Perpetual Crentsil

DEATH, ANCESTORS, AND HIV/AIDS AMONG THE AKAN OF GHANA

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Perpetual Crentsil

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All photographs by Perpetual Crentsil

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Helsinki, December 2006 Perpetual Crentsil



Ghana showing Akan areas (Oppong 1981)

1. HOLISTIC PATIENTS AND SOCIETY

It will not take too long for anybody who arrives in Ghana today to know that HIV/AIDS exists in Akan society. Countless stories, reports, and academic studies circulate about the disease which is also a global epidemic. Many people in Akan society are aware that AIDS is real and it is a fatal disease. Many families have lost a member or even two to AIDS, and much of the accumulated write up on the disease points out the devastating nature of HIV/AIDS. Patients and their families are affected in terms of economic stress caused in households. As the sickness advances, AIDS patients usually cannot work to support themselves, and they become a financial burden on other kin members. But this picture of the devastating nature of the disease in Akan-land,[1] as in other parts of sub-Saharan Africa, is fragmentary (Awusabo-Asare and Anarfi 1997).

There is a broader picture concerning becoming HIVinfected, its affliction, and the consequences of AIDS deaths in Akan society. It encompasses the whole social system. HIV/AIDS afflicts individuals, but it affects many other people and various aspects of the social structure. I call the afflicted persons 'holistic patients' because their case is multi-faceted, embracing many categories in the society.

Akan society is made up of lineages that emphasize the welfare of individual members for the good of the whole group. HIV/AIDS patients are supported by kin members in informal care and the search for therapy. But the effort for therapy usually leaves patients and their families in a financial quandary. Enormous burden is put on carers when the sick persons deteriorate into a state of lethargy in the final stages of their ailment and need to be carried like babies into and out of bed. The government of Ghana is forced to spend huge monies on HIV/AIDS programmes and treatment. In 2005, the purchase of anti-retroviral drugs, diagnostic reagents and drugs for opportunistic infections alone cost over eight million US dollars (about 80 billion cedis).[2] AIDS afflictions and the consequences are complex and multi-dimensional; they also resonate in ongoing processes of transformation in Akan society.

This is a study of HIV/AIDS and its crises in individual lives and in Akan society. While I examine problems of everyday individual

[1] I use Akan-land with the same sense as Akan society or area. I have only coined Akan-land to avoid the monotony in my frequent reference to Akan society.

[2] See Ghana Health Sector programme of work for 2005. Source: http://www.ghanahealthservice.org/includes/upload/publications/2005 Programme of Work.pdf. (14/5/2006). In 2003, one dollar was equivalent to 8,600 cedis at bank rate; in 2005, a dollar changed around 10,000 cedis.

experiences, I focus the investigation on the Akan matrilineal group of Ghana; at a higher level of abstraction, I bring out the many imbalances caused in the lineage structure and Akan cosmology. The changing structure is affecting the way the society organises and reproduces itself. How is HIV/AIDS a disturbance of the health balance in Akan notions; how is it disrupting social organisation? To show this also reveals how health and well-being are connected to various aspects of the social structure, and how HIV/AIDS challenges them. Like Victor Turner (1996[1957]) among the Ndembu of Zambia, I endeavour to show contradictions in a matrilineal group. I reveal how HIV/AIDS afflictions make bare paradoxes in the Akan group. Turner's analysis demonstrates the pulls of matrilineal descent and virilocality at marriage in the face of individual ambitions. Similar pulls of matrilineal descent characterise the Akan system as individual members pursue their goals and, for example, are expected to help others in the group.

The fate of matriliny has been the subject of anthropological studies for some time now. Discussions emerged in the 1960s about the doom of matriliny. Those discussions were influenced by considerations of modernization, an expanding economy and changes in inheritance patterns (e.g., Gough 1961). The negative prognosis, as Mahir Saul (1992) puts it, was that with growing modernization and individually acquired property increasingly left in inheritance to one's own sons instead of the sister's son, the future of matriliny was bleak. One of the first to react to this was Mary Douglas, and she argued otherwise. Using Polly Hill's account (1963) of the matrilineally-supported expansion of cocoa plantations in Ghana in the early twentieth century, Douglas (1969) argued that matriliny is adaptive in the face of development. Mahir Saul (1992: 342) supports Douglas's view. He argues that in West Africa, for example, matrilineality has proved to be highly persistent despite fluctuations in income and consumption under wage and market economies.

Now, if matrilineality may have resisted transitional periods of modernization what is its fate against HIV/AIDS? In this study, I show that the efforts for therapy and care of patients fall back on the Akan matrilineal group, which mirrors its persistence. But AIDS deaths threaten the matrilineal structure and challenge cosmology. An AIDS death is not the good demise which, in Akan notions, produces the all-important ancestors who protect the society and are conceptualised to reproduce the matrilineal group through reincarnation. Furthermore, AIDS deaths in Akan society do not motivate funerals with which the matrilineal group fulfils mortuary rites and names the dead person's successor, an important part of Akan culture.

A study of HIV/AIDS is not merely about its topicality today (Webb 1997). New HIV infections recorded daily in Ghana despite education and awareness about the disease should attract genuine concern. The HIV/AIDS pandemic has compounded the many problems in many countries of Africa, a continent already plagued with poverty, civil wars, and such endemic diseases as malaria and tuberculosis. Ghana recorded the first HIV/AIDS case in 1986, among sex workers who had returned from a sojourn in neighbouring Cote d'Ivoire.[3] An early announcement indicated that AIDS was recognised as a potential threat to human and economic resources. A few years before the disease emerged, Ghana had experienced one of the worst droughts in 1982-83. The drought had had a devastating effect. Those were hard times when the lack of rains caused many bush fires and food scarcity; many starved to death or lost considerable weight. That period was aggravated by the mass deportation of Ghanaians from neighbouring Nigeria in late 1983. HIV/AIDS, then, came as an extension of Ghana's woes and deep economic quagmire.

The country's present 3.1 percent rate of infection is still low, compared with South Africa's 21.5 percent and neighbouring Cote d'Ivoire's 7.0 percent (UNAIDS 2004). Nevertheless, the high-level governmental attention reflects concern about the growth of infections in Ghana and its attendant impact on human resources and development. As Paul Farmer (1992: 10) has noted, the transmission of HIV may indicate that AIDS is grounded literally in individual experience. However, the pandemic affect social, political and economic issues, and thus attracts both national and international concern. Farmer's analysis demonstrates that in the present world of globalisation and free flow of humans and information across borders, what happens in one part of the globe invariably affects another. Moreover, for humanitarian reasons and expressions of goodwill, the international community has not remained aloof while the disease devastates a continent.

In Akan society, HIV/AIDS indexes deep sociological problems—a metaphorical tear in the fabric of the seemingly social harmony in the matrilineal group. The Akan matrilineal structure normally has internal tensions about gender roles. David Schneider (1961: 4-8), who writes about matrilineal kinship, points out the problems of distributing authority between males whose relations are mediated by females. Descent and authority are straightforward in patrilineal groups, in which both notions are enacted through men. In contrast, in matrilineal groups while the line of descent is through women, it is men who wield authority over the women

[3] See The MEASURE Project and the Ghana AIDS Commission 2003.

and children in the group. Schneider (ibid: 13) sees a potential strain in the area of sexuality and reproductive activities in matrilineal descent groups. He contends that huge expectations are on the woman to bear children to perpetuate her own and her brother's group; she is a tabooed sexual object to her brother, yet her sexual and reproductive activities to increase the group and give him an heir are a matter of interest to him (ibid).

HIV/AIDS aggravates the gender roles and, in addition, opens serious concerns about sexuality among the Akan. Women are gripped with uncertainties. They know they have to reproduce into the group whose survival depends on them, yet how can they tell if the men they know are infected with the virus? Many women would want an HIV test for their proposed partners but their lower status in the society often does not encourage that. The main form of HIV infection in Africa is through heterosexual contact; HIV/AIDS can thus be understood as sexually transmitted. It is also associated with what many see as 'waywardness' in sexual behaviour, such as multiple sexual partners which exposes individuals to the risk of infection (Caldwell et al. 1989). Not surprisingly, in Akan society it also points to such problematic behaviours as stigmatisation and condemnation, found more within the family setting.

The main aim for concentrating on HIV/AIDS in this study is to create more awareness about the disease in Ghana and to bring out important information relevant for the country's health policy planning. This study complements other anthropological works on Akan social structure, medical ideas and practices. My work is close to that of Paul Farmer (1992) in Haiti. Concentrating on the crises caused by HIV/AIDS, Farmer showed real human suffering amidst poverty, political economic issues, supernaturalism, and blame and accusations. But unlike Farmer's work, this study also focuses on rituals (including funerary rites), beliefs about death and ancestor creation among the Akan.

One of the few accounts of how crises show a total way of life of an African group is Victor Turner's study of schism among the matrilineal Ndembu. My study of the crises caused by HIV/AIDS in the matrilineal Akan group thus follows Turner's model. This study also echoes the view by cultural anthropologists (e.g., Geertz 1973) that all human experience and structures are symbolic and therefore culturally interpreted. Through the study of local understandings of life and the cultural construction of HIV/AIDS, I hope to indicate other possible paths for Ghana's (and Africa's) campaign strategies against the disease.

The holistic Akan society

The Akan people live in the coastal south and forest zone of Ghana and Cote d'Ivoire. Constituting about forty-four percent of the country's population of about twenty million, the Akan of Ghana are made up of many sub-groups such as the Kwawu, Ashanti, Fanti, Akwapim, Akyem, Bono (Brong), Ahafo, Adansi, and Nzema. These groups are slightly distinct in language—generally classified into Twi and Fanti, but their social systems are virtually the same. Every town or village in Akan society is made up of corporate lineages (*mmusua*, sing. *abusua*). The Akan are a matrilineal society, and social organisation in all Akan subgroups is based predominantly on maternal descent.

Early anthropologists such as R. S. Rattray and later Meyer Fortes who studied the Akan (notably the Ashanti) noted the reckoning of descent through the concept of personhood. Personhood foremost traces the individual's place within the matrilineal group and underlies practices in the traditional, social, and political institutions as well as in much of health-seeking behaviour. Rattray was a pioneer in pointing out the Akan notion of personhood. In this concept a human being is seen as a component of three main substances—the soul *(kra*) from *Onyame* (the Akan supreme God), the spirit (*sunsum*) from the father (the genitor) of the individual, and the blood (*mogya*) from the mother or genetrix. Blood is the determining substance, which marks descent from the mother's side.

The society also upholds certain cardinal values for group cohesion in the kinship organisation. Louis Dumont (1986) points out that every society upholds particular paramount values. In this theoretical model, Dumont argues that every society is organised according to holistic or individualistic ideals. He defines holism as an ideology that valorises the social whole and subordinates individualistic principles; holism is characteristic of traditional societies (Dumont used Indian society as a model).[4] In contrast, modern societies value individualism, which is marked by equality. The Akan, with their prime value on group cohesion and close interaction among members, fit well into Dumont's description of holistic societies. Mutual support and cooperation are crucial for survival in the Akan matrilineal group. Status in

[4] It is obvious Dumont (1986) greatly admires holism, and seems to bemoan modern societies' move away from it. For him, there is a need for reintroducing some measure of holism into individualistic (modern) societies. A Frenchman, Dumont seems to admire modern societies such as Germany [more than France] in which man is still seen as a social being, which unfortunately gave Adolf Hitler the pretext to attack Jews for their individualistic tendencies (ibid: 149-162). For more on Dumont see Armstrong (2005).

the kin-group is important in organising Akan society, as in many other traditional, holistic societies.

In contrast to individualism and its associated equality, holism is characterised by hierarchy which Dumont (ibid: 279) defines as order resulting from the consideration of value. Hierarchy expresses statuses and roles. Systems of authority roles pervade Akan society. As Patrick Twumasi has pointed out, roles are legitimized in various clusters and in institutions such as the family, the chieftaincy hierarchy, the state council, and other membership structures (1975: 7). Roles and positions are constantly upheld and struggled for because the Akan value role-play. For instance, the (traditional) political hierarchy in Akan communities can be depicted as a pyramidal structure where the chief at the apex rules with a co-reigning queen-mother and a council of lineage elders. The chiefship is also vested in a particular (royal) matrilineage although the constitutional position of the chief is defined as an office that belongs to the whole community (cf. Fortes 1953: 32).

In such structures, reversals of hierarchy or opposition to it can occur, which is part of the hierarchy and for the good of the group. Katherine Snyder provides an apt example among the Iraqw of Tanzania. In Iraqw society, the elders' authority as community guardians who hold the ritual to cleanse society and enable the rains to fall is dependent on female elders' legitimation (Snyder 1997: 561). Similarly, the Akan chief as the topmost in the ruling council nevertheless must first be nominated by the queen-mother and approved by lineage elders. Moreover, the Akan council of queen-mother and lineage elders have powers to remove the chief from office for grave offences or gross incompetence. The queen-mother can even assume full control of central authority under certain conditions such as in the absence of a rightful candidate or in the event of a chief's incapacitation.[5] This binary opposition of male authority and female legitimation, or subservience to the chief and the power to remove him work hand-in-hand for the smooth running of the society.

At the lineage level, the encompassing nature of the society and the matrilineage's (*abusua*) interest in the individual member's life and well-being in turn ensures the welfare of the group. The pulls of matrilineal descent and moral obligation ensure that the group seeks the welfare of individual members in economic pursuits, succession to office and inheritance; it is also the group's duty to organise the funeral of its dead

[5] A famous example of this role was the case of Yaa Asantewaa, the queen-mother of the Ashanti town, Ejiso. As the town's chief, she led the Asante army in war against the British in 1900.

members. Meyer Fortes (1950: 255) captures the encompassing nature of hierarchy when he emphasizes that although the lineage is segmentary in form, it is dominated by the rule of inclusive unity. The Akan lineage is a property-owning corporation with rights to offices, land, and property all transmitted through the line of matrilineal descent. Thus maternal descent determines succession and inheritance ensures exclusivity to the group, which is also indicative of internal circulation of property and economic resources.

The encompassing nature of the lineage in its economic functions focuses mainly on land ownership and usufruct rights. By bestowing land as an important means of production in rural Akan areas, the matrilineage protects the economic welfare of its members. As various studies on the Akan have shown land ownership is closely tied to agency and identity as well as to history or genealogical connections. Recently, Sara Berry (2001) in a study of chieftaincy and land ownership has given credence to the claims by the earlier writers. The lineage head (*abusua panyin*) is the custodian for lineage lands, and the actual distribution of farm plots concerning usufruct rights is assigned to minor lineages. The individual man in the lineage cultivates the land with his wife, children and other kin members in a domestic mode of production with simple tools such as the hoe and cutlass.

