kwame’s case, the first filing referred to his medical conditions but included no documentation. After the failure of the first claim, the first appeal included medical reports from consultants, from the emergency facility to which he was admitted, as well as a case history from his physician. Kwame’s appeal was unsuccessful but he was granted the right to resubmit after his condition worsened and new ailments were diagnosed. The new filing included four specialists’ reports, extensive accounts of medications, potential complications, and a prognosis. Because his re-filing included new or newly discovered medical conditions not part of his initial reason for hospitalization, such as melanoma, this filing was treated with

considerable skepticism. One BIA officer viewed new conditions occurring during ongoing treatment to be specifically excluded as grounds for humanitarian relief.

In Akua's case, lawyers submitted a dossier containing detailed medical reports from the outset. Her case was suspended during the year of hospitalization, but once released, and with medical reports indicating a positive response to antiretroviral medication, the BIA rejected her case. Her lawyers immediately reapplied based on the discovery of the post-coma speech and hearing loss, the necessity for ongoing therapy, and the possibility of destitution in Ghana as a kinless former trafficking victim and prostitute with HIV/AIDS. The BIA responded with documented instances of speech and hearing therapy being available in Ghana and rejected the appeal. At a tribunal appeal, however, her lawyers submitted evidence of her PTSD complex, the necessity of specific trauma counseling unavailable in Ghana, and the likely destitution and orphanhood of her son.

Expert Testimony and the Re-Tethering of Claims

Conspicuously absent from both Kwame's and Akua's dossiers was any sense of the availability, prevalence, or supply, of treatment, therapy, and medication. This is the subject of the country conditions expertise, which as a fundamental component of the humanitarian claim re-tethers biomedical claims to the bodily person of the claimant. Over the course of a decade, I have produced many country conditions reports that often discuss the availability of medical and psychiatric care. Here I discuss these reports in general before returning to Kwame's and Akua's stories.

In countries that are emerging from political or sectarian conflict, such as Sierra Leone, where hospitals are crumbling, and pharmaceutical distribution is piecemeal, reports readily substantiate such claims. In countries that briefly flirted with universal healthcare or national insurance, such as Côte

d'Ivoire, government policy specifically dismantling such programs is demonstrable. But ironically, nations that are the site of significant advances and improvements in public medical provision, such as South Africa or Ghana, require qualitatively different reports.

Evidentiary Basis for Public Health Provision

BIA officers routinely cite the optimistic self-representations of the Ghanaian state and do not consider the lack of highly specialized care in particular and care delivery and accessibility in general. Against this approach, an Article 3 claimant must demonstrate that the necessary treatments are unavailable in Ghana. Accomplishing this task requires the production of a report about the current state of treatments in Ghana. When I draft reports, I distinguish between constitutional and legislative provisions, the creation of policy and policy frameworks, and provision on the ground. I reflect on the divergence between policy objectives and actual practice. I engage with and respond to expert medical and psychiatric reports and the evidence deployed by the BIA in rejected claims. Reports are compiled based on objective evidence in the public domain, published scholarship, private research, and personal information shared with me by practitioners in the field, including heads of hospitals and pharmaceutical distributors. The reports I produce are thus a combination of an assessment of general and public provisions and a specific engagement with the individuated needs of claimants.

Constitutional and legislative developments in the 1990s provide both the framework for understanding constitutional rights to care, and legislative provision for the implementation of access to those same constitutional rights. Whereas the constitutional and legislative provisions are explicit, a key focus of expert reports on medical and psychiatric provision concerns the realized or realizable goals of care. In some parts of Europe, country conditions reports are provided by the state,

and I draw upon these publicly available documents for my own purposes. The Austrian Center for Country of Origin and Asylum Research and Documentation (ACCORD 2009) produced a synthetic report on the provision of care by population in Ghana. Based on publicly available data, it highlights how, for example, “for a population of a little short of 23.5 million people, there are only 1,439 health care facilities.”¹⁸ ACCORD’s report echoed an earlier study, which noted that access to facilities remained a primary problem. G.J.M. van den Boom et al. (2004) observed that facilities are not evenly distributed, with most rural areas lacking basic facilities and trained staff.

When rejecting humanitarian claims, the BIA frequently cites what it considers objective evidence of the overall improvement in healthcare provision. Indeed, the evidence for *overall* improvement in provision is incontrovertible. The Ghanaian government embarked on health sector reform in the early 1990s to improve the accessibility and quality of services. Whereas “the health situation in Ghana” is “still far from satisfactory,” with many people relying on self-medication, several projects since the mid-2000s have focused on increasing accessibility (Van den Boom et al. 2004: 1, 4, 20, 21). Between 2002 and 2007, the Ministry of Health (MOH) established 176 health infrastructure projects, including 50 health centers comprising 22 district hospitals and 26 Community Health Planning Scheme schemes.

The BIA may point to evidence of increased healthcare spending as evidence of availability, and indeed, spending on public sector health has increased dramatically during the new millennium. Total expenditures, however, provide an incomplete picture. My expert reports specifically address how

¹⁸ “GHANA: Race against time to cut maternal mortality” (IRIN, 5 August 2008). <http://www.irinnews.org/Report/79645/GHANA-Race-against-time-to-cut-maternal-mortality> [accessed, 29 March 2013].

general and national data skews the broader picture of health provision, drawing on Augustine Asante, Anthony Zwi, and Maria Ho (2006). Resource allocation sits in stark contrast with the highly specific and specialized needs of Article 3 claimants. Poverty alleviation programs follow development models that prioritize basic indices as the primary vehicle for improving overall national health.

The BIA routinely cites the Ghanaian government's commitment to quality healthcare as part of the national poverty reduction strategy. When I write a country conditions report, I thus pay particular attention to the deliverance of healthcare. Basic health indices often undercut the unbridled optimism of many BIA determinations. Despite a national emphasis on basic care, reports indicate that many of the main problems in Ghana's healthcare system stem from simple, sanitation-related diseases.¹⁹ Other important factors augmenting disparities between the delivery structure and its applicability in the health industry include nepotism, favoritism, corruption, and what was once called "tribalism."

Healthcare Objectives and Realities

The BIA views Ghana's healthcare structure and health insurance as an African success story. Officials routinely draw on web-based sources to substantiate claims that health provision is improving. To be sure, healthcare structure is constantly improving in Ghana, and health insurance enlistment and coverage is expanding. By far the most important development in the past decade in Ghanaian health provision has been the launch of the NHIS. This observation, however, is insufficient for understanding what is available for the claimant. Assessing what is available to potential deportees requires that a report reference the most up-to-date information

¹⁹ *Public Agenda*, 1 September 2008; *Ghanaian Chronicle*, 21 August 2008; cited in ACCORD (2009: 5, 10, 15).

about coverage under insurance schemes. The realities of healthcare in Ghana are quite different from what appears on websites—at the onset of the NHIS, there was great optimism for its successful implementation, but closer scrutiny reveals why an attentive and current country conditions report constitutes a crucial component of any successful humanitarian claim.

In addition to public insurance, the operation of private mutual insurance and private commercial insurance schemes are permitted by the National Health Insurance Act of 2003, Act 650, ostensibly in order to give all residents of Ghana “the opportunity to join a health insurance scheme of their choice.”²⁰ All faith-based or “private not for profit” institutions are accredited and operate as part of the NHIS 2005 survey found that “faith-based health services in Ghana provide approximately 40% of the available healthcare” (ACCORD 2009: 15-16). Church healthcare facilities in Ghana include at least 56 hospitals and 83 clinics (*ibid*: 13). In 2004, treatment on a private basis cost approximately USD10 per session, and the average income of Ghanaians was about USD1.5 per day (Van den Boom et al. 2004: 8). Whereas some religious missions may treat the poor for below market rates, those excluded from public provision, including nominally private medical practitioners such as herbalists, animist priests, and some orthodox private practitioners, apply charges, the amounts of which “vary widely” (Asenso 1995).

Thus after laying out the contours of healthcare provision and organization, my country conditions reports address the specific ailments described by the medical and psychiatric experts treating Kwame and Akua. NHIS maintains a regularly updated database of conditions covered under the insurance

²⁰ “GHANA: National health insurance scheme launched,” IRIN, 18 March 2004. <http://www.irinnews.org/Report/49172/GHANA-National-health-insurance-scheme-launched> [accessed 29 March 2013].

schemes. In 2005, at the time of Kwame's and Akua's case hearings, chronic renal failure, most forms of cancer, antiretroviral HIV medications and specific opportunistic infections, and PTSD complex were only covered by private independent schemes and not by the publicly-accessible national insurance scheme.²¹ Whereas two of the treatments required by Kwame and Akua – dialysis and antiretroviral medications – are available in Ghana, and government agents may assist in negotiating costs, the patient is responsible for the costs of care. Chronic conditions such as hypertension, many of which are related to lifestyle and diet, are rarely the focus of government policy. Medical practitioners may provide guidance and monitoring for such conditions and generic medications may be supported with public funds, but the cost of specific medications, such as those prescribed by a U.K. physician to Kwame, would be borne by the patient. Consultation fees and the costs for diagnosing health conditions, in particular for endemic conditions such as malaria and Guinea Worm, constitute the mainstay of the national health policy.

Coupled with specific treatment and therapies, a second important consideration is the provision of specialized personnel. Whereas Ghanaian universities regularly produce new doctors, the country suffers from a dire shortage of specialists. For example, the country's most densely populated region, the Western Region, accommodates ten percent of the population but only 99 doctors. In 2008 there were 91 doctors living in the Volta Region and 33 in the Northern Region, compared to 1,238 public and private medical as well as dental practitioners in the Great Accra Region.²² Organ transplants are

²¹ This has since changed. See <http://www.nhis.gov.gh/?CategoryID=158&ArticleID=120> [accessed, 19 June 2013].

²² Ghana Home Page: Population, undated <http://www.ghanaweb.com/GhanaHomePage/geography/population.php>

not covered under the NHIS, partly because there are few trained specialists, no donation facilities, and no successful organ transplants. If a claimant originates in a rural location, addressing disparities between urban and rural care is important. Other factors such as traditional beliefs, social stigmas, poverty, and illiteracy, still obstruct proper healthcare delivery and the operation of insurance schemes. For example, in the Kassena-Nankana District, some respondents expressed the view that “contributing money for illnesses yet to come” (i.e. insurance) could “invite more illnesses.”²³ Elsewhere people with leprosy and tuberculosis defaulted treatments due to social stigma, lack of funds and/or the need to fend for themselves.²⁴

After establishing whether or not a particular treatment is available, the second function of a report is to document pharmaceutical provision, cost, and supply. My reports address provision and distribution (including legislation), the establishment of the Ghana National Drugs Programme, a National Drug Policy, and a National Essential Drugs List and Standard Treatment Guidelines. Since 1999, Ghana’s health sector has been subject to a national drug policy. My reports address the distribution of medications by referencing the Standard Treatment Guidelines and Essential Medicines List

[accessed 29 March 2013]. For an alternative perspective, doctor-to-population ratio by region from 2007 to 2012, see http://www.ghanahealthservice.org/includes/upload/publications/GHS_2010_Annual%20Report_Final.pdf [accessed 19 June 2013].

²³ Health Research Unit, “Report on The perception and demand for mutual Health Insurance in the Kassena-Nankana district of Northern Ghana,” (May 2005), 8. <http://www.hru-ghs.org/Newsletter.pdf> [accessed 29 March 2013].

²⁴ Health Research Unit, “Treatment Default Among Adult TB Patients Registered At The Effia-Nkwanta regional Hospital: What Are The Contributing Factors?,” May 2005. <http://www.hru-ghs.org/Newsletter.pdf> [accessed 29 March 2013].

(EML).²⁵ In drafting a report requiring ongoing pharmaceutical provision, I pay attention to EML updates.²⁶ Drawing on government data and public media, my reports address how the absence of a “systematic approach to pricing” and the poor functioning of government-run central stores led to “shortages of essential drugs and supplies” in Ghana.²⁷

Kwame and Akua were prescribed a variety of medications for pulmonary embolism, cancer, HIV/AIDS, hypertension, malaria management, anemia, and PTSD complex disorder. I consulted the EML for the specific pharmaceuticals and the prescribed dosage. Whereas some of Kwame’s and Akua’s medications appeared on the list (e.g., Wafarin for pulmonary embolism), several other medications (e.g., new drugs for melanoma and PTSD) did not. Others were listed (e.g., hypertension medications), but they either were unavailable in the correct dosages or could only be prescribed under specific circumstances and not for ongoing treatment of a chronic condition. The appearance of a specific medication on the EML, however, does not mean that it is available or that supply is guaranteed. The MOH noted “improvements in the quality of goods supplied” and a reduction in “malpractice” but also observed that considerable impediments remain with respect to “procurement, stores management and distribution systems.” Other issues identified included rational use, financing, and drug quality assurance.²⁸ Based on this information, my report

²⁵ Now in its 6th Edition.

<http://www.ghanaweb.com/GhanaHomePage/health/artikel.php?ID=187107> [accessed 29 March 2013].

²⁶ http://www.ghana.gov.gh/index.php?option=com_content&view=article&id=2842:standard-medicines-essential-list-guidelines-launched&catid=28:general-news&Itemid=162 [accessed 29 March 2013].

²⁷ Ministry of Health, “Programme of Work: The Ghana Health Sector annual programme of work” (2007), 24, 30. http://www.moh-ghana.org/moh/docs/programs_of_work/pows/AnnualProgrammeofWork2007.pdf [accessed 29 March 2013].

²⁸ *Ibid.*, 30.

also included a discussion of private access and importation of medications on a private basis.

A final factor in terms of pharmaceutical provision concerns price. The appearance of a medication on the EML does not imply the government provides it gratis; on the contrary, the list contains a detailed calculation for co-pays. Sumani could not afford the dialysis treatments, estimated at over several thousand pounds for three months. My reports therefore often address the dimensions of cost and affordability in the context of the individual's means. Although Kwame was educated, had his own business, and came from a family with significant means, cancer treatment remained unaffordable. Akua, on the other hand, was impoverished and destitute. She had no income generating potential and her illness suggested little future likelihood of such a capacity.

Expert Testimony, Between Detachment and Re-Tethering

The experience of detachment and re-tethering, as narrated above, constitutes the framework for understanding the role of the expert report. Although long a mainstay of litigation, expert testimony is a relatively recent feature of immigration and humanitarian law (Rose 1956; Rosen 1977; Thuen 2004). According to Didier Fassin and Estelle d'Halluin (2005), until the 1980s, claimants in France operated within a climate of "trust, in which the applicant was presumed to be telling the truth." Today, however, with the rise of anti-immigrant sentiment throughout Europe, claimants must represent their concerns within "a climate of suspicion," one "in which the asylum seeker is seen as someone trying to take advantage of the country's hospitality" (ibid: 600). Expertise, in a variety of forms, has thus emerged to fill this niche. From the perspective of immigration courts, university professors are eminently qualified to serve as experts (Berger et al. forthcoming).

As explained above, the role of the expert in immigration claims is to testify about the political, cultural, and social

climate in the asylum seekers' home countries and potential jeopardy. Although the figure of the expert may seem relatively straightforward, Anthony Good (2004, 2008) has demonstrated how each specific form of testimony operates within a defined set of parameters and requirements. Judges, for example, may call upon experts when the documentary evidence about persecution is inadequate or its credibility imperiled, such as the case of a Togolese woman, known today as *In re Kasinga*, which opened the door to claims based on female genital cutting. Immigration lawyers may draw on experts to translate the narrative of a claimant "as a personal trauma into an act of political aggression" (Shuman and Bohmer 2004: 396). Experts may be invited to interpret the current status of a domestic statute (such as nationality and citizenship law) and how it pertains to a specific claim of a refugee or asylum seeker, such as statelessness (Lawrance forthcoming). Country conditions experts may level the playing field, as Susan Kerns (2000) argues. Indeed, the tasks of the expert are so wide-ranging that immigration judge Gary Malphrus (2010: 8) suggests that, "what constitutes adequate qualifications to testify as an expert should be broadly defined."

Experts not only reside within a breadth of fields and professions, they also interpret a spectrum of evidentiary matters. Good experts are nimble and respond to challenges. As the case histories of Akua and Kwame demonstrate, BIA officials with no medical training appear to have no qualms questioning the medical directives of qualified clinical professionals. Thus, experts' knowledge base and skill sets should be diffuse and expansive; effective experts may provide new, innovative, and alternative strategies with which claims can be re-tethered to facts, data, and evidence. The best experts are cognizant of their role's pitfalls and contradictions. But just as expertise can re-tether the specificities of a claim, expert knowledge may reify complex social, cultural, and political realities (Speed 2006; Bloomaert 2009; Fassin 2012).

Country conditions reports pertaining to healthcare provision are qualitatively different from medical and psychiatric expertise because they document real and present clinical realities rather than idealized or prescribed scientific provisions. Medical reports must adhere to rigorous objectivity standards and resist partisan instincts (Jones and Smith 2004; Meffert et al. 2010). Healthcare provision reports, however, provide the expert with more leeway for reflection, nuance, and interpretation, especially where they concern the capacity of an individual to access care. Such reports thus emulate country conditions reports more closely than the very reports of clinicians or physicians with which they in fact dialogue.

But neither do reports pertaining to healthcare provision sit neatly with country conditions reports in general. Questions and impediments that may disrupt asylum hearings, such as alleged identity fraud or credibility questions, rarely feature. This form of expert reporting seeks primarily to anchor the medical and psychiatric determinations of clinicians and interplays much less with claimant narratives than other forms of country conditions expertise. Such reports occupy an intermediary space. Notwithstanding this observation, however, healthcare provision expertise may still fall victim to what Vicki Squire (2009) describes as the exclusionary logic of securitization, by reinforcing protocols and judicial determinations. Indeed, by re-tethering claimants to their medical and psychiatric conditions, it might well be argued that such reports further bolster the BIA's capacity to detach claims in the absence of the requisite medical training.

Solutions

It was not always the case that BIA officials without medical training adjudicated humanitarian claims and health. In the past, decisions about whether migrants would qualify for U.K. healthcare rested with local health authorities and NHS trusts; but partly because "guidance was poorly phrased and unclear,"

and possibly because doctors refuse to act as immigration officers, alternative authorities filled the vacuum. Since 2006, accessing healthcare has been subjected to additional tests whereby a burden rests on individuals to demonstrate that they are “of the state,” not simply “in the state” (Stevens 2010: 366). A carefully composed healthcare provision report by a country conditions expert is thus often a last avenue toward a successful humanitarian claim.

The preceding discussion highlights the significant disjuncture between the level of healthcare available in Ghana, and the carefully documented needs of Article 3 claimants. Whereas the evidence for the rapid improvement in Ghanaian public healthcare provision is incontrovertible, attention to the requirements of humanitarian claimants clearly demonstrates that the specific needs of many severely ill Ghanaians in the U.K., such as Akua and Kwame, are unavailable or unaffordable in Ghana. Moreover, evidence supports the view that the Ghanaian government’s public health agenda is specifically focused on broad transformative health improvement and, in contrast with the U.K., it cannot meet or target the highly unusual ailments and extremely personalized care often documented by humanitarian claimants. Indeed, the deteriorating status of the health of the humanitarian claimants and the dynamic improvements in public health provision in Ghana appear to negatively correlate.

What remains unclear, however, is how a government agency responsible for immigration policy enforcement can simultaneously justly and impartially assess claims for humanitarian relief. The preceding sections have demonstrated that the burden remains squarely on the claimant to demonstrate medical need, the absence of appropriate care in Ghana, and that the U.K. has assumed responsibility of care. Although the U.K. Department of Health is actively consulting and revising guidelines pertaining to provision for “overseas visitors” as a whole, it remains the case that decisions about the

most pressing instances often reside with the Home Office and the BIA.²⁹ To some observers it would appear that the BIA has a direct conflict of interest in assessing such claims insofar as its primary government responsibility is the enforcement of immigration policy, which often involves curtailment of rights. To be sure, debating a “right to health” is of less interest to me than disentangling what appears to be a conflict of interest.³⁰ I suggest two possible sites of future research that may provide solutions to this predicament.

The first proposed remedy involves separating the immigration enforcement component from health and humanitarian questions entirely. Under this rubric, the BIA would remain the primary adjudicator of first response in humanitarian claims, but a separate sub-agency comprised of specialist medical personnel and related country conditions experts would meet to consider the medical claims against objective evidence for health provision in respective origin countries. Under this proposal, a separate determination of the merits of the claim would be produced independent of the immigration questions accompanying the threat of deportation. The benefits of such an approach are several. The agency would maintain overall management of such claims, consistent with U.K. immigration policy. At the same time, the incorporation of authoritative specialist voices from the medical and psychiatric fields would provide a level of

²⁹ Consultation papers from February 2010, entitled, “Review of Access to the NHS by Foreign Nationals,” http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_113233 [accessed 29 March 2013], and “Refusing Entry to Stay to NHS Debtors,” <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/consultations/nhs-debtors/consultation-document.pdf?view=Binary> [accessed 29 March 2013]. In the latter, amendments to immigration rules are proposed to make non-payment of NHS charges specific grounds for refusal of entry or further stay in the UK. See Stevens (2010) for discussion.

³⁰ For discussion on the right to health, see Harrington and Stuttford (2010); Anand et al. (2004); Daniels (1985, 2008); Gruskin and Grodin (2005).

legitimacy to the assessment of the diagnoses, prognoses, and questions about the necessity of care.

A second possible avenue involves removing BIA administrators from decision-making process pertaining to humanitarian claims entirely. Under this proposal, the current adjudication process is replaced with an appointed panel composed of medical and psychiatric professionals and country conditions experts, which would exist parallel to the BIA and present its recommendation to the BIA for consideration and evaluation. The BIA would continue to issue its own determinations. In the event that both evaluations were consistent, the onus for appeal (in negative cases) would rest on the claimant. In the event of inconsistent decisions, the determinations would be immediately subject to judicial review without requiring the claimant's petition for review. One benefit to this proposal would be that BIA personnel would no longer be placed in the position of interpreting and evaluating medical and psychiatric reports for which they have no specialist training. Such an approach would insulate medical professionals from any conflict of interest considerations and significantly reduce the burden of appeal placed on the claimant.

Conclusion

All parties involved in humanitarian claims face specific dilemmas. Immigration officers are charged with enforcing immigration policy and assessing the merit of human rights based claims. Immigration judges are charged with interpreting human rights statutes and conventions set against the specific deleterious conditions of particular Ghanaian claimants. And very ill Ghanaians are compelled to appear countless times in court and tribunals, arguing for essential medical care, cognizant of the costs involved and the deprivations faced by imminent deportation. Into this complexity, authoritative country conditions reports about healthcare provision, steeped

in the rich traditions of expert testimony, have the capacity to re-tether the biomedical narrative of the claimant to the real, lived experience on the ground. They provide an opportunity to assess the specific details of an individual facing a potentially terrible ordeal. Further, they are comprised by the fact that they follow a humanitarian logic, one which always relies on single and exceptional cases, which cannot argue for fundamental structural change to address the inequalities giving rise to the claim in the first instance.

The experiences of Kwame and Akua were no less harrowing than that of Ama Sumani. Collectively, they are also illustrative of the challenges humanitarian claimants face in demonstrating the urgency of their case for treatment and humanitarian relief. During a pending additional round of appeals, Kwame passed away quietly in his sleep in 2010 after complications caused by his, by then stage-four (terminal) metastasized, melanoma. In 2011, Akua won her appeal at the Upper Tribunal on the basis of the potential destitution and orphaning of her son if forcibly removed. Whereas the medical and psychiatric evidence and country conditions data abundantly demonstrated the necessity of care and its complete absence in Ghana, the judge sidestepped the debate between lawyers representing the BIA and Akua about the medical questions and adopted a clearer path by addressing the hypothetical needs of a by then six-year old child.

Ghanaian migrants pursuing humanitarian claims in the U.K. are increasingly invoking the poor quality and limited accessibility of medical and psychiatric treatments in Ghana. However, evidence from Ghana about the rapidly improving quality of care available as a direct result of government policy is frequently referenced by the BIA to detach such claims from the biomedical narrative in which they are embedded. Ironically, the evaluation of medical evidence falls in the lap of immigration officials with no medical training. It would indeed appear that a conflict of interest arises when an agency charged

with immigration enforcement simultaneously evaluates medical evidence without the requisite medical training. Moreover, evidence from Ghana rarely supports BIA arguments. Whereas healthcare provision is advancing across the country, the specialized care is often beyond the cost affordability and specialization level available in Ghana.

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MISSION MEDICINE IN A DECOLONISING HEALTH CARE SYSTEM: AGOGO HOSPITAL, GHANA, 1945-1980

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Based on the case of Agogo Hospital, this article provides a historical analysis of biomedical practice in rural Ghana. Until the 1950s, this mission hospital acted to a great extent autonomously from the colonial health care system and focused on curative medicine and hospital-based care. By the end of the 1970s, Agogo Hospital had become integrated into the national health care system and worked more in consonance with current policies that aimed at community-centred, preventive, and basic health care. The article reveals some of the continuities, ruptures and leaps, contingencies and possibilities that accompanied and shaped this process of integration and alignment. It shows how medical practice in Agogo emerged out of the changing constellations of different interests, ideas, conceptions, and values.

Keywords: Medical history, Christian missions, Ghana, decolonisation, mission hospitals, rural health care, nursing.

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Introduction

The article examines the development of medical practice at Agogo Hospital, which was established by the Swiss Basel Mission in 1931.² Today the hospital is run by the Presbyterian Church of Ghana (PCG) and serves as a district hospital for Ashanti-Akim North, Ashanti Region. The article analyses how configurations of interests, values, and ideologies shaped the development, transfer, implementation, and adaptation of medical concepts and health care strategies.

Until the early 1950s, the management of Agogo Hospital acted to a great extent autonomously from the colonial health care system, focused on curative health care, and mainly provided hospital-based medicine. In its first two decades of operation, the hospital was an exemplary institution for colonial mission medicine.³ By the end of the 1970s, the hospital had become integrated into Ghana's national health care system and had incorporated the international health care paradigms geared towards so-called "developing countries." These included preventive medicine, decentralised primary care and community-focused service provision, and a comprehensive understanding of health care encompassing socio-economic factors. Since 1979, Agogo Hospital has served as the district hospital for one of nine pilot districts for the implementation of the World Health Organization's (WHO) Primary Health Care (PHC) strategy in Ghana. Focusing on the central aspects of

² The Basel Mission was founded in Basel, Switzerland, in 1815. After attempts in the Caucasus and Liberia, the mission sent four missionaries to the Gold Coast in 1828, where the first mission field emerged. Later, the Basel Mission became active in Cameroon, India, and China. By the beginning of the twentieth century, a "mission community" of about 25,000 Christians with a staff of about 200 African teachers, pastors, and catechists, as well as an educational system of primary and middle schools and a seminary for teachers and pastors had developed in the Gold Coast (Jenkins 1989).

³ Vaughan (1991: 57); Hardiman (2006: 17–18, 2009: 199); Ityavyar (1992: 69); Mburu (1992: 96); Worboys (2004: 232–33); Bruchhausen (2009: 172).

medical practice at Agogo Hospital, the following discussion examines its development from a prime example of a colonial mission hospital to a PHC pioneer. The history considered here does not recount a steady process of integration or a continual shift from hospital-centred, curative medicine to community-focused, preventive, and basic health care. Rather, the process was curbed and accelerated by the changing constellations of actors in and around Agogo Hospital. These actors, who included doctors, nurses, and patients, mission and church authorities in Ghana and Switzerland, local, colonial, and national politicians, as well as church and non-governmental organisations in Europe, associated their expectations, values, and ideologies with different health care concepts and practices. Accordingly, these actors connected their interests and resources to specific forms of health care. By examining the changing constellations of interests, values, and resources, this article aims to *explain* the development and transfer of concepts and practices, as well as to analyse why they were developed and transferred in a specific manner, at a specific time, and with specific results (Osterhammel 2001: 477).

Legacy: Agogo Hospital before the Second World War

In 1947, when Agogo Hospital reopened after an eight-year closure, its management faced a changed political, socio-economic, and medical environment. It felt obliged to seek a new orientation concerning the hospital's medical practice and relationship with the government. Agogo Hospital, located in a rural setting off major roads and far from the district capital, consisted of a complex of buildings with over one hundred beds, an operating theatre, and X-ray facilities, along with the self-perception and reputation for providing technically high-standard medical services.

These qualities and characteristics were the result of a configuration of actors and processes in and around the hospital during the inter-war period. The bi-national Basel Mission,

associated with the German aggressor, had been forced to cease all its activities in the Gold Coast during World War I. This mission society had been a major player in the Gold Coast not only in religious life but also in education and trade. It had been involved in medical work, including the running of a small hospital at Aburi. When the first missionaries resumed their work in 1926, they faced an entirely new situation. The properties of the mission had been handed over to the Free Church of Scotland. Moreover, in 1918 an “independent” church, the future Presbyterian Church, had been established out of the Basel Mission parishes. The returning missionaries felt restricted in their activities by the new African church leaders and struggled for power and influence with their Scottish counterparts.⁴ Both theological and educational matters were beyond the control of the Basel Mission (Jenkins 1989, 2003: 197–204; Witschi 1970: 301–9, 320–25).

In this situation, Basel missionaries stationed in the Gold Coast strongly lobbied their leadership in Basel to resume medical work, since formal health care was an activity more or less free of African or Scottish influence yet charged with symbolic power.⁵ The missionaries envisioned a hospital in the

⁴ While the newly established Presbyterian Church was anxious to consolidate its status, Basel missionaries remained eager to expand their work into “heathen” territories. See Basel Mission Archive (BMA), D-4-1, “Komitee an die Stationskonferenz Kumase,” 5 March 1927; “Bellon an Komitee,” 28 June 1927; BMA, D-4-2-1, Schimming, “Jahresbericht 1929,” 1930; and Evangelische Missionsgesellschaft in Basel (1929: 36–37). Basel missionaries, who saw several of their plans turned down, reported being marginalized by the Presbyterian Synod and the Scottish Mission leadership: BMA, D-4-1, “Komitee an die Stationskonferenz Kumase,” “Komitee an die Stationskonferenz Kumase,” 30 May 1927, and “Bellon an Oettli,” 20 December 1927. Resentments on both sides led to negotiations between high-ranking representatives of the two missions: BMA D-4-7-3, Bellon, Henking, and Hartenstein, “An das Komitee der Basler Mission (Richtlinien über die weitere Zusammenarbeit mit den Schotten und der Eingeborenen-Kirche; Kopie),” 19 November 1931.

⁵ For Basel missionaries, a hospital should respond to needs and demands of

size and style of its predecessor at Aburi.⁶ However, a large financial contribution from the Union Trading Company (UTC), a subsidiary of the Basel Trading Company, the former Mission Trading Company, enabled a substantial extension of the original plans and thus the building of a 56-bed hospital with several separate pavilions (Witschi 1970: 318). Construction commenced in 1928, operation two years later. In 1931, Agogo Hospital was officially inaugurated. As a state of the art facility, the hospital received much praise. Its first medical superintendent proudly called it a “model facility.” The chief commissioner of Ashanti reported : “From the point of view of design, equipment and staff there is nothing to compare with this Hospital in the Gold Coast outside the Gold Coast Hospital.”⁷ After World War II, Agogo Hospital became the Presbyterian Church’s largest health care institution.

The hospital is situated on the road from Konongo at the entrance to the small town of Agogo, which had fewer than 5000 inhabitants in the 1930s. There was an old link between the Basel Mission and Agogo. In 1869, Fritz Ramseyer, the founder of the first Basel Mission station in Kumasi, passed

the local population, serve as a means of reaching the people, and ultimately become an instrument of evangelisation. See BMA, D-4-2-1, Wilhelm Schäfer, “Jahresbericht 1926,” 1927; BMA, D-4-1, “Bellon an Komitee,” 4 November 1927. This initiative re-animated the mission’s reputation as a pioneer and strengthened its position as an important partner of the Presbyterian Church, since medical work was a concern for at least some of its African leaders (Parsons 1963: 143). Jenkins (2003) implies that the hospital was the result of the Church taking advantage of the rivalry between the two missions. This seems plausible though not confirmed by evidence consulted for this study. A few years before the Basel Mission opened Agogo Hospital, the Scottish mission had built its own “monument” in the form of the new teachers seminary at Akropong – a project “on a much larger scale than anything the Basel Mission had put up before 1914, and ... far more ‘official’ in its architectural style” (ibid: 202–3).

⁶ BMA, D-4-1, “Bellon an Oettli,” 20 December 1927.

⁷ BMA, D-4-2-1, William Stokes, “Jahresbericht 1930,” 1931; Public Records and Archives Administration Department (PRAAD) Kumasi, ARG1/3/3/40, “Acting CCA to Acting Colonial Secretary,” 23 June 1930.

through Agogo with his wife, dying child, and a colleague as prisoners of the Asante General Adu Bofo. In various accounts, the hospitality extended by the Agogo people towards the prisoners is linked with the building of the hospital six decades later.⁸ Yet Agogo was not the location initially desired by the Basel missionaries. Rather the places they selected, Mampong and later Juaso, were rejected by the Scottish missionaries and the government respectively.⁹ The hospital's location remained controversial. Only a few years after the hospital's opening, Agogo's second medical doctor criticized the place as being too remote.¹⁰ Following World War II, the location raised discussion about the hospital's *raison d'être*.

During the 1930s, the hospital's technical standard and its medical work were the subject of a severe conflict, with the Agogo medical staff taking one side of the debate and the mission's leadership in the Gold Coast and in Basel the other. At the centre of the dispute was the hospital's strategic orientation. The hospital was meant to be financially self-sustaining and later – in the view of the Mission House in Basel – even generate revenue to be invested into other missionary activities.¹¹ The hospital management sought to expand

⁸ Interview with Nana Akuoko Sarpong, Accra, 17 February 2009; Agogo Hospital Library, "Agogo Hospital – 70th Anniversary Celebration," 2001, 19–20; "History Agogo Presbyterian Hospital," agogopresbyhospital.org, n.d., <http://www.agogopresbyhospital.org/?q=node/2>, accessed 2 November 2011.

⁹ BMA, D-4-6,2, "Huppenbauer vor Komitee," 14 February 1934. Juaso was the only district capital without a medical officer; PRAAD Accra, CSO11/14/19, "District Commissioner Ashanti-Akim to Commissioner Eastern Province Ashanti, Kumasi," 8 December 1928. Ironically, the building of Agogo Hospital was used as an argument against stationing a medical officer at Juaso – the town only received a medical facility in 1961; PRAAD Accra, CSO11/14/19, "Senior Medical Officer, Kumasi, to Chief Commissioner, Ashanti," 21 March 1929.

¹⁰ BMA, D-4-2-1, Carl B. Huppenbauer, "Annual Report 1931/32 (to Medical Department)," 1932.

¹¹ Ibid.; BMA, D-4-5-1, "Oettli an Leitung Agogo," 26 May 1933; BMA, D-

services and enhance quality. It tried to generate additional income by improving the hospital's attractiveness to European and economically well-off Ghanaian patients from Kumasi and Accra, and by making arrangements with companies such as UTC and Konongo Gold Mines. The management considered high technical standards, a large number of patients, and the running of outstations as crucial for economic survival.¹² However, the missionaries stationed in Kumasi and their leadership in Basel emphasized "proper" missionary work, meaning evangelisation, at the expense of medical work. This stand reflected a specific missionary medical discourse identified by Megan Vaughan (1991: 65): "For medical missionaries the healing of the body had always to take second place to the winning of the soul and the fight against the 'evils' of African society." In accordance with the function assigned to the mission hospital within medical missionary circles (Hardiman 2006: 25), Agogo Hospital was to become a place where people would be healed and hear the word of God; a space where the soul was as much cared for as the body.¹³ The Mission House, seeking to save on expenditures, opted to restrict the number of patients and refer some of them to medical facilities in Kumasi or Accra. The extent of the

4-5-4, "Inspektor an Stationskonferenz," 21 May 1937.

¹² BMA, D-4-5-4, "Stationskonferenz," 17 May 1936; "Stationskonferenz," 21 June 1937; BMA, D-4-5-5, "Stationskonferenz Agogo," 16 July 1938; BMA, D-4-6-2, "Huppenbauer: Privat-Protokoll (Ergebnisse des Besuches des Präses Bellon in Agogo)," 11 December 1933.

¹³ See the published annual reports: "Gebe Gott, dass Agogo, wie einst Aburi, eine Segensstätte werde, ein Ort, wo Schwarze und Weisse Heilung und Erquickung nach Leib und Seele finden können" (EMB 1928: 39). Or, "Gott gebe, dass so Agogo eine Stätte werde, da viele Mühselige und Beladene nicht nur leibliche Hilfe, sondern auch die Ruhe für ihre Seele finden, die der Herr allen verheisst, welche im Glauben zu ihm nahen!" (EMB 1930: 37).

medical practice was to be reduced in favour of proper “mission work.”¹⁴

This conflict led to the dismissal of the medical superintendent in 1938. The hospital management was criticised for neglecting the evangelising function of the hospital and putting too much weight on “medical-technical” work. Agogo, the “most comfortable and best equipped” hospital in all of the Basel Mission fields, was not to become “a European clinic transplanted to Africa.”¹⁵ Indeed, the conflict about finances and technical standards included other elements: the autonomy of the medical doctors in Agogo vis-à-vis the Mission House, their relation to missionaries on the ground, apparent disparities between the behaviour and discourse of individual doctors on the one hand and the predominant values and interests within the mission on the other, and last but not least, some of the German hospital staff’s ideological closeness to national socialism (Schmid forthcoming).

In 1938, the Mission House recruited a new superintendent whom it expected to correspond with the missionary ideals and not suffer from the “known medical superiority complex.”¹⁶ Yet World War II began only a few months after the new doctor’s arrival, and in 1940 the entire German staff including the doctor and all but one nurse was detained and the hospital closed.¹⁷ By that time, the hospital’s capacity had increased

¹⁴ BMA, D-4-5-4, “Stationskonferenz,” 21 June 1937; BMA D-4-5-5, “Inspektor an Stationskonferenz,” 16 November 1938.

¹⁵ BM A, D-4-5-4, “Kellerhals an Station Agogo Spital,” 26 September 1936; BMA, D-4-5-5, “Bericht über das Missionsspital Agogo,” 16 May 1939.

¹⁶ BMA, D-4-5-5, “Inspektor an Büchner,” 26 January 1939.

