

INTRODUCTION: STUDYING HEALTH AND HEALTH CARE IN GHANA

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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

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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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