Most of the inland Akan (the Fante are mostly fishermen because they inhabit the coastline) are cultivators (*akuafo*, sing. *okuani*) who employ mainly the slash-and-burn mode of production. Many people have farms of one or two acres. As among the Lovedu (Krige and Krige 1954), in the past kin members and neighbours would cooperate in work parties for weeding and harvesting. Their rewards were gifts (*akyɛdeɛ*) and not payments (*akatua*). Polly Hill (1978) points out that in the past it was scarce to find paid labour on farms, although she does not account for the need for it. The present study found that paid labour was necessary largely because many young kin members go to school and they do not have much time to help on farms, while older kin increasingly seek paid work elsewhere. A previous gift economy has now changed into a monetary one and today most services on farms take the form of paid labour.[6]

The Akan household economy usually shows that a large part of the food crops cultivated—maize, cassava (manioc), yams, and plantains—are mainly for consumption in the home. Much of relations of production are also still internally generated by the household. Today, due to socio-

[6] A labourer weeding on a farm is paid 15,000 cedis (less than two US dollars in 2003) per day, locally called "by day", from 6 am to 12 noon.

economic transformations, part of the produce is sold for the purchase of other necessities for the home. During my fieldwork in 2003, the highest yield from a one-acre farm in the crop season (March to September) fetched 400,000 cedis (about 46.50 US dollars in 2003).

The rule of matrilineal descent affects many other key points in Akan social organisation. This functionally positions the individual for rights and duties as a member of the group. The cardinal value being group cohesion, individuals need to pursue their goals amidst group unity, where there is an important stress on reference to the group in personal identification. As Meyer Fortes (1950) has pointed out, only free-born members and those incorporated into the group become the most inclusive in the lineage of a particular clan in a community and enjoy benefits from the group. Greater obligations are towards close kin members such as parents and children, and towards siblings than towards patrilateral kin and affinal relations. The strong relations between close matrilineal kin were long noted by both Rattray (1929) and Margaret Field (1960). They observed the high emphasis on the mother-child and sibling bonds, characterised by warmth and intimacy. There is a similar emphasis on the uncle-nephew relation although, as the two authors contend, this is more formalised and often strained because the nephew conceptually waits for the death of his mother's brother in order to inherit from him.

The period of illness, the efforts for healing, and care of the sick person is one significant area in which the matrilineal group's concern for the well-being of its members becomes visible. To my mind, Rattray, Fortes and other research on the Ashanti did not make salient (or failed to notice) the holistic nature of the matrilineal group in the area of illness, healing, and the care of a sick kin member. I see this as a shortfall due to their overemphasis on the politico-jural aspects of the matrilineal organisation. In this study, I construct a model that will present the group's support for the individual's well-being during illness, and at the same time I show the disturbances HIV/AIDS causes in the lineage. The attempts for therapy and caring for the sick person are to be considered as a means by which the individual as a single, independent entity and yet a dependent part of the whole (the matrilineal group) is created and, in turn, creates the whole.

Such a study requires an analysis of everyday social/medical practices, the structures by which they are organised, and how they are linked to kinship and matrilineal ties. One of the important periods to see the holistic nature of the matrilineage is during an illness (HIV/AIDS) episode, when social networks to support and care for the sick person are marshalled. But the contradictions and inadequacies of the group are also revealed by

episodes of the disease. The study also concentrates on how HIV/AIDS is transforming aspects of Akan social life and settings, an endeavour which heightens the need to historicise events and institutions from pre-colonial and colonial past to the present situation in order to take account of change and continuity.

Kwaku B's illness and death

Kwaku B became ill at the prime age of 26. His illness created many crises. Apart from the suffering and desperate attempts for cure his illness resulted in a divorce, his abandonment, economic hardship, bitterness, and a dishonourable burial. After recurrent ill-health, Kwaku B was diagnosed as being HIV-positive. No sooner had his mother revealed her son's status to Kwaku B's stepfather than the latter became angry. The stepfather declared that he could no longer live with the mother and her son as a family.

Kwaku B was an ambitious young man who wanted to have a good standard of living. After his elementary schooling, he moved from his village on the Kwawu mountaintop to Accra, Ghana's capital city, to work as a small shop assistant (usually referred to as a 'store boy'). He worked with two other 'store boys' for the owner of the shop, a middle-aged Kwawu woman who has lived in Accra for years. Kwaku B had vowed never to remain in his home village and live the *ekurase abrab*כ (village life) after his basic schooling. What Polly Hill (1978) found almost four decades ago— people's ideas that village life has many inadequacies—is true today. Village life is often seen as dominated by farming and a difficult way to make money for one's upkeep.

His biological father had abandoned him and his mother when Kwaku B was quite young. Abandonment of wives and children is quite a common feature in Ghana. The abandonment meant that Kwaku B had to struggle for a better life on his own at an early age. It was some years later that his mother married his stepfather. At that time, if Kwaku B was still young his stepfather may help in his upbringing. However, there is no obligation on stepfathers to help raise their stepchildren to adulthood, and many stepfathers decide to concentrate on raising their own (biological) children. Luckily for Kwaku B, he had already started working in Accra when his mother remarried.

In Accra, Kwaku B was such a diligent young man and a good salesperson that the 'Madam' (the shop owner) took a motherly liking to him. He also did well financially, and it was said that when he visited the village at Easter and during funerals, it was obvious from his mannerisms

and outings with friends that he was financially well off. He took to revelling with friends and had children with different women, none of whom he married or lived with. He was adamantly opposed to cautions about his lifestyle.

Kwaku B's illness started as headaches and feverish conditions. In a long conversation with me one day, the patient recounted that he initially visited a hospital in Accra on a number of occasions and was given medications of antibiotics and painkillers. This helped and the symptoms subsided. But the symptoms soon resurfaced. What followed later not only indicated a desperate attempt for therapy; it was also an important revelation about Akan belief systems, traditional medicine, and the holistic and plural nature of Ghana's medical system. Worried that his illness had resurfaced, some members of Kwaku B's matrikin accompanied him to a fetish shrine in the Kwawu area in search of therapy.

Kin members' worry over a sick member is common in Akan society. Kwaku B was a positioned individual in the close kin group. As a grown up first son with a paid job, he supported his mother financially for the upkeep of his other three siblings; he also helped to finance some of the needs of other kin members. Many members of his kin-group had become desperate when Kwaku B's illness was worsening and prevented him from working. He no longer earned money to support his then single mother. The burden of his care and the upkeep of his other siblings thus fell solely on Kwaku B's mother's meagre earnings as a petty trader in Accra. The recurrent nature of his illness also required the frequent purchases of medicines—an expenditure—whenever he went to the hospital.

At the shrine, according to an informant and Kwaku B's close neighbour, the fetish priest divined that the patient was suffering from sorcery worked on him by a colleague. Kwaku B and his maternal kin members indeed suspected that one of his two working colleagues had resorted to sorcery due to envy. Kwaku B stayed for some time at the shrine but when the illness persisted he went back to Accra. He again visited a hospital and his illness complaints prompted an HIV test. Not long after being tested as HIV-positive, Kwaku B moved to his home village. He contacted the Holy Family Hospital in the nearby town of Nkawkaw and became one of their outpatients who received medical treatment every other Thursday. Like others, he also received counselling from the hospital during sessions organised for such patients. The hospital also organises some of its staff into a team that pays home visits to such patients every other Wednesday (in the week when there is no counselling session) to check on

patients' medication. A staff member explained that the home visits are to assure the patients that people care about them.

Kwaku B's mother continued to live in Accra and promised to visit regularly. I was informed that his mother never visited him again. Even other kin members in the village did not visit him. Before he died, Kwaku B's social network had shrunk considerably. There were only the few co-tenants he related closely with. Kwaku B had made a farm on part of the family land a few kilometres away when he settled in the village. Although often in a state of poor health, he was most of the time forced to go to the farm for food when he had the strength, he said. "If I can manage it, I go to the farm for food. What else can I do?" He also often relied on a woman co-tenant who gave him part of her family's meals. Kwaku B was always thankful for this gesture. Like I did with other such patients with whom I interacted closely in other towns and villages, I regularly gave Kwaku B small amounts of money for his upkeep; he was very thankful to me too.

Kwaku B died towards the latter part of the year 2003. One of his neighbours broke the news of his death to me when I visited their village a few days later. Another of Kwaku B's colleagues predeceased him, in similar circumstances. The woman informant who recounted this to me was convinced the two deaths had been caused through sorcery by the suspected colleague. "Interestingly," she pointed out, "since then the guy [the suspect] has vanished from the vicinity. Do you notice that?" My informant stressed the question as an Akan communicative device to convince other people.

When he died, his corpse was prepared for burial at the hospital; it was never taken home for people to mourn and wail over (as the Akan usually do). Kwaku B was not buried at the town's cemetery; instead, he was interred in a grove reserved for unknown people and those who die abominable deaths. There was no funeral on his behalf, and no-one was named to succeed him. As will become clear later, this is against the norm and, more importantly, in Akan notions his death has been a bad one that does not qualify him to become an ancestor.

The open/closed duality in Akan thought

The story about Kwaku B's illness and the efforts for healing him is important for conceptualising the encompassing nature of the Akan matrilineal group and the way in which it seeks the health of its sick members. His illness affected not him alone but others in the kin group. More importantly, his illness and death demonstrate a key category in Akan thought—the classification of the binary opposition of 'open' and 'closed'.

Kwaku B's illness blocked him from supporting himself and helping other kin members financially; instead, he became a burden and was finally abandoned. The nature of his death blocked him from becoming an ancestor in the lineage because he suffered a bad demise. This is the opposite of good death which gives the chance (opens the way) to be incorporated into the league of ancestors who reproduce the matrilineal group and protect the society.

The Akan express many ideas, actions, or situations in metaphors of 'open' and 'closed'. This fundamental duality in Akan thought is employed to describe things or situations that open one's way to prosperity or an achievement, and those that close (or block) the path to such successes. It is a human trait to classify perceptions, thoughts and actions into abstract binary pairs in order to understand the world. This has been one area of particular anthropological interest. A metaphorical Akan concept expressed verbally to capture the image of *ebue* (open) portrays how successful a life, an action, or one's chance in a situation has been or will be. In contrast, 'closed' or blocked (*emu ato* or *kwan esi*) as the paradigmatic opposition expresses the notion of failure, inadequacy, or harm (or other unfortunate situation) in one's condition, such as infertility, when a woman's womb is said to be closed.[7]

The open/closed binary opposition, with its embedded positive and negative notions, is not confined to the Akan. They have been noted in other parts of Africa. In an analysis of Ndembu ritual experiences, Victor Turner (1967; 1969) notes the open/closed dual opposition. Christopher Taylor (1992), using the flow/blockage duality, reveals the metaphors for life's vitality and death in Rwandan healing. Rene Devisch (1993: 54) has shown among the Yaka that the open/closed, life/death duality, with their components or conceptual underpinnings of spatial ordering, have culturally encoded meanings and values. These works use the open/closed idea mainly in healing efforts centred on the human body; I employ the duality in many areas of Akan thought denoting opportunities or failures in discourses about life generally. More specifically, however, I use the notion to demonstrate how bad death (from AIDS) closes the chance to create ancestors and to reproduce the group.

Recently, L. Brydon (1999) has discussed how people cope in urban areas in Ghana. Her discussion points to many images of 'closed' situations in social life. The harsh economic conditions, unemployment and lack of

[7] A similar notion about a woman's closed womb is found in Rwandan thoughts (see Taylor 1992). Nowadays, the most common reference to open/closed duality among the Akan involves travelling abroad. Failed attempts are described as someone's chances closed until he or she finally secures a visa, when it is said that the path is opened (to travel).

opportunities in the villages push people to migrate to the cities. Thus when people migrate to the cities it is to 'open' their chances for a better life. The crisis about HIV/AIDS and the dismal economy is connected to problems associated with the impact of expansive markets and a blockage of people's purchasing power, a result of the monetization of practically all aspects of life. Taylor (1992) and I employ two differing but quite similar notions about blockage (closed), with a common denominator—money.

Christopher Taylor (ibid: 13) maintains that in order to accumulate commodity wealth, Rwandans must block avenues of the free-flowing gift exchange. His premise rests on a situation where people possess the money to be able to 'block' the gift exchange. My use of blockage involving money starts from people not having access to cash and thus being blocked from acquiring wealth. Marshall Sahlins (1972) has stressed that the subsistence mode of production, characteristic of traditional societies, is usually underproductive and hardly makes any optimal profit. The Akan economy is dominated by such a mode. Although a monetary and market system may indicate growth in the Ghanaian economy, the adverse effect is the inadequacies in people's lives—with their pockets 'always dry'.

Structural changes have been rapid in post-colonial Akan society. Socio-economic developments are appreciated but often also lead to strains in people's ability to cope with life. Even formal education, considered a lofty ideal, is sometimes seen as a bane and a block to the chance to prosper and support other kin members. Western education is highly regarded because it enriches one's knowledge and wisdom; those who have not been to school are sometimes viewed as lacking a broad outlook.[8] But a high education is at times viewed as a waste of time. Some question how much wealth highly educated people have except for piles of old books, although many others know that schooling improves lives and 'opens the eyes' (gives a broad outlook).[9] Like in many African societies, a lack of opportunities makes the young unemployed literates travel to the cities, disappointed that

[8] Highly educated people such as professors, (medical) doctors, and lawyers are respected in the society, and this enhances the image of their family/lineage. But the Akan also recognise traditional 'wisdom'. Educated people are sometimes seen as 'too know' (over-confident), and occasionally people pit 'book knowledge' against 'home wisdom'. The elderly are respected for their wisdom even if they have not been to school.

[9] My 75-year-old classificatory mother always bemoans her lack of opportunity to be Western educated and tries to speak English on her own. So, when she met for the first time my American Professor who had come to Kwawu to supervise me, my mother genuinely tried to impress her in 'English': "Me, Hannah O; you, how much?" While I laughed uncontrollably, my Professor did well to answer: "Karen…Karen Armstrong." When I later explained her 'English' to her, my mother blamed her late father who in the 1940s told her and her younger sister he would rather buy fowls to rear than to educate his daughters.

their literacy cannot give them the hope of working in offices. Polly Hill (1978, in Fante villages) argues that inhabitants in the rural areas often say there is no work in the villages because they do not regard farming as work.

Everyday social discourse about health and well-being express village life and poverty in many African societies as situations that close people's path to good health and wealth. Devisch (1993) emphasizes an ambivalent attitude towards village life in Yaka society. On the one hand there is a fondness towards the village because it gives meaning to one's origins; on the other, illnesses exist in the village, where lack of medical facilities threatens well-being (ibid: 16). A similar ambivalent attitude is expressed among the Akan about the village, seen as a place where pure, genuine, and effective folk healing prevails and yet where health facilities are lacking. The contrast with the cities is all too clear; better amenities are in the urban areas— clean water, electricity, and health services even if they are inadequate.