¹⁷ At the outbreak of World War II, the Basel Mission was divided into a Swiss and a German branch which allowed the former to remain active. After World War II, the Basel Mission was able to gradually extend its activities, with health care becoming one of its primary enterprises. By the 1960s, the missionary staff had reached the same strength as prior to World War I (Jenkins 1989, 2003; Witschi 1970; Beeko 2004).

from 56 to 115 beds, several additional buildings had been erected, and technical equipment included an electrical plant, a state-of-the-art operating theatre, and an X-ray facility. After the outbreak of the war, the British army took over this equipment; it would prove difficult for the Basel Mission to get it back in the post-war period.¹⁸ Nevertheless, the hospital's reputation and self-perception as having high technical standards survived the war intact.¹⁹

Reopening and Reorientation

Reopening the hospital depended on the employment of a new Swiss medical staff. The search for doctors, which had begun prior to the end of World War II, proved particularly difficult, as candidates not only needed medical qualifications but also share the mission's "inner attitude." The first medical superintendent fell ill after a few months. His successor left Agogo and joined the colonial medical service when a conflict, similar to the one of the 1930s, over the doctor's ambitious expansion plans and lack of missionary orientation seemed imminent.²⁰ Finally, from 1950 onwards, the hospital was in the firm grip of "real missionary doctors" who committed themselves to a course that would steer the hospital in a new direction. According to Arnold Brack, who took charge in 1950, the location was suitable for neither a general hospital nor a "*Maternité enterprise*" – other missions were building hospitals in more populated areas and along main roads.

¹⁸ BMA, D-4-6,3, "Büchner an Golder," 10 April 1946; "Golder an Kellerhals," 5 October 1946, "Golder an Kellerhals," 16 November 1946.

¹⁹; BMA, D-4-6,3, "Golder an Kellerhals," 15 March 1947; "Golder an Kellerhals," 12 October 1947; Seku, "Dr. Golder, Agogo," *Ashanti Pioneer*, n.d. (1947).

²⁰ BMA, D-4-6,3, "Witschi an Neumann," 23 December 1949; Hermann Witschi, "Bericht über den Aufenthalt auf der Goldküste und über die besondern Fragen betr. Salaga und Dr. Neumann," 17 January 1950; "Witschi an Neumann," 10 November 1950.

Government services had improved their technical standards and, in contrast to the 1930s, Agogo Hospital was unable to compete with the hospitals in Accra and Kumasi for well-paying patients. Agogo's only solution, Brack concluded, was specialisation. He considered turning it into an ophthalmologic centre or a tuberculosis hospital, the latter of which he deemed especially important for the Gold Coast. Moreover Brack suggested training local nursing staff "in terms of Diaconia."²¹ Hans Meister, Brack's successor who was to hold the post of medical superintendent from 1952 to 1975, shared Brack's assessment. In the following decades, all three fields mentioned by Brack – tuberculosis, nurses training, and ophthalmology – were to play a central role.

Immediately after his arrival in 1952, Meister advocated a focus on tuberculosis. Such a clinic would perfectly fit with the missionary aims, not only because of the parallels with the Christian tradition of caring for lepers (Worboys 2000: 213–14), but also because tuberculosis patients would remain at the hospital for longer stays. Such patients were inclined to be "unusually grateful," as Meister had learned from his experience as a missionary doctor in China. Nurses training promised to be "something of high missionary value" if it took on the character of a "real boarding school." Although Meister feared that government subsidiaries would be necessary for both the nurses' training school and the tuberculosis clinic, he remained cautious about seeking state support. Instead, he advised that all risks involved should be considered carefully.²² The concern for "independence from the Government" was an

²¹ BMA, D-4-6,3, "Brack an Witschi," 4 September 1950; Cf. "Protokoll der Spitalkonferenz," 21 October 1950.

²² BMA, PS1-B05-03-1019, Hans Meister, "Spital Agogo. Erste Eindrücke, Gedanken und Vorschläge," 8, 22 April 1952.

anxiety he shared with his predecessor, as well as with the mission leadership in Basel.²³

Nurses Training and the State

The reopening of Agogo Hospital took place in a socio-political environment of rapid change. After the events of World War II had transformed the character of colonialism, development and welfare became key themes of the colonial state.²⁴ In the Gold Coast, the dynamic and turbulent post-war years set the stage for a powerful movement towards self-government and the new constitution of 1951. The 1940s were also a period of major reforms in the colonial health care system, in the course of which the political and medical authorities displayed diverging views. The director of medical service (DMS), James Balfour Kirk, propagated the implementation of a “Policy of Preventive Medicine.”²⁵ Kirk’s ideas, however, did not meet with the approval of the political administration, which was not ready to bear the cuts in curative medical services and the concomitant political costs it expected would result from these plans.²⁶

²³ BMA, D-4-6, 3, “Witschi an Brack,” 21 July 1949.

²⁴ The extent to which this happened as a legitimation and response to critics in the metropole, as a reaction to growing discontent among the local population, or as a means for more effective exploitation of the colonies cannot be discussed here, but see Gocking (2005: 97); Cooper (2005: 157); Rodney (1981: 213–15); Shipway (2008: 116); Clarence-Smith (1994: 73–74); Frimpong-Ansah (1992: 23–25).

²⁵ Kirk envisaged a system based on district hospitals and health centres, an administrative reform that would result in the creation of Department of Public Health with a hospital branch; the training of sanitary inspectors, health visitors, community nurses, dispensers, and midwives; the rehabilitation and improvement of existing district hospitals, as well as “a general clean up of the country by means of mass survey and treatment campaigns, combined with the provision of water supplies and other essential sanitary apparatus and improvements.” PRAAD Accra, CSO11/1/646, Balfour Kirk, “Memorandum on the Type of Department Which Will Be Necessary to Implement a Policy of Preventive Medicine of the Gold Coast,” 5 July 1943.

²⁶ A conflict emerged between DMS and Governor Burns about the

Rather in 1948, the government launched a major hospital-building programme that took advantage of the economic upwind, caused by rising prices for cocoa and other export goods (Addae 1997: 77; Gocking 2005: 99), as part of a considerable increase in expenditures for the Medical Department (Patterson 1981: 112).²⁷ While the late 1940s and the early 1950s saw the realisation of hospital projects and other programmes initiated by Governor Burns, preventive medicine and rural health only became crucial for health care policies by the mid 1950s.

At Agogo Hospital, the relationship with government only played a minor role in its development until the early 1950s. Apart from administrative matters, state collaboration was restricted to consultations with the district office in Juaso and its support limited to the refunding of import duty. Yet following the Nigerian example and the Maude Commission's (Gold Coast 1952a) recommendations on "health needs," the colonial government began systematically to promote and support medical work by missions (Gold Coast 1951, 1952b: 5; Parsons 1963: 148–50).

The new policy led to an increase in mission hospitals from three to 27 between 1951 and 1960.²⁸ The majority of these medical institutions were Catholic.²⁹ By the end of the

relationship between "curative" and "preventive" medical work; Kirk had to retire prematurely in 1944 (Addae 1997: 76–77).

²⁷ PRAAD Accra, CSO11/7/28, Kirk, "Report on Medical Department by DMS," 1943.

²⁸ In the same period, the number of government hospitals increased from 31 to 33 (Addae 1997: 89). In 1951, Agogo with over 100 beds was the largest among the three mission hospitals: Jirapa Maternity in the Northern Region had 14 beds, Worawora Hospital 18 (Gold Coast 1952a: 63).

²⁹ In 1961, 23 of the 38 church-affiliated and missionary medical institutions listed by the Ghanaian government were Catholic; BMA, PS1-B05-03-10198, Hans Meister, "Bericht vom Synod Cttee Meeting, 4.-6. 7. 1961, Besprechung im Ministry of Health am 7. 7. 1961," 17 July 1961. In 1969, the medical facilities affiliated with the Church Hospital Association of Ghana (CHAG, now Christian Health Association of Ghana) included 25

1950s, the Basel Mission, in addition to Agogo Hospital, was running three other clinics and hospitals, one of them owned by the government, the others by local authorities.³⁰ The promotion of mission medicine and the increasing presence of mission societies in health care were to form the basis for the important role that faith-based organisations have played, and continue to play, within Ghana's health care system.³¹

Staff training was one of the main measures the government considered in order to extend health care services. While the 1951 development plan emphasised doctors and the new grade of "Clinical Superintendents," the following year the government appreciated the Maude Commission's emphasis on training auxiliary and nursing staff (Gold Coast 1951: 19, 1952b: 1). The 1959 development plan recommended increasing staff numbers as the "most urgent need" (Ghana 1959: 48). Accordingly, the Ministry of Health approved the project of nurses training at Agogo. In 1950 the hospital, which prior to World War II had informally educated male and female African "auxiliaries," began formal nurses training. The first Agogo trainee graduated as a qualified registered nurse (QRN) in 1952. Since 1953 the hospital has received government subsidies for its nurses training programme. By 1956, the government had granted the hospital "full and definitive acknowledgment."³² Beginning in 1958, about ten nurses

Catholic and 9 Protestant (i.e. Methodist and Presbyterian) hospitals, as well as 13 Catholic and 11 Protestant clinics (Church Hospital Association of Ghana 1969: 32).

³⁰ In 1955, the Basel Mission began operating its clinic in Bechem and the 34-bed Dormaa State Hospital, both supported by traditional authorities. In 1956, the mission took over the operation of the government hospital in Bawku and the responsibility for the new Child Welfare Clinic, Bolgatanga.

³¹ In 2005, CHAG claimed responsibility for 27 percent of the Ghanaian health staff and 33 percent of all hospital beds (Christian Health Association of Ghana 2006: 15–20).

³² BMA, PS1-B05-03-10198, Hans Meister, "Jahresbericht 1953," 19 January 1954, and "Jahresbericht 1956," 1957.

qualified annually, by the 1960s over twenty.³³ Thus nurses training became a “core business,” because of the need for staff at Agogo, as well as at other Basel Mission hospitals and clinics. Additionally, nurses training contributed to the missionary call and the exemplification of Christian ideas, since the hospital’s everyday work stood at the centre of medical practice. Nurses training became the perfect vehicle to implement these ideals.³⁴ For students, this meant that a daily routine, oriented at the inculcation of Christian and Swiss values, was part of their training. They were subjected to regulatory, personal, and architectural means of control.³⁵

³³ Graduation figures included: in 1950, one nurse; 1952, two; 1953, one; 1955, five; 1958, 11; 1959, nine; 1960, six; 1963, 21; and in 1964, 26.

³⁴ Addressing the 1959 PCG synod, Meister noted: “Every Christian is aware that the service of the Good Samaritan must be in [sic] indispensable part of his daily life, wherever he is if only he follows Christ in real faith. But the Christian Church herself also should express this essential side of her faith and help her members to do it. ... To help the sick needs a certain training and skill. Therefore it is one of the main objectives of a Christian Hospital to train young people in medical professions, especially in nursing, i.e. to instruct them in the respective knowledge and practice and to foster a spirit of compassion and love in them.” Meister sought for each nursing pupil “the patronizing cooperation of the pastor” of his or her hometown as “a helpful spiritual link between Hospital and Church” (PCG 1959: 13–14). Cf. Meister (1953); BMA, PS1-B05-03-10198, Hans Meister, “Jahresbericht 1952,” 17 February 1953, “Annual Report 1957,” January 1958; BMA, SV-273, Verena Fiechter, “Jahresbericht 1960,” 1961, and “Kurzbericht von Schwester Vreni Fiechter,” 15 October 1965.

³⁵ This included the introduction of staff associations, institutionalised meetings, house rules, punitive measures, incentive measures, accommodation on the hospital compound, the exclusion of family members, and the design of the premises for the nurses training school; cf. Sophia Asante Agyarko’s memories (Agogo Nurses Training College 1996: 44–45); BMA, PS1-B05-03-10198, Hans Meister, “Jahresbericht 1952,” 17 February 1953; “Protokoll der Spitalkonferenz 9.-10. August 1952,” 10 August 1952; BMA, BM SV-273, Verena Fiechter, “Kurzbericht von Schwester Vreni Fiechter,” 15 October 1965; Schweizerisches Bundesarchiv Bern (BAR), E2005A/1978/137/221, Basel Mission, Pressemitteilung, “Einweihung eines vom Bund mitfinanzierten Entwicklungsprojekts,” 25 July 1964.

Nurses training corresponded with the interests of the Basel Mission and the Presbyterian Church, the latter taking over the medical work in the early 1960s.³⁶ Nurses training became the first area of collaboration between Agogo Hospital and the government. Since nurses training could not be entirely financed by the hospital's earnings, it relied on government subsidies. This support increased after independence, when the Swiss head of the Agogo Nurses Training School became an elected member of the new Ghanaian Nurses Board. The plan to train senior registered nurses (SRNs), who had a higher qualification than the QRNs, was approved in 1961 in accordance with government policy.³⁷ In turn, the government contributed substantial funds for needed structural extensions. At the same time, nurses training attracted the interest of the new Swiss Service for Technical Cooperation.³⁸ The Swiss

³⁶ Although PCG took over the medical work in 1961, the Basel Mission continued to exert major influence by providing for the expatriate staff in terms of recruitment and payment. Rev. Ernst Peyer, Basel Mission secretary in Ghana, served as the first secretary of the PCG Medical Work Committee until 1970, when he was succeeded by the Ghanaian, Rev. A. L. Kwansa.

³⁷ Plans to replace the training of QRNs with SRNs were first developed in the early 1940s but were "postponed" several times; cf. PRAAD Accra, CSO11/7/28, Kirk, "Report on Medical Department by DMS," 43, 1942; "Memorandum on the Training of Hospital Nurses on the Gold Coast," 15 February 1943. By the end of the 1960s, the new grade of "Enrolled Nurses" had taken over QRN training (Kisseih 1968: 209–10).

³⁸ After World War II, the Swiss government provided aid for Western and Southern Europe and launched a bilateral "technical aid" for countries in Asia and South America in 1948. This bilateral technical aid remained limited in scope, restricted to the deployment of experts and scholarships, until 1960 when the founding of the Service for Technical Assistance marked the beginning of a substantial extension and professionalisation of Swiss development aid. In 1961, "technical corporation" replaced "technical assistance," as the service came under the authority of the Political Department (ministry of foreign affairs). The Swiss federal parliament allocated CHF 60 million for technical cooperation for a three-year period. Only a small fraction of these funds, 3.5 percent between 1962 and 1964, went into bilateral cooperation "on the ground" (rather than into multilateral cooperation and scholarships) that were earmarked for projects run by Swiss

authorities, in concordance with Ghana's government, considered such training an explicit need to secure a qualified nursing staff. In addition nurses training would strengthen the existing role of Swiss organisations in Ghana, such as the Basel Mission and several private commercial enterprises in education. Further, it would constitute a politically "unsuspicious" way to "cultivate Western ideas."³⁹ The Swiss government contributed two-thirds of the funds, the Ghanaian government one third for the construction of the Agogo Nurses Training School that opened in 1964.

By uniting the interests and values of different stakeholders that included the Ghanaian and the Swiss governments, the Presbyterian Church and the Basel Mission, nurses training developed into a central element at Agogo Hospital and, more generally, in Presbyterian medical work. A temporary setback in the late 1960s, when the hospital lost its accreditation as an SRN training institution, did not affect the crucial role nurses training played for the hospital's development. The presence of a sufficient nursing staff, with numerous trainees, was a precondition for the maintenance of a large and growing hospital service. In addition, Agogo's significance in the training of nurses for Presbyterian institutions, as well as for other churches of different denominations, justified the maintenance of high technical standards, even if they were at odds with prevailing conceptions of health care in a rural setting during the 1960s and 1970s.

charity and mission organisations (Perrenoud 2010: 6-8; Waldburger, Zürcher, and Scheidegger 2012: 25-39, 51-53).

³⁹ BAR, E 2001(E)1976/17/ 448 (orig.) and dodis.ch/15536, Raymond Probst, "Westafrikareise (Ende März - Anfang Mai 1961)," 15 May 1961; BAR, E 2003-03(-)1976/44/ 165; t.941.1 and dodis.ch/30252, Hans Keller, "Technische Zusammenarbeit mit Ghana und Nigeria," 14 May 1962.

Tuberculosis Work without the State

The development of a tuberculosis station was Meister's first choice for "specialisation" at Agogo Hospital. However, the treatment and care of tuberculosis patients never managed to connect the interests, values, and conceptions of other stakeholders to the extent that a supportive constellation emerged. This was despite the fact that the government did invest in measures against tuberculosis. Before World War II, even though tuberculosis was perceived as a growing threat to public health, the limited measures against the disease remained restricted to urban centres and mining areas (Addae 1997: 387–91; Patterson 1981: 65–66; Dumett 1993).⁴⁰ After the war, with tuberculosis rising high on the international health agenda, the authorities tackled the disease more systematically and established the Tuberculosis Services for the entire Gold Coast in 1954. These services followed, albeit with some delay, the concepts of tuberculosis treatment and control for "developing countries" as stipulated within transnational scientific networks.⁴¹ The Gold Coast Tuberculosis Services focused on case-finding, isolation, and treatment.⁴² In contrast to other parts of the colonial world, there were no wide-scale *Bacillus Calmette–Guérin* (BCG) vaccination campaigns in British West Africa.⁴³ By the end of the decade, tuberculosis control in Ghana had shifted towards "prevention" with a particular focus on BCG vaccination (Koch 1960; Koch and Marolda 1961).

⁴⁰ For a similar approach in other British colonies, see Harrison and Worboys (1997: 109, 117–18).

⁴¹ See Amrith (2004); Brimnes (2008); McMillen and Brimnes (2010); Raviglione and Pio (2002); Litsios (2008: 96–97).

⁴² See British Tuberculosis Association (1950); WHO (1958: 189–92); Gold Coast (1952a: 51).

⁴³ Patterson (1981: 66); Harrison and Worboys (1997: 118); McMillen and Brimnes (2010: 182–183); Packard (1989: 291); Wilcocks (1960: 35–36).

Throughout the 1930s, Agogo Hospital had reported an increase in the number of tuberculosis patients and considered to convert its leper settlement into a tuberculosis unit, which met with opposition from the Basel Mission House.⁴⁴ In 1948, soon after reopening, the disease became a prominent issue, when the hospital's first post-war medical superintendent, Otto Golder, was infected with severe pulmonary tuberculosis. The fact that two nurses had also acquired the respiratory disease, prompted the Mission House to consider abandoning the treatment of tuberculosis patients altogether. Golder, however, vigorously opposed this idea.⁴⁵ His successors extended the hospital's tuberculosis work. Brack converted the leper settlement of a few huts that offered room for about 24 patients into a provisional tuberculosis ward and introduced chemotherapy.⁴⁶ In 1952, Meister added surgical measures such as pneumothorax, phrenic crush, thoracoplasty, and plombage.⁴⁷ Since these methods had become increasingly rare in Western countries due to effective chemotherapy, it was

⁴⁴ BMA, D-4-2-2, Forster, "Jahresbericht 1934," 1935; BMA, D-4-5-4, "Stationskonferenz," 22 March 1937; BMA, D-4-5-5, "Stationskonferenz," 20 January 1938; BMA, D-4-2-4, Gotthold Süss, "Jahresbericht 1939," 1940. The mission leadership expected a higher workload and higher risk for the European sisters and did not want to give up the leper work, which had begun only a few years earlier. BMA, D-4-5-5, "Inspektor an Station Agogo," 22 February 1938, and "Inspektor an Station Agogo," 20 June 1938.

⁴⁵ BMA, D-4-6, 3, "Golder an Kellerhals," 5 July 1948.

⁴⁶ BMA, D-11,9, Arnold Brack, "Bericht 1. August 1948 bis 1. April 1949," 1949.

⁴⁷ These surgical interventions aimed at collapsing the parts of the lung with open cavities to promote the healing process and limit the spread of infection. This was achieved by the removal of ribs (thoracoplasty that required several interventions and had a highly disfiguring effect), the introduction of air into the pleural space (induced or artificial pneumothorax, required regular air refills), the introduction of an object into an artificially created extrapleural space (extrapleural plombage with paraffin or porcelain balls), or the cutting of the phrenic nerve (phrenic nerve crush); see Shields et al. (2009: 792–93, 807–15, 1149–50); Weissberg and Weissberg (2001: 849–50).

controversial among medical circles whether they remained justified and ethical.⁴⁸ For an African context, critics rejected them as too expensive. Meister, however, continued to promote the surgical treatment of pulmonary tuberculosis. At a conference of the West African Council for Medical Research in Nigeria and in a corresponding article in the *West African Medical Journal*, he argued that even with the limited facilities available in many hospitals in the region, satisfying results could be achieved with thorax surgery at a significantly lower cost than alleged by critics (Meister 1959).⁴⁹

For Agogo, Meister accordingly opted for a “tuberculosis hospital ... with the possibilities for active therapy,” which included chemotherapy and surgery, instead of a sanatorium with “conservative therapy,” where only non-critical cases would be treated and incurable patients cared for.⁵⁰ The Basel Mission House, concerned about the proximity of the mission girls’ school to the hospital, was not very enthusiastic about these ideas.⁵¹ However on several occasions, Meister received encouraging signals from the Gold Coast’s first tuberculosis specialist and from the minister for health concerning government support for the extension of his tuberculosis work at Agogo.⁵² Meister developed plans for a large tuberculosis department with new wards, as well as an extra outpatient unit and consultation rooms. He stressed the danger of infections

⁴⁸ See the 1955 controversy among the correspondents of the *British Medical Journal*: Livingstone (1955); Lloyd (1955); Brailsford (1955); cf. Philip (1955); Cameron (1955).

⁴⁹ BMA, PS1-B05-03-10198, Hans Meister, “Bericht über den Besuch der ‘Conference on Tuberculosis and Leprosy of the West African Council for Medical Research’ in Jos vom 17. - 20. Februar 1959.”

⁵⁰ BMA, PS1-B05-03-10198, Hans Meister, “Spital Agogo. Erste Eindrücke, Gedanken und Vorschläge,” 22 April 1952.

⁵¹ BMA, BM D-4-6,3, “Witschi an Brack,” 24 April 1951.

⁵² BMA, PS1-B05-03-10198, Hans Meister, “Jahresbericht 1952,” 17 February 1953, “Rundbrief,” 26 November 1955, and “Jahresbericht 1955,” 1956.

caused by the numerous outpatients who had arrived from beyond Agogo and stayed in town while receiving treatment. The former leper huts, which were “very primitive” and quite far from the hospital, did not provide sufficient space to accommodate all patients.⁵³ In 1957, as tuberculosis policies on the national and transnational level took another direction, Meister reported that, “after initial promises, government has let us down” in respect to a tuberculosis hospital.⁵⁴ The same year on a visit to Agogo, Ghana’s minister of health, J. H. Alhassani, cited financial reasons for the government’s lack of assistance.⁵⁵

It is evident that Meister’s vision of high-standard curative medicine increasingly diverged from Ghanaian and transnational tuberculosis control strategies with their emphasis on “prevention” through BCG immunisation, decentralised basic and free treatment, and centralised expertise. Beginning in the mid-1960s, the integration of tuberculosis services into general health services, home treatment, and “simplified technology” were propagated at the global level (Amrith 2004: 128; Raviglione and Pio 2002: 776; WHO 1968: 129). In Agogo, tuberculosis care and treatment remained similar to the methods of the 1950s. The former leprosy settlement continued to accommodate about 100 inpatients per year. Until his retirement in 1975, Meister annually performed up to 30 interventions against tuberculosis. He prescribed outpatients chemotherapy and informed them about preventive measures, although follow-up visits for home treatment were not organised until the late 1970s. Since the early 1970s, Agogo provided BCG and other vaccinations to children. Indeed, paediatric work was to become an important objective, which

⁵³ BMA, PS1-B05-03-10198, “Meister to Minister of Health,” 10 January 1956.

⁵⁴ BMA, PS1-B05-03-10198, Meister, “Jahresbericht 1956,” 1957.

⁵⁵ BMA, PS1-B05-03-10198, Haaf, “Jahresbericht 1957,” 1958.

integrated Agogo hospital better within current health care strategies than the previous emphasis on tuberculosis during the 1960s and 1970s.

Preventive Medicine and Mission Medicine

In 1958, the WHO public health advisor to the government of Ghana, Axel Höjer, visited Agogo Hospital. Höjer, a Swedish physician, socialist, and director of the Swedish National Board of Health between 1935 and 1952, was well-known for his “efforts toward socializing medicine” (Johannisson 1994: 179). Meister reported that Höjer advocated the “nationalisation” of medical services and wanted to introduce the “Swedish system.” Höjer suggested that Agogo be made the district hospital for Kumasi East, take over the responsibility for out-stations, and function as a child welfare centre. Meister anticipated “all kinds of problems” arising from an integration of the hospital into Höjer’s plans but saw no possibility of resisting such a development in the long run: “If the state wants to assert its authority, a church hospital will not be able to resist, merely out of financial reasons. ... But all this is some distance away. I still don’t consider it wise for us to seek closer connection to the government, as long as there are other ways.”⁵⁶ Indeed, a nationalisation of the mission hospitals in Ghana was not to take place. In the long run, however, Höjer’s idea of a different role for the Agogo Hospital in the local health care system was to materialise.

In 1960, the Ghanaian cabinet approved a scheme for the improvement of rural health care, the centrepieces of which were health centres, community nurses, maternity and child welfare clinics, and the strengthening of the district level within the health care system.⁵⁷ This was not the first scheme of its

⁵⁶ BMA, PS1-B05-03-10198, Hans Meister, “Jahresbericht 1958,” 1959.

⁵⁷ PRAAD, Accra, ADM13/1/29, “Cabinet Meeting, Agenda, Item 2,” 15

kind but rather, despite new rhetoric and high ambitions, an adjustment and extension of the existing structure of health visitors inherited from the colonial era. The scheme was one of many examples that sought to highlight “public health” and “preventive medicine” as catchphrases of a “modern” national health policy and thus becoming an integral part of development plans and rhetoric. To what extent such conceptions were implemented and had an impact on the national health care system and people’s health remains debatable and was indeed debated at the time.⁵⁸

Agogo Hospital faced new concepts of “preventive medicine,” health education, and outreach work as part of the government agenda for “modern development,” which was related to the danger of “state interference into the Christian freedom” at the hospital, as Meister explained in 1961.⁵⁹ A certain amount of educational work was done in the waiting and consultation rooms and, as a concession to “modern development,” the hospital opened a “Well Baby Clinic” where

January 1960.

⁵⁸ In 1961, Sir Selwyn Selwyn-Clarke, who previously had served as deputy director of health service in the Gold Coast during the 1920s and 1930s, painted a picture of retrogression in his report at President Nkrumah’s request: “The present preventive or public health section of the Ministry of Health in Ghana is a pallid shadow of its former self, and until the position is rectified ... there is no possibility of regaining lost ground” (British Medical Association 1962: 1818). In its 1968 development plan, the National Liberation Council sharply criticised the Nkrumah government’s health care policy: “In the past large expenditures have been made on hospitals but these have been distributed unevenly throughout the country. ... With many projects half-way to completion, it was impossible to make a radical change in the pattern of development expenditure, without sacrificing completely the large amounts of money already committed. Yet once the new hospitals were built they would tend to worsen the existing regional imbalance and the excessive emphasis on curative rather than preventive health. The Government considers that the highest priorities are to provide preventive health services and to improve health services in the hitherto neglected regions” (Ghana Government 1968: 92).

⁵⁹ BMA, PS1-B05-03-10198, Hans Meister, “Jahresbericht 1960,” 1961.

“healthy” children were examined each week for half a day.⁶⁰ For Meister, the core business of a Christian hospital, however, remained its curative services. It is symptomatic of this objective that the hospital’s new operating theatre, inaugurated in the presence of Health Minister Alhassani in 1959, was funded by private donors from Switzerland and Ghana. Meister’s statement at the inaugural meeting of the Ghana Medical Missions Fellowship in 1960 is an illustration for what scholars such as Vaughan (1991: 57) and Michael Worboys (2004: 233) have identified as medical mission discourse in comparison with colonial public health work:

The state tends to see only good hygienic condition in the country and a healthy people ... whilst *we* [original emphasis] are called to see the individual patient in its needs as a person and even as a prospective child of God, and we claim that the real building up of a healthy community can be done only if this basic requirement is not neglected. And we think we have a definite responsibility, not only for the individual soul, but also for this community.⁶¹

In 1961, after Ghana had been proclaimed a republic, the cabinet debated the conditions under which the state should grant support to mission hospitals. It approved five of the ten conditions proposed by the minister of health. Among the approved conditions was a paragraph ruling “that irrespective of whether Government subsidy is accepted or not each hospital should be developed to fit into the ultimate health programme of the Ministry of Health.”⁶² Since 1952, Meister had been worried about the loss of self-determination and

⁶⁰ Ibid.

⁶¹ BMA, PS1-B05-03-10198, Hans Meister, “Ghana Medical Missions Fellowship: Introduction to Meeting at Agogo, 24./25. 9.1960,” September 1960.

⁶² PRAAD, Accra, ADM13/2/74, “Cabinet Meeting, Agenda, Item 5,” 2 August 1960; PRAAD, Accra, ADM13/1/29, “Cabinet Meeting, Minutes,” 2 August 1960.

Christian identity as a possible consequence of government subsidies.⁶³ Now he became alarmed about the above paragraph's potential to give the ministry control over strategic decisions of mission hospitals, even if hospitals did not accept government subsidies. At a meeting between representatives of mission and church medical institutions and the Ministry of Health, Meister received assurance that the government would not interfere with the management and staffing of mission hospitals.⁶⁴ In 1962, he reported that Agogo Hospital was not expected to engage in as much preventive medicine as he had feared – and that the establishment of a “mothers and babies consultation service” would be sufficient.⁶⁵ When, in 1965, the minister of health demanded “even more preventive medicine and ‘health education’ [English term in original]” from mission and church hospitals, Meister was “not unhappy” that the senior medical officer of Ashanti had declared this being “unnecessary for the time being” for Agogo and Ashanti Akim.⁶⁶

Consequently, until the mid-1970s, “preventive medicine” remained to a large extent limited to maternal and child health at Agogo, especially in regard to the work of the first paediatrician. In 1961, a children's ward was built with funds raised entirely from Christian organisations and private donors in Europe and Ghana, primarily from the German organisation Bread for the World (PCG 1962: 60–61). In Meister's perception, the new ward combined the hospital's focus on locality, care, and cure with a concern for health education:

⁶³ BMA, PS1-B05-03-10198, Hans Meister, “Spital Agogo. Erste Eindrücke, Gedanken und Vorschläge,” 22 April 1952, and “Ärztliche Mission in Ghana Heute,” 1959.

⁶⁴ BMA, PS1-B05-03-10198, Hans Meister, “Bericht vom Synod Cttee Meeting, 4.-6. 7. 1961, Besprechung im Ministry of Health am 7. 7. 1961,” 17 July 1961.

⁶⁵ BMA, PS1-B05-03-10198, Hans Meister, “Jahresbericht 1961,” 1962.

⁶⁶ BMA, PS1-B05-03-10198, Hans Meister, “Jahresbericht 1965,” 1966.

“Countless children will find care and, with God’s help, healing here. In the kitchen, their mothers will learn how to cook good, hearty food.”⁶⁷ It was to be precisely in the field of maternal and child health that health services were to extend beyond the walls of Agogo Hospital.

In 1962, the first paediatrician, a Dutch woman in her mid 30s, arrived in Agogo. She was to remain at the hospital for over 25 years. Since her studies in tropical medicine in the United Kingdom, Jeltje van der Mei had been in personal contact with the paediatrician David Morley (Van der Mei 2005: 12–13).⁶⁸ She organised the child welfare clinic in Agogo according to Morley’s (1963) model of “Under Fives Clinics”, participated in a measles survey initiated by Morley with WHO sponsorship, introduced “road to health” cards, started vaccination campaigns, and set up several outstations. In all these initiatives, Van der Mei sought collaboration with government agencies.⁶⁹ In 1970, another Dutch doctor took over the obstetrics department.⁷⁰ He attached the antenatal service to the outstation child welfare clinics, initiated “ante-

⁶⁷ BMA, PS1-B05-03-10198, Hans Meister, “Ein Spitaltag in Agogo 1961. Beilage zum Jahresbericht,” 1962.

⁶⁸ BMA, PS1-B05-03-10198, Hans Meister, “Jahresbericht 1965,” 1966; BMA, PS1-G05-03-1624, Fritz Raaflaub, “Gespräch mit van der Mei, 10.3.1972,” 10 March 1972. Morley’s concepts were later diffused in Ghana through the influential U.S.-Ghanaian joint research and health-care-model project “Danfa” (Neumann et al. 1979: 134).

⁶⁹ BMA, PS1-G05-03-1624, “Van der Mei an Raaflaub,” 9 February 1969; “Raaflaub an van der Mei,” 18 February 1969; BMA, PS1-B05-03-10198, Jeltje van der Mei, “The Year 1970 in Children’s Ward and Child Welfare Clinic, Agogo Hospital,” 1971; BMA, PS1-B05-03-10198, Jeltje van der Mei, “1972 Annual Report on Children’s Ward and Under Fives Clinic,” 1973.

⁷⁰ A high number of Dutch “fraternal workers” served in Ghana due to a staffing agreement between the Basel Mission and the Protestant mission agency at Oegstgeest, Netherlands (Jenkins 1989: 206).

natal cards,” and founded Agogo’s first family-planning programme.⁷¹

Expensive Medicine and Financial Hardship

While approaches subsumed under the labels “preventive medicine” and “basic health care” remained almost exclusively in the domain of maternal and child health in Agogo, they played a more central role at other health care institutions run by the Presbyterian Church.⁷² For example, Bawku Hospital in northern Ghana served as the referral point and supply base for the district’s mobile clinics and dressing stations. Additionally, the hospital’s senior medical officer became the district medical officer of health in 1972 (PCG 1973: 46–47).⁷³ There are various reasons for these different trajectories at Bawku and Agogo Hospitals in regard to their integration within the public health care system and their alignment with primary health care (PHC) concepts.

Firstly, Agogo Hospital had a long surgical and curative “tradition” and had historically played a different role by serving as a referral hospital within the local health care system. Moreover, public health in Agogo was explicitly seen as the responsibility of the government (Meister 1971: 54–55). The Health Office at Konongo organised public health in the district, with sub-offices in Agogo, Juaso, and Bompata.⁷⁴ A

⁷¹ BMA, PS1-B05-03-10198, Adam van Enk, “Annual Report for the Year 1970,” 1971, and Hans Meister, “Annual Report of the Year 1970,” 8, February 1971.

⁷² Van der Mei noted: “The preventive work which is done in the Under Fives Clinics in Agogo and its outstations and also in the Antenatal Clinics is important, but relatively limited, compared with the curative work” (PCG 1976: 97).

⁷³ This was part of the 1972 government agreement, Provision of Preventive and Promotive Health Services in the Bawku Health District by the Presbyterian Mission of Ghana; cf. Oosterink (1971).

⁷⁴ Agogo Hospital Library, District Health Management Team, “Ashanti-Akim District Profile,” December 1979.

second factor was the composition and combination of the “overseas partners” supporting the two hospitals. At Agogo, they included, apart from the Swiss government, Swiss and German religious organisations. At Bawku, most overseas partners were Dutch, in addition to the governments of Canada and Germany, church organisations, and Oxfam. For instance, construction for the Bawku District Medical Development Project was financed by the Inter-Church Co-ordination Organisation (ICCO) of the Netherlands (PCG 1975: 99). At Agogo, a striking example is the German Christoffel Blinden Mission that has exclusively supported ophthalmologic services since the late 1960s. In 1976, it funded the establishment of Agogo’s renowned Eye Department, thereby fostering its specialisation in ophthalmology.⁷⁵ The composition of the senior staff at the two hospitals, especially the extraordinary long tenure of Meister and Van der Mei in the case of Agogo, was the third factor for each of the hospital’s trajectory.

The fourth reason was the two hospitals’ relationship with government. Bawku Hospital was an “agency hospital” run by the Presbyterian Church but belonged to the state. In the case of Agogo, nurses training played a central role as the field of state collaboration. The relationship between the hospitals and the government began to change in the 1960s, in connection with increased financial hardship, a coup d’état, and stronger ties between health care institutions of different churches. In 1963–64, the government financially contributed not only to nurses training but also to the running costs of the hospital.⁷⁶ The

⁷⁵ BMA, PS1-B05-03-10198, Hans Meister, “Agogo Hospital Annual Report 1968 to the Regional Medical Officer, Kumasi,” 13 March 1969; BMA, PS1-G05-03-1624, “Verwaltung BM an Afrika-Referat,” 9 September 1975. At Agogo, ophthalmologic work goes back to a physician with ophthalmologic training in the 1930s. Later, an ophthalmologist joined the hospital and founded an Eye Unit in 1957.

⁷⁶ BMA, PS1-B05-03-10198, Hans Meister, “Agogo Hospital Annual Report 1963, to Ministry of Health,” February 1964.

1966-67 annual report to the Senior Medical Officer at Kumasi concluded: "We are happy about the new atmosphere since the time when the NLC [National Liberation Council] Government took over and for the new understanding and co-operation from the side of the Ministry of Health."⁷⁷ This commendation was preceded by a plea to General E. K. Kotoka as the NLC commissioner for the Ministry of Health. In October 1966, Meister wrote to Kotoka: "The Nurses Training School Agogo may have to close down in the very near future if the Government of Ghana does not honour the promise given by the Ministry of Health on 22nd February 1963." Meister described the financial hardship faced by the hospital and the Nurses Training School, the latter unable to admit a new class. He "entreated" Kotoka to make up the loss in balance for the 1965-66 financial year and the full running costs for the 1966-67 school year.⁷⁸

In Agogo Hospital's 1967 annual report, Meister drew a similar picture of financial hardship. As a consequence, the hospital lost its "temporary recognition" as an SRN training institution because the necessary new hospital kitchen could not be built. Meister asked for more support from the Ministry of Health with the assertion that if this support was not granted, the hospital's standards would be brought into question.⁷⁹ In 1969, the Presbyterian Church finally approached the

⁷⁷ BMA, PS1-B05-03-10198, Hans Meister, "Annual Report 1966/67 to Senior Medical Officer, Kumasi," 11 May 1967.

⁷⁸ The plea was to be presented by a delegation of several members, including the moderator and the synod clerk of the PCG, the *Omanhene* (paramount chief) of Agogo, and the chairman of the Regional Committee of Administration, Ashanti. At the same time, the Swiss ambassador was to contact the NLC in this regard. BAR, E2005A/1978/137/221, "Meister an Botschafter, Accra," 29 October 1966, "Med. Superintendent, Agogo Hospital, to Chairman of the National Liberation Council [draft]," 29 October 1966, and "Botschafter, Accra, an Meister," 1 November 1966.

⁷⁹ BMA, PS1-B05-03-10198, Hans Meister, "Annual Report Agogo Hospital Per 1967, to Senior Medical Officer, Kumasi," 1968.

government with the proposal to “accept increased responsibility for planning of the Hospital and its Training School and to subsidize fully its financial needs as far as they are not covered from the other sources,” such as PCG, the Basel Mission, and other donors.⁸⁰ From the late 1960s onwards, government subsidies constituted about a quarter of the hospital’s income.⁸¹

Double-Track Strategy

A review of Ghana’s development plans from the 1960s and 1970s illustrates the failure of different civil and military governments to implement health policies focusing on primary care, preventive medicine, and public health, with an equal distribution of services in favour of curative, urban-biased, and hospital-based medical services.⁸² After earlier regimes had emphasised the importance of rural health and “preventive medicine” in their development plans (Ghana Planning Commission 1963: 176–177; Ghana 1968: 92), Prime Minister K. A. Busia’s government noted in its 1970–71 development plan that “[a] real change of emphasis towards basic rural health services can only be achieved gradually, particularly as a great deal of hospital construction is under way.” Indeed, the budgeted expenditures for 1968–1971 assigned 11.3 million cedis for hospitals and 2.5 million cedis for health centres and health posts (Ghana 1970: 176–77). The 1975 development plan of the Supreme Military Council (SMC) explained that hitherto “[t]he allocation of resources within the health services

⁸⁰ BMA, PS1-B05-03-10198, Hans Meister, “Agogo Hospital Annual Report 1968 to the Regional Medical Officer, Kumasi,” 13 March 1969.