The open/closed duality can sometimes interchange, which means 'open' does not always connote positive ideas while 'closed' implies negativity. A patient's disinterest in seeking early remedy often attracts cautions to him or her not to 'open' his or her way to the cemetery (death). The death of one's livestock or the loss of a valuable is at times viewed to have blocked what would have been a worse misfortune. At other times, a grave misfortune is said to have opened the way for a fortune. A young woman whose first baby died shortly after birth is consoled that it 'came and went away' in order to open the way for others to come and stay (live). This consolation is scarcely used when an adult dies.

Structures, metaphors, and meaning

My work focuses on the Akan social structure and cosmology, and the crises and changes being caused to them by HIV/AIDS. The social structure, encompassing the totality of social institutions and statuses, rights, duties, and norms expresses how a society organises its way of life. In a review of Victor Turner's works from the 1950s to the late 1960s, Mary Douglas emphasizes that any understanding of an action such as a rite in a society requires a detailed analysis of the social structure. For her, Turner convincingly demonstrated how the cultural categories sustain a given social structure (1970: 303). Turner has indeed been a major contributor in the use of structural analysis to show the encompassing nature of a group (in his case, the Ndembu matrilineage). He points out that social structure models have been extremely helpful in clarifying many dark areas of culture and

society (1969: 131). Recently, Marshall Sahlins has given impetus to social structural analysis. In an article about the analysis of cultures he sees the individual not merely as a social being, but as an *individual social being* (2000: 284, emphasis added) with subjective interests and clearly distinguished from others by their different biographies. For him, structure is a state of something, with actions as the temporal processes. I take a wider view of structures. Like Meyer Fortes (1970), I take structures to reflect any distinguishing feature (an institution, a social group, a process) with ordered arrangements in time and space.

Language, of course, lies at the heart of the communicative endeavour in the understanding of the operations in the social structure of a society such as the Akan. It is axiomatic in symbolic discourse that folk beliefs, practices, relationships, and ideas about institutions are transmitted from person to person through language. Metaphoric expressions characterise these endeavours and classify the categories. Thus, in Akan society members of a lineage perceive themselves metaphorically to be of "one blood" (*mogya koro*) (cf. Fortes 1969: 167). As Victor Turner has pointed out, the units of social structure are relations between statuses, roles, and offices (1969: 131). These are also expressed in metaphors that help to understand social and cultural phenomena and relationships. In effect, metaphors describe a given social structure by giving meaning to it. For instance, "siblingship" among the Akan is manifested in kinship words and metaphors, and is expressed in eating customs, incest taboos, jural rights and duties, and in ritual activities in dyadic relationships that are also holistic (Fortes 1969: 47).

The open/closed dialectic may be a major trope but other metaphors (and symbolism) as central referents pervade Akan thought. The referents are tropes that provide the terms with which people view themselves and derive meanings in their mode of life. They enable people to make classifications; thus symbolism, metaphor and other such categorizations signify things and create meaning. Victor Turner (1974: 19) contends that the structure of metaphors involves two referents, and one of them throws light on the other. However, Turner (ibid) seems to take it for granted that metaphor is already understood by the two communicating partners. Like any linguistic genre, metaphoric expressions have to be understood by the speaker and the listener within the context of the culture of the society. Such referents need to belong to the realms of experience, if a common meaning is to be grasped about entities, social behaviour and conduct. Victor Turner (e.g. 1967) and Rene Devisch (1993) have extensively used metaphors to show their significance in conveying meaning in the societies they studied.

Health and illness are replete with metaphors. Illness metaphors are major discursive tools for knowledge about causation in Akan beliefs. For instance, there were four ways in which those afflicted by HIV/AIDS and were gradually dying from it perceived their situation. These were patients' sentiments expressed as medical, protest, betrayal, and spiritual/religious metaphors. The medical discourse expressed the patient's situation as purely medical for which treatment based on therapy at the hospital was fit. A protest metaphor of 'why me' or 'it cannot be me' characterised many of the patients' initial knowledge about their statuses. This later changed to betrayal or disappointment with the patient's self or own body, as well as the attitudes of those around them—family members, neighbours, and health officials. In the realm of the spiritual/religious discourse, some of the patients saw their situation as part of God's will and resigned themselves to their fate.

For other patients, the known cultural categories of witchcraft, sorcery, and curses enabled them to situate the disorder in the spiritual domain and give it a particular meaning in traditional religion. The spiritual illness in Akan thought is not a mere onslaught of a physical or psychological disorder; it is seen as a 'misdeed' worked in the dark, spiritual world—a tool for witches to attack their victims. Thus, by constructing illness as the work of malevolent entities, people are able to give meaning to a world made chaotic by the intrusion of the affliction. As Arthur Kleinman (1980: 77) points out in his study based in Taiwan, illness is understood in the specific context of norms, metaphors and symbolic meanings, as well as through social interaction.

Kinship and marriage as two important structures

A discussion of HIV/AIDS, ideas about its causation, the efforts for therapy and the care of the patients among the Akan shows that kinship and marriage are two important structures within which these notions are expressed. Kinship has always been a core area in the anthropological study of traditional societies and central to the system of relatedness in the social structure. Kinship terminology as a method of classification provides some of the meta-structural aspects of social relations. Among the Akan, it determines who relates with whom and the degree of obligation an individual has towards others in both fictive and classificatory contexts. Indeed, Akan kinship terminology always classifies what and who one is in relation to others.

As Meyer Fortes (1969), who has written much about kinship ties among the Akan has pointed out, there is complementary filiation with both matrilateral and patrilateral kin. Matrifiliation ensures membership in the local matrilineal group with others who are related as parents, children, siblings, and so on. Relations from the father's side, although not emphasised as much as maternal relations, enlarge the individual's kinship network (ibid: 202). Paternal connection also grants the individual membership in the father's *ntor*ɔ cult or spirit that protects the child. Fortes identified group unity and close interaction in two structural domains of kinship relations. There is the familial domain where relationships with members from both the mother's and the father's lines express filial, sibling and affinal interaction. The other is politico-jural domain which concerns descent relations strictly identified with the mother's line (ibid: 250-251). While the politico-jural domain is important to ensure the right to office, the familial domain organises day-to-day activities and support for each other. As will become clear later, kinship connection is important in the search for therapy and care for HIV/AIDS patients.

Ideally, children live and spend as much time as possible with their parents, who are responsible for their children's moral training during the formative years (cf. Kallinen 2004). Sons in particular are expected to live with their fathers who are seen to be better at training boys. The Akan lineage as *abusua* is also expressed as 'house' (*fie*, pl. *efie*); within this 'house' are individual members of the matrikin from whom the sick person gets help and care. Akan lineages are multiple households. Living arrangements in a household are usually fluid in the family or lineage home or in others situated elsewhere. There is always the tendency for kin members to live in households of extended family members and to move with relative ease to the homes of other relatives. Since living arrangements are fairly fluid, the transfer of people from one household to another is common and an important way of life among the Akan.

Equally common are guardianship and fostering of young relatives, which show the sharing of responsibilities and the encompassing nature of the group (cf. Oppong 1981). Women (and less so men) usually live with and are the guardians of a sister's or brother's child with ease, often done voluntarily. Fostering is usually without much difficulty and is based on the consent of the parents of the child. Ideally, kin members foster others, although in some circumstances those from poor homes can be fostered by strangers (ibid). Fosterage by kin members thus ensures continuity of amity and unbroken close bonds in the kinship group.

Marriage enlarges a group and produce legitimate children. It is an achieved status that brings respect for both men and women. In the past, the unmarried woman was not accorded much respect, more so when she entered a relationship of no recognition that was also not aimed at producing children into the lineage. Similarly, the unmarried man who stayed alone for years was frowned on. Polygyny was widely practised in the past, although this trend is changing in the urban areas especially. As in many other matrilineal societies (Schneider and Gough 1961), clan exogamy is usually enforced; the husband and the in-marrying woman (who is married to a man in the lineage) in matrilineal systems are 'outsiders' (ibid). Thus, kinship is filled with metaphors of physical contiguity as much as classificatory relations.

Marriage is a redefinition of people's statuses and their kinship states. In effect, in Akan marriages one establishes a relationship with the partner as well as with the partner's kin group. The ideal match is between a man and a woman from the same village, which used to be enforced by the lineage elders. But social changes have been vast and these days, people easily marry others of different ethnic groups. Marriage, residential pattern and household formation thus also enlarge the individual's sources of social relations and help (in care). Ties of conjugality and affinity are associated mainly with marriage and produce filiation to father and mother, sons and daughters, brothers and sisters, grandparents, and in-laws. And because marriage is always exogamous, a woman from lineage house A and married into house B usually lives virilocally in her husband's family home. Nowadays, however, many couples establish their own neo-local homes, especially in the urban areas. [10]

Whereas in patrilineal kinship organisation such as the Tallensi or Lodagaa (both of northern Ghana) a man takes care of his own children and is under no obligation to care for his maternal kin, a different system operates among the matrilineal Akan. In the Akan system, a man is expected to care for his own children and his nephew or niece (who will inherit from him if he has no brother). In Akan marriages, a father is expected to care for

[10] In real life situations, however, marital residence patterns among the Akan go beyond the anthropological descriptions of virilocality (living in husband's family home), uxorilocality (in wife's family home), neolocality (in new home by husband and wife), and duolocality (husband and wife living separately in their own family homes). For example, there is sometimes the practice where a husband establishes a new home for the wife (and their children) but he lives elsewhere, even outside his own family home, as Katherine Abu (1983) and Timo Kallinen (2004) have both noticed. This usually happens when the husband is involved in a polygynous relationship, or has girlfriends. Usually, the girlfriends would be 'allowed' to visit his home, but his wife (or wives) may not be allowed to do so because he goes to her or them.

his own children despite matrilineal rules that bind him to care for his sister's children too, especially the nephew (*wɔfase*) as his sister's son. As A. R Radcliffe-Brown has argued about the mother's brother in South Africa, ego expects indulgence and care from his mother and the mother's brother (1968: 16-17). It was a popular view among the Akan in the past, especially, that a woman may not even know who the father of her child is, or the man who impregnated her may deny responsibility and disown her. If she has a brother or even the distant mother's sister's son, she knows that he will always be the child's *wɔfa* (maternal uncle) and the child will be taken care of by him (cf. Field 1960).

Culture and medicine

As Kwaku B's story indicates, the search for therapy in Akan society often sees the use of multiple avenues in the attempt to regain health. This is a significant aspect of health-seeking behaviour in Akan society. The quest for therapy also entails social relations with known others in the kin group; more importantly, the illness problem becomes the problem of the others. This is apparent with many HIV/AIDS episodes. The individual in such a holistic society as the Akan is aware of his or her dependence on other members of the kin group. An illness or a breach in social relations in such an integrated social setting is seen to threaten almost the very survival of the group (Twumasi 1975: 23). Hence kin members do everything to help remedy the situation. Both John Janzen (1978a, in Lower Zaire) and Arthur Kleinman (1980, in Taiwan) have shown how deeply involved family members become when a member is ill because the malady affects the others. Janzen demonstrated in his analysis of the quest for therapy that occasions of hostility and other kinds of conflict that threaten the harmony and solidarity of the clan can even become the aetiological explanation of the illness (1978: 102-125).

Medical anthropology continues to point to illness and healing as culture-mediated. Kleinman (1980: 39-50) argues that although health systems have similarities across cultural boundaries, the contents may vary with the social, cultural, and environmental conditions. Medical anthropological studies of how societies' medical systems work take cognizance of the cultural underpinnings. Two of these approaches are related and seem to be dominant today. They are the structural analytical model and the medical pluralism point of view (Whyte 1992: 163). Kleinman (1980) pioneered the sector analytical model, and in it accentuates the micro dynamics of healing. This refers to the influence of social

institutions, social roles, interpersonal relationships, and beliefs and practices associated with healing.

Kleinman identifies three sectors which are overlapping. The sectors are the folk (characterized by the practices of traditional healers), the popular zone (embracing treatment on one's own), and the professional sphere or biomedicine,[11] involving the hospitals and clinics (ibid: 50-60). The second approach, the medical pluralism standpoint, rests on the macro contexts of healing and how systems change. Two prominent exponents of this view, Steven Feierman (1992: 1-23) and John Janzen (1978b: 121), argue that the macro plane should be the analytical basis of local pluralistic health care systems since external forces greatly dictate the units studied by microanalysis. In the present study, a combination of the structural analytical model and the pluralistic mode is for a better understanding of the inner dynamics of Akan medical culture.

One of the important things anthropologists do is to bring out, through cross-cultural studies, how health and illness are perceived or interpreted in other cultures. In many traditional societies illnesses are classified into naturally-caused maladies which often see the use of hospital care, and spiritually-caused afflictions for which the sick persons and their kin members often seek herbalists and spiritual church healers. E. E. Evans-Pritchard (1950[1937]) was a pioneer in the analysis of supernatural aetiologies in Africa among the Azande in southern Sudan decades ago. He showed that in such societies their notions never deny (Western) scientific philosophy, but still see their own non-testable experiences as equally real. These provide the conventions for understanding their life-world. Peter Worsley has emphasized this point, arguing that at a high level of abstraction misfortune such as illness is commonly attributed to some kind of offence against cultural values and social norms. He, therefore, calls for inquiries that apply to a huge variety of forms of social structures and ideas about "this-worldly" and "other-worldly" phenomena, about the actions of the living and the existence of supernatural beings (1982: 330). Among the Akan, the cultural categories of illness, healing or the failed attempt to heal and the resultant death are associated with the individual in the group (matrilineage). They are also social processes that mirror the workings within the social structure.

[11] Medical anthropology refers to Western medicine, biomedicine, allopathy, official sector, modern medicine, or professional sector care to differentiate it from traditional medicine. I mostly use Western medicine, professional health care or biomedicine in reference to Western medical categories and epistemologies. However, following Kleinman (1995: 25) my reference to *biomedicine* largely emphasizes "the established institutional structure of the dominant profession of medicine in the West".

Medical anthropology continues to show how an individual or group constructs social reality about health, illness and healing in both modern and traditional societies. Arthur Kleinman (1988) points out that the construction of social reality and other mechanisms by which the individual or group presumes the significance and meaning of illness and health are usually based on knowledge acquired within the group. For this reason, Kleinman advocates a social constructionist approach with an emphasis on the symbolic meaning of illness. He insists that societies have varying ways of labelling illness, and cultural meanings mark the sick person's place in the local cultural system (ibid: 26). Although Kleinman seems to overemphasize the social (society) and places the individual in the background, his calls for the social construction of illness are important to understand cultural systems such as the Akan.

In his analysis of Rwandan healing, Christopher Taylor (1992) has demonstrated that the medical ideas and practices in traditional societies change because of outside influences. He argues that in Rwandan society such influences as commoditization, the introduction and growth of biomedicine, Christianity, and Western individualism indicate major transformations. Professional sector care began when Western medicine was introduced in Akan-land and in Ghana, like in other African societies. Several meanings have been read into the introduction of Western medicine in Africa, but one can instance a few. Terence Ranger (1992: 256-258) claims that colonial (Western) medical services were seen as a weapon for confrontation with heathenism, "to compel Africans to abandon their unscientific views". This enables us to grasp the idea of two opposing cultures, one trying to supplant the other. For John and Jean Comaroff (1992), it was more an ideological colonisation than mere Western domination of traditional medicine. The domination expresses European hegemony in Africa, and the Comaroffs have rightly revived the concept of hegemony in anthropological writing on Africa. They point out the transformation of consciousness in many aspects of the Tswana [and African] way of life in southern Africa. The encounter with Europeans saw a direct conceptual confrontation between *sekgoa* (European ways) and *setswana* (Tswana ways). The Comaroffs' concept of European hegemony in Africa parallels the criticism about biomedicine's hegemony in medical practices in traditional societies.

Indigenous illness explanations in traditional societies have seen biomedicine criticised for its dominant, superior-looking tendencies (e.g., Kleinman 1980). Biomedicine assigns physical or biological explanations to illness and reduces it to mainly scientific reasons that eschew attempts to

understand illness and care within the social or cultural (spiritual) world (ibid: xii). Medical anthropology continues to challenge the biomedical model for its myopic view and move away from the non-material, super-ordinate realm when categories (as applied by biomedicine) are part of culture. In order to account for cultural issues, medical anthropology makes a distinction between *disease* and *illness*. The notion of disease is based on biomedical diagnosis, while illness refers to the patient's cultural experience.[12] Sickness incorporates both ideas. Medical anthropology also distinguishes between curing, associated with biomedicine, and healing, which embraces folk therapy (Young 1982).

On health, illness (HIV/AIDS), and therapy in Ghana

This work focuses mainly on the crises caused by HIV/AIDS among the Akan, but it is also about health, illness and the search for therapy in Ghana generally. Illness and health are topical issues in Africa's problems of disease and lack of medical resources. Much of the literature on medical issues in Africa has emphasized health inequalities and accessibilities largely along biomedical lines in countries on the continent. Urbanization, chemical and environmental health hazards, as well as perceptions about diseases have equally been topical. In Ghana, the description of health, illness and coping mechanisms or attempts for therapy have been studied by various authors. Among the Akan, some of the pioneer works have come from writers who worked for the colonial administration. The trail appears to have been set by colonial anthropologist R. S. Rattray (1954) whose classical works in the 1920s and 1930s, notably on Ashanti religion and art, covered many medical rituals in the search for therapy. His description of folk ideas about illness and the training of the "ɔkɔmfo" (fetish priest) holds true today as much as it indicates the importance of traditional healers in Akan society.

Some years later, Margaret Field (1960; 1940) dealt extensively with people's search for security when afflicted with various forms of misfortunes. As a psychiatrist who worked at hospitals and clinics and a colonial researcher, her visits to numerous shrines in the Ashanti Region convinced her about how insecure people felt with witch beliefs and the important role of traditional healing institutions in combating the activities

[12] In this study, I mostly use *illness* where the idea leans towards local, folk beliefs or traditional medicine, and *disease* when referring more to Western medical ideologies.

of the witch. The shrines as healing outlets also point to the pluralistic nature of Ghana's medical system.

More recent studies in Ghana have examined medical ideas and practices even more powerfully and raise themes that are relevant in this study. Most of them point to the pluralistic nature of the medical system and the important place of traditional healing in the face of the introduction of colonial medicine in Ghana (e.g., Patterson 1981; Osei 1978). They also show therapy as a means for problem-solving and the attribution of illness afflictions to various factors, mostly mystical ones such as witchcraft, sorcery, and ghosts (e.g., Kirby 1986, among the Anufo of northern Ghana). Other works on traditional (spiritual church) healing (e.g., Mullings 1984, among the Ga of Labadi in southern Ghana; Owoahene-Acheampong 1998), consider ideology in therapy in the context of the role of colonialism, Christianity, and Western medicine in Ghana.

The demographic impact of diseases in Ghana has long attracted attention, with such variables as mortality, fertility, age structure, and access to health care high in studies of the medical and socio-economic forces that affect the prevalence and distribution of diseases. David Patterson (1981), concentrating on the level of health in colonial Ghana from 1900 to 1955, found that while the introduction of Western medicine helped to control most epidemics by 1955, other endemic diseases remained substantially uncontrolled in rural areas without health facilities. Malaria, for instance, caused high morbidity and deaths among children and young adults in many parts of the country (ibid: 106). Today, although medical facilities have increased, biomedical interventions are still lacking in many places, making the health situation in Ghana considerably poor. Certain attitudes and lifestyles such as sexual behaviour also pose health challenges in some age groups in the country. In a study of sexual relationships and birth control in an Akan town in the 1970s, Wolf Bleek (1976) found many negative consequences of sexual behaviour among school girls—unwanted pregnancies, disorganised education, and illness or infertility or even death from self-induced abortion. Pre-marital and extra-marital sex pervades Akan society. Bleek's observation about the "considerable amount of permissiveness towards pre-marital sex" (ibid: 58) is important today. HIV/AIDS in Ghana goes with the worry that the virtually unrestrained sexual relationships help to spread the disease.

Maud Radstake's (1997) work on HIV/AIDS and home care by health personnel in Ashanti sheds light on how the burden of care is often placed on the matrikin with mothers and sisters usually caught between doing the household chores and caring for the patient. Apart from secrecy, stigma, and

denial about the disease, Radstake found that caring for the sick persons shows reversed roles. The elderly increasingly support younger patients, and HIV/AIDS often disturbs relations of respect and reciprocity in the family. Philip Bartle (1978) has laid bare how migration and the effort for a better life are linked to moral obligations in the matrilineage. Migration is often part of the survival strategy of the matrilineage. As Bartle's study shows, rural-urban migration has become a way of life in Akan society, where migrants are expected to send money to kin members back in the home village to improve the household economy. Migration is thus intricately linked to risky activities that result in HIV infection.

In examining HIV/AIDS, this study goes beyond others about medical ideas and practices of the Akan by combining such issues as the search for therapy and medical pluralism, attribution of illness, and kinship care of AIDS patients in a total social system. Thus, instead of viewing transformations—both continuity and change— in Akan society merely from the perspective of the impact of colonialism, Christianity, and Western medicine, this study uses HIV/AIDS as the latest transforming agent and analyzes its devastation in the total social system.

A native among natives

I arrived in Ghana on 3 February 2003. After two days with my mother in the Fanti area, I moved to the Kwahu[13] South District of Ghana's Eastern Region some hundreds of kilometres east. Ghana is divided into ten administrative regions—Greater Accra, Ashanti, Eastern, Western, Central, Volta, Brong Ahafo, Northern, Upper East, and Upper West. These are further split into 110 districts. I was mostly based in the Kwahu South District because it had the third highest prevalence of HIV/AIDS in the Eastern Region during my fieldwork.[14] As a rural setting, it also provided the conditions for testing assumptions about close interaction in kinship organisation, medical practices, and indigenous beliefs.

Enthusiastic to be among my kin members 'at home', I was ready to begin my work. Initially it was to focus, quite simply, on indigenous ideas

[13] 'Kwahu' is the spelling in most official records from the colonial period to today. I have used Kwahu in previous writings. In this study, I maintain 'Kwahu' when it appears in official documents. To reflect the indigenous name, I use 'Kwawu', derived from a legend based on three Kwawu kingdoms, one of which was called Akoawu. It is also associated with the chief's scout who fought till death ('*ako awu*') during their migration (informants' account; also Nkansah-Kyeremateng 2000).

[14] Manya Krobo was the leading district, later overtaken by the second highest, Koforidua. Eastern Region tops the regional records due to migration of women from Manya Krobo. Ashanti is second due to migration and mining activities in the region.

about HIV/AIDS, the use of traditional medicine (healing), and so-called claims by traditional healers to cure the disease even though it has no known cure. But the many deaths I witnessed and heard about, as well as the almost hurriedly organised burials without funeral rites revealed broader and deeper issues about bad death, ancestors, and funeral practices. The matrilineal group was centrally placed in all these, and patients' stories about how they were infected, their experience of the illness, their care, and financial costs embraced many others. It was soon clear that I had come face to face with holistic patients suffering from a disease that affects others in almost every sphere of Akan society.

There are many advantages when anthropologists do research among their own people. Being a native helps to easily understand the people's world. As both Lila Abu Lughod (1986, among the Bedouin of Egypt) and Harriet Ngubane (1977, among the Zulu) have shown, doing research in one's own society ensures easy access to information because there is little or no problem with the language. As a native, I could also not be "deliberately misinformed" about Akan traditions, as Ghanaian sociologist, K. A. Busia (1968: x [1951]) claimed about some flops in colonial British anthropologist, R. S. Rattray's findings among the Ashanti. I was lucky to have my 'sister' (our mothers are related back to three generations) as my main contact person, and through her I could make further contacts fairly easily. Having kin members to make other contacts for me meant that I did not have major problems becoming familiar with the place after my long absence studying in Finland. I did not need research assistants, except to help in the distribution of survey questions for a household study and the recording of medical facilities at Nkawkaw; both were done with the help of a social worker.

This study was conducted over 13 months of fieldwork. I was based in Kwawu but my inquiries also took me outside that area, particularly to Fanti-land. I first lived with a family at Nkawkaw when I began fieldwork; however, later when I had to interact more frequently with patients in towns and villages all over Kwawu area, I moved to Obomeng, my mother's hometown which was quite centrally-placed to make such visits less cumbersome.

My main methods of gathering data in the field were participant observation and mainly unstructured interviews. Both structured and semi-structured questions in English were also used in a questionnaire for the survey on household characteristics. I acknowledge that because of the low level of formal education in the villages, face-to-face interviewing in the local language would have been better. Due to time constraints the

questionnaire type of survey was appropriate, and luckily a member of each household was formally educated enough to fill out the questionnaire on behalf of others as part of support in the families. My sample of interviewees included AIDS patients, their family members and other members of households, medical personnel, AIDS counsellors, social workers, and traditional healers. I attended funerals, church services, and naming ceremonies; I also went to farms with people. All these became important outlets for information. Additional data were secured in archival studies at the national and regional archives in Accra and Koforidua respectively.

Similar to Paul Farmer (1992), I kept close contact with HIV/AIDS patients for in-depth information about their life-world as they endured and negotiated their situation and changed identity till death. Conducting research on HIV/AIDS was not easy. Owing to stigmatisation, the disease creates a fundamental classification—a 'we-ness' against the other. For the patient, it is a double negative presentation of the self; first, afflicted with an incurable disease, and secondly, for what is generally perceived as having been 'immoral'. Very much aware of this, many patients try to avoid other people (including the researcher) for fear of being judged. Luckily, a social worker introduced me to many patients at the counselling sessions. Most of them granted me interviews and discussions, some did so initially and stopped later, but others completely avoided me.

Spontaneous and casual conversations, gossip, and hints became important ways of gathering information. I could not tape-record most of these types of information. I, however, wrote them in my notebook immediately when I was alone. Information from close observation or in accounts by people who had been closely associated with episodes is constructed into case stories in most of the chapters, "as particular events that demonstrate the intricacies of larger processes" (Kapferer 1996: ix). They are also meant to help in the analysis of the conscious cultural models and the less conscious concepts that underlie Akan social life in the context of the HIV/AIDS threat. My many informants ranged from a white-haired old woman, a centenrian at Obomeng who gave me first-hand information about pre-colonial illnesses. The youngest informant was a twelve-year-old boy who received small gifts as a go-between for teenage girls in a household at Nkawkaw and their boyfriends. Many interactions with chiefs were beneficial for ideas about the chiefly office and pre-colonial rituals.

I have yet to read an anthropological work in which the anthropologist tells about initial feelings of doubt, not because of his or her incapability, but based on a key informant's comment. On my arrival at Nkawkaw, my

sister asked about my research. I had told her about it even before I set off from Finland, where I was studying for my doctoral degree. I guessed that she wanted to know the details about my work, and I told her about it again—to study HIV/AIDS among the Akan. Hardly had I finished, when she burst into laughter. "So, you have come all the way from Finland to study AIDS in Ghana? What are you going to find out about— that do people use condoms," she asked. "Auw!" she interjected as an Akan way to dismiss an idea. "Does the disease exist at all?"

This brought many thoughts to my mind. Was the disease taken so lightly in Ghana that my sister saw my study as unimportant? When she seemed to doubt its existence, would she actively help me as a contact person? Would other people be uninterested too? Luckily she agreed to make other contacts for me. A social worker introduced me to the personnel at the Holy Family Hospital at Nkawkaw, which organises counselling sessions for HIV/AIDS patients. My sister never accompanied me to the counselling sessions although she went with me on my visits to the patients in the various towns and villages. Before I left the field, however, she was no more a Doubting Thomas; she often told her friends: "Before my sister came, I never believed that AIDS existed. But I have seen some of the patients myself and I now know that we all have to be very careful."

I had many disadvantages—for the same reason that I am a native. Fetish priests would not allow me to witness proceedings in their shrines because I am a 'child of the place' (an Akan). One fetish priest was candid: "You are from this place and can understand what will go on here. We need to protect our knowledge so that it is not taken away elsewhere." He was alluding to the fact that I had come from abroad. As already mentioned, any discourse on HIV/AIDS invariably attracts further discussions about sex and sexuality. True to the view by Beth Ahlberg (1994), I found that because sex occurs in private it is not easy to do research on it. I also faced a moral question. Despite complaints of present-day moral decadence, sex is treated with deference by many; how do I ask questions and later write them out without creating the impression that I have been 'spoilt' living abroad or that I should have been more circumspect? For, White people are sometimes viewed as quite lax about sex portrayals.[15]

I was very much aware of my role in this study to bring out the meaning of illness in Akan constructs. Meaning is made possible through the articulation of traditional and medical beliefs existing in an atmosphere

[15] Anthropology has always created images of 'exotic' people of traditional cultures who must be studied. How the exotic, subaltern others view the Westerner has, to my mind, not much been explored.

of biomedical and other Western epistemologies. The analysis here also becomes a dialectical one in which I, as the researcher, analyse cultural distinctions to make sense of emic ideas and practices through analytic constructions based on Western theoretical frameworks. I know that I have to detach myself as much as possible and present what people say. But it is my culture too, and how do I write about witchcraft, for instance, without inferring my own beliefs or non-beliefs about it? This study relies on my personal experience as a member of the ethnic group which, I believe, enriches the ethnographic present. It also relies on a large literature on the Akan. To protect the identities of my informants, I have given them pseudonyms. Their stories are the irregular events in the general analysis of crises in individual lives and social relationships in the seemingly regular, uneventful social life of the matrilineal group. I respect them not as objects of my study but as subjects whose interaction with me made it all possible.