⁸¹ This number had increased by 1968/69, with over 28 percent of the hospital’s income coming from subsidies. In the early 1970s, subsidies provided between a fifth and a quarter of Agogo’s income; by 1975/76, they had increased to 35 percent (including salaries for seconded staff).

⁸² See Harrison (2009: 30); Falola (1992: 24–25); McPake (2009: 343–45); Twumasi (1981: 149–50, 1979: 32–33); Neumann et al. (1979: 129–30).

has favoured the curative programmes *vis-à-vis* health promotive and preventive programmes,” and that the government was to “emphasise during the plan period the primary health care segment” including “primary curative care, preventive and promotive services” (Ghana 1977: 370-72).

For Agogo Hospital, the increasing financial dependence on the government during the 1960s and 1970s did not lead to a curtailment of its expensive and deficient curative, hospital-based medical practice – even though the SMC led by Colonel I. K. Acheampong took steps towards a stronger integration of church medical facilities as a consequence of higher state subventions during the financial crisis.⁸³ During the 1970s, a double-track strategy developed at Agogo: the hospital retained its position as a referral hospital with high technical standards and specialisations but also converted into a “pioneer” in PHC. Thus, the fact that Agogo Hospital became integrated into the national PHC policy by the end of the 1970s does not mean that it made a shift away from high-standard curative and thus expensive medicine. The crucial factor for fostering the latter was nurses training. In 1973, the Ecumenical Nurses Training College, a joint venture between government and the Christian Health Association of Ghana (CHAG), was established.⁸⁴ The Presbyterian Church provided the infrastructure that was

⁸³ In 1975, the military government considered nationalising all church health care facilities. Yet due to the insistence of the churches, “integration, that is, closer cooperation” was instead agreed upon, as the PCG secretary for medical work reported (PCG 1977: 80). Subsequently, the government took over the salaries for Ghanaian staff, while the mission hospitals were bound to accept the coordinating and aligning decisions of the Ministry of Health; cf. Agogo Hospital Library, Yao Yeboah and K. A. Enyimayew, “Evaluation of Presbyterian Church of Ghana Health Services (1987-1996),” 1997, 5.

⁸⁴ Founded as the Church Hospital Association of Ghana in 1967, CHAG continues to coordinate the health activities of different Ghanaian churches and acts as the intermediary to the state. Meister played a prominent role in the process of founding CHAG and served as the association’s first chairman.

primarily funded by the Swiss Service for Technical Cooperation; the running costs were once more borne by the Ghanaian government.⁸⁵

Maintaining the nurses training college was bound to the fate of the hospital, a connection stressed by hospital representatives several times during the economically arduous 1970s. In 1975, Meister launched another call for increased government support in favour of high standards, specialisation, and nurses training: “I am aware that rendering combined curative and preventive services in a hospital on a somewhat raised standard, particularly as far as specialisation and good nursing care are concerned, and this in a rural setting, is difficult.” Without the state’s much stronger financial engagement, he argued, Agogo had to abandon its high standards and abolish SRN training to “become a much more simple rural district hospital.” He made clear that he saw Agogo first as a referral hospital and place for the training of SRN nurses and argued that “public health” apart from mother and child health, was the government’s concern (PCG 1975: 77–79). Van der Mei, Meister’s successor as medical superintendent, also defended the expensive curative services and stressed the importance of nurses training: “Its close connection with the NTC [Nurses Training College] makes a rather specialised hospital necessary and we have to try to keep our standards as high as possible.” At the same time she urged: “We should constantly search for ways to increase our preventive services, reach as many people as possible and not be satisfied with the little we do” (PCG 1976: 97).

Finally, it was the generational shift – and with it the shift in training background and linkages to different networks – that

⁸⁵ BMA, PS1-B05-03-10198, Hans Meister, “Annual Report 1972,” 30 January 1973; BAR, E2005A/1985/101/338, Der Delegierte für technische Zusammenarbeit, “Schlussbericht (Spitalerweiterung Agogo),” 1 October 1975.

led to the integration of the hospital into not only the national health care system but also the national health care strategy, officially dubbed Primary Health Care in 1978. At Agogo, it was B. F. Schaeffner, a Dutch doctor arriving in 1976, who introduced the hospital's first "rural health care programme" (PCG 1977: 23, 1979: 103). Van der Mei related:

Since long we are aware that although a lot of good curative work is done *in* [emphasis in original] our hospital for patients from far and near, not much is being done to bring basic health care to the people of our district. This awareness has during this year led to a lot of discussions with authorities in the Ministry, the Church and the Community. These discussions in the end led to a proposal to the Ministry of Health to make our Hospital a District Hospital....⁸⁶

This proposal was accepted. In January 1979, Agogo Hospital was granted the status of a district hospital for Ashanti Akim, with its 156,000 inhabitants.⁸⁷ At the same time, Ashanti Akim was chosen to be one of nine pilot districts to implement the Ghana Primary Health Care Strategy. Agogo Hospital provided Schaeffner, who became district medical officer of health, accommodation and an office; the building of the staff quarters was financed by the Dutch ICCO.⁸⁸ Schaeffner, in hindsight, described it as a "happy coincidence" that the government "took Primary Health Care as a major policy, at the same time that Agogo Hospital was keen to start this work in Asante-Akim."⁸⁹

⁸⁶ BMA, PS1-B05-03-10198, Jeltje Van der Mei, "Annual Report 1978," 1979.

⁸⁷ 19,000 inhabitants lived in the area of Agogo, about 21,000 in the twin-town Konongo-Odumasi. Agogo Hospital Library, District Health Management Team, "Ashanti-Akim District Profile," December 1979.

⁸⁸ BMA, PS1-B05-03-10198, B. F. Schaeffner, "1979 Annual Report Ashanti-Akim District Work," 1980. Bawku took over the role of District Hospital in 1980.

⁸⁹ Akrofi-Christaller Institute Library, Akropong, "Agogo Hospital 1931-1981," 1981, 32.

Conclusion

The introduction of PHC in Ashanti-Akim and the pioneering role Agogo Hospital played in its implementation in Ghana can be accepted as a “happy coincidence.” It can also be understood as the transfer of a health care concept – the PHC strategy – from the transnational and national levels to the local level. This article is an attempt not only to demonstrate that such transfers happened but also to *explain* when, why, and how health care concepts and strategies were transferred, developed, and rejected in a specific context. The examination of the development of medical practice and nurses training at Agogo Hospital shows that the practice on the ground was hardly congruent with the blueprints developed in offices and meeting rooms in Basel, Accra, and London. Categories such as “mission medicine,” “nursing,” “preventive medicine,” and “primary health care” – comprehended as both ideological and normative concepts, as well as tools for specific practices – held different meanings for different actors. Various interests and social relations underlie these categories, different values and ideologies were connected to them, and specific practices were ascribed to them.⁹⁰ In order to explain the transfers, developments, and rejections of concepts and practices, as well as their specific forms, time of occurrence, and results, this article has analysed the constellations of actors that promoted or curbed these processes and to highlight the values and ideas, interests and resources that were attached to them.

⁹⁰ I am drawing here on Michael Werner and Bénédicte Zimmermann’s work about the historicisation of categories. They understand their approach of *histoire croisée* as a pragmatic and reflexive process of induction. Hence, analytical categories are subjected to reflection, this includes the terms of the observer (the historian), as well as the terms of the historical actors (Werner and Zimmermann 2002: 624-27, 2006: 38-42).

The training of hospital nurses proved to be a field in which Agogo Hospital could contribute to the decolonisation of Ghana, for which the training of skilled staff was a major concern. At Agogo Hospital, nursing was associated with the Christian values of compassion and humility. Therefore, nurses training became a substitute for the proselytising function of the hospital. Nurses training served to reinforce the ideal of an everyday life lived in accordance with the beliefs of the Presbyterian Church and the Basel Mission; nursing served as an example of practiced Christian values towards patients and wider society. Here, the Basel Mission leadership's idea of a mission hospital, which prioritized the spread of the Gospel and the spiritual well-being of its patients, survived World War II and the subsequent shift towards benevolence and welfare in a process of "secularisation" in the rationale of missionary medical work (Vaughan 1991: 70, 72). Rather, the influence of this missionary notion was to extend far into the postcolonial period. With the appearance of the Swiss government as a "technical cooperation partner," new economic and political interests, the positioning of Switzerland as being free of colonial legacies, the strengthening of Swiss economic activities, and the aversion of the communist threat enabled the realisation of a nurses training college in Agogo.

Tuberculosis care and treatment is an example of a project requiring substantial investments, which could not be realised as it stood at odds with the globally predominant policies and strategies. However, Agogo Hospital maintained a high technical standard of curative, hospital-based care, notwithstanding the predominance of new health care paradigms emphasising community-focused, preventive, and basic health care. The gap between policies and actual outcome is certainly not unique in the history of health care services in Ghana or elsewhere. In the case of Agogo, however, the maintenance of high technical standards and specialisations in a rural setting are remarkable. This is partly explained by the

hospital's institutional legacies, its relations to various actors that included the government, donor organisations, and the church, as well as the professional and ideological background of its senior staff. In this configuration, the article argues that nurses training played a particularly crucial role.

The hospital's integration into the national health care system and its alignment with transnationally developed health care strategies was characterised by ruptures and leaps. This was not a process on two parallel tracks, nor did the former automatically entail the latter. Rather, the integration into the national health care system was to a great extent driven by the hospital's increasing financial dependency on the government and, until the mid-1970s, focus on nurses training. The "happy coincidence" that led to the early adoption of PHC in Agogo and the hospital's designation as a district hospital was dependent on specific conditions concerning knowledge, infrastructure, and personal and financial resources, which had emerged out of changing configurations of interests and values since the 1930s.

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ACCRA'S WOMEN ON SCREEN, 2001: A DOCUMENTARY PAIR ABOUT BODY, RISK, TONICS, AND HEALTH

R. Lane Clark, Nancy Rose Hunt & Takyiwaa Manuh

The article introduces two documentaries, "Excuse Me to Say"-- Notions of Body and Risk in Accra, and "Where Shall I Go?"-- Tonics, Clinics, and Miracles in Accra, which take viewers on an intimate voyage through diverse territories of women's health" and medical care in West Africa. An outgrowth of the Women's Health in the City of Accra Research Collective, these documentaries grew out of this collaborative project that engaged students and faculty from the University of Ghana and the University of Michigan in qualitative research on gender and health. The films present intimate, subjective material, shedding light on the unique challenges faced by women and girls, and their strategies as they endeavor to live healthy lives.

Keywords: Women's health, health care, film-documentary, Accra, Ghana

By listening to women and visiting their domestic and work spaces, the two documentary films, *Excuse Me to Say*-- *Notions of Body and Risk in Accra*, and *"Where Shall I Go?"-- Tonics Clinics and Miracles in Accra*, thickly describe the complexities of health and health care in a West African metropolis. Each is 28 minutes long, and they were directed by R. Lane Clark and co-produced by Nancy Rose Hunt and Takyiwaa Manuh as the culmination to the Women's Health in the City of Accra Project, an academic program that operated like a research collective. This collaborative project between the University of Ghana and the University of Michigan brought together students

Ghana Studies v.15/16 (2012/2013): 331-335

and faculty in the fields of medicine, social sciences, and humanities from Ghana and the United States to explore gendered practices and ideals in women's health and medical care in Accra.¹ During June and July 2001, a video team of two crews joined and extended the project's research groups by documenting its activities and some of its key ethnographic stories.² The video crews conducted independent investigations as well, interviewing people and filming additional health sites with powerful images and personalities.

The documentaries were shot on video, in a cinema verité style, and grew organically out of the work of the research collective. The video teams visited women and girls around Accra who were willing to share their health views and their lives on camera. Many visits were facilitated by ongoing relationships that members of the research collective had established. Indeed, the films are an opportunity to reflect on the research project itself, to examine the point of view of the researchers with a critical eye to the intricacies of conducting interdisciplinary, transnational work

¹ The Women's Health in the City of Accra Research Collective, an interdisciplinary research training program that took place over a fourteenth-month period in 2000 and 2001, was funded by the Ford Foundation, the University of Michigan (notably its Department of Obstetrics and Gynecology), and the University of Ghana. Participants included nine U.S. students enrolled in programs in American culture, film and video, history, psychology, public health, and sociology at the University of Michigan, and sixteen Ghanaian students (nine graduate students from African studies, environmental science, geography, nursing, nutrition, and sociology at the University of Ghana, four postgraduate residents from its medical school, and two professional students in film and television). Fifteen University of Ghana faculty from its main and medical campuses joined the project as lecturers and mentors, and with their assistance, the students formed themselves into several collaborative research teams.

² The video teams included two University of Michigan film students, two students and one faculty, Charles Pongo, from the National Film and Television Institute of Ghana (NAFTI), and the filmmaker R. Lane Clark.

on women's health. They feature interviews with prominent Ghanaian researchers and medical professionals, among them Phyllis Antwi, Edith Tetteh, and Kodjo Senah.

The films define "health" broadly to include not only curative care, but also social health, the household production of health, economic security, and activities related to seeking joy and leisure, beauty and well-being. The work portrays the complexity of this modern West African capital, with its many social and economic classes, neighborhoods, and ways of life. Accra is a vibrant, multi-ethnic city, with enclaves of great wealth as well as sectors of acute poverty, a city that contains both vexing problems and a richness of creative human solutions. The latter can be fruitfully explored through the strategies that women and girls use to surmount physical, economic, and emotional hardships, such as the rising costs of medical treatments, the lack of an adequate sanitation, and the difficulties of caring for sick children.

In Accra, women have major social and economic responsibility for caring for the needs of household members. It is mainly women and girls who care for children, manage the home, prepare food, and look after the sick. Almost all women work to earn money, whether in trade, the service industry, or professional careers. In this post-structural adjustment era in Africa, where the rush toward economic and technological development combines uneasily with the privatization of medical care, cutbacks in social services, and an emerging awareness of HIV/AIDS, the complexities of patterns of resort to health care are poorly understood. The films embrace a complex set of human faces and voices as a way of depicting the health predicaments of differentially situated women. They turn the camera lens on women from starkly different spaces of the city, including women who are rich, poor, middling, young, old, and middle-aged, recent

rural immigrants, and those whose families have lived in the city for generations. Nurses, market women, academics, public health specialists, doctors, hairdressers, apprentice seamstresses, retirees, porter girls, school girls, and street girls are included. Their stories and ways of thinking are layered and interposed to give viewers a sense of their frustrations, resourcefulness, irony, and needs.

Doubt and uncertainty are pervasive in Accra, as they are the world over. This becomes evident in the films' conversations with these women and girls in Accra, especially in relation to reproductive health and protecting one's self from HIV. Although national and non-governmental agencies have produced extensive, frank television and radio information campaigns explaining the importance of family planning and condom use, individuals emphasize the complexities they face in making health decisions. Issues of trust and power in their relationships, the cost of medications, religious convictions, and "spiritual illnesses" emerged as issues raised complicating processes of seeking and producing health.

"Excuse Me to Say" and *"Where Shall I Go?"* provide a complexity of voices, spaces, places, and human dilemmas. In the first of the pair, *Excuse Me to Say*, the focus is on young women apprentices in catering and seamstress work. They candidly share their dreams and aspirations about beauty, dating, and marriage, and also speak to the dangers of HIV and unplanned pregnancies. Images from popular culture as well as the ideas of health care professionals who work with young women are included, suggesting how such resources complicate the ways young women learn about ideals, health, and agency and maneuvering in relationships. *Where Shall I Go?* takes viewers on a journey around Accra, visiting various therapeutic options accessed by women and girls. Hospitals, clinics, pharmacies, herbalists, spirit

mediums, and healing churches are included. Women speak about how they choose among the range of options in relation to their experiences, budgets, and religious convictions.

As a film pair, these films enhance the teaching and study of women's health and care, medical anthropology and global health history in a modern West African capital of the 21st century. Accessible on the *Ghana Studies* website, on YouTube, and on Vimeo, we welcome their use as conversation pieces, sources of debate, and empirical resources that tell about Accra, gender, and health in 2001.³

³ See <http://youtu.be/h3fcKq6wGGQ> and <http://youtu.be/j4P1CFNOJh0>, <http://ghanastudies.com/ghana-studies-journal/>, and <http://vimeo.com/rlaneclark>

MANAGING THE PAN-AFRICAN WORKPLACE: DISCIPLINE, IDEOLOGY, AND THE CULTURAL POLITICS OF THE GHANAIAN BUREAU OF AFRICAN AFFAIRS, 1959-1966¹

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The Bureau of African Affairs remains one of the most controversial institutions of Nkrumah-era Ghana, with scholars and others connecting it to such activities as the Soviet arms trade, espionage, and even assassination. This article offers an alternative analysis: one rooted in the institution's status as a workplace. It examines the development of a work regime whereby Bureau administrators and party officials transformed seemingly banal workplace contestations over leave, pay scale, and workplace technologies into national and transnational debates over national productivity, state and institutional security, and social and ideological discipline. Moreover, the article argues, these inter-office debates spoke to and accentuated established gender, generational, and class anxieties associated with the changing nature of urban work life in Nkrumah-era Ghana.

Keywords: Bureau of African Affairs, Work/Labor, Pan-Africanism, Convention People's Party.

¹ I want to dedicate this article to the staff of the George Padmore Research Library on African Affairs, particularly to James Naabah and Edward Adu—now of the Ghana Library Board—who not only gave me wide-ranging access to the Bureau of African Affairs archive but, more importantly, have diligently preserved one of the most important and unique archival collections on Nkrumah-era Ghana. I also want to thank Leslie James for her willingness to help me better understand George Padmore's time in Ghana—a period in which both the Ghanaian and British archival records are often unclear—and David Amponsah and David Easterbrook for their assistance in helping me track down some elusive newspaper articles at the last minute. Finally, a very early version of this paper was presented at the 51st annual meeting of the African Studies Association in Chicago, Illinois in November 2008.

Introduction

In the months following the February 1966 coup overthrowing Kwame Nkrumah and the Convention People's Party (CPP), the Ministry of Information and Broadcasting (1966) of the acting National Liberation Council (NLC) marked the end of Nkrumah's rule with the publication of a short booklet entitled *Nkrumah's Subversion in Africa*. The document, designed as a counter to the one-time popular image of Nkrumah's Ghana as—to borrow from South Africa's Peter Molotsi (quoted in Callinicos 2004: 264)—the “Mecca of Pan-Africanism,” detailed what the NLC saw as the Nkrumah government's efforts to transform the continent into a communist haven. No agency featured as prominently in the NLC's booklet as the Ghanaian Bureau of African Affairs. Formed in 1959 and attaining statutory authority a year later, the Bureau quickly gained a reputation inside and outside of Ghana as one of Africa's most subversive political institutions in the early and mid-1960s. Groups ranging from the CPP's opposition to the United States government credited it with everything from espionage in independent African states to the importation of Soviet arms and the maintenance of Soviet- and Chinese-run guerilla training camps in the country (Ministry of Information and Broadcasting 1966: 3-37; Adamafio 1982: 104). Some have even hinted at the Bureau's possible involvement in attempted coups in Togo and, even more troubling, a potential Ghanaian hand in the 1963 assassination of Togo's first Prime Minister and President, Sylvanus Olympio.²

² See Memorandum for Mr. George Bundy, The White House, “Ghana Subversion in Africa,” 12 February 1962, John F. Kennedy National Security Files on Africa [hereafter JFK National Security Files], Reel 8. Also, see Thompson (1969: 308-15).

Accounts of the Bureau's subversive activities dominate the few existing discussions of this Nkrumah-era institution.³ In perhaps the most prominent scholarly analysis referencing the Bureau, W. Scott Thompson's (1969) digest of Ghana's Nkrumah-era foreign policy, the Bureau often stands in for the perceived ineptitude and unpredictability of the CPP government's external affairs. Further, Thompson (1969: 106-7, 220-7) stressed what he interpreted as Nkrumah's path to diplomatic failure. Alternatively, several key CPP officials—most notably, Kwesi Armah (2004: 22-3), Michael Dei-Anang (1975: 26-32), Kofi Batsa (1985: 25-40), and David Busumtwi-Sam (2001: 66-92)—have added to the literature on the Bureau with brief discussions of the institution in their memoirs. Broadly, their accounts of the Bureau modestly outline the institution's position in Ghanaian foreign policy and relationship with key nationalist parties and movements in other parts of the continent, except, in the case of Busumtwi-Sam, who used his discussion of the Bureau to highlight its legal operations so as to vindicate particular positions he took and relationships he formed during his time in the Nkrumah government.

The Bureau, however, was more than the tool of Nkrumahist subversion cited by scholars like Thompson or, for those more sympathetic to the CPP's cause like Batsa and Armah, a vehicle for African liberation. Rather, it was the direct product of the distinctly transnational and socialist vision Nkrumah held for the burgeoning Ghanaian state and Africa more broadly. Operating with a set of standing orders designed to accelerate the continent's liberation and in turn its perceived destined unification, the Bureau—as a workplace—quickly emerged as a site where local and global

³ Perhaps the only scholarly work that deviates from this focus on subversion is archivist Joseph Justice Turton Mensah's (1990) thesis on the BAA, which gives an overview of the Bureau's functions from a distinctly pro-Nkrumah perspective.

concerns over issues of neocolonialism, state security, and the apparent stalling of the continent's decolonization embedded themselves into the more mundane realities of work life in the new and modernizing state.

This article thus seeks to interrogate the intersecting worlds of the transnational and the intimate in the day-to-day work life of the Ghanaian Bureau of African Affairs. As detailed in the Bureau's personnel files, administrative memos, and minutes, Bureau employees, expatriate wards, and even some administrators faced a work regime whereby seemingly banal contestations over sick and maternity leave, pay scales, and workplace technologies were transformed into wide-ranging debates over threats to national productivity, state and institutional security, and social and ideological discipline. More than localized labor debates and disputes, the discussions of work that consumed the Bureau's administrative elite and, by extension, the work lives of its employees reflect a broader array of gender, generational, and class tensions in early postcolonial Ghana. Nkrumah and the CPP had not only envisioned a political revolution in the country. They sought a social one as well, one transforming the citizenry into a model for a disciplined, modern, and ideologically sound workforce. An analysis of the Bureau, through a surviving archive for the institution unmatched by any other Nkrumah-era political organization, uniquely invites us into the intersections between this political and social revolution as a lived experience. For those employed in this highly politicized workplace, I contend, this was a lived experience necessarily shaped by a general frustration inside and outside the party elite with the perceived sluggishness of Ghana's transition to the Pan-African and socialist ideal Nkrumah envisaged and an increasing fear of the threats this lack of progress purportedly posed to the country's newfound sovereignty.

**From the Office of the Adviser
to the Bureau of African Affairs**

The Bureau of African Affairs (BAA) had its origins in competing visions of Ghana's role in the broader movement for African decolonization and the country's own nation-building project. Independence had provided the Nkrumah government with the political and institutional space from which to explore a shared and collaborative model for African anticolonial activism. Nkrumah's (1967: 62) famed 6 March 1957 declaration, pronouncing the "meaninglessness" of Ghanaian independence independent of that of the broader continent, set the tone for debate and political action in the nascent state. In the weeks and months following the country's independence, Nkrumah and the CPP would not only announce their intentions to renew the Pan-African tradition of Du Bois and Manchester but also begin the process of recruiting key Ghanaian and expatriate technocrats and intellectuals to Accra to aid in the country's post-independence transition.⁴ None of these individuals—at least in the context of the BAA's formation—was more important than the Trinidadian Pan-Africanist George Padmore, who had previously worked with Nkrumah to organize the 1945 Manchester Pan-African Congress and, upon his arrival in Accra in late 1957, would establish the BAA's predecessor institution—the Office of the Adviser to the Prime Minister on African Affairs.

Representing the first of several quasi-governmental Pan-African institutions and agencies to find a place in the Nkrumah administration, Padmore's Office of the Adviser aimed to coalesce

⁴ "Pan-Africa: International Confab Here," *Evening News*, 18 April 1957. Specifically on Diasporic Africans like Padmore joining the Nkrumah government, see Gaines (2006).

the “resources and expertise” necessary for Ghana to offer both “practical and ideological support” for the continent’s freedom fighters (James 2012: 223).⁵ As Leslie James (2012) argues in her biography of Padmore, the goal of the Office was to “supplement, not duplicate” the more formalized mission of the Ministry of External Affairs (later Foreign Affairs) and Ghana’s other foreign service agencies.

As a result, Padmore and his Office adopted the lead role in organizing the two showcases of early postcolonial Ghanaian Pan-Africanism: the April 1958 Conference of Independent African States and the December 1958 All African Peoples Conference (AAPC). Moreover, Padmore, along with fellow Pan-Africanist and Guyanese expatriate T. Ras Makonnen, served as the “chief ideological counselors” for Ghana’s London-based National Association of Socialist Students’ Organization (NASSO). According to journalist Colin Legum (1964: 137), many of these NASSO members mentored by Padmore and Makonnen would come to hold some of the most prominent positions in the Bureau of African Affairs in the years following Padmore’s death.⁶ Furthermore, during his short time leading the Office of the Adviser, Padmore utilized his contacts and influence in London’s and the broader United Kingdom’s anticolonial community to recruit promising students to come to Accra, where they would continue their studies with the support of the Ghanaian government. Bright Nyondo, a young Malawian student convinced by Padmore to leave London for Accra in October 1959, recalled

⁵ Two other notable quasi-governmental Pan-African agencies and institutions established by Nkrumah and the CPP include the All-African Peoples Conference Secretariat and the Assembly for the World Without the Bomb.

⁶ Legum (1964) also noted how, following his death, Padmore became a polarizing figure with NASSO members, particularly among those influenced by Tawia Adamafio.

in 1961 how the latter drew him to Accra “by his simplicity, by his sincerity, by his sympathy with my efforts to educate myself and, above all, by his very great interest in my country Nyasaland.”⁷

Padmore’s 1959 death initiated a re-organization of the Office of the Adviser. For Nkrumah, Thompson (1969: 106-7) argues, Padmore’s death presented him with an opportunity to claim unquestioned control of the country’s Pan-African agenda, for, at least in Nkrumah’s opinion, no one left in the country commanded the same respect and experience on African issues as he did. Moreover, Padmore’s death removed a key source of tension in Ghana’s foreign and African policy circles, since several groups of civil servants and party activists, who had previously opposed Padmore’s appointment on the grounds of his nationality and lack of management experience, sought to take advantage of the Office’s power vacuum (Thompson 1969: 106-7; James 2012: 232). As a result, within days of Padmore’s death, Nkrumah announced the Office’s transformation into the Bureau of African Affairs with Kofi Baako as its initial director, and A. K. Barden—an ex-serviceman and Padmore’s former stenographer and confidant—as its secretary.⁸ By December 1959, the Cabinet had begun debate on granting the new Bureau statutory approval.⁹ Moreover, as Thompson (1969: 107) maintains, by the end of the

⁷ George Padmore Research Library on Affairs (hereafter GPRL), Accra, Bureau of African Affairs (BAA)/Research Library on African Affairs (RLAA)/328, Nyondo to Minister of Education, Accra, 25 October 1961.

⁸ “Baako Has New Job in Cabinet Switch,” *Daily Graphic*, 26 September 1959. Also, see Biney (2011: 138). Both Thompson (1969: 107) and Dei-Anang (1975: 26) note that Nkrumah took over the Office of the Adviser/Bureau of African Affairs. However, it appears from the *Daily Graphic* report that Nkrumah did name himself as acting director of the new Bureau, but only until Baako returned from the United Kingdom.

⁹ Public Records and Archives Administration Department (hereafter PRAAD)-Accra, Administrative Files (ADM) 13/1/28, Cabinet Minutes, 8 December 1959.

year, the Bureau had also absorbed the operations of Accra's other prominent Pan-African institution, the AAPC Secretariat. This takeover was most visibly seen in the BAA publishing the AAPC Secretariat's *Bulletin on African Affairs*. Finally, in May 1960, the Bureau formally gained its statutory approval with Barden as its new director.¹⁰

Under Barden, the Bureau rapidly expanded its official and unofficial mission. Similar to Padmore's Office of the Adviser, the Bureau undertook the collection and dissemination of a wide range of information pertaining to the struggle for continental liberation and African unity. From the organization's inception, Bureau researchers and journalists reported for both internal and external audiences on the changing situations in such anticolonial hotspots as South Africa, the Rhodesias, Ruanda-Burundi, and the continent's Portuguese colonies. By mid-1961, the Bureau's magazine *The Voice of Africa* had become the institution's most important publication and official mouthpiece with an approximate monthly circulation of 10,000 issues (Ministry of Information and Broadcasting 1966: 5). Over the subsequent years, the Bureau added to its publication catalogue other newssheets, including the *African Chronicler*, the *Freedom Fighter*, the *Pan-Africanist Review*, and *The Spark*, which, along with its parallel French edition—*L'Étincelle*—quickly emerged as the Bureau's most

¹⁰ Throughout his tenure at the Office of the Adviser, Padmore continuously expressed his utmost support for Barden, highlighting in regular personnel reports Barden's need for pay raises, promotions, and the formal expansion of his duties. Of foremost importance to Padmore was Barden's apparent skill in working with confidential matters. See, for instance, GPRL, BAA/RLAA/1A, Padmore to Permanent Secretary of the Ministry of Defence and External Affairs, "Establishment Proposals," Accra, 21 January 1959; GPRL, BAA/RLAA/1A, Padmore to R. K. Gardiner, Accra, 25 March 1959; GPRL, BAA/RLAA/1A, Padmore to A. L. Adu, Accra, 19 May 1959. I want to thank Leslie James for directing me to these files.

controversial publication.¹¹ Furthermore, the Bureau continued with the publication of the AAPC Secretariat's *Bulletin on African Affairs* till the early 1960s. The result of the Bureau's journalistic and research mission was the creation of one of the continent's fastest growing archives and presses on African affairs in its Accra offices. Moreover, over the course of the institution's existence, the Bureau's publications attracted the attention of anticolonial activists and freedom fighters from as far afield as southern and eastern Africa, Nigeria, Great Britain, the United States, and the Soviet Union.¹² Bureau-led campaigns, such as the 1962 "Read about Africa" initiative, further raised the institution's public profile among the country's and continent's activist communities, since the Bureau promised to provide free copies of Nkrumah's speeches and several of its publications to all interested parties.¹³

In addition to the expansion of the Bureau's research mission, the Bureau continued with the Padmorean tradition of inviting freedom fighters, students, and other activists to Accra, where they

¹¹ For instance, in its embassy reports, the United States government described *The Spark* and similar ideological newspapers as "NOTHING MORE THAN VEHICLES FOR SOVIET PROPAGANDA," while it also complained about what it perceived as the weekly's "vicious attack[s]" on the CIA and other American governmental agencies. See United States Embassy in Accra to Secretary of State, Accra, No. 995, 1 February 1963, JFK National Security Files, Reel 9; Memorandum for Mr. George Bundy, The White House, "Positive and Negative Factors in Ghana," 9 September 1963, JFK National Security Files, Reel 9; emphasis in original.

¹² For example, see GPRL, BAA/RLAA/612, J. A. Asiboje to Ghana High Commissioner, 31 January 1960; GPRL, BAA/RLAA/729, Lawrence Uzoma D. Echemazu to A. K. Barden, 25 February 1961; GPRL, BAA/RLAA/1047A, Ansu Osaio to Nkrumah, Moscow, 26 December 1961; GPRL, BAA/RLAA/25, Ossama el-Tayeb to BAA, Chicago, 12 March 1962.

¹³ For a collection of the letters requesting these BAA publications, see GPRL, BAA/RLAA/27, "Read About Africa Campaign, 1962." Predominately advertised in the *Ghanaian Times* and the *Nigerian Daily Express*, the "Read about Africa" campaign not surprisingly garnered the strongest response from Ghana and Nigeria.

could continue their studies while engaging with their colleagues from other parts of the continent. Many of these expatriates—including for short times such high profile figures as Kenneth Kaunda and Mbiyu Koinange—were housed in the Bureau-affiliated African Affairs Centre (AAC).¹⁴ Established in 1959 and run for much of its existence by Padmore's and Nkrumah's Manchester compatriot, Ras Makonnen, the AAC served as a hostel for those arriving in Accra.¹⁵ Similarly, students who came to the country were sent to secondary schools in Accra, Kumasi, and other Ghanaian cities and towns. Funding for these students appeared to have come both directly from the Bureau and from such institutions as the Cocoa Marketing Board.¹⁶ However, regardless of the actual source of their funding, it was almost invariably to the Bureau where these students turned (sadly often unsuccessfully) when they encountered financial and other troubles during their stay in Ghana.¹⁷ Meanwhile, expatriate students attended these explicitly political institutions, such as the Kwame Nkrumah Ideological Institute in Winneba, while others were sent to the Bureau's "secret" guerilla training camps in Damongo, Half Assini, Obenemasi, and Mankrong (Ministry of Information and Broadcasting 1966: 6-27).

Thus, in recounting his experience in the Bureau, Kofi Batsa (1985: 37-8), who was named one of *The Spark*'s founding editors in December 1962, explained that "[i]n the Bureau of African

¹⁴ However, it is important to note that most prominent activists and political leaders living in Accra did not stay at the AAC, at least long term. Rather, they were generally given more private housing in Accra.

¹⁵ For an account of the AAC, see T. Ras Makonnen and Kenneth King (1973: 211-25). Also see Ahlman (2011: 26).

¹⁶ See, for instance, the student records of Miss Joanna Garba-Jahumpa (GPRL, BAA/RLAA/147) and Nam D. M. N. Jallow (GPRL, BAA/RLAA/154).

¹⁷ GPRL, BAA/RLAA/328, Romance MacDonald Kachere, "A History of Myself (ms.)," 6 September 1961; Terretta (2010: 206-7).

Affairs we regarded ourselves as being the factory of the ideas of Kwame Nkrumah. It was our job,” Batsa continued, “to take his ideas, turn them into actuality—and to create the Africa he imagined before it was too late.”

Discipline and Security in the Pan-African Workplace

Inside the Bureau’s offices, the institution’s distinctly Pan-African mission framed how both the BAA’s administration and its employees understood their work on the job and their broader role in the Ghanaian Pan-African and nation-building project. Throughout the Bureau’s existence, discipline stood at the forefront of the institution’s envisioned workplace culture. As the Bureau’s director A. K. Barden explained to members of his staff in a 1964 meeting, the Bureau required a special kind of worker. The Bureau worker, reflecting the inherently political nature of the institution’s mission at home and abroad, was to be an individual wholly dedicated to the security and prosperity of the state.¹⁸ As a result, each employee, Barden and the Bureau’s other administrators would argue throughout the institution’s six-year existence, had an obligation to his or her job that extended beyond his individual needs and desires to the fruition of the state and continent at large. The result was a work environment in which traditional labor concerns such as sick leave, pay scale, and productivity became imbued with an ideological meaning reciprocally connected to the security of the state and the pursuit for continent-wide liberation and unity. For, as Barden reminded his employees in a 1961 instructional memorandum, a “worker’s

¹⁸ GPRL, BAA/RLAA/159, Meeting in the Director’s Office, Minutes, 28 September 1964.

efficiency increase[d] with his cheerfulness, hopefulness, honesty, sobriety, discipline, secrecy, and [the] extent of his knowledge.”¹⁹

For Barden and his fellow administrators, though, the Bureau’s employees, as well as its expatriate wards, represented persistent threats to the institution’s security and in turn its productivity. These perceptions, in many ways, followed a broader trend in the CPP’s reading of the early postcolonial era. From even before the country’s independence, Nkrumah and the CPP government had aimed to set the terms of continental liberation on both the international and domestic stages. Initially, in the early and mid 1950s, this included statements and speeches that connected the Gold Coast struggle to other African nationalist struggles.²⁰ As the Gold Coast’s path to independence became clearer following the 1956 parliamentary elections, Nkrumah and others in the CPP sought to take advantage of Ghana’s unique position as the first black sub-Saharan state to achieve its independence by portraying the Ghanaian path to independence as *the African path*.²¹ Furthermore, many outside of Ghana also adopted such an image of Ghanaian decolonization and nation-building, with, for instance, the American National Association for the Advancement of Colored People’s famed *Crisis* magazine once arguing that “[t]here is hope for all Africa when this leaven of Ghana is at work throughout the continent.”²² However, as Nkrumah and the CPP began to confront the realities of their envisioned political and social revolution at home and abroad, they

¹⁹ GPRL, BAA/RLAA/376, Barden, “General Office Instructions—All Staff,” Accra, 5 September 1961.

²⁰ See, for instance, Agitator, “African Survey,” *Freedom: CPP Monthly Magazine* 1 (December 1952); “CPP—Africa’s Greatest Hope of Salvation,” *Evening News*, 8 April 1954.

²¹ See the various quotes by Nkrumah in Drake (1957: 1, 3).

²² “We Salute Ghana,” *The Crisis* (March 1957).

began to focus on the forces they saw as impeding their progress. Beginning shortly after independence and accelerating exponentially in the early 1960s, these forces increasingly came to include for Nkrumah and the CPP the bipolar world of the Cold War and the resultant threats of neocolonial subversion in Ghana and in the continent at large.²³

Fears of neocolonial and Cold War subversion constituted a foundational part of everyday life in the Bureau. Even before the organization's formal inauguration in 1960, Bureau and Office of the Adviser reports had cited concerns with unidentified individuals hovering around the institution's offices and its expatriate community. One May 1959 incident had officials questioning the presence of a man—a "Mr. Brooks"—consorting with the expatriates in one of the AAC's houses. This (presumably white) man, Barden's aide-memoire on the incident noted, proved particularly suspicious due to his ability to speak "several African dealects [*sic*]" and his tendency to ask "searching questions" of the AAC's expatriate wards.²⁴ As the aide-memoire continued, Barden went so far as to accuse Mr. Brooks of falsifying his name, nationality (claiming U.S. as opposed to British), and of attempting to "lure one of the Congolese to his residence," where, the document editorialized, "one can rightly imagine the kind of conversation which took place there."²⁵ In another instance, the Bureau questioned the presence of a student—a Mr. Oliveira Moita de Deus Luis Carlos—sent to Accra on an Angolan passport. As

²³ As Jean Allman (2008: 96-7) has argued, 1960 and early 1961 proved a pivotal moment in how Nkrumah and others read the relationship between Africa and the Cold War, since they sought to make sense of the escalating French war in North Africa, the massacre in Sharpeville, and, by early 1961, the assassination of Patrice Lumumba. Also see Ahlman (2010, 2011).