Chapter 2 discusses the importance of ancestors in the Akan matrilineage. Ancestors are constantly revered (in rites prominently involving the Akan chief, in Chapter 4), and are conceptualised to be the starting point for social order. They are significant as the extension (spiritual base) of the matrilineal group and for their ability to reproduce the group and society. Attention is given to death, classified into good and bad, and through which ancestors are produced (good death) or not produced (bad death). Every death necessitates a burial and, circumstances permitting, funeral rites. Chapter 3 focuses on funerals as an important social performance mainly by the matrilineal group to send the deceased off properly (into the league of ancestors after a good death) and to enable the living to come out of their mourning period, while it creates social relations. Funerals are not performed (or are not elaborated) following bad deaths, involving young persons and after illnesses of long suffering, such as AIDS.

Chapter 5 concentrates on HIV/AIDS as the latest illness disorder and a threat in the group and in society. Its mode of infection also reveals sexuality and the workings of matrilineality. Marked by dominant discourses— poverty, sexuality and a call for behavioural change to avoid infection—the disease is sometimes explained indigenously as spiritual disorder perpetrated by witches, sorcerers and angry ghosts, and suspected from the kin group. Chapter 6 analyzes the many possible avenues for healing; individuals and kin members practically seek therapy and other measures to combat the illness. The many therapeutic avenues also portray the holistic (and pluralistic) nature of Ghana's medical system, based on Kleinman's (1980) three-sector analytical model— Western medicine, self-therapy, and traditional (folk) healing. Folk healing, so-called claims by

traditional healers to cure HIV/AIDS and the use of herbal mixtures in many Ghanaian hospitals also show the 'desperate' attempts to combat the disease without cure.

The focus on traditional healing continues in Chapter 7 with a discussion of spiritual (church) healing and divine intervention. Caring for the sick person is a major aspect of combating an illness such as HIV/AIDS. Chapter 8 analyzes informal care for AIDS patients mainly expressed within the matrilineage and the burden or crises it entails. Chapter 9 examines the effects of AIDS afflictions and deaths in the lineage and in society. There is a short part at the end devoted to recommendations based on the findings in this study.

2. OF ANCESTORS AND 'BAD' DEATH

It was a Friday evening. This is usually the day and time when corpses are brought home from the mortuary to be prepared for burial the following day. It was a scene full of activities. Just before the body of a ninety four-year-old woman was washed and laid in state, a lineage elder offered libation. In front of the family house, he poured rum on the ground intermittently as he spoke. He invoked the dead woman's spirit and prayed through her for ancestral intercession on behalf of the living members of the lineage:

> As you go [to join the other ancestors], we ask for long life, money, prosperity… let us multiply [children], protect us from illnesses that lead to death, especially sudden deaths…

There was a group of women wailing in the compound where the corpse laid on the bare floor in a corner. Many people stood in groups engrossed in discussions; others took time to organise themselves. Such are common scenes at Akan funeral events as major occasions that call for collective action to allot duties. The situation on such occasions is always volatile. It often has the potential to spark quarrels at the least provocation. Planning and organising in preparation for burial are done weeks or months back, but people continue to organise and reorganise themselves. Children usually busy themselves carrying the bags of mourners arriving from other villages and towns. They would receive and be very happy with verbal expressions of gratitude, small presents or coins.

More women joined those weeping near the corpse, still draped in the clothes from the mortuary. After washing the body, the clothes would be changed into a new white gown for the lying-in-state ceremony and burial. The group of women continued to wail near the corpse. Suddenly, one of them went closer and addressed it: "As you go," she said as she wailed, "please be reminded that I need a child. Come back to me [reincarnate, *bɛbra*] and let me bring forth a child to name after you." She was addressing the corpse as though it was still alive, assigning it the human (living) qualities it used to have and thus never cutting the deceased off conceptually from this world.

The scene above reveals how central Akan ancestors are in the society and the beliefs about their power to give (long) life, fertility and prosperity. It is obvious from the scene above that in terms of Akan ideas about ancestors the deceased old woman is a potential dead forebear even before the ritual of burial (and funeral rites) to properly send her spirit off and formally turn her ghost into an ancestor. She died at a very old age and has

left descendants. Her spirit is therefore being invoked as it is done with all other ancestors; in this instance, she is being given a message to deliver to those already gone, knowing her potential as a would-be ancestor.

This should be understood in terms of cognition and the sacred. Cognition theorists and psychologists in the study of religion (or about the supernatural) argue that humans try to understand certain religious concepts with something counter-intuitive about them; for instance, lifeless sacred agents or icons are consciously given human-like or living attributes. Pascal Boyer (1996) explains that humans are intuitive in many aspects of life; that is, they are able to understand experience in life largely based on how they feel about their world. In religious thought, however, humans have an intention that is not based on mere intuition, but one calculated to achieve a certain effect (ibid: 83-85). For instance, in a high religion such as Christianity, God as an invisible agent is viewed with human-like qualities. Similarly in folk religion or thought about the sacred (as pertains among the Akan), the lifeless body of a person becomes an icon that is seen as a 'living' ancestor.

Akan culture is prolific with rites and religious observances perceived to seek the good of the society. The ritual performance regarding libation (prayer) before preparations for burial is one such rite. It is enacted by the head or an elder of the lineage before every corpse is washed, dressed and laid in state for subsequent burial. The epistemological concern here, however, does not lie with the enactment of death rituals. Instead, this chapter tries to show that Akan ancestors continue the matrilineal structure and play a significant role as the starting point of social order in the society. The chapter starts with a discussion of how ancestors are created through the notion of good death. The next section moves to the status of ancestors in the lineage and society; finally, it examines bad death as a blockage to the production of ancestors and reproduction of the matrilineal group and how this threatens the survival of the society. Ancestor veneration indeed lies at the heart of the indigenous Akan belief system and organises many aspects of social life.

Sadly, only few studies have been done on ancestor veneration among the Akan. These studies have noted the importance of ancestors as a part of the indigenous religion. The studies are, however, fragmentary because they usually were a part of a larger discussion of Akan chiefship (e. g., Busia 1968) or the traditional religion (cf. Rattray 1954 [1927]; Opoku 1978). Hence, we owe much to Meyer Fortes (1965; 1969) for deeper discussions about ancestor reverence among the Akan. Ancestors ensure the continuity of the lineage and, by extension, the society. Indigenous belief in the holistic

Akan society designates ancestors to watch over their living kin members to ensure their welfare. The many Akan beliefs and practices venerate and implore the dead forebears to protect the group (Busia 1968). This conforms to the pattern generally portrayed in ethnographies from other African societies (see, e.g., Kopytoff 1971, among the Suku of Congo).

There seems to be no records of the origins of ancestor reverence in Akan society. A set of beliefs and practices about the relationship between the living and the dead seems to have been prominent in prehistoric times. There is almost no direct evidence about these practices (Klein 1996). Oral history indicates that ideas about their ancestors may have intensified as the Akan migrated southwards from the north, beyond Ghana. They were led by people who, upon death, were preserved and carried along to the group's final abode (see Apter 1955). Keeping in mind the difficulty in historicising oral narration, A. Norman Klein (1996) has tried to reconstruct the origins of the Akan and their ancestral practices. He cites very important pre-historic stone axe, *Nyame Akuma*, found by archaeologists and originally identified by Rattray (1954: 294-301).

In his attempt to reconstruct Akan origins, Klein (1996) dismisses Rattray and Ivor Wilks (1993: 64-66) for relying on the oral tradition account of 'the hole in the ground from which our ancestors sprang' to look for the history of the Akan (ibid: 254). Instead, he tries to reconstruct the origins based on radiocarbon evidence and sickle cell traits found in the Akan area. To me, Klein's evidence does not help in any way. For, he succeeds in showing that the Akan have a long history of residence in their present abode, the forest areas of Ghana, but fails to show the origins of their ancestral practices.

In the absence of any literature on the nature of the demise that creates ancestors in Akan society, we may look to notions found in India. As in India (Parry 1994), the Akan classify death into good and bad. According to Jonathan Parry (ibid), in Indian society a good death produces ancestors; when a good death occurs, there is a rebirth in which ghosts are turned into ancestors. On the contrary, bad deaths "result in a *blockage* of biological and material reproduction" (ibid: 226, original emphasis). Thus, the Akan and Indian notions are quite close, even though the two societies are quite distinct and our analyses also have different starting points. Parry examines priests and other 'sacred specialists' in India who perform death rituals before burial and serve mourners and pilgrims to the Indian holy city of Banaras. Although his analysis takes him to a further discussion of hierarchy, power (ritual authority), and avarice, he is able to show that ancestors play a significant role in the growth of the society. Since my

approach begins with how Akan ancestors are created and their significant role in the lineage and society, a central idea is that the dead forebears create the society and society, in turn, creates them. The theme of death and the regeneration of life in many traditional societies has been the focus of recent publications, notably the edited work of Maurice Bloch and Jonathan Parry (1982).

Becoming an Akan ancestor: 'good' death

The first prerequisite to become an ancestor among the Akan is death. Someone can only become an ancestor only after death. This is an important point about death in Akan society. Death, however, is highly abhorred in the society. A person's demise is seen as a great loss in the lineage. Ironically, deaths are far too common in Akan-land as in many other societies in Africa.[16] The funeral events held almost every weekend in many Akan communities are a constant reminder of death. While in the Western world death is infrequent and distanced because it largely occurs in the seclusion of the hospital (Mellor 1993: 21), it is the contrary in Ghana. The high rate of fatal motor traffic accidents on Ghana's major roads and deaths from such illnesses as malaria, cholera, and HIV/AIDS are indicative that death is an everyday occurrence. Ghana has quite high adult mortality rates compared to Finland, although it is lower than South Africa's figures. With regard to child mortality, however, Ghana has the worst records as the figures below shows.

Mortality rates for Ghana, South Africa, and Finland in 2003

	Adult mortality		Child mortality	
	Male	Female	Male	Female
Ghana	352	295	99	92
S. Africa	642	579	70	61
Finland	134	57	5	4

Note: All figures are per thousand deaths.

FIGURE 1: The adult and child death rates for Ghana, South Africa, and Finland in 2003. Source of figures: World Health Organisation (WHO)— internet homepage: http://www.who.int.html (10/4/2006).

As in many African societies, the high mortality rates also reflect the woefully inadequate medical interventions in the country. The Akan know too well that death is inevitable. This is expressed in the saying that life is a

[16] For instance, John Middleton (1982) says something similar about the Lugbara of Cameroon.

journey at the end of which is death. They know that everyone will die some day. Yet they abhor death, viewed as polluting. It is associated with the left hand as a profane side of the body, in line with Robert Hertz's (1960 [1907]) theory about body metaphor and a homology with the negative view of death in many traditional societies. Because of its negative nature, the death that produces ancestors is a consolation to the Akan. Being dead, however, is not sufficient enough a criterion to become an ancestor.

Many studies on Akan ancestors say how a dead person 'qualifies' to become an ancestor (e.g. Rattray 1954; Fortes 1965; Opoku 1978), but they do not tie it to the kind of death. To become an ancestor, a person's demise needs to be one of two kinds considered to be good. The death should have been *abodweewuo* (peaceful death) or *nsramuwuo* (death at the battlefront). The main defining characteristics of a good death are age, status, and accomplishments (van der Geest 2004). *Abodweewuo* is considered to be the best type of death in Akan society. It involves the elderly, even if they had been ill (except with leprosy, apparently because of its contagious nature). It is believed that the illness leading to death, even if prolonged, is part of the phasing out process. Death at the battlefront may connote a violent ending; it is still considered good and honourable. It is accompanied by a respectable burial and funeral rites. I do not know if those who died in war at young age could become ancestors. My inquiries did not yield definite answers because people hardly gave it a thought. Others believed that such deceased people were regarded as national heroes. I assume that they are mentioned during libation, but not as ancestors.

Ancestorhood is conferred on persons of the parental generation in the lineage group. Meyer Fortes (1965), who cites mostly his better known data on the Tallensi of northern Ghana and occasionally makes references to his findings in Ashanti, has made the connection between ancestors and jural authority in the lineage. He explains that ancestors are those who had jural authority when they lived and not just those who imprint their personality on offspring by virtue of their part in bringing them up (ibid: 130). Fortes claims that it is only members of a lineage who had been invested with authority as lineage heads or as office holders in the external politico-jural domain who become enshrined in stools of worship after death (ibid). This assertion seems vague and too narrow for the creation of ancestors. Indeed, anyone who died close to or at the age of 70 and above (informants did not seem to base it on the Biblical notion of three score and ten, the general Christian belief about man's number of years to be spent on earth), was considered as an ancestor.

To better understand the Akan ideas about a good death in terms of the nature of demise, age, and status we may consider the death of an old man in his sleep during my fieldwork. He was aged 79 and the father of ten children; he was also quite successful. His burial and funeral rites came weeks after his death, well attended by mourners from far and near. The Akan appreciate this as "a long and well-spent life" (van der Geest 2004: 899), which is close to local Indian perceptions about age and good death. According to Jonathan Parry, a good death in India is a demise "after a full and complete life having lived to see the marriages of one's son's sons" (1994: 158).

Early anthropologists on the Akan, that is, R. S. Rattray and later Meyer Fortes, grappled with the constituent part of the individual which turns into an ancestor. Meyer Fortes, for instance, claims that it is not clear what essence of the person transforms into an ancestor upon death among the Ashanti. He notes:

> As to what constituent of the living person is transmuted into an ancestor, our authorities are vague and I myself never succeeded in getting a coherent account from my informants. An ancestral 'spirit' is not thought of as a kind of nebulous being or personified mystical presence but primarily as a name attached to a relic, the stool, standing for ritual validation of lineage ancestry and for mystical intervention in human affairs. In more precise terms it is thought of as the counterpart, in the context of lineage cult, of the matrilineal component of the living person (1965: 129).

I think Fortes is mistaken in his claim of vagueness. My informants' accounts and my own understandings as an Akan would throw more light. It involves the Akan view of an individual as composed of the three essences of soul, spirit, and blood. At death, the soul returns intact to its owner, *Onyame*. This seems to correspond to the Christian doctrine of immortality of the soul. There is an Akan belief that the soul is received at conception and is "a small indestructible part of God" which he gives to the individual and with it his or her destiny[17] just before birth (Sarpong 1977: 5).

While no transformation affects the soul, death converts the two other essences (the blood/body and the spirit). At death, the body, in which ran the blood, becomes a corpse (*efun*). The spirit (*sunsum*) then leaves the corpse and becomes a ghost (ɔ*saman*). The ghost goes to the abode of ghosts

[17] Destiny (*nkrabea*) is God-given too or is taken in his presence and cannot be reversed. Seen to determine the final fate of an individual, destiny is either the final words the soul receives from *Onyame* before it enters this world, or it is the soul's own description of what it would be doing when it starts life on earth. For more on the notion of destiny, see Fortes (1959) and Opoku (1978).

(*nsamanfo*) in the underworld (*asamando*). In this sense, ancestors are *nsamanfo* like any other ghosts. There are many types of ghosts in Akan society. Ancestors, however, are revered ghosts. In fact, there are only slight differences between ancestors and living elders in terms of the jural authority they command in the lineage. They are accorded "fearful respect", as Eugene Mendonsa 1976: 63) says about attitudes of the Sisala of northern Ghana towards their ancestors. Akan living elders such as grandparents go by the title *nananom* (sing. *nana*) as a sign of respect for their seniority in age and status (or rank). Ancestors are often referred to as *Nananom nsamanfo* to differentiate them from living elders and ordinary ghosts.

It is thus the spirit which becomes an ancestor, when death separates and metaphorically scatters the three human components that made the individual one whole in life. Death thus ends in a "dispersal of the various elements of a dead person", as John Middleton (1982: 140) puts it among the Lugbara. These transformations caused to the individual at death made R. S. Rattray (1954) note among the Ashanti that death was seen as generating life because it was conceptualised merely as a transition. "Like birth, [death is] from one kind of life to another," Rattray (ibid: 106) observed. Such an observation, however, is vague or seems to consider the regeneration of only one aspect of life, that is, the end of the earthly existence into the other world. In fact, two sets of lives are generated after death. First, through the Akan ritual of burial and funeral, conceptualised to separate death from life, the deceased person is sent to the underworld to begin life there as a ghost/ancestor. Secondly, through reincarnation by ancestors new lives are regenerated into the matrilineage in the world of the living.

There is no gender separation in Akan ideas about ancestorhood. Both men and women are capable of becoming ancestors in the lineage. Although it is usually performed by a lineage head or elder, any man or woman too can appeal to the ancestors to bless an occasion or a person by pouring rum on the ground in supplication. Unlike among the Nyole (Whyte 1997), there are no shrines and shelters for Akan ancestors. Instead, blackened stools, made black by being smeared with animal blood mixed with charcoal, are kept for royal ancestors and those who were lineage heads (see Rattray 1955 [1923]). Stools are the only artefacts created for ancestors. They symbolise the presence of the dead forebears. There seems to be no explanation for using stools, but I assume that its importance lies with a significant Akan practice. Each person is allotted a stool on which he or she sits for everyday activities at home, although it is not rigidly followed these days (probably due to social transformations).

Not every ancestor is given a stool. Only dead royals and lineage heads are enshrined. But they and all others receive ritual offerings and prayers from their successors and other elders on behalf of the whole lineage on occasions (cf. Fortes 1969: 189). In Nyole society, Susan Reynolds Whyte (1997) associates the graves of the dead in or near the courtyard with the sign that ancestors belong in the family. There are only rare occasions when the dead are buried in Akan homes these days. The dead are mostly buried in the cemetery a few kilometres away at the outskirts of the community. Therefore, a similar argument based on their graves as a reflection of their presence in the lineage would not be apt for the Akan. Instead, the presence of Akan ancestors is tied to the regular libation at the doorstep of lineage homes and, of course, to the stools.

Upon becoming an ancestor among the Akan, any negative attitudes the deceased may have displayed in life are not taken into consideration anymore. He or she may have been a liar or adulterer, quarrelsome or mean (cf. Fortes [1965] among the Tallensi); yet, such a person would qualify to be an ancestor in the all-important league of dead forebears in the lineage. The good death neutralises any negative traits about the deceased when he or she lived, and eulogies never mention any bad attributes. Akan ideas about death and ancestor creation then give credence to an assertion by Mircea Eliade (1977). He notes that because death is never conceptualised as annihilation in many traditional societies, mythologies about it and religious thought express transformations into a higher order filled with symbols of transition and rebirth. Symbols and metaphors about death as a paradigmatic model of a significant transition emphasize the "spiritual" function that embraces the images of birth, rebirth, or resurrection into a new and sometimes powerful life (ibid: 18).

Ancestors as an extension of Akan lineage

Ancestors are an extension of the Akan matrilineal descent group; that is, they ensure the continuity of the lineage. They do so in two ways. First, they form the spiritual end of the lineage and give the group a spiritual foundation. Secondly, through reincarnation, they renew the world of the living—that is, they reproduce the group, and they are produced again after a good death. Meyer Fortes provides an apt explanation of ancestors as the extension of the lineage. He notes that "(a)ncestors symbolise the continuity of the social structure and social relations created by kinship and descent" (1965: 137).

In the 1970s, Igor Kopytoff (1971) offered an explanation about the status of ancestors with the idea of eldership among the Suku of the Congo. This helps in our understanding about Akan ancestors in the lineage. Kopytoff explained that in Suku society the elder status is assigned to dead forebears. According to him, an elder—any elder—represents to a junior the entire legal and mystical authority of the lineage. Kopytoff says that there is a continuum of eldership, and everyone goes to his elder. Since the elders of the old people are dead, old people in the society go to the graves or to the cross-roads at night (ibid: 129-133). It also shows that the ancestors are seen as an extension of the lineage in that society. This aptly fits the Akan situation. Generational or genealogical ties are at work here in both societies. When the Akan speak of the collective ancestors commonly as *nananom nsamanfo*, the notion that the ancestors are the elders is expressed. *Nana* as a title for a grandparent (or a grandchild who would have been named after the grandparent or another elderly person) or to address the chief (because he is named after a predecessor and royal ancestor), is also a generational marker. A generational recognition is thus transferred to the dead forebears. Indeed generational emphasis is important among the Akan and any elderly person can be addressed as *Nana*.

The continuity of the lineage lies with ancestors' power to increase productivity both in humans and crops, a notion that pervades all Akan-land and is significant today. In his study of Ashanti (Akan) art and religion, R.S. Rattray noted that the notion of ancestral spirits in Ashanti is intimately bound up with the predominant emphasis on the fertility of humans and nature (1954: 120). Thus ancestors reproduce the land in a double meaning. The beliefs about reincarnation and the ability to bring prosperity to living kin members indicate the symbolism of fertility, as "the fecundity of people, or of animals and crops, or of all three" (Bloch and Parry 1982: 7). Reincarnation, a belief in pre-existence, and the afterlife are closely associated with ancestors and continuity. The underworld, which links pre-existence to the afterlife, is seen as "the place of origin of mankind as a whole" (Grottanelli 1961: 1). As the spirit of the deceased makes the journey to the land of the dead where other deceased members of the matriclan (*abusua*) meet him or her, they pass those being reincarnated. This ensures a constant flow of spirit traffic. Ancestors are often appealed to for children due to their power to reincarnate and ensure fertility.[18]

[18] The Supreme God, *Onyame*, is frequently petitioned for procreation, and the deities may be appealed to for children. 'Deity-given' children are referred to as *abosomma* (sing. *abosomba*). They may have dreadlocked hair and called *begyin*a (lit. come to stay), as a sign of their status and to forestall their suffering an early death. Rattray (1955 [1923]) talks about *begyina* children but does not explain.

Continuity is also expressed in the traditional naming of a child.[19] People are usually named after dead forebears or living senior members of the kin group (who would have been named after a long dead elder, an ancestor). This expresses identification with the particular ancestors of the group. In the child-naming ceremony, gratitude is first expressed to *Onyame*, then to the deities and to the ancestors in libation "to come and drink rum". The conversational space is extended from the physical to the abstract, and the purpose for the gathering is explained to the ancestors— to thank them and name the child given to the lineage. The participants are thus reminded that ancestors form the reservoir from which the group renews itself. Good death thus produces ancestors who reincarnate into the lineage in a cycle of production and reproduction, as shown by the arrows forming a triangle on the right in Figure 2 below:

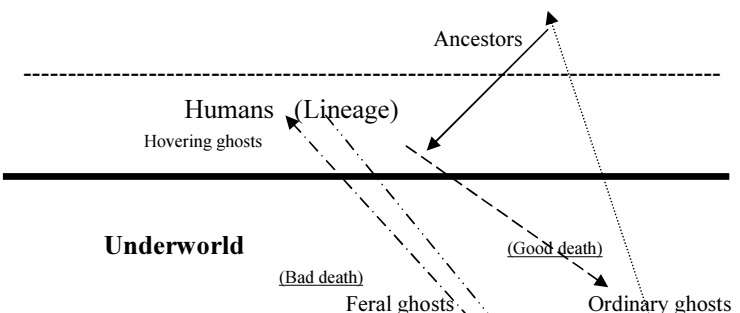


FIGURE 2: Good death, ancestors, and reincarnation: good death produces ancestors who are reproduced back into the lineage, but bad death does not allow the deceased who becomes a feral or hovering ghost, to enter this cycle.

The Akan ideas about reincarnation allow the death of man to be viewed as part of the human condition and explain existence in the underworld. When someone is seen as a direct reincarnation of a deceased forebear various criteria are employed to ascertain the fact, based on some

[19] Every child has to be named a week after birth, on the same day the baby was born, when mother and child are brought out of seclusion for the naming rites (*abadinto*) or "out-dooring". The rites, but not necessarily the period of seclusion, may be delayed due to ill health. Until health is restored, the child remains officially unnamed although the day on which he or she was born could be used. There are different explanations for the weeklong waiting period. Sometimes, it is believed that a newborn baby's ghost mother goes in search of her child, and the baby surviving the first seven days gives the assurance that it will not go back to *asamando*. Also, a newly born baby is seen as a 'visitor' and people wait for a week to be sure the visitor will not go back to where he/she came from (Opoku 1978). These two notions seem to contradict the notion of ancestral reincarnation. The Akan, however, do not seem to see that contradiction. As E. E. Evans-Pritchard said of the Azande (1976), such contradictions form part of the traditional thought.

unique features about the newly born. Resemblance in facial or other physical appearance or mere close similarity in mannerisms between the child and the particular deceased kin member when he or she lived, or some other thing convinces kin members that it is indeed their deceased member who has returned to them. A seven-year-old boy, according to one of my informants, helped to secure the original demarcation of the family land from opposing claims by a man sharing a border. The incident convinced kin members that the boy was indeed the reincarnation of their long dead relative. Since no living member of the lineage knew the actual margins of the land, the elderly challenger would have taken a large portion of the overgrown farm land but for revelations by the child. The boy is said to have persistently urged his parents and other relatives onto the land where he showed the real border by questioning the challenger: "We used to rest under that tall tree, didn't we—you in your farm and I in mine?" He then urged both parties to search underneath the tree where they would find the stone sharpener he used for his cutlass; it was there indeed. The elderly contestant went away in shame, having been exposed and defeated.

The Akan lineage members constitute a congregation descended from their ancestors. Every lineage has a single apical ancestress as a collective point of reference and social representation. The idea that ancestors are part of the lineage is that they are 'housed' in the lineage home. There is no stool for the apical ancestress, but those of the other ancestors are kept in a special place. Every maximal lineage has a house (the *abusua fie*); in a consecrated room in this house the blackened stools of certain ancestors are permanently kept, together with other ceremonial paraphernalia that belong to the lineage. Every matrilineage also has a male head (*abusua panyin*) who is assisted by a female head (ɔ*baa panyin*). The *abusua panyin* exercises authority over the internal affairs of the lineage. As the head of the lineage, he also acts as the custodian of the sacred items on behalf of the group (cf. Rattray 1929).

Lineage meetings involving the top hierarchy of the male elders take place in the consecrated room, and the lineage head may reside there if he wishes. In the past, every lineage also had its own ɔ*bosom* (deity). This is not popular any more and many feel reluctant to show it exists for the group because of Christianity. Ancestral influence in Akan thought does not express universalistic attributes. Not just anybody in the community is eligible to benefit from the ancestors. It is context-bound—limited to a specific group, the lineage. As among the Suku (Kopytoff 1971), dead members of the lineage are constantly appealed to for long life and prosperity, and in time of crises such as sickness. Akan ancestors cannot be

traced generation by generation as in Japan (Smith 1974); instead, they are lumped together as those who watch over the living and their names may be remembered individually.

There is a constant memory of ancestors, which conveys continuity. When Susan Reynolds Whyte (1997: 88) argues that because they are immanent in Nyole homes ancestors in that society can be taken as ideas of continuity, a similar notion can be expressed about Akan ancestors. Akan ancestors are immanent in the society. In the past a morsel of the meal was first put on the ground for the ancestors before people ate, which leads K.A. Busia to observe that the Akan constantly have their dead forebears in mind. People "used to offer the first morsel of food to the ancestors and to pour libation to them daily" (1954: 201). Structural changes due to Western education and Christianity in Akan-land have, however, affected this practice and it is almost obliterated because it is viewed as superstitious. I remember I used to perform this rite as a youngster, when I watched some of my senior siblings, quite young themselves, and my playmates do it. I, however, stopped it as I grew up and went to school. Today, in everyday life ancestors are not talked about and nothing shows Akan attitudes of 'respect' or 'worship' that early colonial writers and anthropologists of the 1930s to 1950s used to describe in the veneration of dead forebears. But the frequent rites ensure a constant memory, the past always brought into the present and the profane in common with the sacred.

The notion of ancestors evokes a realisation of shared links of place of origin and residence, history and the lineage. In the mythical narrative of the arrival of the groups, an ancestress is said to have led the crowd from a hole in the earth. As told by the white-haired centenarian old woman, the Kwawu, then consisting of the Aduana clan, emerged from within the earth. They came into this world at a place near the rocky mountains of the Kwawu scarp. A mythical ancestress, an old woman called Aberewa Musu, led them. The ancestress led the huge crowd, unafraid of anyone. She was said to be a witch, and people associate the Aduana clan with witchcraft. Common blood underpinning the descent principle enables people to categorize themselves in metaphors of 'who I am' and 'who we are'. This is known in relation to 'those who brought us into the world'. The Akan say they are the descendants of a common forebear or refer to 'our dead forebears' in common expressions. Consequently, references to an apical ancestress and other ancestors in the lineage create an important social identity. This also indicates unity since they conceptualise themselves to be of a common stock, which people constantly remind themselves and each other of.