²⁴ GPRL, BAA/RLAA/961, Barden, "Aide Memoire," 10 May 1959.

²⁵ Ibid.

Barden noted in his memo on the case, given the strained relationship between the Ghanaian and Portuguese-controlled Angolan governments, Luis Carlos's case proved troubling. Citing his fears about "awarding a scholarship to a European spy," Barden arranged to discuss Luis Carlos's case with the Bureau's allies in Angola, namely Holden Roberto's *Frente Nacional de Libertação de Angola* (FNLA).²⁶

The 1960 transition to the Republic and particularly the series of strikes that accompanied the introduction of the CPP's "austerity" budget the following year only intensified the Bureau's fears of subversion. Citing a series of incidents including the recent sacking of an employee of the Bureau's Linguistics Section for exercising a "loose tongue" at a party at the American Embassy, Bureau officials, beginning in November 1961, sought to limit the public's access to the institution. This included cordoning off the Bureau for unauthorized personnel and making it illegal for others to photograph the institution's headquarters.²⁷ Additionally Barden and other members of the senior staff complained about a laxity of discipline in the Bureau. Barden noted how employees and even certain members of the senior staff would arrive late for work, while also breaking early.²⁸ Three years later, Barden and the Bureau's other top officials can still be seen dealing with many of these same issues as they addressed the case of Mark Aloo-Kessie, a northerner who had been seconded to the Bureau from the United Ghana Farmers' Cooperatives' Council (UGFCC). In their dealings with this man, Barden and his lieutenants accused Aloo-Kessie of everything from divulging Bureau activities to non-privileged

²⁶ GPRL, BAA/RLAA/961, Barden, "Mr. Oliveira Moita de Deus Luis Carlos," [n.d.].

²⁷ GPRL, BAA/RLAA/327, Meeting of the Bureau of African Affairs Senior Officers, Minutes, 21 November 1961.

²⁸ Ibid.

personnel to the spreading of lies about his previous wages at the UGFCC.²⁹ Even more disconcerting to the Bureau's leadership was Aloo-Kessie's tendency to invoke Nkrumah's name in his personal affairs by, at least in one instance, reportedly claiming that Nkrumah sent him to the Bureau "to spy on the Director [Barden]."³⁰ Moreover, Aloo-Kessie's accusers went on to assert that their colleague had ridiculed the Bureau's leadership by citing shortages of food, cigarettes, and other commodities in the Bureau's camps and freedom fighter community. Coupled with his invocation of Nkrumah's name, Aloo-Kessie's condemnation of the Bureau's administration eventually proved too much for the institution, resulting in the termination of his secondment in October 1964 after a brief period of surveillance.³¹

In less dramatic circumstances, issues of talkativeness and rumor mongering framed much of the debate over workplace security and discipline in the Bureau. As did all other government and party employees in the Nkrumah era, Bureau employees took an oath of secrecy upon their employment.³² The oath, however, did little to quell Bureau officials' concerns about the spread of illicit information inside and outside the BAA's offices. Technological innovations such as the telephone proved particularly worrisome for BAA officials. The agency's telephone networks, they suggested, were a space rife for both foreign and internal manipulation, since telephones provided an often unwanted conduit into the Bureau's daily activities. Furthermore, it was argued, telephone access weakened the Bureau's productivity

²⁹ GPRL, BAA/RLAA/159, Meeting in the Director's Office, Minutes, 28 September 1964.

³⁰ Ibid.

³¹ GPRL, BAA/RLAA/159, E. Ofori-Bah to Mark Aloo-Kessie, "Termination of Temporary Secondment," Accra, 21 October 1964.

³² GPRL, BAA/RLAA/337, Republic of Ghana, "Oath of Secrecy," [1964?].

as, according to certain officials, it allowed employees—with a likely emphasis on female employees—to waste frivolously the day away on personal calls by providing them access to the general public during working hours.³³ Even in the Bureau's case against Aloo-Kessie, the telephone would come to play a foundational role in the charges against him. His accusers noted claims that Aloo-Kessie had reportedly made about possessing eight separate telephone numbers that would give him direct access to the President. For Barden and the Bureau's other top officials, Aloo-Kessie's telephone claims—much as his others—read as a not-so-veiled threat to their leadership and in turn the Bureau's mission in Ghana and the continent at large.³⁴

Fears over the security of the telephone also reached other government offices, including Flagstaff House, where security officials inveighed against the dangers of telephone usage in the workplace.³⁵ However, concerns over the use of the telephone and to a lesser extent other communication technologies in the Bureau point to broader tensions within the burgeoning Nkrumahist state, since the government sought to weigh concerns over security and discipline with Nkrumah's own fascination with all that was new and modern. From at least the mid-1950s, Nkrumah and other party officials had singled out the extension of the country's telecommunications systems as a central element in the creation of

³³ See below.

³⁴ GPRL, BAA/RLAA/159, Meeting in the Director's Office, Minutes, 28 September 1964.

³⁵ PRAAD-Accra, Record Group (RG) 17/2/110, Chief Bodyguard to Chief Officer, "Outside Calls on Presidential Telephone: Mr. E. Y. Yerenkyi," Accra, 13 November 1964. Also, see a 1962 report from the Volta Regional Commissioner, H. K. Boni, to Nkrumah asking that the government establish direct lines between his house and office with those of Nkrumah so as to "avoid any leakage" in the nation's security; PRAAD-Accra, Special Collections [SC]/BAA/150 (RG 17/1/85), Volta Regional Commissioner to Nkrumah, "Security and Political Report on the Volta Region," Ho, 1 February 1962.

the modern nation he imagined. Writing in an April 1956 edition of the *Evening News*, for instance, Kojo Botsio brought this belief to the fore, when he cited the addition of sixteen new trunk circuits—lines connecting switchboards—to the then colony's nascent telecommunications system as one of the party's greatest achievements in the preceding year. As a result of this endeavor, Botsio noted, the Gold Coast government was thus able to increase the number of operating telephones in the colony to over 2,200.³⁶ Seven years later in 1963, the release of the CPP's new Seven-Year Development Plan (1964-71) again highlighted the centrality of telecommunications to the government's modernization, since the Plan dedicated nearly £10 million to the expansion of the country's telecommunications systems.³⁷ Even inside the Bureau, the necessity and the allure of innovation drove recommendations for the creation of at least two new telephone lines in 1962 and the creation of an internal telephone system to better accommodate the institution's growing press requirements.³⁸

Inside the Bureau's disciplinary regime, though, security tended to trump innovation, at least as it pertained to administration-employee relations. Beginning by at least 1961, most employees faced severe restrictions on their access to the Bureau's telephones, as well as to the types of information they could discuss over the phone.³⁹ Furthermore, for Bureau officials,

³⁶ Botsio, "CPP Gov't Achievements 1955-56: Sessional Review," *Evening News*, 6 April 1956.

³⁷ PRAAD-Accra, RG 8/2/863, Office of the Planning Commission, *First Seven-Year Development Plan (Draft)* (March 1963), ch. 5, 6-7. Also, see "More About the Seven-Year Plan: Focus on Work and Happiness," *Evening News*, 23 April 1963.

³⁸ GPRL, BAA/RLAA/251, Douglas Rogers, "General—What the Rotary Will Produce," Accra, 16 February 1962.

³⁹ GPRL, BAA/RLAA/376, Barden, "General Office Instructions—All Staff," Accra, 5 September 1961.

security concerns bled into broader disputes over productivity. Telephone usage, even at its most innocuous, had the potential to lead to idle chatter and gossip. In response, officials demanded additional supervision regarding all employee movements on the job.⁴⁰ The result was a workplace whereby employees faced often severe sanctions for leaving their desks or designated workspaces without permission. The September 1961 set of office rules even called upon the Bureau's senior staff to meticulously document employee movements on the job, apparently including those during one's free time, as shown by a 1962 incident involving a group of women chastised for eating their lunches outside the Bureau's official canteen.⁴¹ In the report against these women, Bureau Assistant Secretary D. B. Sam cites a lack of hygiene and in turn a "considerable decline in [the women's] standard of discipline" as the official reason for their sanction and their resultant three-day suspension and forfeiture of pay. Yet the severity of their punishment suggests an underlying concern with issues of security pertaining to the women's desire to socialize outside of management's direct supervision. Sam promised "more severe action" should these women "be found guilty of breach of discipline" in the future.⁴²

More than just an idle threat, promises of disciplinary action proved a central component of the Bureau's work life, yet one not surprisingly meted out in unequal ways. As the Bureau's own minutes and memos illustrate, senior staff regularly violated

⁴⁰ Ibid.

⁴¹ Ibid. GPRL, BAA/RLAA/215, D. B. Sam to Comfort de Souza, Accra, 19 April 1962. The same letter with different addressees also appears in the personnel files of Dinah Patterson (BAA/RLAA/237), Victoria Cosmas (BAA/RLAA/134), and Felicia Welbeck (BAA/RLAA/217). Other women included in the incident were Kate Kissieh, Gladys Kumah, Mercy Lamptey, Mable Akuffo, and Gloria Lamptey.

⁴² GPRL, BAA/RLAA/237, Sam to Dinah Patterson (2), Accra, 19 April 1962.

institutional and state policies on the job. Not only did they leave their desks unattended and confidential files open to the public, but, as noted above, many apparently even absented themselves from whole workdays entirely without notice.⁴³ The result was an institution in which many of the Bureau's most integral tasks, including the publication and dispersal of its own news organs, were left neglected and months behind. In both 1963 and 1965, for instance, this apparent lack of professionalism came to a head with delays in the publication of the *Voice of Africa*, leading to the censure of its editor, B. Myers-Biney, in 1963, and the removal of Boakye Kwakwa from its editorship two years later.⁴⁴ Writing in response to the former case, Barden accused Myers-Biney, after having "been given every opportunity to learn and reform," of attempting "to ruin the work of our Leader and the nation" with his indiscipline.⁴⁵ Yet, despite the seriousness of Myers-Biney's offence and the repeated nature of his indiscretions, it appears that, beyond a brief probationary period, Barden took little in the way of formal disciplinary action against his assistant secretary. Instead, he and his associates reserved their harshest and most personal criticism—not to mention punishments—for their female employees, much as they did with the women eating outside the Bureau's canteen.⁴⁶

⁴³ GPRL, BAA/RLAA/327, Meeting of Senior Officers, Minutes, 21 November 1961.

⁴⁴ GPRL, BAA/RLAA/120, Barden to B. Myers-Biney, "Publication—Circulations by the Bureau," Accra, 16 December 1963; GPRL, BAA/RLAA/327, J. K. Appiah to Boakye Kwakwa, "Termination of Appointment," 15 October 1965.

⁴⁵ GPRL, BAA/RLAA/120, Barden to Myers-Biney, "Publications—Circulations by the Bureau," 16 December 1963.

⁴⁶ Ibid. For a full accounting of Myers-Biney's indiscretions and eventual promotion up to the directorship of the AAC, see his personnel file; GPRL, BAA/RLAA/120, "B. Myers-Biney."

Discipline, Gender, and Modernity in the Pan-African Workplace

From early on in the institution's history, discussions of discipline in the Bureau took a distinctly gendered tone. As in an increasing number of workplaces throughout the nascent state, women joined the Bureau serving as cooks, clerical assistants, telephone operators, typists, and bookbinders, among other positions. For these women, part of a global generation of women making their way into the world's offices, the Bureau offered them access to the formal sector and the steady paychecks it entailed. As typists, for instance, the Bureau's women took home paychecks beginning, at least by 1965, at around £10 per month.⁴⁷ At home, these paychecks could be used to either supplement the family income or, as in the case of many women in the informal sector, held for personal use.⁴⁸ Furthermore, in the press, working women were presented as one of the icons of a new Ghanaian modernity. The CPP and others celebrated what they saw as the female population's seeming transition into the modern, disciplined, and productive workforce required of the envisioned Nkrumahist state.⁴⁹ Inside the Bureau, though, female employees often worked under a stigma that classified them as inefficient and unproductive workers and, as in the case of the women cited above, threats to the modernity and hygiene of the workplace. The result was a context whereby these women received undue attention from their male supervisors, while also having extreme actions taken against them for even the most minor offences.

⁴⁷ GPRL, BAA/RLAA/222, Jonathan Tetteh Yumu et al. to Ofori-Bah, Accra, 11 November 1965. An undated complete list of worker pay scales appears in GPRL, BAA/RLAA/633, Bureau of African Affairs Pay Schedule, n.d.

⁴⁸ See Lindsay (2003a: 43-6). On traders, see Robertson (1984); Clark (1994).

⁴⁹ See my discussion of female tractor drivers in the Ghanaian Builders Brigade (Ahlman 2012: 97-8).

Foremost shaping the BAA management's impressions of its female workforce were the issues of sick and maternity leave, of which Bureau officials tacitly labeled as uniquely women's problems and distinct threats to the Bureau's proper operation and in turn the security and fruition of the Nkrumahist state. Writing in a 1962 report on a young clerical assistant named Dinah Patterson, Bureau Assistant Secretary Sam openly mocked Patterson for her recent absence from work, exclaiming in his report that Patterson reportedly could not work because of "a boil attack on a vital part of her anatomy!"⁵⁰ Three weeks later, after missing work once again, Miss Patterson received another letter from Sam describing her "habit [of falling ill as] incompatible with the efficient running of the Bureau." More to the point, Sam then proceeded to accuse Patterson of setting "a precedent which is likely to be followed by other members of the staff." For this reason, he proclaimed that her "case [was] getting intolerable" and surmised that, as a result of her and what he anticipated to be others' absences, "our output would drop and the Bureau will not deserve its existence."⁵¹

Similarly, on another occasion, clerical assistant and telephone operator Mercy Odoom lost a day's pay and received a warning for attending to a sick child in 1965. Odoom, who does not appear to have had a history of frequent absences or other significant disciplinary issues, promised her bosses that this would be an isolated incident. However, an apparently frustrated D. A. Dzima, another of the Bureau's assistant secretaries, responded to Odoom's claims by dismissively noting in his report that "This is

⁵⁰ GPRL, BAA/RLAA/237, Sam to unknown, Accra, 6 February 1962. Exclamation in original.

⁵¹ GPRL, BAA/RLAA/237, Sam to Patterson, Accra, 28 February 1962.

the usual lame excuse offered by our young mothers.”⁵² Debate over Odoom’s case went all the way to the Bureau’s highest ranks, with E. Ofori-Bah, the Bureau’s new Director and longtime Executive Security, responding in agreement to Dzima’s assessment of Odoom’s “excuse.”⁵³ In other instances, women were openly defamed, such as Victoria Menka whom a 1964 report described as simply “another lazy girl who goes out more than ten times a day.”⁵⁴ Even more disturbing, still others—including school-age expatriates—apparently became the objects of sexual intrigue among key members of the BAA and AAC senior staff. Bureau files directly and indirectly linked figures as high up as Ras Makonnen (and, external sources, Barden) to accusations of sexual malfeasance with the Bureau’s female employees, wards, and women in general.⁵⁵

In all of these instances, issues of gender, generation, and class contextualized the Bureau’s treatment of its female staff. Rarely did even the most unproductive men ever suffer from the same scrutiny and ridicule as these women.⁵⁶ This was ridicule that, at least in the case of Dinah Patterson, not so subtly connected imagery of the female body with threats to institutional and state security. Moreover, Bureau administrators appeared to have reserved this ridicule and criticism for Ghana’s so-called “modern

⁵² GPRL, BAA/RLAA/232, Dzima to Odoom, Accra, 13 December 1965. The quote is from an inter-office note attached to the bottom of the letter addressed to E. Ofori-Bah.

⁵³ Ibid.

⁵⁴ GPRL, BAA/RLAA/187, E. A. Tetteh-Batsa (?) to Barden, “Misbehaviour of V. Menka,” Accra, 6 February 1964.

⁵⁵ GPRL, BAA/RLAA/729, Williams A. Utchay to Makonnen, Accra, 23 July 1962; National Archives-Kew (NA), Dominions Office (DO) 164/40, “Ghanain [*sic*] Pan-Africanist Activities,” 2 January 1962; GPRL, BAA/RLAA/365, Nancy W. Mungai to Principal Secretary, African Affairs Secretariat, Accra, 15 September 1965. I want to thank Jean Allman for sharing this file from the NA.

⁵⁶ Cf. the above discussion on B. Myers-Biney.

women.” For the most part, these were relatively young women who had benefited from the opportunities opened by the educational reforms initiated by the CPP in the early 1950s, the most important being the 1952 introduction of fee-free primary education.⁵⁷ By the early 1960s, these women were now making their way into the workforce and, according to the CPP’s own rhetoric, were evolving into active contributors to the country’s nation-building project.⁵⁸ As Nkrumah (1969: 196) himself would boast following the 1960 inauguration of the First Republic, Ghana’s women had now “taken their places side by side with men” by advancing the country’s development in a range of fields including politics and chieftaincy. Even internal party publications appeared dedicated to the cause of gender equity in the workplace, with the *Party Chronicle*, for instance, proclaiming in 1963 that any discrimination against women on the job was not only un-socialist and un-African, but also “a crime against our womanhood.”⁵⁹

Yet, the actions taken against the Bureau’s female employees and particularly the rhetoric used against them were not necessarily unique to the Bureau. Rather, they were indicative of a broader trend in how male officials sought to make sense of women’s increasing prevalence in the country’s workplaces. Writing in a 1962 edition of *The Ghanaian*, Kwesi Bonsu in his regular “It Occurs to Me” column openly questioned the wisdom of allowing too many young women into the nation’s workplaces by arguing

⁵⁷ On the CPP’s educational reforms, see George (1976); Zimmerman (2011).

⁵⁸ At the time of independence, for instance, approximately 11,000 Ghanaian women had wage-earning employment in the formal sector. By 1960, Miranda Greenstreet (1971: 222) estimates that that number had increased to 16,000 and, by the time of the 1966 coup, to almost 35,000.

⁵⁹ PRAAD-Kumasi, ARG 17/6/7, “Attitude Towards Women’s Employment,” *Party Chronicle*, 11 December 1963.

that “[m]any of our girls I find in the offices do only a few hours work for a whole week.” This in turn, Bonsu continued, created an atmosphere whereby these “working girls” passed their time in “silly talk and sheer gossip.”⁶⁰ Similarly, other writers appeared to conflate all types of wage employment—manual labor and office work—when they argued that women were simply not physically built to handle the type of work necessary to build a modern nation, a fact of nature purportedly proven time after time “for many hundreds of years.”⁶¹ The result, one author argued, was that women themselves believed it to be unjust, presumably in any field, to accept “equal pay for equal work.”⁶² Furthermore, by mid-1963, even Nkrumah began characterizing women workers in such ways, as he had noted in his May Day broadcast: “how our telephones girls who are normally so friendly, polite, and well-behaved at home are rude and abrupt” in the workplace. “In the shops,” he explained, “the assistants ignore customers while they chat among themselves and treat them [the customers] with nonchalance and disrespect, forgetting that but for these same customers they would not be in employment.”⁶³

Here, as in the Bureau, there was more at stake for men than women’s apparent unreliability on the job. The perceived inundation of women into the world of formal, wage-earning employment threatened men’s positions in their communities and homes. Men, it was argued, were to care for their families, support their wives, and, at least for the nationalists, build the nation.⁶⁴ In Ghana, as elsewhere, the maintenance of this familial arrangement

⁶⁰ Bonsu, “It Occurs to Me,” *The Ghanaian*, January 1962.

⁶¹ “Is There Equal Work Between the Sexes?,” *The Ghanaian*, August 1964.

⁶² *Ibid.*

⁶³ PRAAD-Accra, SC/BAA/40 (no RG number), Nkrumah, “Broadcast by Osagyefo the President on 30th April 1964.”

⁶⁴ On African breadwinners, see Lindsay (2003b).

through specialized knowledge gained in the workplace thus emerged as a central feature of the masculine identity of many so-called modern men. The workplace—whether it be the office, the shop floor, the docks, or a construction site—was a site for a unique form of knowledge production and control in not only mid-century Ghana, but in world historical terms more broadly.⁶⁵ Similar to industrial societies in the West, where the nineteenth- and twentieth-century deskilling of the labor force had strengthened workers' self-identification with their work, key groups of Ghanaians—on the job and in the press—encouraged the development of new, often patriarchal strategies through which to monopolize masculine knowledge and skill in the workplace. In the Bureau, among other settings inside and outside Ghana, these strategies included the sexual segregation of the workforce, the maintenance of differentiations in wages, and the denigration of female workers, since male officials and others aimed to protect their own positions as men, workers, breadwinners, and nation-builders.⁶⁶

The result was a social environment whereby women who left the home often endured acute forms of surveillance and skepticism from their male colleagues and bosses and, in so doing, faced regular questions about their abilities to balance their obligations in the home (productive and reproductive) with those on the job. This problem, though, at least as argued here, was one that was perhaps most dramatically felt in highly politicized settings such as the

⁶⁵ See Rule (1987); McKelland (1987). In the case of Africa specifically, see Crisp (1984); Cooper (1987).

⁶⁶ Outside the Bureau, for instance, Jennifer Hart (2011) cites the gendered workplace identities and strategies of *tro-tro* and taxi drivers. Likewise, Emmanuel Akyeampong (1997: 169) and Bianca Murillo (2011: 345-6) note how Gold Coasters/Ghanaians used the term "UAC" (United Africa Company) to stigmatize successful businesswomen. For a non-Ghanaian example, see Rose (1988, 1992).

Bureau of African Affairs, where worker productivity tended to be read in terms of state security and progress along the path towards continental liberation and unity. For the women working in these settings—most of whom did not come from elite or high-profile families, but instead were attracted to the security, opportunity, and perceived independence that government and party employment offered them—their work in the Bureau and similar institutions, while often publicly celebrated as the embodiment of progressive Nkrumahist notions of modern African womanhood, also cast them as distinct threats to the supremacy of men's positions within this particular and a generically conceived workplace, even if men rarely completed the tasks for which these women were hired. However, as the Bureau expanded in the early and mid-1960s, the institution's male officials increasingly found themselves with little choice but to hire more women and, in certain cases, even supervise aspects of their education (i.e. typing school), if they were to fulfill the institution's mission at home and abroad. The result, seemingly to the dismay of many of the Bureau's male officials, was a reality whereby the institution's presumed most volatile and undisciplined employees were increasingly put on the frontlines of the struggle for continental liberation. It was these women—as they typed, bound, filed, and answered phones for the Nkrumahist revolution—who shaped the daily life of the Bureau and perhaps had the most to lose in 1966.

Work, Discipline, and the Bureau's Decline

Similar to most CPP-era institutions, the Bureau of African Affairs was a casualty of the 24 February 1966 coup overthrowing Nkrumah and his government. Yet, the weakening of the Bureau had actually begun several months in advance of the coup with the implementation of a plan to re-organize the government's national

security apparatus. Under this plan, advanced to the Bureau by Nkrumah himself, the government intended to divide the Bureau into three independent departments: the Operations Department, the Political Department, and the Bureau Press Department.⁶⁷ This re-organization, Nkrumah explained to Barden, was necessary so the Bureau “may not only function more efficiently and effectively, but take on more responsibilities.” Moreover, Nkrumah argued, it was to free Barden—who was to remain the Bureau’s director—to concentrate more fully on the Bureau’s continental operations, namely work “assisting the freedom fighters movement in Africa” that Nkrumah, at least here, deemed of the utmost importance.⁶⁸ Likewise, Nkrumah designated Barden’s longtime Executive Secretary Ofori-Bah as head of the new Political Department, and Kofi Batsa, the editor of *The Spark*, was to head and serve as editor-in-chief of the Bureau Press.⁶⁹ However, less than a week after Nkrumah announced his plans to Barden, Nkrumah relieved him of all his posts at the Bureau following an unspecified dispute presumably tied to this re-organization, resulting in Nkrumah’s promotion of Ofori-Bah to the Bureau’s directorship.⁷⁰

The effects of the Bureau’s transition on the institution’s workforce are not necessarily clear. Little appears to have changed in the Bureau’s disciplinary regime or gender relations, with, as Mercy Odoom’s case shows, Bureau officials still defining their female employees as significant threats to the institution’s productivity as well as its security. Other employees, not surprisingly, also faced vehement reactions from their bosses for addressing a growing array of rumors and popular narratives about

⁶⁷ PRAAD-Accra, SC/BAA/357, Nkrumah to Barden, Accra, 4 June 1965.

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ PRAAD-Accra, SC/BAA/357, Nkrumah to Barden, Accra, 10 June 1965.

the President's potential demise in late 1965, including one security guard who—days before Nkrumah was to visit the Bureau—claimed to have dreamt about saving Nkrumah and his family from a series of assassination attempts.⁷¹ However, certain employees did seek to use this period of transition as an opportunity for personal and professional gain. Writing to Ofori-Bah in November 1965, a group of six typists—one man and five women—petitioned their new director for a re-evaluation of their pay scale. More importantly, they did so by speaking directly to the Bureau's interests in security and party loyalty. "We feel that we are doing a very important job for the Bureau," Jonathan Tetteh Yumu explained on behalf of himself and his fellow female typists, "since most of the things we type are strictly private and confidential."⁷² As Yumu continued, he made a direct gesture to the sense of socialist collectivity, discipline, and productivity, which the Bureau's leadership cultivated in its workforce. Yumu proclaimed: "We want to make it clear that we are not out to cause trouble but rather we are only asking that our position should be improved a bit in order to enable us to give more efficient and loyal service to the Bureau."⁷³

An answer to the petitioners' request does not appear to have survived, if it ever existed, nor does an account of what happened to the institution's staff following the coup. Like with most other controversial CPP programs, the Bureau underwent an almost immediate disbanding, with only the AAC (reconceived as a

⁷¹ GPRL, BAA/RLAA/230, Senior Research Officer, "Security Precaution RE: The Visit of Osagyefo the President to the Bureau of African Affairs," Accra, 13 December 1965.

⁷² GPRL, BAA/RLAA/222, Yumu et al. to Ofori-Bah, Accra, 11 November 1965.

⁷³ Ibid.

student hostel) surviving.⁷⁴ What this disbanding meant for the Bureau's staff is unclear, but, if the case of the Kwame Nkrumah Ideological Institute is at all instructive, the coup likely left most of its employees in a state of limbo and fear, as the NLC wavered in how it wished to treat non-political employees of such explicitly political organizations like the Bureau and Ideological Institute. Questions of how to reign in governmental waste without dramatically expanding the country's unemployment rolls overshadowed the fate of these workers under the NLC.⁷⁵ For the employees of these institutions, however, the effects of the coup were immediate. They faced not only the likelihood of at least the eventual loss of their jobs, but also (and even more immediately) threats of public "molest[ation]" for their efforts "to earn our living as honest and hardworking workers" for Ghana, as one group of Ideological Institute employees described to the NLC.⁷⁶ The coup likely recast the Bureau's employees—no longer dedicated laborers for the state and continent—as little more than recipients of Nkrumahist patronage, when public recognition of their work shifted from valorization to demonization literally overnight.

Conclusion

Nearly fifty years after the institution's demise, the Bureau of African Affairs maintains a unique legacy in Nkrumah-era Ghana.

⁷⁴ PRAAD-Accra, RG 3/5/1636, Office of the NLC, "Special Audit Investigations Ordered by the National Liberation Council," 19 April 1966.

⁷⁵ PRAAD-Accra, RG 3/5/1642, E. K. Minta to NLC, "Staff of the Former Ideological Institution," Accra, 16 May 1966; PRAAD-Accra, RG 3/5/1642, J. E. Pessey to Minta, "Staff of the Former Ideological Institute," Accra, 16 June 1966. Similar debates took place in the NLC in regards to the Builders Brigade. However, unlike the Bureau and the Ideological Institute, the Brigade continued to play an influential role in Ghana well after the coup (Ahlman 2012: 102-5).

⁷⁶ PRAAD-Accra, RG 3/5/1636, E. K. Acquah et al. to NLC, Winneba, 4 March 1966.

At its most foundational level, this legacy has little to do with the Bureau's many controversial anticolonial operations throughout the continent or its maintenance of "secret" freedom fighter-training camps in the country—the subjects to which most scholars have turned in their (usually brief) references to the Bureau. These references offer dramatic, if not romantic images of Ghanaians actively participating in the movement for continental liberation for those sympathetic with the Nkrumahist cause and, by contrast, a paradigmatic example of the subversion, wastefulness, and corruption of the Nkrumah regime for his critics.⁷⁷ Even contemporary popular narratives surrounding the activities of the Bureau and similar Nkrumah-era institutions reflect such dichotomous distinctions. Speaking on Nkrumah's Pan-African mission as a whole in December 2007, one longtime Accra resident and former supporter of the Ga Shifimo Kpee explained that he, like many others, simply could not understand why Nkrumah would invest so much time, energy, and money into the distant lands of eastern and southern Africa, while the markets at home were void of such urban staples as milk, sugar, and sardines.⁷⁸ Others, in contrast, celebrated in what they saw as the collegiality and sense of shared mission Ghanaians showed towards the broader African struggle through the work of institutions like the Bureau of the African Affairs.⁷⁹

The uniqueness and importance of the Bureau, however, extends well beyond such narratives of liberation, beneficence, and corruption. For, it is in the relatively mundane act of archival collection and preservation that the Bureau becomes exceptional in the histories of Nkrumah-era Ghana. No other of the Nkrumah

⁷⁷ Cf. Thompson (1969); Mensah (1990).

⁷⁸ Interview with Thomas Daniel Laryea, Accra, 6 December 2007. Also, see interviews with Eden Bentum Takyi-Micah, Accra, 17 March and 10 May 2008.

⁷⁹ Interview with Ben Nikoi-Oltai, Accra, 27 November 2007.

institutions, including the CPP, the Young Pioneers, the Farmers Council, and the Builders Brigade, at least to my knowledge, created such a complete and informative archival record.⁸⁰ The Bureau's little used archive offers an intimate glimpse into the internal workings of one of the cornerstone initiatives of the Nkrumah regime. Personnel files, circulars, memos, reports, letters to and from freedom fighters (prominent and obscure), and newspaper clippings not only catalog key Bureau activities inside and outside Ghana but more importantly detail daily life in the heart of the Nkrumahist Pan-African project. If, as Jean Allman (2013) suggests, the postcolonial archive possesses new challenges and possibilities compared to that of its colonial predecessor, the Bureau archive and the histories that could potentially emerge from it raise the stakes of Nkrumah-era and CPP historiography. Incomplete and replete with the "phantoms of the archive" that Allman celebrates, the Bureau archive specifically hints towards the wide-ranging processes encapsulating the social construction of the Nkrumahist Pan-African and socialist ideal as a lived experience in early postcolonial Ghana. Here in the Bureau as in other state- and party-run institutions, if not in other private workplaces, groups of typists, clerical assistants, bookbinders, and other wage-earning employees coped with the political and gendered pressure of becoming the "good," disciplined, and ideologically sound workers Nkrumah imagined, while, at the same time, through their purported malfeasances, highlighted the limitations of this ideal.

⁸⁰ The Builders Brigade via the files on the Ministry of Defence at PRAAD-Accra (RG 14/1/-) perhaps comes the closest among these institutions, but even then it pales in comparison to the nearly 1000 files found in the Bureau archive at the Padmore Library.

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STAGING UNITY, PERFORMING SUBJECTIVITIES: NKRUMAH, NATION-BUILDING, AND THE GHANA DANCE ENSEMBLE

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This article explores how Kwame Nkrumah and subsequent Ghanaian leaders used Ghana's state dance ensemble to create and solidify a sense of unity among this nation's citizens by propagating ideologies of African Personality and Pan-Africanism. Performing a diverse repertoire of dances, the Ghana Dance Ensemble has continually encouraged individuals to cross ethnic and national boundaries. Examining how artists variously interpret, embody, and express nationalism through music and dance performance, I interrogate processes by which performers reconcile national identity within themselves as it comes into contact with a pre-existing set of beliefs, identities, memories, and ontologies. I argue that while nationalism largely pushes individuals into an objectifying unitary identity, it is nevertheless embodied subjectively, according to the will of individuals.

Keywords: Nationalism, dance, music, performance, African Personality.

I am depending upon the millions of the country, and the chiefs and people, to help me to reshape the destiny of this country...We are prepared to pick it up and make it a nation that will be respected by every nation in the world...We have awakened. We will not sleep anymore. Today, from now on, there is a new African in the world!
Kwame Nkrumah, 6 March 1957

¹ Gratitude goes to all the participants in Ghana's national dance ensembles. Particularly I would like to thank their current directors, Ben Ayettey and David Amoo, as well as past directors, Francis Nii-Yartey, E. A. Duodu, and Oh! Nii Kwasiwa. This work would not have been possible without the assistance of Apetsi Amenumey and the generosity of Prof. J. H. Kwabena Nketia.

The Map

As the guitar of a Youssou N'Dour track sounded a cheerful melody, six female dancers, one by one, skipped onto the stage of the National Theatre of Ghana. Clad in the red, green, yellow, and black star of the Ghanaian flag they swung their large calabashes as they moved to their positions in a semi-circle at the back of the stage. They began a refrain of unison movements, collecting imaginary water as they moved their calabashes with ease. They continued this playful sequence as a male dancer entered from stage left performing a series of elegant gestures and acrobatic rolls. Two more dancers quickly followed, all dressed in costumes that streamed with the colorful symbolism of the Ghanaian flag. They paused, as two more dancers entered from backstage, performing a series of elongated movements, spins, and stretches in perfect unison. The audience, comprised of Ghana's President J. A. Kufuor, a host of government officials, teachers, and school children, watched quietly as the five male dancers came together. They performed a complex series of contemporary dance movements in close proximity, blurring the boundaries between them, uniting them in a bundle of spins, turns, gestures, and rhythms. Three dancers exited the stage, leaving a pair of dancers to perform a short duet as the female dancers continued their refrain. The duet included a combination of counterpoint and unison leaps and lifts. After mirroring each other's movements one leapt into the other's arms. They displayed their strength as they balanced in a statuesque form. The female dancers, still gesturing with their colorful calabashes, moved forward and consolidated behind the male figures. The male dancers triumphantly stretched out their arms, while all the dancers continued to close in, forming a mass of moving bodies, as the audience applauded.

Suddenly, the female dancers scattered offstage, and a new song played on the speakers. “Africa oh!” the chorus sang, while the dancers quickly scurried to their positions for the second movement of this dance suite. The dancers formed groups of four – three males fronted by a female dancer. Moving in rhythmic harmony they made their way forward while performing gestures and turns. After a few movements and brief pauses, the male dancers broke away to form a tight mass in the center of the stage. Looking left, looking right, leaping, rolling, bending forward and back all in unison, they embodied social solidarity. They quickly ran off stage and the audience applauded.

A moment later, two females came to the back of center stage. The curtain behind them slowly opened to reveal a giant three-dimensional map of Ghana with a framework outlining the various regions of the country. As the map became recognizable to the audience, they cheered. Several male dancers then dutifully walked in a line onto the stage, each carrying a large colorful cardboard object that resembled a particular region of the country/map. They paraded the regions of Ghana around the stage before bringing their pieces to the map. One by one, the dancers inserted the pieces into the appropriate positions. As the map was filling in, applause started to build, and as the final piece was hoisted into place the audience let out whistles, thunderous claps, and yells of joy and approval. The dancers, male and female, then united in front of the map, bobbing to the musical refrain “Africa, Africa, Africa, eh!” Fanning out across the stage, they danced, combining movements from the various Ghanaian regions that were represented in the multicolored map behind them. In unison, a pair of dancers leapt into the arms of their respective partners, and posed for the final time as the singer let out a climactic “Africa!” (see Fig. 1).



Figure 1. Ghana Dance Ensemble (Legon) performing “The Map” at the National Theatre, Accra. Photograph by author.

This choreography was an original artistic work performed during the nation’s Golden Jubilee anniversary by the Ghana Dance Ensemble (GDE) – a state-sponsored troupe formed in the wake of independence. On 11 April 2007 the Ministry of Education, Science, and Sports (MOESS) launched “Education Reform 2007.” To give cultural expression to this political action MOESS called upon this national dance company to perform a piece that would, as the emcee stated, “unify the country around education reform.” Watching the performance I was reminded that as education must be reformed and updated to suit the present so too nationalism must be reshaped to resonate with contemporary times. This particular educational reform, which was curiously similar to the scheme of the U.S. grade level system, aligned the Ghanaian academic system more closely with North America, whereas previously it had been aligned with Britain. The dance, however, re-affirmed Ghana’s national identity, and connection with Africa.

State officials and organizers of this event were exploiting the power of music and dance to “integrate the affective and identity-forming potentials of both icons and indices in special ways,” that often are, “central resource[s] in events and propaganda aimed at creating social unity, participation, and purpose” (Turino 1999: 236). The icons and indices of each region of the map can also be associated with particular ethnic or language groups within Ghana. Thus, as the “geo-ethnic” pieces of the map came together and the dancers moved in rhythmic unison amidst the Afro-pop musical chants of “Africa,” the ensemble signified both Ghanaian and transnational unity; the performance produced an emotional outburst from the crowd of Ghanaians, indicating that these individuals were likely simultaneously basking in the achievements of their nation and continent. Five decades after Ghana’s independence, this ensemble continued to reinforce national and transnational solidarity, staging unity by propagating Nkrumah’s notions of African Personality and Pan-Africanism.

Nkrumah, African Personality, and Cultural Liberation

African Personality has a stand, and that stand is our culture, and our culture is our identity. We need to keep our identity. We need to keep our culture. We need to preserve it so that it will become our weapon to fight.

Abubakari Salifu Merigah, GDE member²

This article explores ways in which Kwame Nkrumah, and subsequent Ghanaian leaders, used music and dance to create and solidify a sense of unity among Ghana’s citizens. Namely, Nkrumah founded the Ghana Dance Ensemble (originally called the National Dance Company) to propagate his nationalistic

² Interview with Abubakari Salifu Merigah, Accra, 26 July 2006.

ideologies of African Personality and Pan-Africanism.³ Over the past several decades, through the performance of a diverse repertoire of dances, this state-sponsored troupe has continually encouraged individuals to form a cohesive nation by “going beyond ethnicity.” Spurred by a phenomenological attention to the intimate experience of individuals, I furthermore examine how artists variously interpret, embody, and express nationalism through music and dance performance. In other words, how do performers reconcile national identity within themselves, as it comes into contact with a pre-existing set of beliefs, identities, memories, and ontologies? I argue that while nationalism largely pushes individuals into an objectifying unitary identity, drummers and dancers push back by asserting their own sense of self. In this way, I suggest that while nationalism is often universalizing, it is nevertheless embodied subjectively, according to the will of individuals.