The Akan mythical ancestress is never traced in concrete terms or may be traced to few generations. Unlike in Japan where the ancestor of origin is not worshipped at a tomb but at a shrine (Smith 1974), the Akan lineage ancestor of origin is not worshipped at all. In fact, while there is an abundance of myths about the supreme God, *Onyame*, there are few about ancestors; these concern origin stories. The many myths about *Onyame* and only a few about ancestors may be indicative of the Akan recognition of God first. In the Akan belief system the universe is created by *Onyame* as the supreme God. He is the all-powerful and the source of all life, despite the Akan belief in reincarnation. There is also an important point about the lack of myths about Akan ancestors. This concerns the widespread eligibility to Akan ancestorhood. For instance, in Hawaii there are many myths about ancestor kings (or chiefs), about mythical figures who became 'gods' (Sahlins 1985). Royal myths seem to dominate the traditional narratives of Hawaiian cosmology and society, and only royal kings become ancestors (see Kirch and Sahlins 1992: 24-25). In contrast, Akan cosmology is open to all because anyone could become an ancestor in the lineage by dying at an old age with descendants. The encompassing group is the matrilineage. Hence, there will be no particular myths in a society as the Akan where everyone is capable of becoming an ancestor. Hawaiian cosmology is also different from that of the Akan in terms of corporate lineages. According to Sahlins, the Hawaiian society was "not a world of determinate kinship groups, as in the anthropological tradition of corporate lineages" (1985: 19), which Akan society is.

The ideology about Akan ancestors assumes great fondness among fellow clan members from distant localities. A member of the Kwawu *Aduana* clan, on migrating to, say, Fanti-land in the coastal region of Ghana, may show up to the corresponding *Aberadze* clan and would be regarded and treated as a kin member. He or she enjoys some rights and there are some duties to perform. The sojourner clan member usually pays funeral contributions (*ayieaseto*כ) to the host clan as required of any other member; conversely, contributions are collected for the sojourner in bereavement, and members may accompany him or her to the home village for the funeral. It is through ancestors that maximal exogamous matrilineages form clans, which unlike lineages, have a wider social frame of reference to the maximal ancestress. In Kwawu clans were sometimes also referred to as *nton* (cf. Bartle 1978); to ask someone to which *nton* he or she belongs is the same as asking which larger *abusua* he or she is from.[20]

[20] In anthropology, there is a distinction between family and lineage/clan. The Akan, however, do not make such a distinction in their everyday language; *abusua* could mean

I have recently been fascinated by ideas about ancestors as extensions of the family in some holistic Asian societies, ideas which come close to those of the Akan. In China, for instance, ancestors emphasized the continuity of familial lines. The holistic nature of the society was expressed in the belief that the family was a closely-knit group of both living and dead relatives rather than as individuals loosely comprising the group. In Japan, ancestors are seen to maintain an abiding concern for the continuity and prosperity of the house because they retain full membership in it after death (Smith 1974: 56). Among the Akan, there is a constant presence of the spirits of the ancestors in the life of man on earth, which brings the world of the spirits close to the land of the living (Busia 1954).

The Akan matrilineal system as an important cultural category closely tied to the structures and functions of the social system finds expression in the continuity of the lineages created by the ancestors. Matrifiliation foremost allows membership in a local matrilineal descent group whose members trace their genealogy to a common apical ancestress. As a fundamental corporate group with social, religious, political, and economic functions the Akan *abusua* is a major index for relatedness, identity, and the sense of belonging. There is also a link between matriliny and patrifiliation in the notion of ancestor creation in the matrilineage. This relates to the notion of the *sunsum* (spirit, derived from the father) of the deceased which becomes an ancestor in the matrilineal group. It shows the holistic or encompassing nature of the matrilineage, or that it is 'democratic' enough to recognise the significant paternal role in the individual's formation.

The authority of ancestors

In traditional Akan thought, all authority is vested in ancestors. Living persons may have authority in some situations, especially those that deal with everyday issues. But the authority of the living is not absolute. It may also be subject to challenge. In contrast, the authority of Akan ancestors is pervasive and absolute. Authority, as used here, subscribes to Weber's definition and is important to conceptualise the place of ancestors in Akan society. Max Weber defined traditional authority as a position which rests on established belief in the sanctity of immemorial traditions and the legitimacy of the status of those exercising it (Eisenstadt 1968). Ancestral authority is the key to the workings of the kinship system in traditional

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clan or lineage or family. The notion of *nton,* however, should negate any assumption that the Akan do not differentiate between the three concepts. In the context of this study, however, I use the ideas interchangeably, as the Akan talk about them.

Akan religious thought, even to the reproductive capacity of the group and society.

Akan ancestral spirits are regarded with profound respect and revering them consists of ritual relations with those deceased forebears, but it is not synonymous with the worship of the dead. Rather, the ancestors are thought to exist for mystical intervention in human affairs. Ancestors must be remembered frequently in order not to incur their anger for being ignored and to make them constantly watch over the lineage. As a result, ancestors in Akan conceptions are not "mere ghosts" such as in Lugbara thought (Middleton 1982: 137). They are prominent and active players in the lineage organisation.

Libations and animal sacrifices honour ancestors, and society reminds itself in rites to propitiate them. This is an aspect of the authority of ancestors. They command respect and the honour to be 'fed', their existence constantly expressed in the lives of the people. As Daryll Forde (1954) has pointed out, belief and ritual tend to mirror the scale and degree of social integration. When attention to ancestors is contravened, it is conceptualised that the society will suffer misfortunes. The usual food of mashed yam is offered together with rum as the main substances to the ancestors. When animal sacrifices are made on ceremonial days, the ancestors eat the blood of the slaughtered animals while the matrikin enjoys the meat. In this way, as among the Nyole (Whyte 1997), the living and the dead share a meal in the same way as (living) family members do. Scholars on Akan ancestral practices list countless ritual occasions when ancestors are 'fed', including Akwasidae, Odwira, the new harvest season, and on ordinary days when necessary. Feeding them gives credence to the belief that ancestors continue to live the same kind of life they led when on earth (Busia 1968). In the past (and sometimes even today), water was placed in front of homes or on doorsteps (but not at the grave sites at the cemetery) for ancestors visiting the homes to drink.

The manifestation of the authority of Akan ancestors is also found in land ownership. Ownership is expressed in two forms—spiritual or sacred and secular. Because ancestors are conceptualised to be the sacred owners they are also the true owners of the land on which Akan society is situated (cf. Rattray 1929; Busia 1954). Humans are secular owners, and this status is subservient to and made possible by ancestral ownership. Lineage (or family) land, regarded as an inalienable object, may not be given out or sold largely because of this ideology. The land belonged absolutely to past, to present, and to future generations yet unborn (Rattray 1954).

Its economic significance aside, the Akan system of land holding essentially organises social relations between humans and the sacred beings. The farm produce (including livestock) is attributed to the benevolent actions of *Onyame* and the ancestors, both of whom are appealed to for good rains to ensure good harvests. They are thanked for the fruits of the season and requests made to them for rains in the next season. In the past before a farmer started a farm he (it was not common for women to offer libation on their own) would sacrifice a fowl or offer libation on the land (cf. Busia 1968). This persists in the rural areas and reveals its continuity and social relevance as a practice in honour of the ancestors and for the good of the farmer.

There are secular rules and regulations in the effort to ensure an ordered world, but an important context for ensuring that order is found in the ideology about the ancestors. Social order and moral behaviour are spiritually sanctioned by ancestors and physically enacted by humans on earth. Social order is thought to start with the individual in relation to his or her social existence. Social order and local contiguity are high moral values in Akan society. A stress on good behaviour and good neighbourliness is usually to show that they are for healthy coexistence in the community. They are also the tenets handed down from the ancestors who must be obeyed. The idea is constantly played out that the individual does not live in isolation, that he or she is a social product and part of the individuals who create the matrilineage. There is thus an encompassing structure which is in-lineage.

The Akan high regard for courtesy to other people, altruistic behaviour, exchanging greetings with known and even unknown others, a respect for seniors and older people, and to be there for kin members and neighbours in time of need is for the good of the community. It also pleases the gods and the ancestors. The social system of the Akan was (and still is, because colonialism and Christianity could not completely obliterate traditional thought) organised around the belief in ancestral spirits who could punish the living for misdeeds or reward them for good behaviour. Studies about ancestors in Africa generally postulate them as good (in the real meaning of the word) for the lineage and its descendants (McCall 1995). The Akan provide a vivid example.

What contribution, then, do ancestors make in the understanding of Akan social representation, religious ideas and social order? On becoming ancestors, dead lineage members also become perpetual guardians and judges of kin morality (Opoku 1978). In the past, the ancestors were believed to be the custodians of the laws and customs of the society (Busia

1968). Today, they are still thought to be constantly watching the moral conduct of their descendants, although such notions have waned. In this regard, one sees both persistence and change. The ancestral role in African societies is often portrayed as a key component in the maintenance of jural authority, land tenure systems and segmentary social organisation (McCall 1995). In Akan society, notions of ethnicity, community, maternal descent and other relations—the components of every individual's sense of himself or herself in a multiplicity of social identities—are ensured through ancestors.

There should be a strict adherence to what is sanctioned by the sacred beings, in line with the Akan high regard for respect and recognition of seniority (in age, status, knowledge and experience, or rank). Such is the extent of the authority of the ancestors. In the 1970s, the study of African ancestors culminated in a heated debate over the difference between ancestors and living elders. It was initiated by Igor Kopytoff (1971) in the *Africa* journal, and continued in *Ma*n well into the 1980s. Kopytoff (ibid) rejected the conceptual separation of the world of the living from the world of the dead. He relied on his own data from among the Suku to argue that there was no significant difference between the respect accorded ancestors and living elders. Therefore, the terms ancestor 'worship' and 'cults' should be replaced with 'eldership complex' for a true reflection of how the two groups of elders are viewed in society.

Kopytoff's uneasiness about the words 'worship' and 'cult' is obvious and appreciated. But, then, his uneasiness can mainly be seen as a problem of semantics. Indeed, to use those words to describe the Akan beliefs and practices would not be a true description, but Kopytoff's suggestion does not paint the right picture either. About the Akan practices, it may be better to describe them as ancestor 'veneration' or 'reverence', even though to me, whether they are viewed as 'dead elders' or 'respected ghosts', is beside the point. What is important about beliefs concerning the authority of ancestors is "the significance of cosmological ideas" in relation to material conditions of life and the total social order (Forde 1954: x).

Honour is done to the ancestors both in general and in particular ways, and the honour is important for cosmological ideas. People are expected to lead upright lives; this means they have to obey and follow what the ancestors have sanctioned. To live this way is to be a source of honour to one's family or lineage and not to bring its name into disrepute. In that way, the ancestors, who have passed through the lineage genealogy, are honoured too. Uprightness guarantees a continued ancestral protection and ensures that living individuals become ancestors in future.

The individual enjoys security and protection from a dominant lineage and ancestral ideology, which sanctions right conduct in social relations (ibid: xvi-xvii). The traditional Akan society achieved considerable social decorum based on its strict adherence to ideals of life and ethical values that also had (traditional) religious foundations. Religious, moral, and social principles were, and still are, community-centred because these norms are regarded as pleasing to *Onyame* and the ancestors, which also promoted communal well-being. When the lineage is protected, it in turn promotes the well-being of its individual members.

C. J. Calhoun (1980: 2), drawing on the insights of Meyer Fortes about the Tallensi, argues that the people need not search for signs of the existence of ancestors. Rather, they look for signs of the will of ancestors. Among the Akan, moral behaviour and values, strictly followed, are assigned to the satisfaction of the ancestors. The ancestors sanction the relationships among members of the descent group by giving supernatural support to the wielders of traditional authority. They also threaten mystical retribution to members of the group if they should be at fault. There is thus ambivalence about ancestors in the respect for them on the one hand, and the fear of them on the other. Good death (and through that ancestors) ensures the creation and affirmation of the legitimacy of an ideal social order. This order (and the society itself) is threatened when bad death occurs.

Bad (AIDS) death as blockage

In Akan society, any death that cuts short what should be a long life full of accomplishments is a bad one (van der Geest 2004). Bad death is generally grouped into two categories: *atɔfowuo* and *ammumuwuo*. Deaths from lorry accidents, suicide, drowning, and victims of homicides are all *atɔfowuo*. On the other hand, the demise of a pregnant woman or during childbirth or through an abortion is *amumuwuo*, the other type of bad death. Most of these deaths are sudden and premature and both kinds of death are generically referred to as *atɔfowuo*. It is obvious that bad death lacks social recognition; it is not easily incorporated into cultural frames (Romanoff and Terenzio 1998: 704).

The Akan classify many kinds of death as bad. They include death from lightning, epidemics, or that of those whose demise offended the Earth goddess (witches, suicides and those sold into slavery).[21] In the past, deaths from illnesses such as leprosy and tuberculosis were extremely bad. Better medical services have seen such illnesses virtually eliminated from Akan

[21] Jack Goody (1962) says similarly among the Lodagaa of northern Ghana

society; it is rare to find someone who died from, say, leprosy. But attitudes about them seem unchanged. The death of infants before they were weaned is bad because infants are not regarded as full humans; they are sometimes viewed as beings of the wild that frequently come back to life to worry parents. One can say that sudden and violent deaths at young age and from some strange illnesses result in a double loss to the lineage or clan. There is the physical loss of the deceased and ultimately it is a loss to the whole society because it fails to produce ancestors into the matrilineage and thus threatens the continuity of the group. AIDS, because it is regarded in Akan-land as strange, easily lends itself to end in bad death.

Akan ideas about death and spiritual existence in the underworld are situated in terms of status and recognition. By the Akan theory of dishonourable deaths those who end this way are not given any recognition in *asamando*, the land of the dead. Bad death actually turns the deceased's spirit into a feral or wandering ghost (*saman twentwen*), hovering around the threshold with no good intentions. The wickedness of wandering ghosts is said to be ferocious, and they are imagined to be angry that their lives were cut short. They return to the earth mostly to cause mischief and havoc—such as to strike people spiritually with illness and eventual death.

Hertz (1960) explains that the soul [among the Akan, ghost] is capable of visiting misfortune on the living kin members when they are provoked because death imbues it with power. Such was the wickedness of a hovering ghost in a story at a funeral in a Fanti town one day in 2003. My inquiries about a 40-year-old woman revealed that she had been dead almost ten years. She died because her late senior brother 'struck' her spiritually, an important cultural category in illness aetiologies. The sister shunned him when the man was suffering from an undiagnosed illness. She would not go near him and when she took his meals to him she placed them disrespectfully and unsympathetically, very much against the Akan norm of respect for seniority. After his death the man's ghost 'struck' his sister to make her suffer a similar fate as he had. Not long after, the sister was taken ill with similar symptoms and she died. People explained that the male ghost had become a hovering one with no abode since he was not accepted in *asamando*. He was still young to have died at 44 (cf. van der Geest 2004). Their family members did not suspect and would not discuss anything suggesting AIDS as the cause of both deaths.