From its inception, the GDE has been an overtly nationalist project. It was initiated in 1962, five years after independence. Housed at the University of Ghana, the ensemble became the “nucleus” of the National Theatre Movement. This movement was an artistic extension of Nkrumah’s African Personality and Pan-Africanist ideologies (Botwe-Asamoah 2005; July 1987), which, in short, sought to unify diverse African culture groups to raise their “dignity” throughout the world (Nkrumah 1963: 174-75). This elevation of culture was necessary because, although Nkrumah and other African leaders had successfully gained independence for their countries (most before 1961), they continued to battle long-held prejudices and stereotypes about Africa. Additionally, by

³ The National Dance Company of Ghana was initiated in 1962, and often referred to as such until it was inaugurated five years later; in 1967, the name of the group was officially changed to the Ghana Dance Ensemble (GDE). Cf. Adinku (2000); Akrofi (2002: 34).

achieving independence many Africans consequently had to confront and create new identities as particular nationals, and Africans in general. Throughout its history, the GDE has embodied African Personality and Pan-Africanism through its staging of the nation. In this way, Nkrumah and subsequent leaders have transformed these ideologies into a tangible and powerful force in the world, indoctrinating citizens into new national and transnational identities.

As a young man growing up in the Western Region of the Gold Coast, Kwame Nkrumah excelled at scholastics, and in 1926, at the age of seventeen, he entered the teacher training college at Achimota. It was through his studies at Achimota with Dr. Kwagyir Aggrey, over the course of four years, that Nkrumah developed a deep passion for the ideas of cultural nationalism, Pan-Africanism, political national movements, and the liberation of the Gold Coast (Botwe-Asamoah 2005: 3). Aggrey encouraged his students to study the lessons of the past in order to overcome colonial rule in Africa. Emulating other Pan-African pioneers he had learned about through Aggrey, including Marcus Garvey and W.E.B. Du Bois (Taylor 1994: 87), Nkrumah took his professor's advice and continued his studies in the United States and Britain. At Lincoln University, Nkrumah received Bachelor degrees in Economics and Sociology, as well as in Theology. Later he obtained a Master of Science degree in Education and a Master of Arts degree in Philosophy at the University of Pennsylvania.

Subsequently, Nkrumah left for Britain where his academic credentials granted him an appointment on the organizational committee of the Fifth Pan-African Congress meeting to be held at Manchester in October 1945. At this conference, Nkrumah stated, "A definite plan of action was agreed upon" with the "fundamental purpose ... [of] national independence leading to African unity"

(Nkrumah 1963: 134-35). Realizing this ideal became the primary aim for the remainder of his life. Nkrumah, like many other African leaders, wanted to transform Africa into an influential world power. Nkrumah (1963: 193) proclaimed: "A Union of African States will raise the dignity of Africa and strengthen its impact on world affairs. It will make possible the full expression of the African personality."⁴

Emerging from his interpretation of African Personality, Nkrumah viewed the attainment of national independence as the first measure toward the restitution of African humanity. By way of numerous political maneuvers enacted through his Conventions People's Party, Nkrumah led Ghana to its independence on 6 March 1957 (Davidson 1989). At midnight on this date, Nkrumah gave the most important speech of his life. He told the thousands of Ghanaians assembled at Independence Square in Accra, "We are going to demonstrate to the world, to other nations, that we are prepared to lay down our own foundation – our own African identity...We are going to create our own African Personality" (Nkrumah 1957).

Overall, while prime minister and then president of the newly created nation of Ghana, Nkrumah's cultural policies were guided by his philosophical notion of African Personality. As he explained:

African personality is merely a term expressing cultural and social bonds which unite Africans and peoples of African descent. It is a concept of the African nation, and is not associated with a particular state, language, religion, political system or color of the skin. For those who project it, it expresses identification not only with African historical past, but with the struggle of the African people in the

⁴ African Personality is a phrase that is often attributed to seminal African nationalist Edward Wilmot Blyden (1832-1912); see Falola (2001).

African Revolution to liberate and unify the continent and to build a just society. (Nkrumah 1973: 205)

African Personality simultaneously embodied many forms of nationalism and transnationalism, as it created communities based on culture, territory, ideology, and language. In particular, Nkrumah's concepts position him as a "cultural nationalist," because his philosophies imply that the essence of a nation is its distinct culture. This conception stems from the Herderian idea that, "humanity is endowed with a creative force which endows all things with individuality – nations are organic beings, living personalities" (Hutchinson 1987: 12), and in Nkrumah's formulation, African personalities. Like many of his contemporaries (most notably, Léopold Senghor), Nkrumah ascribed to the notion that nations and national identity could be constructed, and should be built on a foundation of cultural practices.

Hence, as Robert July (1987) suggests, Nkrumah interpreted African Personality as a form of *cultural liberation* of Africa from the West, which attempts to re-assert and interject African modes of expression, aesthetics, ethics, philosophy, and art into the world. Although Ghana had achieved political independence in 1957, it had a long road to travel in order to realize the ambitions of African Personality. Namely, as Kwame Botwe-Asamoah (2005: 71) remarks, African Personality acknowledged that, "the mere achievement of national sovereignty could not ensure a cultural independence," and it was not faithful "unless it is rooted in African people's historical and cultural experiences." Therefore, before exporting African Personality to the world, Nkrumah had to first decolonize the culture of his own nation by utilizing African-centered approaches to policy formation.

Achieving this cultural independence, Nkrumah knew, was essential to the political and economic independence of Ghana and the rest of the continent. As July (1987: 19) notes, however, there must first be an “intellectual decolonization” before traditional African values could be revived, and then allowed to adapt to the environment of modernity. Nkrumah ascribed to the notion that indigenous elements may provide the “firmest foundation for building economically healthy, politically autonomous, and physically secure African societies” (ibid: x). Yet, according to July, Western cultural practices were so “deeply imbedded” in African life that the leaders of independence movements could not dismiss them entirely; nor did African leaders naively appeal to a romanticized African past. Rather, in many instances, they combined Western and African practices to re-invent traditions to suit Africa’s interpretations of modernity. Despite concerns that, “[Africa may be] degenerating into a collection of client states and economic satellites guided by an adulterant version of Western civilization ill adapted to the African environment” (ibid.), an ideology of fusing Western and African practices continued to be Nkrumah’s approach to the cultural liberation of Ghana, and, in turn, his policies directed at the arts throughout his presidency.

In short, the global and the local coalesced to shape nationalism in Ghana. The ideas of nation-state and colonial rule, which were imposed on Africans, had to be countered, in part, on their own (Western) terms, but also in ways that resonated with local Africans. The mobilization of indigenous cultural forms, Nkrumah asserted, was the most productive way to consolidate and galvanize African populations to create a distinct and viable *African* nationalism. Yet, Western practices and ideas were not wholly discarded, but reconfigured in African-centered ways. This is unsurprising given that nationalism is a “cosmopolitan”

phenomenon in which cultural forms and practices that are widely diffuse around the world are realized in locally specific ways (Turino 2000). African Personality and Pan-Africanism were the expressions of such a cosmopolitan form of nationalism. As part of Nkrumah's National Theatre Movement, which sought to institutionalize the cultural arts of Ghana, the GDE became a central platform for the realization and dissemination of these nationalistic ideologies.

A Dancing Cadre

Nkrumah was highly influential in the initial ideological objectives of the GDE, due partially to its location at the Institute of African Studies (IAS) at the University of Ghana, Legon. The first IAS director Thomas Hodgkin, appointed in 1961, was under the direct authority of Nkrumah who had made himself Chancellor of the University of Ghana that same year. This position allowed Nkrumah to hire faculty that were likely to further his own political and cultural policies. In 1962, Nkrumah tapped renowned ethnomusicologist Kwabena Nketia to head the newly established School of Music, Dance, and Drama. The same year, the IAS received a subvention from the Ministry of Culture to found a national dance company, later called the Ghana Dance Ensemble, with Nketia as its first administrative director (Akrofi 2002: 34). Nketia was appointed, I would argue, not only for his knowledge of various African traditions and Western academic credentials (Ph.D.), but primarily because he shared many of Nkrumah's views concerning the role of art to further African Personality. Nketia, according to July (1987: 181), "recognized the importance of cultural awareness in generating a desire for independence." Moreover, Nketia's conception of African Personality was similar to Nkrumah's. Nketia explained:

The concept of African Personality was meant to be at once liberating and creative, bringing into focus *African alternatives to Western values and institutions* that had been imposed upon subject peoples by colonialism. It was important to combat the claim to the universality of Western culture... [and] to put forward an African alternative that would assert a valid African civilization, both at home and abroad. (Nketia quoted in July and Benson 1982: 71; emphasis mine)

Like Nkrumah, Nketia asserted the need to create an African-centered approach to revitalizing indigenous traditions in order to overcome racism and colonial oppression. Furthermore, both men argued that idiomatic cultural performances would help establish Ghana as a unique nation, but, on the other hand, acknowledged that these cultural displays had to simultaneously resonate with international audiences.

Nketia was aware of the need for Ghana to resemble other nations to gain credibility as such. Regarding the circumstances of the dance ensemble's formation, he recalled:

We had a special relationship with London University...but Nkrumah wanted an independent university. At the time the University [of Ghana] was starting from scratch (1961) and we had to build on a tradition, too. It was good to have [a relationship with] London University which was a well-established university. In 1961, the University [of Ghana] became independent, but we still kept some of the mechanisms for ensuring standards. [In] those days it was important visibly to have certain standards that the academic world approved of, and for others to know they were also being maintained here.⁵

In short, by adopting European standards of education, the University of Ghana was aligning itself with the Western world and the international academic community.

⁵ Interview with Kwabena Nketia, Legon, 18 August 2005.

In addition to this outward visibility, Nketia attempted to ensure social stability within Ghana through means that resonated with local communities. In general Nketia shared Nkrumah's desire to institute practices that would influence a large group of individuals. He noted:

It is certainly my hope that in the creative arts there will be interaction between the narrow circle of intellectuals and the community at large, so that the gap between past and present, between the traditional and the contemporary can be bridged, creating social solidarity and national unity. (Nketia 1959: 2)

In other words, the arts were viewed by Nketia as a part of the post-colonial shift of nationalism from an elite-driven movement to one which attempted to include the masses.⁶ Consequently, Nketia recognized the vital role that regional practices would have to play to create this broad movement, remarking that, "It is only then that we can restore, through the media now available to us, the *African* concept of the arts as a form of community experience" (ibid. emphasis mine). This "traditional community experience" ascribed to past "African" societies, however, was becoming reconfigured to serve contemporary nationalistic agendas, such as unifying the country's populace in order to create a Ghanaian community. Namely, Nketia's aim as the first Ghanaian IAS director (appointed in 1965) was to train students so that they could eventually teach in the national school system, forging a new community of citizens, or cadre, which would propagate African

⁶ It has become a commonplace assertion in scholarly discourse that African independence struggles were primarily elite-driven movements; cf. Cooper (2002); Davidson (1992); Falola (2001); Freund (1998); Shillington (1989: 374-408). Recently, Africanists have begun to explore the ways in which national sentiment was subsequently transferred to the citizenry in the post-colonial period – i.e., the masses; cf. Allman (2004); Askew (2002); Geiger (1997); Moorman (2004, 2008); Peterson (2004).

Personality within Ghana and abroad. Therefore, one of Nketia's most important tasks was to hire faculty to carry out these objectives.

In 1962, Nketia chose Mawere Opoku as the first artistic director of the National Dance Company (later GDE). Nketia did so, I argue, for three primary reasons: 1) Opoku's knowledge of indigenous traditions, 2) his Western training, and 3) his nationalistic ideologies. Opoku was brought to Legon by Nketia in part for his exceptional abilities in the traditional arts of Ghana. Both sides of Opoku's family were Asante chiefs, ensuring that Opoku had received special training in traditional lore and etiquette. As a result, Opoku was especially sensitive to indigenous cultural aesthetics expressed in terms of linguistic symbolism and religious or communal ceremonies. This included, particularly, dance, which occupied such a central position in African social and cultural life (July 1987: 97). Realizing that the dance company would need to resonate with international as well as local audiences, Opoku was tapped by Nketia and Nkrumah to lead it because of his familiarity with Euro-American culture. Like many others in the Ghanaian intelligentsia, Opoku had received Western training – both in Britain and the United States. Opoku had gone to New York to study with Martha Graham (a leading modern dancer and choreographer) in order to gain a greater understanding of theatrics, body movement, and staging. He had also traveled to London to study with leading dance instructors. Illustrating his nationalistic agenda, according to July (1987: 98), “when Opoku was still in London, he and other Ghanaians had looked forward to the day when they could form a traveling team that would visit the country's regions, not to play soccer matches but to exhibit *the nation's dances*” (emphasis mine).

Upon his return to West Africa, Opoku was eager to promote indigenous Ghanaian culture, which would further his previous work in this regard. During the 1950s, Opoku gained a reputation as an excellent organizer and performer of indigenous African art forms through his leadership of a dance troupe at the Asante Cultural Centre – a civic enterprise founded by his cousin Alex Kyerematen. This group performed mostly Asante dances for Akan dignitaries, but on special occasions they would perform dances of other ethnic groups, which foreshadowed Opoku's nationalistic leanings. On weekends this ensemble frequently traveled to Legon to teach dance forms from many Ghanaian regions. While at the University, Nketia became familiar with Opoku's excellent work, and when Nkrumah asked for someone to organize music and dance performances for the Independence Day anniversary celebration in 1958, Nketia recommended Opoku. It was because of this performance, Opoku remarked, that Nkrumah got the idea to form a national group in order to further the "cultural emancipation of Ghana and Africa" (Adinku 1994: 6).

Subsequently, when the National Dance Company was officially established at the University of Ghana in October of 1962, Mawere Opoku became its first artistic director. The president welcomed this suggestion because Opoku, like Nkrumah, had both national and Pan-African agendas. Opoku's approach to the dance company was to "unify the country" through the "dance forms, thereby underscoring Nkrumah's drive for a unified nation and a unitary government" (Opoku quoted in Botwe-Asamoah 2005: 200). Supporting this position, Opoku remarked that, "traditionally, the artist and citizen were one," and that, "in African societies the artist has always had the civic duty of political commentary... [or] public mouthpiece" (quoted in July 1987: 230). Opoku also aligned with Nkrumah's cultural thought,

stating that African Personality meant, in part, refuting the lies told about the past by European scholars (Opoku 1976: 70).

Given this ideological alignment, once the senior staff of the dance company was in place, Nkrumah primarily adopted a “hands-off” approach. While Nkrumah mandated that highlife (popular) bands be trained by the Arts Council in traditional music and dance (Plageman 2013), he was less directly involved in the practices of the dance company. This discrepancy was likely because the company, by its nature, already had knowledge of traditional culture and was thus more closely aligned with African Personality. Moreover, Nkrumah did not articulate a clear cultural policy during his presidency. Although Nkrumahism shaped many cultural practices in Ghana, a lack of policy has led some to characterize him as a “non-interventionist” (Hagan 1993) in this regard. That is, in select cases, like the dance company, he allowed African Personality to act as an “invisible hand” to guide cultural practices. As Mustapha Tettey Addy, the renowned Ga musician and founding member of the GDE, recalled when asked about performing for Nkrumah during state events:

He didn’t get too involved in the dance ensemble’s affairs, except to say that he wanted different ethnic dances to be performed for him. Usually we play the [Dagbamba] Damba. Sometimes we play the calabash drums, and we play Kete a lot, and Fontomfrom. When he’s coming from a plane usually we play Damba with the breketes and dondons. When he comes to Legon we usually play Kete, or sometimes Sikyi. He liked the highlife ones a lot. But he liked all the pieces we played. Nkrumah is not a tribalistic man at all.⁷

Another ensemble member who performed for Nkrumah, Foli Adadae, also acknowledged that at such occasions, “[Nkrumah]

⁷ Interview with Mustapha Tettey Addy, Kokrobitie, 3 March 2007.

never said anything much to us. He didn't criticize us. He just praised us to go on and continue our work."⁸ While attesting to Nkrumah's non-interventionist approach to the ensemble, such comments indicate that he strategically used a wide variety of "ethnic" dances to reify the state's rhetoric of "unity in diversity," which was a crystallization of African Personality.⁹

In all, Opoku, Nketia, Nkrumah, and members of the GDE fused Western influence and training with local sensibilities to form a type of cosmopolitan dancing cadre that became a vital way to assert African Personality within Ghana and abroad. Achieving the full expression of this ideology, however, was a process that "entailed hard work" (Nkrumah 1957). One of the most important and difficult tasks within this process was to unify individuals of various ethnic groups under the new umbrella of the Ghanaian nation.

Beyond Ethnicity and Subjective Unity

Although Nkrumah gained overwhelming support for his campaign for Ghanaian sovereignty, he faced many opponents leading up to independence and throughout his term of office from 1957 to 1966. Writing about the early days of postcolonial Ghana, David Apter (1963: 328) notes that, "by the summer of 1957 bitterly anti-Nkrumah groups could be found everywhere." The most well known of these oppositional groups were the Asante National Liberation Movement (NLM) (Allman 1993), the Togoland

⁸ Interview with Foli Adadae, Accra, 11 July 2006.

⁹ There is, however, one infamous incident in which Nkrumah directly influenced the ensemble's affairs. During the early 1960s, the state threatened to ban a Ga social dance called kpanlogo due to its sexually provocative movements. Otoo Lincoln, who invented this dance in the 1950s, called upon the GDE to perform a sanitized version of this dance for Nkrumah in 1964. Because of Opoku's "cleaned-up" version, this dance was given state approval, and subsequently flourished in Ghana and abroad; cf. Thompson (2000).

Congress (Austin 1964; Skinner 2007), and the Ga *Shifmo Kpee* (Apter 1963). As Ben Abdallah (former Chairman of Ghana's Commission on Culture) recalled, "[The NLM] were practicing terrorism – explosions – of the Flagstaff House [Nkrumah's office and residence], trying to kill Nkrumah."¹⁰ Generally, in the wake of Ghana's liberation, Victor Ametewee (2007: 33) states that, "Political party rivalry became linked up with the ethnic background of the leaders." Such "ethnic," or "tribalistic," assertions threatened the political stability and solidarity that Nkrumah sought. To combat this separatist activity, Nkrumah strategically appropriated the cultural (royal) symbols of the nation, attempting to seize power from local chiefs and elders, undercutting their authority in the process (Coe 2005; Lentz 2008; Rathbone 2000).

Most notably, Nkrumah viewed the public display of the performing (cultural) arts, and particularly "drumming and dancing," "as the best able to legitimate [state] power" (Coe 2005: 54) and unify a diverse population.¹¹ That is, while there were many disputes between Nkrumah's Convention People's Party, the NLM, and other anti-Nkrumahist groups, "these disturbances invariably vanished in the dance arena" (July 1987: 100). Nkrumah and the staff of the National Dance Company recognized this unique ability of music and dance to transcend political and social classes, reunite ancestors with the living, and cut across ethnic boundaries. In other words, company members were tapping into the "tuning in" (Schütz 1971 [1964]) phenomenon that can occur through the performance of music and dance as performers partially share each other's experiential flux of inner time. In this

¹⁰ Interview with Ben Abdallah, Legon, 25 April 2007.

¹¹ Cati Coe (2005) convincingly shows that "drumming and dancing" is often synonymous with "culture" in Ghana.

way, as Martin Stokes (1994: 12) notes, these arts “can provide a powerful affective experience in which social identity is literally ‘embodied’.” The following discussion explores the processes by which Akans, Ewes, Dagbambas, Gas, and members of other ethnic groups have been encouraged to unify – embodying the social and national identity of being “Ghanaian” – through music and dance performance.

To implement their national agenda Nketia and Opoku, after some debate, decided to recruit specialists from several regions to teach a range of dances to young students with various ethnic backgrounds. Nketia and Opoku predicted that individuals would become familiar with the traditions of their African and Ghanaian neighbors, resulting in the solidification of unity among diverse groups through shared cultural experiences. When asked about this recruitment process, Nketia remarked that, “we were trying to go beyond ethnicity...we are all involved in things that cut across ethnicity, and that cutting across ethnicity is the national thing.”¹² In going “beyond ethnicity,” the GDE directors attempted to display the diversity of the nation rather than solely use the politically and demographically dominant culture group (i.e., the Akan) to represent the nation – a practice that has been common in many national dance companies (Castaldi 2006; Shay 2002).¹³ Francesca Castaldi (2006: 154), for example, describes the “Wolofization” of national music and dance generally in Senegal as the majority Wolof ethnic group dominates the country’s

¹² Interview with Kwabena Nketia, Legon, 18 August 2005.

¹³ Population data according to the 1960 census: Akan (Twi, Fante, Nzema) 44.1 percent; Mole-Dagbani (inclusive Dagarte, Frafra, Kusasi, Dagomba, Mosi) 15.9 percent; Ewe 13 percent; Ga-Adangbe 8.3 percent; Guan 3.7 percent; Gurma 3.5 percent; Grusi 2.2 percent; Yoruba 1.6 percent; Mande 1.4 percent; Hausa 0.9 percent; Central Togo Tribes [sic] 0.8 percent; Tem 0.7 percent (Gil, Aryee, Ghansah 1964: xxxiii-xxxiv).

national culture. Particularly, there has also been a “Mandification” of Dakar’s Ballets, because these companies “tend to privilege exclusively the Mande dance complex.” One could easily imagine an “Akanization” of dance repertoire within the GDE, because this ethnicity comprises nearly half of the entire population of Ghana. While Akan dances are prominent in the ensemble in various ways, other minority ethnic groups (most notably, the Ewe and Dagbamba) have actually dominated the dance repertoire, both in number of pieces included and the frequency with which they are performed.¹⁴ Despite placing emphasis on certain ethnic groups at various times, the ethnic diversity of the GDE staff has encouraged an overall diversity of the ensemble’s repertoire. According to William Adinku (2000: 132), a member of the ensemble since its inception, there were staff from Ga, Asante, Ewe, and Dagbani language groups, who each taught and performed their respective traditions.¹⁵ In this way, author Botwe-Asamoah (2005: 208) states, “The repertoire of the Ghana Dance Ensemble and its performance ... marked the highest expression of African personality that Nkrumah envisioned.”¹⁶

¹⁴ Elsewhere, I propose that the GDE’s repertoire is dominated by Ewe and Dagbamba pieces because (as opposed to the slow stately dances of the Akan) these often fast-paced, energetic, dramatic dances are well suited for the aesthetic expectations of the theatrical stage context, which emphasizes artistic spectacle (Schauert 2011).

¹⁵ The staff of the GDE initially included Mustafa Tettey Addy (Ga-Adangbe), Hunusu Afadi (Anlo-Ewe), Iddrisu Alhassan (Dagbamba), J. Asmah (Ahantan), Kwesi Badu (Asante), John K. Bennisan (Togo-Ewe), Osei Bonsu (Asante), Kodzo Ganyo (Togo-Ewe), and Seth Kobla Ladzekpo (Anlo-Ewe).

¹⁶ In the 1960s, the repertoire of the GDE included twenty-three Ghanaian dances: six Asante (Akan), nine Ewe, five Dagbamba/Hausa, one Lobi, one Nzema, and one Ga (Opoku 1968: 25-26). In addition to performing an increasing diversity of dances from these ethnic groups, over the past few decades the repertoire of the GDE has grown to include dances from the Frafra, Dagara, and Paga ethnic minorities.

The repertoire's diversity did not necessarily ensure that performers would adopt these diverse cultural practices, appreciate the pluralism of their nation, and unite across ethnic lines. The following examples, however, will illustrate that GDE members have often been able to dance and drum across ethnic boundaries, and that this ability has resulted in increased feelings of national pride and national solidarity among them. Despite their boundary crossings, however, I will argue that individuals do not jettison those identities already held, and, in fact, may find these identities more "grounding." That is, while national unity is predicated on the adoption of a collective identity and identification with others, it is subjectively embodied by individuals as it is reconciled with a participant's unique set of memories, identities, and ontologies. Moreover, the meanings and manifestations of ideologies such as African Personality, Pan-Africanism, and others employed in the pursuit of uniting Africans and Ghanaians are individualized as they are brought into contact with the consciousness and bodies of particular participants. In short, while Ghanaians have worked to form a collective identity, they have remained a collection of individuals (Dumont 1970).

When asked about how diversity was approached in the early days of the ensemble, Nketia stated that, "the object [of the GDE] was to ensure that whatever constitutes the national heritage is shared, and that you had a model of what we thought the nation could profit from in terms of making use of what all the culture groups had to offer in a national context."¹⁷ According to dancer Patience Kwakwa, an original GDE member, the "sharing of culture" did, in fact, guide the procedures of the ensemble, as she states:

¹⁷ Interview with Kwabena Nketia, Legon, 18 August 2005.

Opoku had this thing. If you come from an [certain] area Opoku would not allow you to do that dance. You would do a dance from other areas. ... The whole idea was to unite the people in Ghana. And if you could perform somebody else's dance, it was already an element of familiarity that is being expressed. So you get closer to the people when you can do their dance. It's just like speaking a language. So what's the point of coming in with what you have and sticking with that? So he forced us to learn dances from other ethnic groups.¹⁸

Because she said she was “forced” to learn dances outside her own ethnic group, I asked her how it made her “feel” to learn other's dances. She replied, “Oh, it was a very good feeling, because wherever you go, people take you as one of their own. And therefore they are cordial and they cooperate with what you do.”¹⁹ Several interviewees remarked that learning a variety of ethnic dances made them feel “more proud of Ghana,” and “more Ghanaian,” because, as dancer and long-time GDE member Grace Djarbatey commented, “You can fit in anywhere at all.”²⁰

Another dancer's comments highlight Opoku's encouragement of ethnic boundary crossing. When I asked Abubakari Salifu Merigah, a self-identified Dagbamba from the Northern Region, about learning Akan dances in the GDE, he remarked:

Some people they ask: where is this guy from? He's a northerner, and he can dance [Akan dances] like that, eh! Because of Professor Opoku, people say that I don't express myself like a northerner, but I express myself like an Asante [Akan]. And he [Opoku] is very happy, and nice, and smiles very big. Opoku made himself very open and willing to teach you. They can see the will coming, so they like it. It's because of the company, without the company I would not have been

¹⁸ Interview with Patience Kwakwa, Legon, 26 July 2006.

¹⁹ Ibid.

²⁰ Interview with Grace Djarbatey, Accra, 25 July 2006.

able to jump inside the dances like that ... it empowered me to do any dance I would meet on my way.²¹

Merigah was not the only GDE performer to experience the empowering effects of national unity. More broadly, referring to the time soon after Ghana's independence Nketia recalls: "In terms of our concept of a national culture we were beginning to integrate... We had Dagomba drummers playing Asante dances, and Ewe playing Akan and so forth ... so Gideon [a regional specialist employed by the GDE], an Ewe drummer, became an expert Adowa (Akan dance) drummer."²² In other words, by convincingly performing the traditions of neighboring ethnic groups, Merigah and others embodied national unity and often felt empowered by their ability to identify with these groups. Overall, Opoku was largely successful at putting his ambitions for a unified Ghanaian nation into practice, encouraging performers to "go beyond ethnicity."

Although the musicians and dancers were quick to adopt cultural diversity, Nketia's following remarks indicate that audiences required more time to accept the shift to a national culture. Regarding the early days of the dance ensemble Nketia recalled:

Right at the beginning of independence the ethnicity was very strong, even though we were bringing things from various places. People would identify with a particular group, and as soon as they come and begin to dance they are shouting and so forth. And then a couple of years later we were getting used to the things from various places, so that you find when the Agbadza [an Ewe] dance comes on, the Asante, all of them are clapping. So you are beginning to appreciate the differences which become part of the composite.²³

²¹ Interview with Abubakari Salifu Merigah, Accra, 26 July 2006.

²² Interview with Kwabena Nketia, Legon, 18 August 2005.

²³ Ibid.

In other words, music and dance played a vital role in the creation of a national consciousness. As Ghana entered a new phase of its political and cultural history following independence, its citizens began to embrace the ethnic diversity of their nation through these cultural forms.

Following the brief period where “ethnicity was very strong” in Ghana, both audiences and performers crossed ethnic boundaries with increased fluidity. During the formative years of the GDE, it performed in local communities, seeking and often receiving approval for their interpretations of cultural forms. As Nketia narrated:

We [the GDE] went to Christian Village, which was close by [to Legon], and had an Ewe community. Our dancers danced [Ewe dances] with them ... and they [the villagers] would make comments. They liked it, and point to the ones they liked best. Sometimes the dancers were not even Ewe.²⁴

I have collected a plethora of cases in which dancers were attributed the ethnic identity of the dance they were performing despite self-identification with a different ethnic group. For example, a senior Ewe dancer, Wisdom Agbedanu, stated that after a GDE performance of the northern Dagbamba dance called Bamaaya, an audience member came up to him and greeted him in Dagbani. The audience member, who was from the Northern Region, was shocked to learn that Wisdom was an Ewe, and subsequently rewarded him with 10,000 cedis (about one U.S. dollar) and a handshake.²⁵ Similarly, Nketia remarked that when Gideon Alorwoyie (cf. Davis 1994), an Ewe master drummer employed by the GDE, played Asante dances for an Akan

²⁴ Ibid.

²⁵ Interview with Wisdom Agbedanu, Legon, 9 August 2005.

community, the “teacher of this [Akan] tradition” preferred Gideon’s drumming to that found in the local community.²⁶ Furthermore, many GDE members stated that they enjoyed performing and identified with dances from other ethnic groups as much or more than the groups with which they regularly affiliated. Many of these individuals noted that they never received criticism for their performances of other’s traditions. Rather, to the contrary, they were showered with praise. In all, these performers convinced audiences of their artistic ability to embody multiple ethnic identities, providing a tangible illustration of moving “beyond ethnicity,” which, in turn, has contributed to the national integration that Nkrumah envisioned.

Although dancers and drummers performed a variety of dances – ostensibly going beyond ethnicity – several performers’ comments remind us that identity is always multilayered, in that, adopting a new national identity does not necessarily eradicate the strong ties individuals may have with a particular ethnic affiliation. “Ethnicity does not preclude national identity,” Jean Allman (1993: 7) has remarked in reference to Peter Osei-Kwame’s 1980 study, “but in fact provides a basic building block for it.” In short, ethnic and national identities can co-exist.²⁷ Yet, this situation may create individual struggles to reconcile the two.

A vivid example of this identity negotiation is offered by Mustapha Tettey Addy. When I asked him about ethnic tension in the early days of the GDE, he replied: “I remember one time I beat one guy. He was calling me a Ga, and I said, ‘Don’t call me that I am a Ghanaian’. And he kept calling me that. He was older than

²⁶ Interview with Kwabena Nketia, Legon, 18 August 2005.

²⁷ Richard Handler (1988: 49), studying nationalism in the Canadian province of Quebec, notes that when nationalists often prodded individuals to choose between identities, many participants responded by asking, “why can’t we be both Canadian and Quebecois?”

me, but the way I beat him. He got shocked [laughing].”²⁸ His comments indicate that identity formation within the GDE was not only an internal struggle, but could entail an external physical confrontation in some instances. Subsequently, Addy acknowledged that it was partially the experience in the GDE that inspired him to create original drum and dance compositions, which, while rooted in Ga traditions, incorporate those from other ethnic groups in Ghana and Africa.²⁹ As such, Addy and his artistry embody and perpetuate Nkrumah’s ideological legacy of “unity in diversity,” while reaffirming the subjectivity of this process.

Although national identity has become more widely accepted in Ghana, GDE members have often struggled to reconcile it with their ethnic heritage. As one young male Ga dancer from Accra explained:

[The] dance ensemble has ... really changed my life, because at first I always think about my ethnic background. I always do what the Gas do. I don’t respect anybody [else]’s tradition. When I came to the dance ensemble I always fight with them and say our festival is the best. Our festival is richer than everyone else’s festival. But when I got to know about other people’s festivals I said, “Oh so there are festivals like that.” Because, when I came to the dance ensemble, I only knew about my own festival, and I was not the type to go out. When I first came I thought about that, but now I think everybody is one. I respect other traditions now as a whole. I respect each and everyone’s ideas. I feel like I am a part of all Ghana.³⁰

²⁸ Interview with Mustapha Tettey Addy, Kokrobite, 3 March 2007.

²⁹ For a discography of Addy’s works see:

<http://www.allmusic.com/artist/mustapha-tettey-addy-mn0000621183>

³⁰ Interview with Leslie Agyete, Legon, 17 August 2007.

Although the dance ensemble had helped this individual adopt and appreciate a national identity, his later comments illustrate that his ethnic affiliation remained strong. “When I first joined the ensemble,” he continued,

I always came early to ... learn my own hometown dances first – to learn Kpanlogo, to learn Gome, to learn Kpatsa. Because it would be a shame if someone asked me my ethnic group, and I say I am a Ga, and then they say do something from your area and you can’t. So I just thought it would be wise to learn my traditional dance first.³¹

Many other GDE members’ (past and present) referred to the strong ethnic affiliation that remained as they adopted a national identity. For instance, when I asked a former female GDE member whether she felt differently when she performed other Ghanaian dances outside her self-proclaimed Ga heritage, she replied: “I feel mine more than other Ghana dances.”³² Similarly, one Ewe ex-member noted, “Because I am an Ewe I need to feel mine. I feel all, but let me say I feel Ewe’s more than the different tribes.”³³

Overall, musicians and dancers noted that participation in the GDE has been a transformative experience. Yet, while GDE members frequently crossed ethnic boundaries by performing a mosaic of Ghanaian dances, nearly all remarked that they were strongly linked to particular dances that were associated with their own self-identified ethnicity. National unity or unification, in other words, although embodied through similar processes by GDE members, is experienced subjectively as each unique individual negotiates and creates their own identity through music and dance.

³¹ Ibid.

³² Interview with Augustana Abua, Accra, 9 May 2007.

³³ Interview with William Kwesi Mensah, Accra, 9 May 2007.

Beyond Ghana: Performing Pan-Africanism

Our independence is meaningless unless
it is linked up with the total liberation of Africa.
Kwame Nkrumah

Kwame Nkrumah certainly did not invent the concept of Pan-Africanism, for, the seeds of this movement, which sought to unite diverse African populations across the globe, had been planted long before his birth (Esedebe 1982). Nevertheless, he was a powerful figure in the post-World War II era. As evidenced by the famous quote above from his Independence Day speech in 1957, Nkrumah was a “passionate Pan-Africanist” (Maillu 2007). He organized and attended a number of Pan-African conferences, continually advocating for the union of African states (Nkrumah 1963). Since its beginnings, the GDE has performed, or put into practice, Nkrumah’s notion of Pan-Africanism. Moreover, in various ways, GDE members have interpreted and woven these ideas into the fabric of their own identities.

The GDE was the “nucleus” of Ghana’s National Theatre Movement, which served as an artistic extension and expression of Nkrumah’s Pan-African ideals. Speaking about his experience in the GDE during Nkrumah’s rule, E. A. Duodu, a founding member of the ensemble who later became its artistic director, remembered: “In those days this ethnic group [was] superior to that. Nkrumah tried to kill that kind of tribalism and nepotism. And, whether you are Nigerian or Malian, you are the same people. And, the dance ensemble projected this.”³⁴ One of the ways the ensemble “projected” this sentiment was by incorporating a number of pieces from outside Ghana. A book about the GDE published in the 1960s lists a Nigerian dance called Ijaw, while the Dahomey Dance Suite

³⁴ Interview with E. Ampofo Duodu, Legon, 7 June 2007.

I and the Dahomey Dance Variations listed therein are both from Benin (Opoku 1968). Additionally, I have found pictures from the 1960s of the dance ensemble performing “Togo” Atsia. This, however, was the extent of the GDE’s “Pan-African” repertoire at the time. Explaining this limitation, Nketia remarked: “There were always problems, because when you do it you need the music and then you need the musicians. And, there is a limit to the budget.”³⁵ In other words, pragmatic obstacles prevented the ensemble from becoming more Pan-African.

Over the years, although the company’s inclusion of African dances from outside Ghana has grown only slightly, its Pan-African spirit has not diminished. Since the 1990s, Francis Nii-Yartey – the GDE’s artistic director from 1976 to 2007 – has collaborated with a number of choreographers from the African Diaspora. For instance, Nii-Yartey co-choreographed the piece *Images of Conflict* with Germaine Acogny from Senegal.³⁶ Similarly, a piece titled *Musu* was co-created with Monty Thomson from the U.S. Virgin Islands; it draws on the experiences of African slavery and has undoubtedly resonated with individuals throughout the Diaspora, as it has been performed on numerous international tours. Affirming such bonds, Nii-Yartey has incorporated dance styles and music from the African community writ large in his “contemporary” choreographies such as *Solma* and *Sal-Yeda*.³⁷ He has been particularly inspired by the legendary African-American choreographer and dancer Alvin Ailey.

³⁵ Interview with Kwabena Nketia, 18 August 2005.

³⁶ Acogny was born in Benin in 1944, but moved to Senegal at the age of ten. In 1968, she established her first dance studio in Dakar, and later became a renowned international figure in contemporary African dance.

³⁷ Nii-Yartey is widely regarded in Ghana for developing what participants refer to as “contemporary African dance.” Whereas the GDE’s “traditional” repertoire is primarily based on pre-existing local material, “contemporary” dance liberally

Recently at Legon, the GDE has learned the “Dumba” from a Senegalese dancer in residence at the University of Ghana in 2005. Within this and other pieces, the ensemble has used the djembe, which has West African roots, but is not of Ghanaian origin (Charry 1996). This widely recognizable drum acts as a powerful Pan-African symbol that connects Ghanaians to other Africans and to the world more broadly.³⁸ Further, as in *The Map* choreography discussed above, Ben Ayettey, the current GDE artistic director, and Nii-Yartey often employ Afro-pop music from various countries, such as works by Baba Maal and Youssou N’Dour, as accompaniment for “contemporary” pieces. Yet, the presentation of particular African dance styles from beyond Ghana performed as individual choreographic works within themselves (i.e., Ijaw and Togo Atsia), remains limited. Similar to Nketia’s remarks above, Ayettey stated that the GDE’s “repertoire would probably include more dances from outside Ghana, if the funding [were] available to bring in specialists to teach at the university, or travel outside the country to conduct research more often.”³⁹ In all, while choreographers have found numerous creative ways to include other African nations and the African Diaspora, the pragmatic financial situation of GDE remains a significant obstacle to achieving an even greater expression of Pan-Africanism.

While the Pan-African scope of the GDE repertoire may be somewhat limited, GDE travels have reached nearly every part of the continent and the globe, performing Pan-Africanism and creating bonds among Africa’s Diasporic populations. In July 1964, as its first performance abroad, Nkrumah commissioned the

incorporates artistic elements from a broad palette of sources to create new original works.

³⁸ According to GDE members, the djembe only entered Ghana in the late 1980s, or early 1990s, but has since quickly become ubiquitous.

³⁹ Interview with Benjamin Ayettey, Legon, 16 August 2005.

dance company to represent Ghana at Malawi's Independence celebration. The following year, Nkrumah, who adopted many socialist ideas, sent the ensemble on a three-month tour of Eastern Europe with stops in Czechoslovakia, East Germany, Hungary, the Soviet Union, and Poland as part of his "Moscow-oriented foreign policy" (Adinku 2000: 133). In April 1966, the ensemble represented Ghana at the first World Festival of Negro Arts in Dakar. Although the GDE's own written documentation from the late 1960s through the 1980s is scarce, I was assured by Nii-Yartey and others that the ensemble had toured "all the corners of Africa, and all over the world."⁴⁰ Indeed, according to my own research, the GDE has traveled throughout the world.⁴¹ Furthering Nkrumah's legacy, these performances have re-affirmed and strengthened bonds with African Diasporas across Europe, the Americas, and Asia.

As GDE members perform Pan-Africanism, whether domestically or abroad, they are intimately confronted with its ideological objectives, requiring them to reconcile their notions of

⁴⁰ Interview with Francis Nii-Yartey, Legon, 6 August 2006.

⁴¹ These include in chronological order: Britain, Mexico Olympic Games, Nigeria, Italy, Paris, and New York in 1968; U.S. and USSR in 1969; Germany in 1970 and 1974; Jamaica in 1977; Germany in 1979 and 1980; Italy in 1980; Paris and Yugoslavia in 1981; Paris in 1983; U.K. in 1984; London in 1985; New Delhi and Bombay, India in 1987; Guyana and New York in 1988; Canada, Germany, Netherlands, Nigeria, Switzerland, Tokyo, Zimbabwe and U.K. in 1989 (*The Legend of Okoryoo* n.d.: 20). Further, U.K. and Korea in 1993; Germany in 1994; Japan, Indonesia, Zimbabwe, and Korea in 1995 (www.ghanaculture.gov.gh). "Dance/Africa '95" in Chicago (*Weekly Spectator*, 21 October 1995). France, Denmark, and U.S. in 1996 (www.ghanaculture.gov.gh). "Images of Africa" in Copenhagen, Denmark in 1997 (*Weekly Spectator*, 2 October 1997). Angola in 1998; Ivory Coast, Denmark, U.K., and U.S. in 1999; Nigeria in 2003 (www.ghanaculture.gov.gh). Jamaica in 2003 (*Weekly Spectator*, 10 August 2002). Through personal conversations I learned that the GDE had toured Malawi in 2006 and had performed in India as part of the Ghana @ 50 celebrations (March 2007).

ethnic, national, and transnational identity. When I asked a group of dancers about how it felt to perform other African dances outside Ghana one of them remarked: “I am from Ghana, first; I have to remember that, and do my tradition.”⁴² Another agreed and said: “I just learn mine. I just do mine. I learn Nigerian dance too, but I *feel* Ghana dances more than other African dances.”⁴³ Other dancers present nodded in agreement. Similarly, when I asked the current artistic director how the ensemble balances national and transnational identities through performance, his remarks revealed his own emphasis on nationality over a Pan-African identity. Although Ayettey stated that, “We try to present African unity, not Ghanaian unity; it’s African culture that we are portraying,” he conceded:

Normally when we go outside we don’t perform dances from a different [African] country, because we’ve got to be proud of our country. Other countries sell their material, so we should also sell our material. Because others believe theirs is the best I also believe that mine is the best.⁴⁴

Not only does Ayettey affirm his desire to assert his national identity rather than explicitly projecting Pan-Africanism, but he indicates that his national pride is reactionary, reminding us that identity is relational. Confronted with a social world that is given to him, he sees national pride in others and counters it with his own.

In all, there seems to be no shortage of Ghanaian patriotism within the GDE. While the ensemble helps to forge bonds among Africans across the Diaspora, the Pan-African repertoire is somewhat limited, and the focus of the ensemble has largely been

⁴² Interview with Augustana Abua, Accra, 9 May 2007.

⁴³ Interview with Solomon Atagi Agyari, Accra, 9 May 2007.

⁴⁴ Interview with Benjamin Ayettey, Legon, 16 August 2005.

on the dances of Ghana. As evidenced by performers' comments, national identity has remained stronger in most cases than a broader connection with Africa or its Diaspora. Much like when participants graft new national identities onto ethnic ones, as individuals adopt transnational and Pan-African identities, they remain deeply grounded in those previously internalized. As a former GDE member told me, "I love Ghana. There's peace and freedom here. It's good to travel to different places to experience different countries, but I like Ghana. It's nice to come home."⁴⁵

Conclusion

Nkrumah conceptualized African Personality as an ideology, which enveloped Pan-Africanism and would contribute to the unification of a diverse African population across ethnic and national boundaries. As a cultural nationalist he believed that a national consciousness could be constructed, along with a common belief in African unity, through the indigenous traditions of a people. Through a complex series of social negotiations, the Ghana Dance Ensemble emerged as a focal point for the pursuit of Nkrumah's ideological aims. With Nketia and Opoku (both strong advocates for Nkrumah's transnational goals) at the helm, the GDE's diverse repertoire and personnel embodied African Personality and Pan-Africanism. As a "dancing cadre," the ensemble generally encouraged its members to cross cultural boundaries – to go "beyond ethnicity" and "beyond Ghana" – and engendered such behavior in its audiences.

As one peers behind the scenes of this ensemble, exploring the details of its activities, the complex intersubjective construction of such unity is revealed. That is, as the GDE ostensibly stages national and transnational unity in colorfully engaging

⁴⁵ Interview with William Kwesi Mensah, Accra, 9 May 2007.

performances that showcase a coherent whole, beneath this veneer, individuals subjectively negotiate and interpret the ideologies of nationalism, African Personality, and Pan-Africanism for themselves. That is, as the nation appears as an indivisible unit on stage, Ghanaians, nevertheless remain a collection of individuals.

Like African Personality, or the GDE repertoire, individuals simultaneously embody many forms of nationalism. However, unlike an inanimate set of ideologies or dance forms, performers must subjectively reconcile these various identities within their *bodies* to re-construct a cohesive sense of self. In this way, I agree with other scholars who have found the body to be a primary repository, and locus, for the re-shaping of identity (Reed 1998). The intense physical practices of drumming and dancing which, as I argue, simultaneously inscribe identity within the consciousness and flesh of individuals, eradicate Cartesian notions of mind/body duality. In this way, the GDE's diverse repertoire of dances is transformed within the bodies of performers from Diana Taylor's (2003) materialistic "archive" to her conception of "repertoire" as "embodied memory." Through the enactment of these expressive forms, African Personality and Pan-Africanism thus become part of the *habitus*, or "matrix of perceptions, appreciations, and actions" (Bourdieu 1977: 82-83) of a performer.

To nuance this point it is important to recognize that performers embody these ideologies in particular ways as uniquely situated individuals. As artists adopt identities which are new to them, often individuals remain *grounded* in older (longer-held) identities. For instance, when national identity is adopted, ethnic ties often remain strong, and similarly, when a transnational identity such as "African" is adopted, national identity appears to retain prominence. It is the totality of individual experiences, or subjective *habitus*, which informs the degrees to which GDE

members feel this “groundedness” in various identities. It almost seems paradoxical, then, that the ideology of unity, while generally emphasizing human commonalities and universals, is nevertheless performed, represented, and embodied subjectively as each individual reconciles new identities with a corpus of previously held memories, identities, and ontologies.

Lastly, because I have examined the GDE from its formative period in the early 1960s up until recent times, such observations also indicate that although the historical moment of African and Ghanaian independence has long passed, individuals still struggle to adopt nationalism, including national and transnational identities. Thus nationalism, which requires a continual updating to meet the demands of the present, results in a relentless re-negotiation and renewal of the nation as well as the individual self.

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DISCOURSES OF LOVE AND NEWSPAPERS ADVICE COLUMNS IN GHANA

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Advice columns have animated Ghanaian newspapers since colonial times; interest in them shows no sign of abating. The dilemmas of courtship, love, sex, commitment, and marriage, vex Ghanaians just as they do people everywhere. Newspaper advice columns are a place for instruction and amusement regarding Ghana-specific variations on these dilemmas. Interviews columnists suggest that the Ghanaian press relies on the columns and similar “soft content” to stay relevant and vibrant. The content of columns supports the view that tension points in the domestic lives of Ghanaian populations drawn to them include definitions and insecurities about love, the meaning and importance of fidelity and commitment to a partner, and the financial responsibilities and implications attaching to relationships.

Key words: *Ghana, newspapers, advice columns, love, courtship, marriage.*

As early as 1955, earnest young Ghanaian men puzzling over romantic love were writing for advice to an Accra-based newspaper columnist (Jahoda 1959).¹ Their questions—“How does one approach a girl?” “How can I know she has fallen for me?” “Is she a true lover?” “How does one choose a good wife?”—are little different from those of young Ghanaians vexed by love today, still seeking advice in the newspapers: “Did

¹ Jahoda (1959: 77) does not name the advice column or newspaper, which he describes only as having “a national circulation.” The paper may have been the *Sunday Mirror*, the weekend edition of the *Daily Graphic*, which published advice to the lovelorn in the mid-1950s (Ainslie 1966: 32-5; Jones-Quartey 1974: 37-9). Omari’s 1962 marriage guide also makes use of letters from the *Sunday Mirror*’s “Dear Hilda” and “Aunty Eva” advice columns.

his kiss means he loves me?” “Please advise, I am in love with a girl who has no time for me.” “Should a woman propose love?” “Why do women reject me and tend to go in for my friends?”²

The quandaries and concerns expressed in Ghanaian advice columns are, with allowances for local culture and expression, those of uncertain persons the world over who seek expert help in understanding their emotions and navigating social life, especially the complicated dance of courtship and marriage. Advice-column questions and the answers of the columnists go to the depths of peoples’ lives; they are far from trivial. They also are a window into the state of popular social discourses, especially discourses surrounding love, affection, disaffection, partner selection, sex, marriage, and family relations. Both parties to these exchanges—the letter writer and the columnist—occupy the unsteady ground of emotional crisis and uncertain or contested meanings. The writer has worries; the columnist is a voice of reason and usually provides solid advice, but even the columnist knows that the terrain of the heart is unknowable, the available vocabulary inadequate, and the details of most problems too complex to be satisfactorily addressed in a few sentences. Uncertainties abound in all societies about social relations and the meaning and value of words and concepts connected with emotional life. But this may be especially true in a youthful country such as Ghana, which has undergone remarkable social changes in the span of a few generations, where the median age is 21 (*CIA World Factbook* 2012), and where the cities are cosmopolitan engines driving syntheses of local and globally circulating social forms and discursive formulations.

² From *The Spectator*’s advice columns 31 January 2004, 21 May 2005, 1 November 2003, and 1 August 2009.

Herein lies the theme of this article. Over the last several generations in Ghana (as in much of the rest of the world), romantic love—marked by attraction, passion, adoration of the other, and desire for an enduring relationship (Jankowiak and Fischer 1992: 150)—has captured the imagination of society and come to dominate normative discourses of coupling. A plentiful literature on kinship, family life, marriage, and relationships makes clear that love is not new in Ghana; couples in earlier time certainly experienced passion and the hope or expectation of a lifetime together.³ Yet today's intensified connections made possible by advances in communication and transportation have accelerated a public discourse of love inflected with globally circulating tropes that can be broadly labeled “romantic.”⁴ Like all globally circulating discursive packages (human rights, democracy, and the television drama are no different in this regard), romantic love carries with it words, phrases, packaged attitudes, and global networks of meaning that require fitting into the realities of each

³ See for example, Adomako Ampofo (1997, 2005); Adomako Ampofo and Boateng (2011); Allman and Tashjian (2000); Amoo (1946); Ardayfio-Schandorf (2006); Assimeng (1999: 74-99); Bochow (2008b); Clark (1999); Dankwa (2011); Darkwah and Adomako Ampofo (2008); Dinan (1983); Doodoo (1998); Fortes (1950); Frost and Doodoo (2010); Gyekeye (2002: 75-92); Heaton and Darkwah (2011); Kalu (1981); Little and Price (1967); Miescher (2005: 115-52); Mikell (1988); Nukunya (1992); Omari (1960); Oppong (1981: 144-59); Takyi (2001).

⁴ For discussions about romantic love as a universal and the global circulation of discourses about love, both historically and contemporarily, see Coontz (2005); Giddens (1992); Illouz (1997: 1-47); Jankowiak and Fischer (1992); Lewis and Stearns (1998: 1-14); Murstein (1974); Reddy (2001); Swidler (2001); Thomas and Cole (2009: 1-30); Wardlow and Hirsch (2006: 1-31). For specific studies about romantic love and companionate relationships in different regions and historical periods, see Ahearn (2001); Cole and Thomas (2009); Dowd and Pallotta (2000); Hirsch and Wardlow (2006); Jankowiak (1995); Johnson (1998); Mutongi (2000); Seidman (1991); Shumway (1998); West (2011); Wilbraham (1996); Wouters (1998); Zimmerman, Holm, and Haddock (2001).

place it lands. In other words, just as “curry” connotes differently in Mumbai and Manchester, just as the telenovela *Rubí* resonates in unique ways in rural Mexico and rural Niger (Masquelier 2009), so too do words and concepts that circulate around the world in the discursive package of romantic love land differently everywhere. “Valentine’s,” “soul mate,” and “marriage partner,” for instance, will find their own nestings of meanings in different locales. The subject of this article is the translation of globally circulating discursive packages surrounding romantic love into the Ghanaian milieu, and of Ghanaian truths into adjusted globally circulating discursive packages, as revealed in the advice columns.

The processes by which any global discourse and any local reality accommodate one another are not always easy to sort out because global and local beliefs and ideals are not entirely separable. Typically there have been long interactions, with influences extending for years or generations in both directions: local to global and global to local. Certainly this is true in Ghana. But this difficulty should not require us to set aside the question of discursive adjustments and accommodations, only to be careful about it. For it is undeniable that global media influence contemporary discourses of love around the world.⁵

Newspaper advice columns give particular insight into this matter because they tend to be focused on romance and are produced for instructional purposes.⁶ More than 50 years ago, scholars Gustav Jahoda (1959) and T. Peter Omari (1962)

⁵ For examples from Ghanaian popular culture, see Abudu (2008); Adjabeng (1999); Adomako Ampofo and Asiedu (2012); Agyin-Asare (2004); Bochow (2008a); Burrell (2012); Cole (2001, 2007); Collins (2007); Darkwah and Arthur (2006); Dwomoh (2001); Fair (2004); Frimpong (2009); Ikiddeh (2002); Newell (2000); Omari (1962); Shipley (2007, 2009).

⁶ On the importance of advice columns to understanding public meaning attached to love and romance, see Jahoda (1959); Illouz (1997); Seidman (1991); Shumway (1998); Wilbraham (1996).

recognized their value to those interested in how young Ghanaians framed their thoughts about the details and complications of love, courtship, and marriage. Then and now the work of advice columnists in Ghana is little different from that of their counterparts elsewhere in the world, for competing expectations and discourses of courtship, sex, and marriage are realities everywhere. But the particular questions posed and answered in Ghanaian newspaper advice columns say much about the certainties and uncertainties that animate popular culture in Ghana and West Africa in general. They say a good deal about media as venues where these certainties and uncertainties are being tested and worked out. In this sense, this article is secondarily about *expertise*—in this case expertise in romance and love—as a device used by Ghanaian media to mark their credibility and market their products to a public eager simultaneously for guidance (for courtship, sex, and marriage are fraught) and amusement (for courtship, sex, and marriage are ripe for making nervous humor). These two themes—discourses of love in Ghanaian popular culture and the commercial value to Ghanaian media of expertise in the realm of love—come together in the overarching fact that romantic love is a global concept that needs fitting into every culture, into every discursive frame it encounters.

The Ghanaian Press, Love, and Lifestyles:

Theoretical Foundations

Ghana's newspaper environment is vibrant, with private and state outlets competing for readership and advertising revenue (Fair 2008; Gadzekpo 2008; Hasty 2005). Public debate over Ghana's economic rollercoaster, political dramas, and international intrigues reverberates across the country at newspaper kiosks, chop bars, markets, and *trotro* stops, energized by reporting and

commentary in a vigorous and varied press. As seriously as Ghanaians take “hard news,” they are often just as exercised by stories from popular culture: stories about the personal lives of well-known officials, extraordinary, even unbelievable events involving ordinary people and public figures, unusual crimes, personal health concerns, public safety, celebrity sightings, gossip, jokes, and commentary about everyday life on the street and in the village. It is this kind of “soft” news content that fills the pages of many of Ghana’s newspapers, including its two most popular weeklies, *The Mirror* and *The Spectator*.

These two papers are billed as “entertainment weeklies” with educational missions. Their front pages—lined with sensationalized, bombastic, and prurient headlines and photos—demonstrate a tabloid aesthetic that may have been partly modeled on British antecedents but is popular, of course, worldwide.⁷ Published today by state-owned enterprises and nationally distributed, *The Mirror*, since 1950, and *The Spectator*, since 1958, have focused on social issues, with sectioned pages devoted to feature stories, profiles, and columns addressing lifestyle, gender, family, and/or relationship concerns.⁸ These papers were not the first to carry social feature stories and columns. During the 1930s, Ghanaian memoirist Mercy Ffoulkes-Crabbe published her column

⁷ When Cecil King, owner of mainstream and tabloid newspapers in Britain, acquired the *Daily Graphic* and the *Sunday Mirror* in 1950 and 1954, he invested in the latest press production technology, which allowed the papers to regularly include photos, color, and bold headlines. The papers also began publishing human-interest stories, sports, columns, and entertainment (Ainslie 1966: 57; Asante 1996: 6-8; Chick 1996; Jones-Quartey 1974: 34-7). Today *The Mirror* and *The Spectator* continue in this style.

⁸ For the two newspapers’ current mission statements, see: http://www.graphic.com.gh/graphic_corporate/about.html for *The Mirror* and <http://newtimes.com.gh/about> for *The Spectator*. Both corporations publish several other newspapers, the flagship papers being *The Daily Graphic*, with an estimated circulation of 200,000, and *The Ghanaian Times*, with 150,000.

“Gloria” in the Women’s Corner of the *Gold Coast Times* and Mabel Dove, writing as columnist Marjorie Mensah in the *West African Times*, commented for the edification of all on the social and economic aspects of women’s lives in British colonial Africa (Gadzekpo 2006; Newell and Gadzekpo 2004; Newell 2002: 119-34).⁹

Part of the appeal of tabloids or entertainment-oriented newspapers is their personalized stories written in conversational and colloquial tones that focus on local events, sports, crime, fashion, and personalities and use prominent photographs, graphics, and headlines (Sparks 2000; Wasserman 2010). With the liberalization of the African press in the late 1990s and early 2000s, the tabloid press surged across the continent (Nyanmjoh 2005; Tettey 2001). In Ghana, despite competition from new entertainment weeklies featuring advice columnists, as well as the increasing access of young people to online love forums (Burrell 2012; Fair et al. 2009), *The Mirror’s Nana Ama Advises You* and *The Spectator’s Obaa Yaa* remain, by far, the country’s most widely read advice columns (Prah 2008: 4).¹⁰

Nana Ama’s and *Obaa Yaa’s* thoughts and advice on love, dating, relationships, and marriage provide Ghanaians with a public script for private matters. Their columns are forums for negotiating private and public spheres and for opening up discussion subjects, notably anything to do with sex and the

⁹ For further discussion of Mabel Dove’s political commentary, see Prais (2008: 237-325).

¹⁰ The persona and voice of the columns is female. *Obaa Yaa* means the Woman Yaa (Yaa being an Akan first name given to a girl child born on Thursday). *Nana Ama* is a common woman’s name (Ama, for a girl child born on Saturday), but *nana* in Akan/Twi also is an honorific, a term for royalty and elders; *nana* is also the term used for grandmother and father. *Nana Ama* thus connotes advice given by a wise and experienced woman.

relations between men and women.¹¹ These columns and others like them point people toward predictable, usually commonsensical ways of reconciling ideas and ideals from home and afar that Ghanaians and people elsewhere, according to David Chaney (1996: 1-24), are crafting deliberately into *lifestyles*.

Chaney's *lifestyle* concept, which assumes that the agreed-upon meanings that inhere in any society are crafted and fluid, rather than inherited and static, can be quite helpful in exploring discursive shifts of the kind addressed in this article. According to Chaney (1996), nearly all people everywhere in our era are active creators of personal lifestyles: ways of being, ways of understanding, ways of interacting with one another that to some considerable degree are matters of personal choice. In many respects, *lifestyle* is a categorical analog of *culture*. It encompasses the assumptions and preferences of individuals as members of a larger community that shares certain values and history. But unlike *culture*, which carries a presumption of stasis or only gradual change, lifestyles are fluid and dynamic. Moreover, whereas one is born into a culture, people *create* lifestyles, in common cause with like-minded others. The materials from which people craft lifestyles—attitudes, practices, ideas, symbols, and aspirations—are both local and global, often media made or media conveyed. Lifestyles are not assembled willy-nilly. They are under-girded by values that include liberty, equality, happiness, and justice, and they have moral footing. Lifestyles aspire to coherence. Yet in contrast to cultures, lifestyles are shifty. Particular formulations

¹¹ Newer tabloids such as *Funtime*, *My Joy*, *People and Places*, *Top Story*, *Love and Life*, and *News One* (and the websites associated with some of these papers) have had to stretch Ghanaian discursive boundaries regarding sex, sexuality, relationships, and love in ribald ways to compete with commercial radio (Nkomo 2009). To do so, they regularly carry photos of young women provocatively posed and features with explicit sexual language.

move rapidly in and out of practicality and fashion. Even their underlying values evolve.¹²

The dynamism and fluidity described so well by the lifestyle concept fits the remarkably transitional age in which Ghanaians and people everywhere today are living. As much work on contemporary society demonstrates, there is a sense in urban Africa that the future will be both intercontinental and digital.¹³ Thus, Ghanaians coming of age today share the need of young people almost anywhere to feel that they are functional, competent agents in their immediate milieu, and are also reasonably worldly cosmopolitans conversant in global trends on their own terms. The challenge of young urban Ghanaians is therefore complex: to weave together coherent lifestyles that are attentive simultaneously to attitudes, preferences, and discourses that make sense at home, as well as to those they find circulating globally. While many young urban Ghanaians who write to *Nana Ama* and *Obaa Yaa* may be equally at home in online forums and dating sites, the newspaper love columnists remain important sources of guidance precisely because they are grounded in local values and realities.

Method

The article is based on close study of Ghana's two most important newspaper advice columnists: *Nana Ama* and *Obaa Yaa*, both of which attempt to inform, instruct, and entertain readers with questions and answers about contemporary love, dating, relationships, and marriage. All quotations, interpretations, and

¹² See Chaney (1994, 1996, 2002); for Ghana particulars, see Bochow (2008a); Burrell (2012); Cole (2001); Collins (2007); Fair (2004); Fair et al. (2009); Newell (2000); Prah (2008).

¹³ See Burrell (2012); Fair (2004); Fair et al. (2009); Farivar (2011: 71-108); Griswold, McDonnell, and McDonnell (2006); Johnson-Hanks (2007); Schulz (2012); Smith (2007: 28-52, 79-87); Wildermuth (2008).

analysis come from 152 letters (and their answers) in *Nana Ama* and *Obaa Yaa* published in 2003, 2004, 2005, 2008, 2009, and 2010.¹⁴ I make no claim about their representativeness as a formal sample of Ghanaian advice columns, but I believe they fairly span the range of Ghanaian advice column themes during this period. Most were collected during visits to Ghana for other projects. The letters are cases in point. They are examples, yet I have no reason to think that these particular letters are a deficient set or in any way introduce a bias with regard to letters' content (see Jahoda 1959). The advice column themes found in studies in Ghana by Jahoda (1959), Mansah Prah (2008), and here are remarkably similar. Their main themes are how to find the right partner; how to know if one is in love; assessing whether to form or stay in a relationship; faithfulness and infidelity; family, peer, or social pressure on relationships; financial stresses on couples; and sexuality.¹⁵ The only thematic contrast between Jahoda's 1959 study and today's letters is worry expressed about HIV/AIDS.

Unlike Jahoda (1959) and Prah (2008), my interest is less in categorizing the love concerns of Ghanaians than in exploring how talk about love is positioned discursively in Ghana today. This I do

¹⁴ Of the 152 letters, 69 appeared in *Nana Ama* and 83 in *Obaa Yaa* since *The Spectator* often publishes one or two letters more each week. Across the six years, I collected 38, 32, 27, 28, 15, and 12 letters respectively.

¹⁵ Demographically, Jahoda's (1959: 178) letter writers were overwhelming men, which he attributes to education and literacy. Of the 362 male writers, they ranged in age from 16-35; 251 were unmarried with a median age of 22; and, married men's median age was 28. Prah (2008) provides social background details for only 13 of the letters that she uses as teaching material in her gender and sexuality class. Of these, women wrote eight. Letter writers were 13-25 years old, with the average age, reported as a range, as 19-22 (ibid: 8). In my collection of letters, women wrote 90 and men 62. Among those who reported their age, women's median age was 24 and the range was 16-43, while men's median age was 26, and the range was 16-52. Unmarried men (39) and women (60) were the primary correspondents.

by focusing on three themes that offer particular insight into the way Ghanaians are navigating the waters between longtime local realities and global discourses of romantic love. These three themes, each discussed in a separate section, are all obvious flashpoints in the reconciliation of local realities and global discourses: the challenge of finding an acceptable partner (“Somebody to Love”); the contours of domestic life, disaffection, and divorce (“We’re in This Together”); and the transactional aspects of courtship and domesticity (“You Never Give Me Your Money”). In sections devoted to each of these themes, I quote letter-writers and columnists at length to convey the texture, phrasings, and framings of love concerns in Ghana and to open up opportunities for analyzing discursive tensions.

In addition to reading the columns, and to help me understand their contexts, I interviewed three of the writers who produce them: a woman and a man from *The Spectator* who have been responsible for *Obaa Yaa*, and a woman from *The Mirror* who writes *Nana Ama Advises You*.¹⁶ Interviews were conducted at the writers’ newspaper offices in Accra. I asked the writers to describe how they produced their columns, who send in questions, who they thought read their columns, what contributed to the columns’ popularity, what purpose or objective they had for their columns, and whether their news organizations placed any constraints (e.g., subjects addressed or language) on their columns. I also talked with them about their opinions and impressions of love, relationships, marriage, and social change in Ghana. I did not enquire about specific columns, either questions or responses. In addition, the three writers requested anonymity because, as the

¹⁶ I interviewed the writer of the *Nana Ama* column on 11 January 2008 and 13 July 2009, the female writer of the *Obaa Yaa* column on 8 January 2008 and 9 July 2009, and the male writer of *Obaa Yaa* on 9 January 2008.

columnist from *The Mirror* said, “It would be disappointing for readers to find out that we are journalists reporting on other business” (11 January 2008). The columnists were emphatic that the letters are real, not fictional, as many Ghanaians believe. Indeed, one of the writers pulled out a folder stuffed with letters as proof. Letters today are also submitted via email.

When I first conducted interviews in January 2008, the primary writer of each of the two columns was a woman, and both women continued to produce their columns when I visited again in July 2009. *The Mirror*’s columnist had been involved in producing *Nana Ama* since 1987. *Obaa Yaa*’s writer, though a practicing journalist for many years, took on the column in 2007. The male writer at *The Spectator*, who would barely admit to having been responsible for *Obaa Yaa* for several years starting in the early 2000s, said that though he wanted to help letter writers, especially when they had “serious problems that could mess them about,” he also approached the column as entertainment for his readers (9 January 2008).¹⁷ He said that because he had both men and women among his readers he had to balance “earnest help and a little fun” (9 January 2008). For him, the fun was responding in forthright ways that conveyed to the advice seeker and readers “the ridiculousness that people are placing on themselves” (9 January 2008).

The two women described writing their columns as fulfilling an educative or instructional objective, one open to any subject or concern so as to give “people suffering from love some help and some hope” (*Obaa Yaa* writer, 8 January 2008). They rejected

¹⁷ Male writers of the advice column “Dear Dolly,” which appeared in the Accra edition of *Drum* magazine from the 1960s to mid-1980s, also intended their columns to be instructive and amusing. However, they viewed their primary audience as men and so selected titillating subjects and used jocular language in their responses to add entertainment (Mutongi 2000: 2-4).

entertainment as the primary purpose of the columns. “Making people a laughing stock is not my aim. Certainly, I choose letters that are interesting. Ones surely my readers will enjoy. But I want people to learn about proper love and marriage, not to make the same mistakes over and again” (*Nana Ama* writer, 11 January 2008). The writer of *Obaa Yaa* concurred: “My work has a higher calling. The column is not meant be profane or make people spectacles by sensationalizing their hurting. It should benefit readers, be for their personal development” (8 January 2008).

At any time, both columns have one primary writer who selects and organizes letters thematically, and edits them for grammar, clarity, and length. Sometimes the column writer disguises the identity of the advice seeker. Unless an advice seeker specifically asks to have his or her real name attached to the letter—some do so for the notoriety of having their name published—the columnists all said they preferred to create pseudonyms because “many people have the same love problems and so why put someone in trouble, say from a jealous husband who recognizes his wife?” (*Nana Ama* writer, 13 July 2009). This is the reason, too, that columnists may change a letter writer’s location. “Age and man or woman we keep right. Names of cities or towns are sometimes not the ones the letters are coming from. Everyone anywhere in Ghana has love problems” (*Nana Ama* writer, 13 July 2009). Though “love problems” may be everywhere, 140 letter writers (of 152) were identified in the columns as living in and around Accra and in the regional capitals or other towns, such as Kumasi, Sekondi-Takoradi, Cape Coast, Akosombo, Ho, Sunyani, Wenchi, Wa, and Tamale. “Sometimes I put in small, small towns to give my column a national flavoring. ... Readers are wanting to know that other people share their burdens” (*Obaa Yaa* writer, 9 July 2009).

A Word on the Layout and Content of Ghanaian Tabloids

As long-time features in *The Mirror* and *The Spectator*, *Nama Ama Advises You* and *Obaa Yaa* each appears regularly on the same page. Occasionally the page has other short features, usually dealing with relationships, or small, boxed advertisements. The page that features *Nana Ama* includes a caricature of a “city” woman wearing a dress, shawl, and large hoop earrings sitting in an office, hand gesturing to make a point, calmly advising a younger man. In the early 2000s, *Nana Ama* was depicted in a more old-fashioned drawing, as an older woman in traditional dress, seemingly in a rural area, wagging a sharp index figure. For *Obaa Yaa*, only a bold-printed title labels the page. In each column, four to six letters usually are printed, depending on length. Each letter has its own headline, varying in font size to attract the reader to the juiciest of them. Big headlines include: “Parents Object to Lover ‘Cos He’s a Foreigner,” “I Can’t Stand My Mother-in-Law,” or “She Is Too Demanding!” Smaller headlines include: “He Is Deceiving Me,” “She Is Putting Pressure on Me,” or “I’ve Lost Interest in Him But Can’t Tell Him.”

Nana Ama and *Obaa Yaa* are parts of larger “love packages” that both newspapers run each week, featuring stories on love, relationships, and marriage, as well as the advice columns. Syndicated columns from abroad make up much of the content of these love-package pages. They offer quite general observations and recommendations about romantic love that have no specific Ghanaian cues or allusions. They appear under headlines such as “Steps to Become a Love Magnet” or “Top Romantic Things to Do as Lovers.” Accompanying these stories are stock photos of attractive, young men and women in romantic settings: kissing by a candle-lit restaurant table, holding hands as they walk,

passionately embracing. Alongside this syndicated content are announcements and photos of Ghanaian weddings and anniversary celebrations and stories produced by Ghanaian writers that explore various aspects of relationships in considerable depth: “The Proper Roles of Husbands and Wives,” “Youth and Sexuality,” “Children of Divorce,” and “The Marriage Covenant.”

This mix of features, domestic and international, gives the “love-package” pages a bifurcated quality. The international features are sometimes anodyne and sometimes provocative, but always they are written in a tone of confident universalism, as if qualities such as “romantic things” or “love magnet,” were the same everywhere. Likewise, the stock photos of couples—usually tightly framed or close-ups—give no clue as to where the photo was taken or who the couple is. This way the images can circulate freely. The couple might be Ghanaian, but they could also be from anywhere else. The advice columns, by contrast, along with the announcements and the relationship stories produced by Ghanaian writers, signal in every way, *by Ghanaians, for Ghanaians*. This bifurcated quality is nothing new to readers accustomed to sorting through the global and the local in print or music, on television or the Internet. With each encounter of the love package’s blend of domestic and international stories and photos, readers may find they need to consider which parts of the globally circulating, confidently universalizing love discourse fit with Ghanaian particularities and how.

Somebody to Love

It is safe to assume and generally conceded in the literature that falling in love—or something like it—is a human universal (Cole and Thomas 2009; Jankowiak 1995; Jankowiak and Fischer 1992). Desire, longing, jealousy, and heartbreak are the stuff of stories,

songs, and poetry from all recorded time and all places. Yet, romantic love, shared intimacy, the idea of the love match as the basis for long-term relationships and marriage is a relatively recent innovation, having developed over the last several hundred years, mainly in Europe and North America (Coontz 2005; Giddens 1992; Illouz 1997). Today the primary reason most people everywhere say they marry is love, and a marriage that is loving is by definition successful.¹⁸

The rise of romantic love also brings anxiety, however, because romantic love is not always achieved and sustained in practice. Anxiety may be especially high where the discourses and accoutrements of love rest uneasily atop older and quite different foundations for bond formation and family making. Helping people negotiate the chasm between the ideals and the often-fraught experience of romantic love is the main work of advice columnists. Responding to questions about love, Ghanaian columnists must themselves grapple with differences between local and international practices of courtship, relationship formation, and marriage. As one columnist bemoans: “Love, love, love. Everything is love these days. And nobody is stopping to ask whether it is working so well for us here” (*Nana Ama* writer, 11 January 2008).

The following two letters illustrate the tension between global discourses of love (“everything is love these days”) and local practices (how does love work?) that Ghanaian advice columnists try to sort out for their readers.

Dear *Obaa Yaa*,

My friends are insulting me for not paying attention to the girl who is chasing me because she is in love with me. This girl does not

¹⁸ Coontz (2005: 161-95); Giddens (1992: 38-64); Illouz (1997: 208-46); Jankowiak (1995); Swidler (2001: 111-34); West (2011: 28-67).

need anything from me except my love, and she desires that I marry her. She has parents in America who are remitting her all the time. She tells my friends that if I should accept her proposal, her parents are willing to sponsor our wedding “big time.” *Obaa Yaa*, I keep running away from the girl anytime she comes to my house or phones me for a date.

The reason I am running is for another girl. Please advise I am in love with a girl who has no time for me.

Response:

First, your priorities must be set straight. You are chasing a girl who doesn't have time for you. So the obvious thing is that you might not be able to go far with her. On the other hand, there is another girl dying for you. You might not love her, but at least she has all the time for you. So, comparatively, she is preferable. The ultimate consideration is whether you are prepared to live all your life with the girl who is promising a funded wedding. If you don't really love her, don't get committed. But if you were dodging her only because you were chasing someone else, and not because you don't love her, then she definitely would be the better of the two evils. (21 May 2005)

This exchange shows one of the most frequent flashpoints in the advice columns: financial security, or at least relative prosperity on the one side, and passion on the other. The young man's quandary is plain: continue pursuing a girl who ignores him or accept the marriage proposals of another girl, whom he does not necessarily love but who has money. The choice he faces is by no means a uniquely Ghanaian one, but the columnist's response reveals certain Ghanaian practicalities. The columnist urges him to stop wasting his time with unrequited love, and then implies that if he does turn his attention to the girl who is dying for him he might be able to love her. The funded wedding looms as a consideration, an apparent factor to weigh in, though certainly a less important one than love. The “two evils” comment at the end may be the most instructive part of the reply; it is a thinly veiled hint that the columnist understands that just as the first girl does not love him,

there may be little chance of his mustering the requisite love for the other.¹⁹

In a letter on a similar subject, family complicates a couple's plans to marry:

Dear *Nana Ama*,

I am 28 and a businessman and she is 24 and a hairdresser. We have been in a relationship for two good years and plan to get married soon. We love each other very well. But the problem is that her family doesn't approve of the relationship. Her sister says it is not good to marry two women from the same house. When I ask for explanation the only reason they gave me was that it was an abomination for brothers to marry from the same family.

We are so much in love that we cannot separate. What should I do? Should I go ahead with the relationship? I am so confused. Please help me.

Response:

Although your letter was not clear about the nature of the relationship between the two people who are already married from both families, you may have to investigate further what your girl's family is saying. Talk to other members of the family, elders and any well-informed person from your families about what you have been told. If it turns out that their assertion is true, you may have to consider a break-up, painful as that decision may be. (14 June 2003)

Here, too, the columnist puts a high value on love, but it is not paramount. It does not necessarily conquer all. Customs and family considerations must be given their due; love may sometimes have to be sacrificed for a greater good.

The tension between ideas and ideals about love as a globalized discourse and love as local practice animates the questions raised in these letters and the answers provided by the column writers. How does one choose a partner? What qualities

¹⁹ Advice seekers' socio-economic status is difficult to gauge. But to give some insight into their lives, I include information about education, employment status, livelihood, and/or age when letters contain it.

should a love interest possess? Can family force a loving man and woman apart? Can a couple get together or marry without family approval? Why hold out for love when an unloved suitor is financially secure? What are the limits to personal decision-making about relationships? Always invoking love, these advice seekers show themselves to be convinced of the desirability of partner selection as a fundamentally personal choice based first and foremost on desire and affection. But the writers are tentative, in one case fearful of flouting the practicalities of family expectations and in the other case torn between material betterment and the possibility of future romantic love. The columnists seem to share their “in-betweenness”; in these examples they are far from daring avatars of romantic love. They urge caution. They are advocates of romantic feelings, but they also seem to want to shake impracticalities out of their readers, give them hard lessons on the importance but also the shortcomings of the desires of the heart.

Letters to *Nana Ama* and *Obaa Yaa* sometimes reveal writers’ confusion about whether they are in love, and where love—if this is love—will or should lead them. More often, writers are sure they are in love but they are desperate to know what to do with their powerful feelings; they need to know how to turn their love into a happy and successful love match. Letter writers often use language that indicates great intensity, overwhelming thoughts, and incapacity to deal practically with deep and unfamiliar emotions. Writers describe their feelings as: “being so much in love,” “being too much in love,” “truly, truly in love,” “aching with love,” “finding genuine love” (as well as soul mates and true lovers), “carried away with love,” “crazy with love,” “falling to [his] knees in love,” “disturbed by [his] depth of love,” “troubled with love feelings,” “overcome with love,” and “so silly with love [she] cannot sleep.” Both men and women express these powerful

emotions; they want to turn these emotions in productive directions, but they often don't know what direction that is or what to do.

A frequent concern is how "to propose love" to the man or woman inspiring their passion.²⁰ Proposing love has various meanings, of course, and the advice columnist knows that his or her first task is to interpret within the letter's context what "proposing love" means. For example, one woman writes: "I have fallen for a co-worker. Should I propose love?" The assumption of the columnist in her published response is that the letter writer wishes to express her feelings to this man—and for now no more. She is advised to try to get to know her office co-worker better so that he might notice and return her affections (*Obaa Yaa*, 1 November 2003). Some advice seekers hope love proposals will change the nature of their relationships: "She is allergic to love proposals. She just wants to be friends. How do I have her fall in love with me?" (*Obaa Yaa*, 15 March 2003) or "Thoughts of her are driving me crazy. I have tried everything to win her love. How many times should I propose love?" (*Nana Ama*, 7 June 2003). These letters imply that "proposing love" may be polite language for seeking intimacy. Sometimes there is no question about it. When a 16-year-old boy writes to say that his thoughts about proposing love to a woman eight years his senior are "affecting his Christian life," he is chastised and told he "should be concentrating on his studies, not having those other thoughts. ... Do not make a proposal of love to this lady, lest you make a big fool of yourself" (*Obaa Yaa*, 20 March 2004).

²⁰ There are no letters about proposing love within a gay or lesbian relationship. The four letters writers (three women and one man) who asked about these relationships wanted to know either how they "became" gay or lesbian or how not to be (*Obaa Yaa*, 23 July 2004; 9 April 2005; 16 July 2005; *Nana Ama*, 7 June 2003).

Making an imprudent love proposal, losing oneself in charged emotions, and losing oneself in the sexuality of love: Such moves are reckless and unwise. The columnists are quick to set writers straight when their love seems irrational. To an 18-year-old female student who wants to know whether a kiss and constant texting indicates a proposal of love, *Obaa Yaa* warns:

The beginning of every love affair can be rosy. But it is always necessary for young folks not be carried away before they realize they have made a mistake of a lifetime. And mistakes, these days, can be costly. Normally, words don't mean much in love. Action is better appreciated. Words can be flattering, but when a boy, for instance, offers you an Oxford Learner's Dictionary to help you in your studies, it is something you can describe as meaningful, caring, and loving.

Unfortunately people are carried away by flowery words in text messages that might or might not be sincere. Most often, they are designed to lure you into bed. I'll advise you not to be overly enthusiastic about this relationship, because your boy might not be the angel you think he is. (21 May 2005)

The columns counsel letter writers, and by extension the reading public, to be cautious about entering and maintaining a love relationship. For example, "If she loves you she will return your kindness but do not misconstrue her liking you for love. Be discerning" (*Obaa Yaa*, 15 March 2003). To a 22-year-old student concerned that her boyfriend will leave if she continues to deny him sex, "People do extremely silly things according to the dictates of the heart. Think about the error you are about to make" (*Obaa Yaa*, 9 April 2005). On the subject of a boyfriend's cheating, "The misconduct of one man should not be the source of grief and agony to you for all your life. The man has no scruples and is not worth crying over. ... Keep smart, and God willing, you will get a partner who will give you peace and love" (*Obaa Yaa*, 16 July 2005).

Nana Ama tells a male college student who writes about a finished relationship, “You may feel heart-broken now, but you’ll get over it. Keep your mind busy and do not think of her” (31 May 2003). And a young man who writes with a long list of the qualities he seeks in a mate is told, “You are sounding very desperate indeed. You have many requirements, but have you looked at yourself and your offerings to a woman? Pray to know yourself better” (*Obaa Yaa*, 2 July 2005).

In all, the columnists take it for granted that their writers’ feelings of love, expressed in idioms familiar the world over (“truly in love,” “crazy with love,” “overcome with love”) are authentic, valid, and good for the individual as well as for the society that depends on bonds of affection. But precisely because letter writers often are in the throes of passion and may not be thinking clearly about repercussions, the columnists’ usual stance vis-à-vis those newly in love is to remind them of practicalities—their age, the expectations of their families, possible motives of the loved one, community moral standards, and money—and to urge caution.

Let’s Stay Together

A central theme in the advice columns is making and keeping long-term commitments. The writers of *Nana Ama* and *Obaa Yaa* said that almost all the letters they receive are from men and women seeking advice about love and relationships. Marriage often looms, whether as an objective, a fear, or as the great unknown. According to the writer of *Obaa Yaa*, “If a lecturer is going to be talking about national development, forget it. Nobody is coming. If a lecturer is going to be talking about love, then the hall will be so full you won’t be finding anywhere to sit. Ghanaians want to learn and talk about love, modern love. They

want to marry nicely” (9 July 2009). The authors of both columns said that in their experience letter writers (and readers) more and more define love as essential to “romancing” or courtship and later to forming a monogamous “serious” or “committed relationship” or marriage. A serious relationship, they noted, is one in which the partners have selected one another for individual qualities. They expect to live in a nuclear household, have financial security, enjoy each other’s company, and have an emotionally satisfying sexual relationship (5 and 12 January 2008). “People are wanting so much these days. Not only things like big church weddings but the right lover. ... People know of more outside influences, a greater openness in Ghana as the country passes through much social change and globalization. Finances are tight, job market competitive, so love is the one sphere they believe they can have some control over” (*Nana Ama* writer, 13 July 2009).

Though *Obaa Yaa* and *Nana Ama* counsel their readers to approach love prudently, they strongly affirm love as the best basis for marriage. To a young man in love with three women but confused over which one he should marry, *Obaa Yaa* says:

I would advise you to consider moral uprightness, temperament, character, neatness, industriousness, respectfulness, diligence, and ability to make the best of financial resources available at any given time. But foremost also consider which one loves you most as against which is likely to desert you in time of trouble. (8 January 2005)

Letters show women worry that men proposing love and promising marriage are merely out for sex, and men are equally convinced that women avowing love and advocating marriage are doing so for economic gain. The expectations for love as a foundation for marriage are high. As a 28-year-old businessman writes:

Truly, from all indications, she loves me a great deal. In spite of that, I'm a bit afraid to enter into a serious relationship with her, which would probably end in marriage, lest I regret later. I don't want to encounter any disappointment whatsoever in my future marriage. (*Nana Ama*, 14 June 2004)

Yet, being in love or saying one is in love does not always lead to marriage in ways that the letter writers anticipate. One man, after promising marriage for nearly three years to his girlfriend, professes shock when he discovers that the woman he loves has left him to marry someone else. *Nana Ama*'s rebuke is short: "I believe she knows very well that though you are saying you love her and want to win her back, you are not in the position to marry her" (*Nana Ama*, 31 May 2003). In another example, a woman who has lived with her boyfriend for four years in a "loving, faithful, and committed relationship" asks *Obaa Yaa* how "to achieve the state of marriage." Her response:

The relationship between love, commitment, and marriage is a complex issue ... you feel like you are in a stuck point, ready to go to some next level of commitment. ... Maybe he's comfortable with the two of you just living together and does not see the need to go further. If that is the case, then you need to advise yourself, because you cannot live with a man for years, and yet he does not go the extra length. (15 August 2008)

At each step in the dance of courtship—finding someone, proposing love, building a relationship, and marriage—young Ghanaian advice seekers invoke globally circulating tropes, behaviors, and values, recognizing that enmeshing oneself in the ascendant global discourse of romantic love is part of love's pull. *Nana Ama* and *Obaa Yaa* push hard for local grounding, for practicality, for reconciling the global discourse with Ghanaian realities. In particular, they remind writers and readers that while love may be a garden of private delights, a world unto itself,

marriage, by contrast, is a social institution. As one local columnist observes, “Marriage is not for fun.”²¹ Thus we arrive at the central tension in the rise of romantic love in Ghana: It elevates and celebrates private emotions, then sets them on a course to be bulwarks of a society that is accustomed to frank consideration of marriage’s social and economic utility.

In an online column titled “Did Love Kill Marriage?” the Ghanaian author notes, “Love is a private matter but once it goes beyond that and develops into marriage the whole of society is affected in one way or another” (Allotey 2007). This sentiment and the question posed in the article’s title encapsulate the tensions that permeate discourses of romantic love in contemporary Ghana. What do men and women expect of love matches and of each other, and is the love match a solid base for marriage and society? The author of the piece carries on with his critique of the foundations of modern marriage, arguing that Ghanaians

... mistook the industrialization of the West for civilization. Ghanaian children began to resist arranged marriages. They did not understand why they should be forced to marry partners they did not love or even know. Education, cinema, and radio open our eyes to other cultures. ... In the end, the youth won the battle so love as a condition for marriage was etched into our culture. Unfortunately, with the birth of love as a condition for marriage came the inevitable afterbirth—divorce. (Ibid.)

The love match is inherently unstable and may undermine society, says Allotey. A man responding to a letter sent to *Obaa Yaa* about the letter-writer’s intent to leave her husband argues similarly: “Marriage is one of God’s creations, so it is good. ... God intended it for the purpose of the maintenance of the chain of the human

²¹ Godfred Arhen-Kumi, “Preserving the Sacred Institution of Marriage,” *The Spectator*, 4 January 2004.

race through procreation and companionship.”²² On the other side, making the case for romance and partner selection based on love, a Ghanaian woman columnist writing for *The Spectator*’s “Relationship” page notes, “Today nobody wants to even imagine the thought of being married off to anybody whatsoever by her parents. I am referring to women. She would rather die first or on the lighter note she won’t be bothered if she were threatened of being disowned.”²³

In the advice columns of *Nama Ama* and *Obaa Yaa* the health and stability of love-based relationships and marriage are a cause for anxiety. Syndicated columns from abroad abound with lessons on managing divorce, surviving divorce, explaining the reasons relationships fail, telling children about divorce, dealing with post-divorce emotions, attracting a new partner, remarrying, and blending families. Local stories explore reasons why marriages break down: women who can’t cook, sexual incompatibility, infidelity, problem parents, nagging, extended family interference, and men ignoring their partners. These stories, special columns, and letters to the editor identify divorce as a new growing national problem.²⁴ Long-term relationships and marriages of the past are

²² Ibid.

²³ Edozdi Segbefia, “Marriage Changes Your Pronouns,” *The Spectator*, 14 June 2003.

²⁴ Ghana has three forms of legal marriage: ordinance (civil), customary, and Islamic. Couples may dissolve an ordinance marriage by showing irreconcilable differences. In customary marriages, a husband may ask for divorce on the grounds that his wife is barren, practicing witchcraft, has committed adultery, or deserted him. Women may seek divorce for a husband’s impotence, financial neglect, cruelty, and laziness. Unless a marriage has been registered with state authorities as in an ordinance marriage, men and/or women who want to end a relationship do not seek to do so through the courts. Thus, statistics on marital status may not provide a complete picture. A summary report conducted by the Ghana Statistical Service on households in the Greater Accra Region shows that 43 percent of population (aged 15 and older) is married or in a consensual union, and 4 percent are divorced (Ghana Ministry of Local Government and Rural

idealized, held out to be the standard that Ghanaian men and women today should emulate. As one columnist says, “Let’s learn to marry for the right reasons and our generation will hear very little of divorces just like in the days of our grandparents and great-grandparents.”²⁵ Yet, almost no one argues seriously for the arranged marriages of yesteryear. Falling in love and personally selecting a partner, even if the love might later falter, is deemed by nearly all the letter writers to be an essential precondition to marriage.

Despite hand wringing about divorce in the relationship pages and occasional letters to the advice columns on the subject, divorce is at most a second-tier preoccupation in the columns (only 12 of the 152 letters refer directly to it). More common are letters citing problems within relationships, with “breaking off” a frequent explicit possibility in non-marital relationships and divorce an unmentioned though sometimes looming possibility in marital ones. Typically, columnists discourage letter writers from “quitting” serious relationships or marriages, emphasizing that these partnerships are “life-long journeys” or “life-long vocations,” with smooth and rough patches. They caution both advice seekers and the public about the pain of “broken homes” for children, the social embarrassment divorce brings to themselves and family, and the financial implications. They invite advice seekers to examine the “root cause” of a split: too much nagging or drinking, lack of attention to hygiene, or too little consideration for each other’s needs. Staying together is nearly always preferable and must be tried: “Is there any love remaining?” (*Obaa Yaa*, 14 May 2004). “If talking to him does not work, you should consider going for

Development 2006). However, the *Ghana Demographic and Health Survey, 2008* reports 7 percent of women as divorced or separated and 4.3 percent of men (GSS 2009: 6).

²⁵ See note 23.

counseling to help both of you” (*Nana Ama*, 24 October 2009). “He realizes he made a mistake. Are you sure you want to move on? Why not forgive? Why not think about why you first fell in love?” (*Nana Ama*, 3 May 2003). But if the relationship is irreparable, the pragmatic advice usually is to leave.

Framed as life-long journeys traveled by men and women who have chosen each other, the love match, when promoted, is depicted as a refuge against the pressures of extended family and the rest of society; the love-matched couple forms an exclusive, satisfying, and intimate emotional and physical bond. But love and the love match may disappoint. Advice columns and the syndicated features printed near them instruct readers on how to keep relationships from faltering. Feature stories often suggest that love fails because of inherent biological differences between the sexes, leading to all sorts of misunderstandings and troubles. Typical tips for a successful union include better and more communication, more couple time, more fun, more passion, and more romance. Men need to pay more attention to women’s needs, and women should not overanalyze the relationship.²⁶

To be sure, these stories—part of the newspapers’ larger discursive love package—summon the pabulum of “Men Are from Mars, Women Are from Venus”—offering images of idealistic companionate partnerships among equals. But as the letters sent to *Nana Ama* and *Obaa Yaa* attest, Ghanaian men and women experience love and companionate partnership differently.²⁷ Infidelity tends to elicit different reactions depending on which partner is unfaithful. A businesswoman who wonders whether she

²⁶ “What Men and Women Want,” *The Spectator*, 1, 8, and 15 November 2003.

²⁷ Much research has addressed male privilege and dual standards in relationships. See for example Adomako Ampofo and Boateng (2011); Darkwah and Adomako Ampofo (2008); Darkwah and Arthur (2006); Dinan (1983); Frost and Dodoo (2010); Heaton and Darkwah (2011).

should confront her “Cassanova” husband or his girlfriend after she discovers text messages and photos on his mobile is scolded for snooping on his private phone (*Obaa Yaa*, 2 July 2005).²⁸ A university student writing to ask whether he should tell his fiancée that he has contracted “gono” after engaging in a series of affairs when she was out of town for three months is advised to avoid sex with the fiancée, “hurry up to the clinic for medicines,” then tell her the truth so she can forgive him (*Obaa Yaa*, 13 August 2005).

When a housewife discovers her husband at home having a sexual liaison with a family friend, she is advised to: “Report her [the family friend’s] conduct to her family on both sides, and they will support you. I guess your husband is now hooked on her and won’t support your idea, but when your family and his are sympathetic to your cause he’ll be compelled to play ball” (*Obaa Yaa*, 13 August 2005). By contrast, when a married man returns home to “meet my wife on our matrimonial bed with another man,” he is told that: “The Bible frowns on divorce but the same Bible endorses divorce which results from adultery. So if you feel deceived and cannot trust your wife any longer, divorce is an option” (*Obaa Yaa*, 18 October 2003).

Advice columnists do occasionally side with wives of philandering husbands.²⁹ For example, women who discover their

²⁸ A 2010 survey conducted by a private Ghanaian information technology consultancy found that 33 percent of respondents (sample size unreported) said that cell phones enabled them to maintain multiple relationships; 25 percent said that “suspicious” calls and texts messages had caused a relationship to end; 47 percent reported being informed of the relationship’s end via text message (“Suspicious Phone Calls Breaking Love Relationships in Ghana” 2010). Indeed, a letter sent to *Nana Ama* deals with the pitfalls of texted love proposals when a man’s intended not only rejected his proposal but refused to pick up his calls or messages (10 July 2010).

²⁹ In instances where women write to ask about leaving a relationship because of physical domestic abuse, they are advised to leave and/or return to their families. For example, *Obaa Yaa* tells a 28-year-old woman: “Marriage is a life-long

husbands have deceived them by having other families are advised to split (*Nana Ama*, 31 May 2003, 17 July 2004; *Obaa Yaa*, 26 August 2003). In the case of one woman who wants to “forgive and forget,” she is warned, “You are allowing your emotions to rule your better judgment. I know that it’s difficult to break relationships but when you are being taken for a ride, you must know it and back out” (*Nana Ama*, 31 May 2003). In stronger language *Obaa Yaa* disdains polygamy: “If you stay in such a marriage [with five other wives] it means you are condoning polygamy which Christianity is vehemently against. If you break a polygamous marriage, heaven will not hold it against you” (26 July 2003).

In the love relationship, at least from the advice columns’ depictions of it, women should expect monogamy but should not be surprised by men’s infidelity. Confronting a male partner about where he has been and with whom is tantamount to questioning the emotional and physical bond that is the basis of a companionate union (see Smith 2006). Risk of sexually transmitted infection seems to be one of the few acceptable reasons for a woman to broach the subject and details of infidelity. Writes a woman married for 10 years:

Dear *Obaa Yaa*,

I have always known my husband to be the unfaithful type. I forgave him but have insisted that he runs an HIV test before I allow him to make love to me. My husband does not seem to understand this and he is rather seeking for divorce. In spite of everything I still love him.

journey but with slaps at every turn, I don’t think you can go half way through” (15 March 2003). See also Cole (2007), Gadzekpo (2009), and Newell (2000: 135-42) who address representations of violence against women in popular theater, the press, and literature. The edited volume by Cusack and Manuh (2009) provides a powerful examination of the impact of poverty, economic dependence, and social structures on violence against women in Ghana.

Obaa Yaa, what should I do? I believe I am only protecting myself from this infection.

Response:

You are right in insisting that he does the test because husbands are infecting the wives in numbers. Innocent women are dying at the hands of their husbands. It would be better for you to be divorced and to be free from AIDS than to risk AIDS in order to save your marriage. (8 February 2003)

In general, the columnists portray it as unwise from a practical standpoint and disruptive of the union for a woman to challenge her husband too readily on the subject of possible infidelity, but HIV/AIDS in particular may be altering this calculation.³⁰

For women especially, the love match represents an opportunity for shared intimacy and a partnership between equals (Thomas and Cole 2009; Wardlow and Hirsch 2006). But many letters written by women to *Nana Ama* and *Obaa Yaa*—and many of their answers—suggest that maintaining a love relationship is the woman's work. For example, when a wife discovers that her lawyer husband has given his married lover money and expensive gifts and wants to know whom she should confront (the husband, the lover, or the lover's husband), she is asked how she has contributed to causing the problem:

Sometimes it is necessary to diagnose the cause of a man's infidelity to tackle the problem. Is his infidelity a result of your nagging or bad character? Men go for extra-marital affairs because their wives make them uncomfortable at home. Have you also not been attractive enough due to your sloppy way of life, your unattractive dressing or something objectionable on your part? Time has come to examine the

³⁰ Several studies demonstrate that women have a higher risk of infection because they have far less power in sexual relationships. See Adomako Ampofo (1997); Adomako Ampofo and Boateng (2011); Ardayfio-Schandorf (2006); Doodoo (1998); Mann and Takyi (2009).

marriage, yourself, then have a heart-to-heart with your husband.
(*Obaa Yaa*, 23 July 2004)

Such shifting of blame from the unfaithful husband to the wife nicely illustrates the point of Ashley Frost and Nii-Amoo Dodoo (2010: 42) that gender inequalities in Ghana “manifest most insidiously within marriage.”

While letter writers and advice columnists alike appear overwhelmingly to admire the idea of the partnership of marriage based on love, the wide gap between the idealized love match and lived reality means there is broad ground in every marriage for disappointment and contestation. The common Ghanaian assumption that men philander while good women do not, and that women possess domestic instincts and a greater interest in harmony and stability, appears to burden women with most of the responsibility for managing relationships and keeping their partners and husbands interested: in them, in monogamy, and in domestic life.³¹ The challenge of fidelity and infidelity is by far the most frequently expressed cause of concern and discord in partnerships and marriages described in the Ghanaian advice columns, but one other challenge runs especially deep.

You Never Give Me Your Money

The pleasures of romantic love notwithstanding, marriages and other companionate relationships remain deeply entwined with everyday material reality, the wish for prosperity, and the self-interest of all parties. When relationships go sour for any reason,

³¹ The relationship of gendered inequity and the dynamic that holds women as responsible for relationships is well documented in many studies. See Adomako Ampofo and Boateng (2011); Clowes (2005); Frost and Dodoo (2010); Darkwah and Adomako Ampofo (2008); Darkwah and Arthur (2006); Dinan (1983); Miescher and Lindsay (2003: 1-29); Miescher (2005: 1-16, 115-52); Morrell and Ouzgane (2005); Takyi (2001).

Nana Ama and *Obaa Yaa* often find themselves reconciling love's emotions with the transactional exchanges implicit or explicit in every union.

Just what men and women should bring to a companionate relationship is complicated by persistent concerns about the cost of love. For women advice seekers, the lack of *chop money*—money provided by men for housekeeping—is a recurrent point of contention. Men who do not pay chop are chastised for their irresponsibility, especially when the couple has children. To a woman whose husband had not remitted for five years, *Nana Ama* says: “He is not fulfilling his marriage obligations, and this is good ground for divorce. See a lawyer” (15 February 2003). Yet, admonishment is sometimes tempered. “Your man sounds like a very mean fellow. But I wonder whether you have encouraged his mean behavior with your demands for chop money” (*Obaa Yaa*, 8 January 2005).

Several feature stories penned by Ghanaian writers for the newspapers' relationship pages suggest that relationships fail because women put too much financial pressure on men.³² As one features columnist writes, “Women need some new attitudes. ... They take men's money, expect men to pay for everything, like prostitutes. ... Total dependence on men is probably the reason that they [women] can have EMANCIPATION—with strings [chop money, Valentine's Day gifts] attached!”³³ Similarly, advice columnists caution women not to demand too much, either financially or emotionally, from men if they want their love relationships to succeed. “Using money for drinking, smoking, and

³² For example, see *The Spectator*, 17 May 2003; 15 November 2003; 29 January 2006; 4 April 2006; 1 August 2009; and *The Mirror*, 14 June 2003; 14 May 2005; 11 June 2005; 20 August 2005; 12 January 2008; 27 March 2010.

³³ “Women and Liberation,” *The Spectator*, 17 May 2003.

chasing women is neglectful, but sometimes wives must become the breadwinners to save the children from hunger" (*Obaa Yaa*, 23 October 2004). One young woman writes that she is tired of her unemployed husband's "poverty and laziness." Though she still loves him, she wants to know whether she should continue to "sponsor" him. In short order, *Obaa Yaa* takes her to task for not taking better care of her husband: "He may be jobless, but you have not really helped him to get one. From the tone of your letter, all you do is berate him ... Please do your best for him because sometimes ladies must assist their men with love support and money so they can make it in life" (12 July 2003).

Under the headline, "What Are Wives Not Doing Right?," a male writer to the editor asserts: "If the rise of the nation begins in the homes of its people, then I pray the good citizens of Ghana to be mindful of how the family, and for that matter the matrimonial home, is being treated."³⁴ His central concern is that accoutrements of middle-class lifestyles may destabilize the institution of marriage. With middle-class life comes conspicuous consumption. In a society of economic inequalities, material aspirations lure young people into hollow, illicit relations with married men and women. Derided as "sugar daddies" and "sugar mummies," the better-off person in these pairs (more often the man) exchanges money, clothes, mobile phones, employment, and other favors for the attention of the usually younger aspirant. The sugar-daddy/sugar-mummy category is fraught because there is some level of financial inequality and dependence in all relationships, and inequalities do not preclude or invalidate love. The concern Ghanaians so often express about these unions appears to derive from their discomfort with the reality of poverty, from parallels between such unions and prostitution, and from the still-

³⁴ *The Spectator*, 8 October 2005.

incomplete resolution of romantic love on the one hand, and from security as legitimate alternative bases for companionship and marriage on the other.

Letters to *Nana Ama* and *Obaa Yaa* often derive from disappointment that economic security and material goods that the writer hoped to leverage in a union did not pan out, but just as often the letter writer wants to know how to leave a relationship that may be materially fulfilling but lacks love. The columnists are invariably unsympathetic to letter writers who feel trapped by money, telling writers, both male and female, “there is no free lunch.”³⁵ They are especially unsympathetic to persons involved with married partners for financial gain. To a 30-year-old woman who has been involved with a married man for 10 years and wants to break off the relationship, *Obaa Yaa* advises: “Focus on getting a good man to marry you. Be sober and reflect on your life” (6 March 2004). *Nana Ama* tells a 22-year-old man in a similar predicament: “A man worth his salt does not depend on women for money. Get a job and stop wasting your time and energy” (24 March 2005).

Rarely if ever do letter writers involved in extramarital relationships, whether men or women, address consent or power differentials; rarely, that is, do they portray themselves as victims of inequality. The writers clearly understand and accept the exchange value embedded in their relationships. They either just want more access to material goods or have become disenchanted with their partner.

More broadly, the advice columnists react consistently, strongly, and negatively to “sugar” relationships. Their illicit

³⁵ For example, see *The Spectator*, 15 March 2003; 18 October 2003; 6, 20, 27 March 2004; 7 August 2004; August 2005; and *The Mirror*, 31 May 2003; 17 June 2004; 5, 12 January 2008; 21 November 2009.

nature and their explicit exchange values challenge what is acceptable within the parameters of love as they see it. Take, for example, *Obaa Yaa*'s response to a first-year university student's query about how not to get "caught up in the sugar daddy craze":

Moral decadence is a modern-day problem. ... Youth need moral education, new attitudes because social and economic forces are responsible for immorality. Poverty and break down in the extended family due to modernity and urbanization. So a veritable crusade must be launched against moral decadence to overcome the negative forms that spiral it. (18 October 2003)

In short, whereas in their advice to the love-struck, unmarried young, the columnists are pragmatic and realistic about "Ghanaian realities" and the need to take material considerations into account as a balance against the delights of love, in their advice to those who have attempted to benefit mainly materially from a relationship, especially an extramarital relationship, they are scathing.³⁶ That love in Ghana may encompass both powerful affection and the satisfaction of needs for security and money seems unremarkable to the advice columnists, but they appear to be venturing to draw sharp lines in the contested borderlands between the licit and illicit.

Discussion

Love sells, and media producers know it. Love sells particularly well in Ghana, where uncertainties and insecurities about courtship and marriage guarantee readership for credible advice and for the cautionary lessons and tension release provided by the poignant

³⁶ The letters to *Nana Ama* and *Obaa Yaa* lay bare the mismatch between the discursive and the lived. Although both men and women can be unfaithful, only male philandering is tolerated to some degree. However, the columnists are quite contemptuous of relationships where the exchange of sex, affection, and materials goods is explicit.

and comic love mishaps of others. The advice columns—and the love and relationship feature stories that accompany them—are part of a broad if unspoken marketing strategy on the part of the Ghanaian tabloids to attract readers with insights into relationships and ways of bringing globally circulating discourses about romance and love into line with other realities of being Ghanaian.

In an era of new media and online social networking, newspaper advice columns might seem like a throwback to habits of past generations. Young Ghanaians with discretionary cash do have access to web-based relationship advice. But the weekly columns in *The Spectator* and *The Mirror*, unlike advice found on the Internet, feature reliably Ghanaian takes on resolving Ghana-inflected problems. Readers know that many of their friends at work, their girlfriends and boyfriends, and family members all probably saw the columns over the weekend. In contrast to the online experience, where friends and family may be off in myriad transnational discussions, old-media advice columns provide a connected space for public discourse about the parameters of love and relationships specifically in Ghana, generating conversation and jokes that reverberate across the nation for days.

One feature of advice columns everywhere is that columnists position themselves to be arbiters, rational voices of “the other side,” whatever the other side happens to be. This is part of the entertainment value of the columns and also central to the educational ambitions of the columnists. To letter writers falling hopelessly in love, the columnists urge caution. To letter writers who are hidebound or overly cautious or practical, they stress the importance of feeling, emotion, and love. Thus advice columns are built around almost-automatic binaries: rational/emotional, self/society, Ghanaian/Western, traditional/modern. This tendency is to a considerable degree a natural function of the narrative

format of the columns. The advice-seeker writes to the columnist as advisor. The latter, promoting a balanced life and the middle ground of reasonable compromise, tries to relieve the seeker of his or her distress from a position on the other side of the fulcrum. Constrained as in all newspaper writing by word or space limitations, and writing for a broad audience, the columnist must be parsimonious and easy to understand. Balancing familiar if somewhat simplified oppositional positions is rhetorically efficient and effective. Yet the habit of the binary in advice columns bolsters rather than attempts to correct a general preference in the public (hardly unique to Ghana) for dualistic, often hackneyed framings of social realities, such as traditional/modern and Ghanaian/Western.

Chaney's work (1996) implies that dynamic lifeworlds, constellations of lifestyles, are ascendant worldwide. More than ever before, the individual has creative license to choose peers and mentors and build or join communities structured around voluntary and sometimes shifting interests of his or her own. In this context, young Ghanaians may be especially eager for expert advice on love. More and more, love is a maze of choices. Sex now? Marriage? How important is monogamy? Polygamy? Cohabitation before marriage? After marriage? A good provider? A partner of my choice? Should my family have a say? People the world over face choices like these. But in places such as Europe and the United States, where a rhetoric of personal choice has long dominated public discourses of love and family creation, the individual at least can usually be certain that society will validate his or her decision-making right, even if some might object to the actual decisions taken.³⁷ Elsewhere, including Ghana, there are

³⁷ See Note 4.

strong competing discourses about family structure, sexuality, and lineage with which individuals contend.³⁸

Young Ghanaians may have fewer models in the family for navigating the vicissitudes of love. Many of their parents and older family members may be in arranged and/or polygynous marriages and raised their children under natalocal and other non-nuclear household arrangements, systems that the young may wish to reconcile with new realities but which do not necessarily equip their elders to offer practical guidance.³⁹ Expert help from the columnists to some degree fills a generational gap.

It should not be surprising that the themes covered in the advice columns have not changed dramatically from those reported by Jahoda in 1959. The challenges of reconciling Ghanaian customs with romantic love are little different now from 50 years ago. What has changed is that a late colonial vanguard of youthful modernizers has become a twenty-first century majority. Young urban Ghanaians now must come to terms—Ghanaian terms—with globally circulating ideas of courtship, love, and marriage. In the 1950s, columnists addressed the few venturing into romantic love. These days, they speak to the many.

The concerns of persons writing to the advice columnists and the responses of the columnists reveal several obvious tensions in Ghanaian discourses of romance and love today. Readers of the columns learn again and again: Love matters; all should seek it; but love is not everything. Stubborn practical and cultural realities

³⁸ See Note 3.

³⁹ The natalocal domestic unit, common in Akan society, involves each spouse remaining with his or her family of origin after marriage, children raised by mothers in residential units consisting of generations of brothers, sisters, and sisters' children. Wives in these situations are linked to their husbands economically to some degree even though they do not reside with them. See Ardayfio-Schandorf (2006); Assimeng (1999: 74-99); Frost and Doodoo (2010); Takyi (2001).

have to be given their due, have to be factored in to the calculations of every seeker. Gifts—a man's duty to provide them, a woman's expectations of them—are a central preoccupation. Marriage beyond one's station, up or down, is portrayed as a recipe for disaster. Such financial considerations and worries in courtship and marriage are only partly a function of the relative poverty of many young Ghanaians. They are also a reminder that the arranged, transactional aspects of courtship and marriage in Ghana bear upon those making choices about love, sex, and marriage today.

Column readers are assured that both men and women are capable of falling utterly in love. While men may sometimes behave responsibly in love and should be encouraged in that direction, maintaining the love match is portrayed in the columns as largely women's work.⁴⁰ According to the columnists, the astute woman will be attentive to this responsibility. In courtship she is advised to stay enticing, clean, cheerful, willing, and desirable. In marriage she must forgive her husband's foibles. Men, on the whole, for all their strength, are depicted in the columns as weak, at least as regards their capacity for fidelity.

The columns present a sexually bifurcated picture of love in Ghana: Women seek monogamy and stability but men philander. Men may be criticized for infidelity, but as letter writers and columnists note regularly, they should not be criticized too harshly, for men will be men. A mistress or a second wife may be his right. The social science literature on Ghana is straightforward on this matter: Romantic relationships are rife with gendered power inequalities (Adomako Ampofo and Boateng 2011; Frost and Doodoo 2010). And yet—imply letter writers and columnists again and again—is this differential fair? Can it really be just? Social

⁴⁰ See Note 32.

scientists and historians recently have begun suggesting that new ways of being men, and new ways of being women, are emerging in contemporary Ghana. While men still must negotiate a normative terrain that rewards them for conquest and control over women (Adomako Ampofo and Boateng 2011; Frost and Dodoo 2010), increasingly they are drawn, even if tentatively, to alternate masculinities that offer openings for greater gender equality, partnerships that conform more overtly to the ideals packaged in portions of the global circulating discourse of romantic love (Bochow 2008a; Darkwah and Adomako Ampofo 2008; Miescher 2005).

The columns suggest strong feelings but deep uncertainty about the future of male privilege in Ghanaian society, a real wavering among young men and women alike. This uncertainty, not limited to the question of the need to forgive or accommodate male infidelity, is sometimes expressed directly but is more often evident just below the surface of nervous humor about subjects such as faithfulness, bridewealth, and polygamy.

Finally, the columns tell us that whatever new variants of courtship, love, and marriage may be emerging in Ghana, love—wherever it blossoms—does not put an end to the exchange values implicit in relations involving desire, sex, and passion (Hirsch and Wardlow 2006; Jankowiak 1995). As the columns point out, women should not expect too much material support from suitors, boyfriends, and husbands, but they certainly should expect some. Men should not be coarse or too obvious about the advantages they might hope to obtain in return for their generosity, but they are reasonable in expecting *something*.

In writing to *Nana Ama* or *Obaa Yaa* about yearnings and the woes of romantic love, and in reading the columns and discussing them with their fellows, young Ghanaians are tentatively testing

new lifestyles against the values, norms, and mores of the generations of their parents and grandparents. Letters published in the columns—on choosing a partner, proposing love, fearing deception, saying hard things, questioning love’s durability, and contemplating break-up and divorce—reveal an awareness of the middle position of young Ghanaians. Rooted in Ghana but connected outwardly through global media, young Ghanaians are trying out their own creative framings, testing and building lifestyles that push themselves and their society toward ever-new accommodations with local and global discourses. While the advice columns offer ideas, direction, and courage, they also caution the youth, conservatively, mainly by way of a rhetoric of compromising binaries, to avoid extremes. Thus, young Ghanaians fitfully push the boundaries of love and of family expectations in the lifestyles they are crafting, inspired, aided, cautioned, restrained, and often entertained by *Obaa Yaa* and *Nana Ama*.

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NEW WINE IN OLD WINESKINS: THE CONSERVATIVE TRADITION IN GHANA'S HISTORICAL SURVEYS¹

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This review article examines historical surveys of Ghana's past published since the country's independence in 1957. The young nation's historians, particularly A. A. Boahen, wrote accounts that foregrounded African rather than European actors and criticized the impact of European colonialism, though they retained the focus on political elites of earlier works. Historical surveys written since the late 1990s have been more conservative or cautious in several respects. Their authors have been reluctant to privilege one pre-colonial state or ethnic group, and to criticize either colonialism or Ghana's post-independence leaders. Rather they present conventional political narratives without incorporating recent scholarship on social and cultural history. These textbooks' conservatism is due both to the demands of the modern nation state and to more durable Ghanaian traditions.

Key words: Ghana, historiography, historical surveys, Albert Adu Boahen, history textbooks.

Introduction

Ghana boasts an impressive history and historiography. Asante has long lain in its center, a powerful empire the British did not subdue until the turn of the twentieth century. Fifty years later Africa's "black star" and its charismatic founding father, Kwame Nkrumah, were in the vanguard of African independence movements. Ghana became a focal point of Pan-Africanism and drew such distinguished Diasporans as W.E.B. Du Bois, George Padmore, Richard Wright, and Maya Angelou.

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Since 1992 Ghana has achieved an impressive record of political democracy and stability. Even before independence it sent a relatively high number of its children to western-style schools, and the University of Ghana soon emerged as one of sub-Saharan Africa's leading institutions of higher learning, particularly in African Studies. Albert Adu Boahen became one of the leading historians of the continent and was a key player in moving the field from the Eurocentric biases of colonial histories to an exploration of "Ghanaian (and African) reactions to European colonialism, emphasizing how indigenous states were created, functioned, and evolved, into complex civilizations" (Adjaye 2008: 11). Boahen put particular emphasis on Asante and the Akan, the diverse ethnic group that constituted Asante's core.

Yet as Joseph K. Adjaye (2008: 20) points out Ghana's later historians have had trouble moving beyond the work of Boahen, F. K. Buah, and other earlier historians, particularly in producing "a truly comprehensive history of Ghana." A consideration of three recent historical surveys written and published in Ghana supports this argument. The textbooks not only perpetuate Boahen's focus on big states and big men, they are also less bold in their general historical interpretations; less complimentary toward Asante; more positive toward Europeans. In sum, the recent surveys are conservative.

The British Legacy

In Ghana, as elsewhere, British histories accompanied and justified British colonization. For many years William Claridge's (1915) massive two-volume study focusing on relations between Asante and Britain during the nineteenth century constituted its leading history. Then W. E. F. Ward (1958) began publishing a series of historical surveys in the 1920s. A more academic scholar, J. D.

Fage (1961), added a brief survey shortly after Ghana became fully independent. These British histories of course influenced Ghanaian historians, who internalized some of their assumptions even as they contested many of their conclusions.

Ward had a long history as a teacher and writer of Ghanaian history by the time his final version of *A History of Ghana* appeared in 1958, the year after Ghana had achieved independence. Ward had started teaching at the colony's most distinguished school, Achimota College, back in 1924 and published a *Short History of the Gold Coast* eleven years later. A fuller account of the colony's history appeared in 1948: *A History of the Gold Coast*. The 1958 edition consumed more than 400 pages and reflected many years of reading, interviewing chiefs and elders, teaching, and writing about Ghana—and responding to Ghanaians who had criticized his work for ignoring or understating the historical achievements of black Africa and ignorance of native languages and culture (Jenkins 1994; Ward 1991).

Ward's (1958) chapter 1 begins with this telling sentence: "The first European sea captains, coasting slowly and cautiously along the West African surf, named the different stretches of coast according to the principal cargoes they found there" (13). Even processes or events of great concern to black Ghanaians are told largely from the British point of view. This long book at times tries to capture a Ghanaian perspective. In treating the emergence of Asante, for example, he emphasizes that it should be regarded as "an organized state" and credits its formation to Okomfo Anokye, "a priest of extraordinary genius" (124, 117). Africans in what would become Ghana were "living under" a "well-developed constitution" before "the Europeans came, with their individualism, their emphasis on money, and their preconceived idea [disputed by Ward] that a barbarian chieftain must be a

despot” (102). Ward depicts indigenous slavery as relatively benign until the arrival of Europeans and explains how the British determination to end slavery, centuries after exacerbating it, harmed African merchants whose opposition to abolition was therefore understandable. But *A History of Ghana* remains a Eurocentric book. Ward treats British colonialism as inevitable and, for the most part, beneficent. “The creation of the Gold Coast Colony has always been a sore point with many Gold Coast Africans,” but “it is hard to see any practical alternative” (263-64). He also describes the British response to nationalism as, on the whole, reasonable and measured. The book is dominated by political actors and events. The chapters on pre-colonial states emphasize their emergence, migrations, and political fortunes. There is little treatment of culture. The colonial period, too, is dominated by big men—especially, British—and events. Chapter sixteen, the final one, promises a “Social and Economic History” but is largely concerned with European economic and educational activities. “African music, art and general culture are very much alive,” Ward concludes—without telling us how (413).

Fage’s *Ghana: A Historical Interpretation* (1961), published originally in 1959, is in many respects a very different book. This is a brief, erudite historical synthesis drawn from a series of lectures delivered near the end of Fage’s decade-long tenure at the University College of the Gold Coast—which became the University of Ghana shortly after his departure. Fage would go on to become one of the most respected historians of African history in Britain.

Fage (1961) is more Eurocentric than Ward. Although the first chapter is entitled “The African Background” it is largely given over to a discussion of how British colonialism determined the young nation’s borders and, especially, how “Mediterranean

Africa” shaped West Africa’s “pre-European period” (10). The clear implication is that Ghana’s history does not begin until the arrival of more civilized outsiders. The second chapter, “European Contacts and Influences,” delivers what its title promises: a history focused on Europeans, especially the Portuguese. Ghanaians receive little attention until they are identified as being integral partners in the trans-Atlantic slave trade. But although Fage charges Africans with being as responsible for the “unholy” trade as Europeans were, he asserts that Europeans were behind the growth of Ghanaian states such as short-lived Akwamu and more durable Asante. Asante rulers aggressively expanded their state in response to external stimuli: “to secure a control of the supply of slaves and gold to the coastal [European] markets” and to distribute “the European imports received in exchange” (55). Armed conflict ensued when the coastal states, such as the Fante, resisted Asante expansion. The closing chapter, “The Emergence of Modern Ghana,” explains how Europe calmed the waters that it had unwittingly roiled: it broke Asante imperialism by helping the Fante and other Ghanaian states that opposed the aggressive empire. Colonialism ensued because the “British finally took it upon themselves to accept full responsibility . . . for the destinies” of Ghana’s peoples (57). It brought order and civilization where chaos had reigned. Colonialism’s many benefits included:

The simple preaching of Christianity and the Christian way of life, to the active development of agriculture and industry and the begetting of new and more profitable trades to swamp the slave trade, and even to the establishment of European administrations in Africa which would root out the slave trade, by force if need be, and impose totally new conceptions of government and behaviour upon its peoples. (62)

British investments in education, health, and industry played a crucial role in advancing the welfare of Ghanaians. Even the prime

movers of Ghanaian independence were European, for western schools taught Ghanaians about freedom, and the European economy stimulated a widely shared desire for more wealth that threatened both traditional and colonial authority. Only in the last ten pages of the book does Fage turn to Ghanaian actors: “[t]he coastal elite” (77) who because of their contact with European people and ideas wished to exercise more control over the colony. Even here, though, more ink is devoted to Governor Guggisberg, who allied with the chiefs to thwart “the urban intelligentsia” (80), than to any black actors. Not until after World War II when the expanded education system and economy had produced a larger class of “individuals emancipated, or seeking emancipation, from the leading strings of the traditional communal order” (82) did the movement for independence gain a requisite mass. The final four pages of the book (roughly 5 percent of its eighty-five pages, are set aside for the modern Ghanaian independence movement—though even here British officials are lauded for their “tact and political acumen” (85).

Though Fage is much less interested in and respectful of indigenous developments than is Ward, their books share much in common. Outsiders’ exploration, commerce, and colonization are the prime movers in each history. Both focus on macro political developments: the formation of and conflicts between states; the policies and leading personages of colonial administration; the leading events associated with independence. There is very little attention to social or cultural history. A young scholar at the University of Ghana would soon take issue with the British histories—even as he perpetuated some of their assumptions.

Ghanaian Nationalists: Boahen and Buah

Albert Adu Boahen came of age during Ghana's surge to independence and began teaching at the University College of the Gold Coast in 1959, a year after taking his Ph.D. in London. His goal was "not just to educate but to create a relevant knowledge for the newly independent countries of Africa" (Falola 2003: 5). Indeed, Boahen soon became an extremely active scholar and citizen. His widely read *Topics in West African History*, first published in 1966, was based on a series of radio lectures delivered in 1963-64. *Ghana: Evolution and Change in the Nineteenth and Twentieth Centuries* appeared in 1975 and was adopted from television lectures for high school and college students. Boahen completed his trilogy with what he described "as a sequel" to *Ghana*: a series of lectures on recent Ghanaian history delivered and published in Ghana in 1988 and 1989, respectively, then revised in 1992: *The Ghanaian Sphinx: Reflections on the Contemporary History of Ghana, 1972-1987*. Boahen was an exemplary scholar-citizen whose political engagement culminated in a second-place finish to Jerry Rawlings in the 1992 election for Ghana's presidency—the first of a long string of free elections in Ghana's fourth attempt at democratic rule. This political activism no doubt contributed to the opinionated nature of his scholarship. But Boahen's central message is simple: Ghanaians and other West Africans must move beyond the colonial frameworks and assumptions of British historians such as Ward and Fage and take their own pasts seriously.

Topics in West African History treats the entire region but affords extra attention to Ghana generally and Asante particularly. Boahen (1966) contradicts Fage by attributing Asante's ascendance mostly to internal rather than European factors: "the rise of many states in the region of modern Kumasi" and "the very

harsh and unpopular role of [the state of] Denkyira” (70). Boahen also charges the British colonists with being motivated by greed. They opposed Asante because they believed that it “would be detrimental to their commercial interests” (72). They “therefore did everything to prevent it mainly by supporting all the petty states along the coast.” British opposition notwithstanding, Asante created a “vast and prosperous” empire” that by the mid-eighteenth century was “much larger than modern Ghana” and characterized by “peace and order”—precisely the claim that Fage had made for British rule (77, 76, 80).

Boahen (1966) also disputes Fage’s interpretation of slavery and colonization. The trans-Atlantic slave trade “did not confer benefits of any kind on West Africa.” It robbed the continent of millions of productive men and women; spawned bloody raids and wars that, unlike traditional conflicts, were “motivated by greed” rather than “self-preservation” or “imperial ambitions”; and it retarded manufacturing and agriculture, in part because the slave trade was part of a larger British determination to shape the region to its own imperial and economic needs (112-13). Colonization entailed the destruction of a beneficent (Asante) empire and the diversion of West Africa’s material bounty into the pockets and bank accounts of Europeans.

Boahen’s second historical survey, *Ghana: Evolution and Change in the Nineteenth and Twentieth Centuries* (1975), compresses and supplements the material already covered in *Topics*. Many of the themes set out in that earlier work remain salient. Not until chapter 6, “The Growth of British Power and Jurisdiction in Ghana,” does the focus move from indigenous Ghanaians. Asante is again praised. Even “European visitors and observers” remarked that ““Law and order is just as great in the Ashantee Kingdom as with the Asiatic Eastern peoples”” (27).

Writing of the strife-filled 1860s, Boahen observes: “Had the British recognized the fact that they were not dealing with a ‘ruffian’ and a ‘barbarian’ but a king who administered his empire in accordance with established law and custom and who had respect for his oath, some of the wars, could have been avoided” (32). Boahen again reminds his readers that pre-colonial Ghana featured a powerful state with impressive and efficient bureaucratic and economic structures comparable to other parts of the civilized world.

Perhaps it is this desire to underscore Asante’s power and beneficence that prompts Boahen (1975) to depict weaker states less charitably and to neglect non-elites. There is little attention to the texture of every-day life before colonialism. The sections on Ghana under British rule focuses on British leaders and activities—and not always in a critical fashion. Though missionaries condemned many elements of African culture, Boahen gives them high marks for promoting “an improved standard of living and the abolition of such hideous practices as human sacrifice and domestic slavery” (84), as well as promoting education, health, and the study of indigenous languages. Likewise, his chapter on economic development spends most of its ink on industries dominated by Europeans: export agriculture, mining, roads, railroads, telephones, and telegraphs. The chapter on social developments treats the emergence of new social classes and the growth of cities. But the entire chapter is just six pages long, barely half as many as he devotes to Guggisberg.

By the middle of the book and the 1930s his interpretation is again African-centric—and increasingly opinionated. A detailed chapter on Pan-Africanism is followed by several on the growing independence movement. But the focus remains on large, national movements and personages. Indeed, of these chapters’ nine

photographs, only one does not feature a leading individual. Though Boahen (1975) gives Nkrumah high marks for most of his work in the 1950s, he becomes increasingly critical of Ghana's leading founder. In his assessment, Nkrumah "became obsessed with his own power and ambition," "accepted . . . ridiculous and nauseating appellations," "acquired more and more mistresses on whom he lavished fantastic presents," engaged in and encouraged widespread corruption, and punished his enemies. Moreover, he turned Ghana into a one-party state, "blundered" in the rest of Africa, and left the young nation "virtually bankrupt" (209, 221, 216). Boahen's account of the six years separating the fall of Nkrumah from the completion of his manuscript starts with much optimism but then closes on a plaintive note. The penultimate paragraph celebrates the return of democracy, an act which illustrates for "the whole of Africa . . . that there can be an orderly transition from military to civilian rule" (240). But a postscript notes that still another coup, this one led by Colonel Acheampong, "marks the failure of our second attempt at Parliamentary democracy. Why we failed again and what will happen next, time alone will tell" (240).

In 1988, Boahen provides some answers in a series of lectures, published as *The Ghanaian Sphinx* (1989). He opens with the still vexing question: Why has Ghana, with all of its material, educational, and cultural advantages, "failed so dismally to develop and progress" (2)? Unlike the first two books, Boahen, who would run for president a few years later, repeatedly invokes his experiences as a politically engaged citizen and critic, including an arrest in 1978. He explains to Chairman Rawlings, the military man heading the government, that Ghanaians have become quiescent not out of contentment or trust, but because of fear: "We

are afraid of being detained, liquidated or . . . being subjected to all sorts of molestation” (52).

Though Boahen (1989: 10) notes “the neo-colonialist nature of the international economic order,” he lays the blame for Ghana’s problems since independence at the door of Ghanaians. Military coups draw extensive criticism, for they breed political instability and elevate to high office soldiers unqualified to run modern countries or economies. The fundamental causes behind the Acheampong administration’s failings, for example, were “the utter ignorance, greed, corruption and immorality of Acheampong himself” (11-12). Of course this begs the question of why Ghanaians had countenanced so many coups and coup makers, why they had often collaborated with or at least tolerated a succession of incompetent and corrupt leaders—military and civilian. Boahen identifies several broad sets of factors: immorality (especially corruption); extreme inequality; “tribalism” or individualism at the expense of patriotism; a sense of hopelessness or alienation, which he several times refers to as a “Culture of Silence” (30); and a lack of national consensus or cohesion.

But if Ghana’s contemporary problems lay in contemporary attitudes and culture, the way out of them was to cultivate ancient Ghanaian virtues. Here Boahen (1989) invokes the Akan-based “Ghanaism” articulated by J. B. Danquah—the man in whose honor the lectures were originally delivered and a martyred leader of Akan opposition to Nkrumah. “The ideology of Ghanaism,” Boahen explains, “emphasizes the worth of the individual, individual initiative and individual enterprise.” But it also entails social responsibility. “In the traditional set-up,” for example, “disgrace was not attached to the individual who committed that offense alone but to the entire extended family” (4, 65). A restoration of the practice of shame or guilt by association might

therefore reduce “sycophancy, careerism, and opportunism . . . rampant among technocrats, bureaucrats and the educated elite” (65). The way forward lay in the countryside, for “agriculture” ought to be “so much more lucrative than the selling of dog chains, hair creams and imported goods” (72).

Boahen criticizes British colonialism but reflects on many of its judgments. *Topics* and *Ghana* devote substantial space to British colonizers and activities and mirrors their cultural assumptions about what is historically significant and culturally desirable. Like Ward and Fage, Boahen is fixated on large political events and politics. “The political history of Ghana, like that of many other countries, both in Europe and Asia, is essentially the history of the rise and fall of states,” he remarks early in *Ghana* (Boahen 1975: 7). *The Ghanaian Sphinx* is larded with European allusions as well as Akan aphorisms. The title references a Greek myth; coup leaders are “men on horseback.” The brief book features occasional descriptions of poor people and popular culture, such as a vivid quotation from a 1987 article commenting on the progression of hunger: “Protruding collar bones, known as Rawlings chains, have been replaced by protruding stomachs, now known as Rawlings coats” (Boahen 1989: 6, 50). But this reference to poverty serves to illustrate the failures of corrupt political administrations; the subject of hunger is not historically significant in its own right.

Still, *Topics*, *Ghana*, and *Ghanaian Sphinx* added up to an historical survey that decisively broke with and advanced far beyond its British predecessors. Despite his focus on macro political developments that at times privileges European administrators and activities, Boahen treats colonization not as the beginning of Ghanaian history but rather as an unnecessary and largely harmful interregnum between a pre-colonial era dominated

by a great and effective empire and a troubled modern state which needs to return to its traditional principles. Scholars and general readers alike of course could and can take issue with both the aptness and the accuracy of this prescription. But Boahen's emphasis on the viability of ancient indigenous cultures and polities—together with his clear and often impassioned prose—make for lively and intellectually engaging reading. These are not mere historical surveys. They advance bold and important arguments.

Boahen could have reasonably expected subsequent historical surveys of Ghana to build on his strengths and remedy his shortcomings. But that is not really what has happened. The main alternative to Boahen's trilogy for many years was a one-volume history by the founding headmaster of Tema Secondary School: F. K. Buah's *A History of Ghana*, published in 1980. Buah's (1980) preface makes it clear that he will follow the broad outlines of Boahen's argument, for he asserts that Ghana has "many independent kingdoms and states which developed their own culture and civilization" long before outsiders arrived. The British "repressive colonial system" caused much more harm than good and prompted a successful struggle for freedom by "enlightened and courageous leaders." Buah also promises "a departure" from earlier textbooks "by giving ample space to the cultural, social, economic and other institutions" (vi).

A History of Ghana delivers on some of these promises. The early chapters on pre-colonial nations emphasize big events and leaders. But in the second edition—which featured only superficial revisions—Buah (1998: vi) remarks that the history will "continue to be based mainly on the careers of leaders." Buah (1980) also privileges the Asante people who "To this day . . . stand out as the leading custodians of Ghana's cultural heritage" (28). In fact one

chapter bears the inelegant heading “The Non-Akan.” But part of a chapter is devoted to traditional social institutions, including a brief consideration of class structure, and the text includes some photographs of indigenous artifacts. A brief chapter describes agriculture, fishing, and craft production.

Like Boahen, Buah (1980) is critical of Europeans. The trans-Atlantic slave trade “had a devastating effect” on Africa and “encouraged many wars” between and “barbarism” by black Africans (72-73). Buah is much more sympathetic to Asante than to Britain, and the British are described as motivated by a desire for economic and political power rather than humanitarianism, as Fage had argued. Though Buah devotes several pages to Guggisberg and credits him with some accomplishments, he was nevertheless “[a] child of the imperial system” (115) that stubbornly resisted Ghanaian independence for generations. Buah is less critical of Christian churches which, despite their hostility to many aspects of African culture, brought a great deal of moral and material progress. But like Boahen, Buah suggests that European domination was a largely unwelcome interlude in Ghana’s history, not the opening act.

Buah’s (1980) major difference with Boahen is his interpretation of post-independence Ghana. As one might expect in a book dedicated “To my teacher/Kwame Nkrumah/Founder of modern Ghana” (iii), Buah directly disputes Boahen’s criticism of the prominent leader. Buah excuses even Nkrumah’s repression of dissent and asserts: “History has already begun to point to the debt modern Ghana owes Nkrumah for his vision in tackling the comprehensive programme of economic and social developments which were not only revolutionary but stood second to none in all developing countries” (181). The chapter on subsequent administrations is matter of fact—if hardly hopeful. A three-page

conclusion, “Lessons of the Past,” identifies several reasons for the instability of independent Africa in general and Ghana in particular, including a jarring transition to western party politics at the expense of traditional practices which emphasized consensus; ambition for power and wealth; impatience; and, a point Boahen would soon echo, the frailties of military rule. Unlike Boahen, Buah does not identify Ghana’s past as the way forward. But the book’s cover bears the Akan image of Sankofa, the bird looking back to see how best to proceed. *A History of Ghana* shares Boahen’s pride in durable, indigenous polities and modestly broadens the scope of that history to include a wider range of subjects and people.

Recent Surveys

Three recent historical surveys, written by Vincent N. Okyere, Seth Kordzo Gadzekpo, and D. E. K. Amenumey, present interpretations of Ghana’s past that are more conservative and constrained than those by Boahen and Buah. These books, which appeared from 1997 to 2008, are similar in several respects. They range in length from 237 to 281 pages. All three were published in Accra. Okyere and Gadzekpo taught history at some of Ghana’s distinguished senior secondary schools. Amenumey, whose book is based on undergraduate lectures, was a professor at the University of Cape Coast. The back cover notes that his book was written for “Senior High School students and the general public.” Indeed, given the books’ similar lengths and subject areas, it seems likely that all three authors expected students taking Senior High School history courses to be their primary audience. Gadzekpo (2005) explicitly notes that his volume “is an attempt to assist students and candidates” for the national history examination, that “possible examination questions are presented at the end of the chapters” (v).

The second half of his book consists of sixty-three brief essays that discuss questions on Ghanaian history since 1900.

The three books are much more derivative than the earlier surveys. They deal with the same subject areas as Buah but stop their coverage in the early 1990s, just as Ghana began its long series of successful presidential elections. Okyere's (1997) bibliography lists thirty-six secondary sources; Gadzepko (2005) has fourteen (including five by Boahen or Buah); and Amenumey's (2008) survey offers just fifteen, only one published since 1990. None of the authors insert many personal opinions or fresh scholarly interpretations. Amenumey (2008)—by far the most qualified of the three—describes his book as a “chronicle,” a choice of words which suggests a succession of events rather than analysis or interpretation. In the most literal sense, these are textbooks: historical surveys concerned with conveying factual information and conventional, well-established assessments.

The authors' treatment of the Akan and Asante illustrates their cautiousness. Unlike Boahen and Buah, the three seem reluctant to identify them as Ghana's most powerful ethnic group and empire, respectively. Gadzepko (2005: 2) in fact follows Fage in arguing that the Europeans along the coast “corrected” a Ghanaian “imbalance” of power by opposing Asante. Indigenous states' resistance to Asante is treated as natural and understandable rather than, as Boahen would have it, a consequence of British interference.

The authors interpret colonization much more positively than Boahen and Buah. Okyere (1997) is focusing on the British by the second chapter—even though it is entitled “Trade In Ghana before the Arrival of the Europeans.” Nearly 10 percent of his book is consumed by a very detailed and positive account of European missionary activity in Ghana, much more than the far from

insubstantial treatments by Boahen and Buah, and the other two historians follow suit. His section on nineteenth-century politics reserves much of its space for British leaders (especially Governor Maclean) and measures, and he devotes an entire chapter to Guggisberg. The trio note harmful European practices, especially the trans-Atlantic slave trade and the destruction of Ghanaian states and cultures through colonization. But although Gadzepko (2005: 112) terms the European presence a “mixed blessing” the positives seem to outweigh the negatives. His brief chapter on traditional medicine is critical, an interpretation evidently rooted in his belief that pre-contact societies were both static and inferior; he remarks that “traditional” practices were “based on conformity to what had always existed” (70). He credits Christian missionaries and churches with ridding Ghana of “[s]lave raiding and trading, inter-village wars and human sacrifices” (138) as well as with encouraging education and even nationalism. “They provided some African leaders with a forum, and an unaccustomed freedom of expression, both in the pulpit and the press” (138). Colonial authorities are also credited with creating town councils in the mid-twentieth century to counter “quite conservative” traditional leaders whose “cultural systems . . . lacked progress” and were “not moving fast enough in developing their areas” (143, 153). Amenumey (2008) is more critical of British rule. But, like the other authors, he devotes a great deal of space to European and especially British activities and leaders. Like Fage, he attributes the rise of large states to European trade, and he is at times critical of Asante. Even chapters detailing Ghanaian protest movements foreground British initiatives rather than Ghanaian reactions to them. These historians seem to be implicitly agreeing with Fage rather than Boahen: they more often identify Europe than Asante

as the prime mover behind Ghana's economic and political emergence.²

All three authors are more tentative and cautious than Boahen in their summation of Ghana's post-independence period. All three adopt a centrist position on Nkrumah, praising his leadership but criticizing some of his policies, especially in the 1960s and in relation to political dissent. Okyere (1997) notes evident U.S. interference through the CIA in Ghana during the coup that toppled Nkrumah but does not decry this blatant disregard of Ghana's sovereignty. In fact none of the authors explore in any depth Boahen's warning that Ghanaians should be wary lest western nations and institutions impose a system of neo-colonialism on Ghana's economy. Okyere and Gadzepko instead offer a detailed and uncritical account of Ghana's participation in international organizations. Gadzepko (2005) is more charitable to Ghana's military governments than Boahen. He remarks of Rawlings's 1981 coup: "Rawlings had to collect the baton back and continue the race of 'cleaning the house.'" Hence "[m]any historians saw this coup as . . . inspired by the desire to . . . end corruption and ensure social justice" (263). Amenumey (2008), the most sure-handed of the three, caps his book with a highly ambivalent conclusion. Ghana's economy has remained focused on "the export of raw agricultural and mineral produce" and is "dominated by outside forces." "By and large," however, "the rulers had succeeded in keeping the country together." They had made "impressive progress in 'education, health, and infrastructure" and "had contributed a lot to raising the dignity of the blackman." But "few successes . . . had been achieved so far" (280).³ The three

²Amenumey (2000: 2) remarks that his studies of the Ewe "exploded the myth that all the peoples of present day Ghana were contained within the Asante Empire."

³Amenumey (2000: 5-11) offers a bolder interpretation of modern Ghana.

surveys are indecisive over whether to treat the history of post-independent Ghana as a triumph or a tragedy, and their accounts of its past—unlike Boahen's—offer no solutions for the country's present and future. These textbooks remain calculatedly apolitical.

Nor do the three surveys expand their coverage beyond what Boahen and Buah had offered. Okyere's chapter on "Economic and Social Developments in Colonial Ghana" simply covers British initiatives in industry, infrastructure, and education. Gadzekpo pays more attention to early peoples' technologies and economies and devotes a substantial proportion of his book to pre-colonization. Amenumey has one chapter on pre-contact industry; another one on pre-colonial "Kingdoms and States" is the longest of his book. His chapter on trade has eight pages on African enterprises before turning to European merchants. But aside from some treatment of early customs and industries, he covers little social history. As in the earlier surveys by British and Ghanaian authors alike, the history of Ghana remains the history of big states and big men, of large political events and, at times, of processes. The reader learns little about the lives of the great majority of Ghanaians—especially women—and about the developments in literature, journalism, religion, music, popular culture, urbanization, gender, dress, food, labor, sport, or inequality, subjects that have received extensive scholarly attention (Adjaye 2008).

Taken together, then, the three surveys make little progress in broadening the narrow scope of Ghanaian history presented in the earlier accounts. Rather, they back away from the bolder and African-centric interpretations once advanced by Boahen and Buah. In these recent textbooks, African and Ghanaian histories do not begin with the arrival of outsiders as Fage suggested. Yet they

continue to imply that it was European trade and colonization that civilized and modernized Ghana.

Roads not Taken

These recent historical surveys written by Ghanaians have been accompanied by two rather different accounts presented by outside scholars. Ivor Wilks, a British-born historian and former professor at Northwestern University in the United States, delivered a set of lectures at the University of Ghana in 1995 published a year later in Accra. Wilks is a renowned historian of West Africa, particularly of Asante. A decade later Greenwood Press, in its series on Modern Nations, published a historical survey on Ghana by Roger S. Gocking, a seasoned scholar of colonial history.

Wilks's brief, highly interpretive *One Nation, Many Histories: Ghana Past and Present* (1996) recalls in many ways Boahen's work. Like his distinguished Ghanaian counterpart, Wilks asserts that Britain did not create a colony or a nation, as earlier British historians had claimed: "What the British had done was systematically to destroy a nation, Greater Asante, and to create one out of it" (53). Like Boahen, Wilks believes "that Asante has played a unique role in Ghana's history" (27)—this due in part to its "sheer geographical extent," but also to a highly effective and responsive form of governance that inhibited "autocracy" and "despotism" (30) and led other indigenous nations to accept its rule. Wilks asserts that recognizing Asante's pre-eminence and uniqueness "has nothing to do with [contemporary] Asante nationalism, it is just patently obvious" (27). Ghana's "main course of history, as we now view it from the end of the twentieth century, ran *through* Greater Asante to a Greater Gold Coast, and so to the present day Republic of Ghana" (58).

Gocking's *The History of Ghana* (1995) is longer and more cautious. The Greenwood Press series requires its authors to focus on recent history "because the modern era has contributed the most to contemporary issues that have an impact on U. S. policy" (viii). Hence well over half of the book deals with Ghana's half century of independence. Gocking is more interested in political than social history, and the book is not thesis driven. That said, Gocking differs in some striking ways from the Ghanaian textbooks. The book features more than 600 reference notes, and his bibliography includes 155 works, mostly scholarly books, many of them recent. He pays less attention to the British and dispenses with missions in just one page and a half. Maclean gets less than one page. Even Ghanaian histories that are critical of British colonialism credit it with ending slavery. Gocking, however, remarks that the colonial government did not put much energy into enforcing abolition. Further, he chides historians for focusing on the high-profile political movements and elites of Ghana's long independence movement rather than exploring local political struggles, which included women and "illiterate fishermen or farmers" (70). His own account of independent Ghana foregrounds political leaders and events yet also makes reference to developments and themes neglected in the other historical surveys. This includes, among others, literary productions such as A. K. Armah's influential novel *The Beautiful Ones Are Not Yet Born*; increasing socio-economic stratification, Nkrumah's usurpation of chiefly power, Northern Ghana's "Foul War" that killed more than 1,000 people, and recent debates over privatization. Gocking's epilogue begins with an examination of why once-impoverished Asian nations such as Malaysia have prospered while Ghana has foundered.

One could argue that Wilks and Gocking point backward and forward, respectively. The former joins Boahen and Buah in

foregrounding the Asante past elided in the more recent Ghanaian textbooks. Gocking's aims are less grandiose and more particularistic; neither Asante nor British colonialism are the primary actors in his narrative. Like his recent Ghanaian counterparts, he is largely concerned with political history and abjures ambitious interpretations. But his work points forward to scholarship that is grounded in a diverse body of secondary sources, offers fresh interpretations of well-worked topics, and—its focus on politics notwithstanding—includes a wide swath of Ghanaians excluded from the other historical surveys. Wilks and Gocking are less cautious and conservative than their Ghanaian counterparts.

Discussion

Conservatism, broadly defined, has become more pronounced in the recent historical surveys published in Ghana. The early accounts by British authors, Ward (1958) and particularly Fage (1961), dwelled on the influence and actions of Great Britain. Such histories were—consciously or not—an extension of the colonial project. Nor is it surprising that Ghana's first generation of historians both internalized some aspects of their colonial educations (an emphasis on elites) and discovered a strong and beneficent civilization (Asante) pre-dating colonialism. As Toyin Falola (2001: 240) observes, for these scholars "the European presence" became not the starting point and foundation of Africa's history but rather "just an interlude . . . a short phase in a long history." This was precisely Boahen's argument. Falola also explains that such historians were so determined to find glorious indigenous civilizations and leaders in Africa's past that their histories often neglected both brutal acts committed by these powerful men and empires and the history of less prominent

peoples and people. Adjaye (2008) makes a similar point, namely that the first wave of nationalistic Ghanaian historians were so “conditioned by colonial epistemological categories” that they placed “an overemphasis on the history of states.” Like the conventional European histories they absorbed at school, these scholars manifested a “preoccupation or fascination with kingdoms and empires.” According to Caroline Neale (1986: 114), early African historiography “set out to show . . . not that whatever Africa had had was somehow humanly worthwhile [regardless of whether or not it meshed with western sensibilities and expectations], but that Africans deserved the respect of others, and could respect themselves, because they had had in their past the things that *Europeans* valued!” Therefore the successful creation and management of modern African states became “in some sense the natural culmination of indigenous development” (116). The work of Boahen, especially, can be understood from this perspective: he was determined to show Ghanaians that they could create an effective nation state because they already had. Historical study shifted from the study of white to black elites.

Falola (2001: 270) writes of how in the 1970s a younger generation of African historians became bored with “stories of the great African past and mere descriptions of structures and institutions.” Certainly many historians of Ghana, from inside and outside of the country, have thoroughly investigated a wide range of social and cultural histories in theses, dissertations, articles, and books. Three prominent examples are: Emmanuel Akyeampong *Drink, Power, and Cultural Change: A Social History of Alcohol in Ghana, c. 1800 to Recent Times* (1996); Jean Allman and Victoria Tashjian, *“I Will Not Eat Stone”: A Women’s History of Colonial Asante* (2000); and Akosua A. Perbi, *A History of Indigenous Slavery in Ghana: From the 15th to the 19th Century*

(2004). But, as shown above, these histories and perspectives have seldom found their way into historical surveys offered by Ghanaians. There are structural or practical reasons for this. Textbooks tend not to break new ground but stick to well-worn topics and interpretations. Ghanaian professors heavily burdened by the requirements of teaching, administration, and producing original pieces of scholarship find it difficult to find the time to write the sort of detailed and original textbook as Gocking did. Ghanaian writers are also apt to confront publishers who demand surveys tailored to the curriculum of its senior high schools, a potentially lucrative market. Hence the question of why Ghana's textbooks have remained narrow in scope and increasingly oriented to British rather than Asante antecedents may ultimately rest in the preferences of the modern state.

The state's agenda for Ghanaian history is perhaps most manifest in its junior high school Social Studies curriculum, the point at which students are required to study its history. These brief histories in fact resemble the textbooks written for older Ghanaians. There is the same flattening of the pre-colonial political landscape so that the Akan and Asante are but one important ethnic group and nation, respectively, among several. The British, especially missionaries, are treated at length and favorably. One text lists the advantages of colonization as outnumbering the disadvantages and most of those advantages are attached to unity (overcoming "tribalism") and material progress (the arrival of European schools and technologies). "National integration" requires "total allegiance to the state instead of individual or ethnic objective[s]" (Peterson del Mar 2012: 27).

Historical interpretations that privilege British colonialism over indigenous and especially Asante accomplishments serve pragmatic ends. The modern state—as well as a large swath of its

citizens—puts a great deal of emphasis on material progress; hence historians' stubborn emphasis on European schools, technology, and industries. More to the point, privileging European contributions to modern Ghana over Asante's helps contemporary Ghanaians to tamp down ethnic tensions that still arise around the distribution of political power and wealth—and that have led to the deaths of millions of people in other parts of Africa. Ghanaians have long feared and decried "tribalism" or ethnocentrism. Voters identifying themselves as Ewe or, in much larger numbers, Asante or Akan, have tended to vote in blocs, and the Fourth Republic's constitution stipulates that "every political party shall have a national character," that party "membership shall not be based on ethnic, religious, regional or other sectional division" (Arthur 2009: 51). Though ethnic identification has been less pronounced in Ghanaian elections than in many other African nations, candidates such as Boahen who identified as Akan have tended to do very well among voters who share the same identity—and to battle perceived "Ashanti imperialism" among voters who do not (Nugent 1999: 308). Focus groups exploring the impact of ethnicity on the 2004 election at first denied any relationship between the two; "tribalism" was a problem in Nigeria, not Ghana. But upon further probing, participants admitted that Ewes and even the "pure Asantes" of their own area tended to vote in blocs. Such remarks illustrate "that not only are ethno-linguistic divisions an important factor in Ghanaian politics, but almost everyone understands this social fact as a dirty little secret to be suppressed" (Fridy 2006: 301-2). The salience of ethno-cultural politics—and the very understandable fear that it provokes—provides an explanation of why recent history textbooks have preferred to treat Ghana's leading ethnic groups as having equivalent histories, even to the point of crediting the British rather than Asante with

unifying Ghana. After all, the British, unlike Asante, are no longer perceived as a threat to political and social order.

The history textbooks' reluctance to treat social and economic divisions suggests a less charitable explanation, namely the maintenance of a highly stratified status quo. Adjaye (2008: 14) takes Ghanaian historians to task for their "unresponsiveness to the concerns of the urban poor, the exploited, and the marginalized." Some scholars in fact argue that Ghana's educational system is designed to both placate the poor by making primary education widely available, and to reproduce privilege by allocating a disproportionate amount of tax money to schools for privileged children.⁴ Boahen (1989), the scholar activist, wrote passionately of how Ghana's various regimes had failed the poor. Recent historical surveys created to mesh with a government-sponsored curriculum are much more likely to articulate non-controversial and consensus-oriented interpretations and to avoid potentially divisive topics such as class inequality.

Furthermore, the practice of focusing on big men and big states at the expense of poorer people and controversial subjects has a long history of its own in Ghana. Jennifer Hasty (2006) argues that the Ghanaian media's fixation on political elites is part of a long tradition of "royal oratory, praise-singing, and public mediation." "Just as Akan chiefs have relied on a professional spokesperson to make their proclamations public and official, so too contemporary Ghanaian journalists perfect and reproduce the discourse of state officials" (73, 72). Early writings about Northern Ghana also dwelled on the lives of elite leaders and states: "The commoner masses, upon whose productive labours the whole edifice of society ultimately rested, were of no interest to the

⁴This theme is developed by Wrigley (1971); Addaeh Mensah (2000); Folson (1995).

Muslim writers whatsoever” (Wilks et al. 1986: 18-19). History textbooks written by Ghanaians have attended to big men and big events not simply in imitation of their British predecessors or in deference to the interests of the modern state. Rather, Ghanaian textbooks have focused on the political elite because of a long indigenous tradition.

Conclusion

Ghana’s historical surveys have become more constrained and conservative even as the scholarship at their disposal has become deeper and wider, more prolific and sophisticated. Recent textbooks have moved little beyond the narrow political confines established by earlier authors. Instead, they echo some of the colonial interpretations advanced by earlier British historians that Boahen had striven to refute.

It would be misleading to characterize these recent histories as neo-colonial. Rather, their conservatism serves well the modern Ghanaian state, an entity whose educational apparatus is attuned to political and social order. This emphasis on history as tool of consensus, pace Boahen, has profound pre-colonial roots. The Gonja and the Asante, according to Buah (1980), attempted to obliterate the history of conquered states, whose members were forbidden, “under pain of death . . . to make any reference to their past independent status and history” (34). Many years later Nkrumah centralized power and fought factionalism by assuming numerous chiefly titles and symbols (Baku 2005). Recent textbooks’ neglect of Asante’s uniqueness perhaps represents an Asante and Ghanaian tradition of using the state’s control over the past to weaken a defeated but potentially potent rival.

The conservatism embodied in the historical surveys of Africa’s Black Star therefore seems unlikely to disappear in the

foreseeable future. A focus on big events and big men, and a wariness of ethnic, political, or social divisiveness reflect ingrained historical assumptions and practices, as well as entrenched political and economic interests.

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Christine Oppong, Delali M. Badasu, and Kari Waerness (eds),
Child Care in a Globalizing World: Perspectives from Ghana.
Bergen: University of Norway, 2012. 346 pp. ISBN: 978-82-7453-084-3.

This book is one of the productive results from a multi-year collaboration between the University of Bergen and the University of Ghana which began in 2002. Several of the chapters are written by those whose graduate study and research were supported by this collaboration. As a result, the book contains detailed information close to the ground, generated through interviews and careful observations. Furthermore, the geographic diversity of Ghana is well represented.

The book argues that there is a crisis in the care of babies and children in Ghana. Several factors have contributed to this crisis, as Christine Oppong details in an insightful discussion in one of the introductory chapters. Time among adults has become scarcer. Women's workloads have increased. Labor migration results in male migrants' absence from children's households and female migrants' lack of kin support in child care. Cooperative practices of caring such as fosterage are not working well today. Men are avoiding their responsibilities as fathers. As a result, Oppong writes, women are in "an increasingly solitary struggle to maintain self and children" (p. 50). Mothers are engaged in a "balance and reshuffle," as Peter Kodzo Atakuma Agbodza says, writing about child care in Dzemeni, a Volta Lake re-settlement community: "they carried out adjustments that ensured [the] survival of all," but which were not always organized towards their young children's wellbeing (p. 237).

The chapters detail the crisis in a number of different contexts. Katherine Abu found that economic considerations became more

prominent in fosterage arrangements in Tamale in the early 1980s. Among the Dagaaba in the Upper West, Edward Nanbigne argues that male migration results in the burden of care for children and the sick falling to women. Cuthbert Bataar examines changes in familial relations among the Dagara in Nandom in the Upper West due to Christianity, higher bride prices, alcoholism, and tighter male control of grain stores. Deborah Atobrah explores the fosterage of AIDS orphans in Manya Krobo in the Eastern Region, where there is a higher AIDS prevalence rate than elsewhere in Ghana. Adam Bawa Yussif examines how Dagomba female water vendors in Tamale struggled to balance their work with child care. Benjamin Kobina Kwansa discusses how male teachers in Accra participate in child care but that women bear the heavier burden. The male teachers who did the most housework and childcare (about a quarter of the 140 interviewed) had wives who had busy schedules as traders.

The only chapter which challenges this overwhelmingly gloomy picture is by Douglas Frimpong-Nnuroh, detailing how fostering is alive and well in Ellembelle Nzima in the Western Region, generating social cohesion, kin ties, and productive adult-adolescent relationships. Yet, even here, there is some cause for concern. The mothers of many fostered children in Ellembelle are deceased, and their fathers have absconded from their parenting responsibilities. The foster mothers are generally poor. Likewise, in some of the more depressing chapters, there is a recognition that kin do help with child care, even if such support is less secure than in the past, such as in the case of orphans in Manya Krobo.

One of the volume's virtues is its focus on how the crisis in child care affects the health of babies and young children. Recent health surveys in Ghana have found high maternal and child malnutrition, with surprisingly little difference across income

quintiles and levels of maternal education. A chapter by Delali M. Badasu documents why the children of highly educated mothers in Accra might be stunted and wasted, and their mothers more likely to give birth to low-weight babies: the mothers worked long hours and were less likely than other Ghanaian mothers to exclusively breastfeed. While these mothers usually had domestic servants or relied on matrikin, poorer women in Accra, discussed in another chapter by Badasu, sent their children to understaffed day care centers. Furthermore, traffic congestion in Accra led to long commutes and little time with children. Agbodza describes how mothers in Dzemeni force-fed their children and replaced more nutritious soup with pepper sauce because of their lack of time for eating and cooking. Adam argues that water sellers in Tamale weaned their children so that they could leave their children at home while they worked, replacing breast milk with not-very-nutritious porridge (*koko*). Thus, the volume suggests that mothers' lack of time, among poorer and richer mothers alike, resulted in poorer health outcomes for their children.

This volume's description of the crisis in care in Ghana has been documented in other parts of Africa, particularly East Africa. Scholars of Ghana should find the volume worth reading, for understanding how family life, household work, and care is changing in Ghana.

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