Because they do not bcome ancestors, wandering ghosts fail to enter the cycle to reproduce society, as shown in the two arrows on the left in Figure 2. It may have been for this reason that people who died in such a manner in Akan society were in the past buried furtively in an accursed

grove far away at the outskirts of the community. This was practiced among other Ghanaian ethnic groups such as the Ga of southern Ghana (see Field 1961). The practice has waned considerably these days in Akan society, but traces remain and people are still buried in such manner (especially unknown or unclaimed corpses), as happened to Kwaku B in the opening story. In India, those who suffered bad death were thrown into the river Ganges (see Parry 1994).

If they are not buried furtively in an accursed grove, those who suffer the abominable *atɔfowuo* in Akan society are interred almost without delay, as happened to a 14-year-old schoolboy who was knocked down by a car at a village. One bright sunny morning in February 2004, a few weeks before I left the field, I came upon a gathering of school children in their uniforms in front of a house. Not in school that day, a weekday, the pupils had gathered in the house of the teenage colleague who had died the previous day in the accident. He was to be buried the following day. As the usual practice, the pupils joined the procession to the cemetery. It was indeed a pathetic scene. Apart from his close family members and a number of schoolmates, there were not many mourners and, I was told, there would be no funeral rites. Fitting it into Robert Hertz's (1960) perspective, the deceased school boy's social being was not fully grafted upon his physical being by society. Being a youngster, he had died without leaving children behind and without accomplishing much in life.

The demise considered a bad one lends itself to moral evaluation. In the past, it was perceived as punishment for wrongdoing (Opoku 1978). A great sense of shame characterised those who wilfully caused their own demise. Suicide among the Akan, very much like in many traditional societies, is bad death *par excellence*, to put it in the words of Bloch and Parry (1982, original emphasis). The value of life being so strong in Akan society, suicide is seen as defeatist and a failure to face stoically the vicissitudes of life. In pre-colonial Akan society, the one who committed suicide was not dealt with leniently, a situation that also characterised instances of the chief's role as a ritual specialist through whom misfortune to the society was averted. The traditional ruler judged the deceased and declared him (often men) guilty of taking his own life (see Busia 1968: 71).

Suicide was a crime because it was believed to pollute the land and bring misfortunes to the society. The corpse was always found guilty and the punishment was beheading (ibid). This verdict was announced to the gathering and in libation to the Earth goddess, who was thus appeased and was expected not to be angry with the whole society. These days, the corpse is not beheaded but it may be whipped, jeered at or simply insulted and the

rite to appease the Earth goddess must be enacted. Equally abominable and dangerous is a pregnant woman who fails to deliver the baby inside her and dies with it. She has not only failed to add to the number in the lineage but she has subtracted herself too from it. Dishonourable too was the death of a woman who attempted an abortion, just as anybody who died childless.

Although many deaths are outright bad, others can be turned into a good one after some rites have been performed. The possibility of making 'right' a bad death means that there are some exceptions regarding the kind of death. Just as it falls outside good demise, an AIDS death is also outside the chance to be rectified. Deaths that can be rectified mostly concerns lorry accidents (and sometimes drowning in the sea) for which rites may be performed 'to draw home' the ghosts of the deceased, especially if he or she was quite old. There was no such rite during my fieldwork, but as a native growing up in Akan society I have watched many instances. An instance of this occurred some years ago in a Fanti village after a lorry accident. Kin members of a 62-year-old woman trader among those who died instantly performed the rites at the spot a few days later to 'draw her ghost home' to their village many kilometres away. Offering libation at the spot where the accident had occurred, a lineage elder called on their ancestors to see them through a successful rite. After the ritual, they never looked back at the scene as the group returned to their own village. It is explained that to look back would destroy the whole process and fail to pull the ghost home.

There are many grey areas as part of classifications about bad death, pointing to ambiguity. For instance, the death of young people as a result of illnesses is 'bad'; however, it has no specific name. It is agreed that such a death is not violent or sudden, yet it does not fall under *atɔfowuo* or *amumuwuo*. On the surface, the grey areas indicate no clear separation between good and bad death. The grey areas are mainly the result of transformations due to outside influences such as Christianity (and probably Western education). Church burials are popular in Ghana, and they do not seem to make a separation between good and bad death as the traditional Akan religion does based on such variables as the manner of death, age, descendants left behind, and status. For the churches and their adepts who pay up their tithes (*ntosodu*) or annual fees, a good death is when the church buries them and is present (even if represented by a group) at the funeral. A bad death, for such churchgoers, is when the church refuses to bury them if the deceased member failed to pay the monthly and annual fees. The church may also refuse to perform the burial rites of those who were irregular at church services and other events.

The church is not the only contributing factor to contemporary ambiguities about good and bad deaths. Sjaak van der Geest (2004) has pointed out other influences too, such as the financial status of the deceased. The social standing of the deceased causes uncertainties about a death which would have straightforwardly been regarded as bad. The wealth of the individual or the family (lineage) often attracts many mourners and people equate a well-attended burial or funeral event with success at its organisation. So, could a wealthy person who died of AIDS have a well-attended burial or funeral, associated with a good death? That is, can money overcome and turn a bad death into a good one?[22]

My inquiries did not yield any straightforward answer, for a plethora of reasons. People do not associate the rich with AIDS, perhaps because such people have money to eat nutritious food and remain good-looking. When the rich suffer afflictions in Akan society it is usually attributed to witchcraft or sorcery due to envy of their wealth; this suggests that HIV/AIDS is largely associated with poverty. Moreover, since opportunistic infections always set in at the latter stages of AIDS, the cause of death could always be attributed to that illness rather than to AIDS per se. This was the case of a rich man in one of the Kwawu towns who was known to be a womaniser. When he died of AIDS [because he is believed to have infected his wife who received counselling at the Holy Family Hospital at Nkawkaw and was known to me], it was attributed to "a strange illness". AIDS was never mentioned, and his wife did not talk about it in public.

Lineage role is strong in creating the idea of bad death. Close family and kin members decide the time for burial due to the jural authority of the lineage over the individual and because the lineage springs into action when a member dies. It always is the practice that those who have long been ill (except the elderly) are buried almost immediately without much ceremony, perhaps because people show apathy in attending the funeral of those who die after a protracted illness. All who died from AIDS while I was in the field were buried in such manner, indicating that their situations were treated as bad deaths. Even where the church is ready to bury the deceased irrespective of the form of death, or even if the deceased had money that would overcome the notion of dishonourable death, the lineage seems to always follow tradition. The church's influence and the wealth of the deceased or family may ensure a well-attended burial, but conceptually it still remains a bad death according to traditional Akan thought. All in all, bad death spells doom for the deceased individual by turning him or her into

[22] My attention was drawn to this question by one of my supervisors, Professor Karen Armstrong.

a feral ghost and blocking his or her chance to become an ancestor, while it blocks the chance to reproduce the lineage.

3. FUNERARY RITES: FOR THE LIVING AND THE DEAD

It is the duty of the Akan matrilineage to bury its dead member and organise the funeral rites. These rites send the deceased off properly to the land of the dead. Ethnographic literature from the beginning of the twentieth century and more recent accounts have shown how Akan funerals are significant for their religious role in the society. Funerals also mirror an important area of the encompassing nature of the matrilineage in the holistic Akan society. The group sends the dead member off and through the rituals ensures the welfare of its living members. It does this in many ways; first, it creates sociality and social relations out of the death rituals, which help members to quickly forget their sorrow. Again, it fills the vacuum created by the deceased with a successor, and through inheritance it ensures internal circulation of property and economic resources. There is also a collective representation and members feel a sense of belonging to an *abusua* that buries them at death (if circumstances permit).

The Akan matrilineal descent group springs into action for funerary rites at the loss of a member, although critics see a major contradiction about the lineage's interest in organising funerals. Where members of the lineage may have neglected the deceased in life, organising the funeral on his or her behalf attracts the criticism that the *abusua* is more interested in the corpse (*abusua dɔ fun*) than in the welfare of the person when he or she lived (cf. van der Geest 2000). People sometimes find it nauseatingly hypocritical that someone who was neglected in life or even during the illness that resulted in death is treated specially, the *abusua* spending millions of cedis to organise a lavish funeral. But others see the lineage role as reflecting the unity expected to exist in such a closely-knit social group. Many people feel that in matters about the death of a member, all past misgivings within the lineage need to be ignored. The lineage should be the prime group to bury its dead member.

In her discussion of Akan custom and death rituals in the face of conversion to Christianity in Akuapem (also Akwapim), Michelle Gilbert (1988) observes that funeral rites in the Akan society are arguably the most important social and ritual event in an individual's life, Christian or non-Christian. She demonstrates that death and its rituals reflect social values among the Akan and are an important force in shaping them. Funerary rites reassert and reflect the social order which is threatened by the death of a member of the group (the lineage, the community). Akan funerals are the most elaborate in relation to other rites of passage— birth and naming, marriage, or the completion of schooling or a vocation (ibid: 297). As I.

Chukwukere (1982: 63) has rightly emphasized, the people's mortuary behaviour embodies "the most consequential life-crisis rituals of the Akan generally". An interrelatedness of social, political, and religious ideologies structure Akan funeral rites as an important rite of passage.

I attended so many funerals during my fieldwork that I lost count of them unless I referred to my notes. None involved AIDS deaths (or were not spoken of as such, even if it may have been so).[23] Some involved my relatives, many of whom died in old age, including a ninety-year-old queen-mother from my father's side. Many others involved mere acquaintances or people I did not even know when they lived. Nevertheless, I had to attend because a member or two of my own kin were attending and asked me to come along. It was necessary for my study, although my relatives who invited me did not see it that way. Even if I was not engaged in fieldwork, as a native, I would still have been expected to attend once I learned about the event. It is almost obligatory. How people view funerals in Akan society may be guessed from the short conversation below which I had with a lineage elder at the funeral of an old man in a town in Kwawu.

Perpetual Crentsil (PC)*:*	*Opanyin (Elder), what if the funeral rites for a deceased person are never performed?*
Elder*:*	*Eh?* [His countenance changed for a moment]. *But, that is not a good omen. It means the personm is given no respect and has not been treated as a human being. It is animals for whom funeral rites are not performed.*
PC*:*	*Hmm?*
Elder*:*	*Yes… if the funeral is not performed on behalf of a deceased individual, it means he or she may have died an abominable death, from a strange illness or something like that. Funerals are not performed on behalf of strangers and unknown people who die in the vicinity, and also children.*

It was obvious from the man's briefly transformed countenance in the conversation that failure to perform the funeral rites on behalf of someone is an outright disaster.

There is a paucity of ethnographies or detailed study of Akan funerals, such as Jack Goody (1962) has done among the Lodagaa of northern Ghana. Given their popularity and religious role, Akan funerals need a rigorous

[23] Even if it involved AIDS deaths, it was not easy to know. Family members of the deceased do not discuss it. In Ghana, records of each death are kept at the Births and Deaths Registry in major towns and cities. However, the public has no easy access to information about them. The hospitals too adhere to confidentiality (cf. Radstake 1997).

study. Akan funerals are closely connected to ideas about the all-important ancestors and people's intimate relationship with these revered dead forebears. My main aim in this chapter is to examine the importance of funeral rites in the Akan society and the matrilineal group's role in organising them. I also focus on how bad (AIDS) death prevents the matrilineal group from organising funerals. As will be clear later, this denies members of the group the opportunity to come out of grieving (or to reduce it), even if conceptually. Akan funerals can be placed within Victor Turner's (1969) view of rituals generally as ensuring change from one status to another. Rituals "connect the known world of sensory experience with the unknown and invisible realm of the shades [spirits]" (ibid: 15). My endeavour is also an analysis that follows the anthropological view of death as a challenge to order in a society, and funerary practices become ways of transcending individual death to restore order.

One of the first detailed works on burial rituals was by Robert Hertz (1960). Although criticised for using second-hand data searched from the British Museum (see Evans-Pritchard in the Introduction to the English translation of Hertz's book), Hertz's three-sided analysis concerning the treatment of the corpse, the fate of the soul, and the fate of the mourners was highly insightful. He maintains that death rituals see to the sending off of the corpse to a distant land of the dead. Like his teacher, Emile Durkheim, and his friend Marcel Mauss, Hertz (ibid) was concerned with collective representations, which he found in death and the rituals associated with it. Death is a challenge in Akan society because of the loss and sorrow it creates. Whenever it occurs in the matrilineal group, various practices emerge. The events involve properly sending the deceased off through burial and other rites, and also allow the living members to mourn and thus relieve the grieving. Ideas about death rituals are important for the understanding of Akan religious categories and how they order social life. Ritual and social reality are closely linked; they reflect a religious ideology and a human relationship with the sacred.

The Akan matrilineal group and sending the dead off

Every death in Akan society necessitates a burial and after that the funeral rites. The holistic nature of the Akan group and the jural authority of the lineage over the individual is prominent during death rituals. At the moment when a member dies, the lineage head's duty is to take charge of the mortuary arrangements and observances, and to preside over the eighth day, fortieth day, and one-year anniversary obsequies (cf. Fortes 1969: 187).

Unlike among the Zulu (Ngubane 1976), where a woman is the chief mourner in recognition of womanhood and women's role as repositories of tradition, among the Akan the lineage head is always the chief mourner, supported by other lineage elders. The roles and responsibilities played in the organisation of funerals are not arbitrary; they are hierarchically ordered and enacted. It is the responsibility of the matrikin, represented by its head, to formally inform people when death occurs within the group.

In his analysis of death rituals, Robert Hertz (1960) demonstrated that in many societies much anxiety surrounds the failure to send the deceased off properly to the land of the dead. According to Hertz, there is the belief that if the dead is not seen off properly it will spell doom for the living members of the group. Hertz had many theories about death practices. Regarding sending off the deceased properly, he explained that the souls [ghosts among the Akan] of the dead watch the mourning of relatives sharply. The dead exercise their power and retribution if members of the group do not properly fulfil the duties towards the deceased. Hertz further explains that the fear of doom to the group is motivated by the belief that death has endowed the soul of the dead person with magical powers (ibid: 36). This is true of the Akan. The failure to perform the funeral rites on behalf of a kin member, where it was deemed possible to organise them, is always regarded as an anomaly that must be rectified.

The importance of Akan funeral rites is that they classify domains of action and social standing. The *abusua panyin* personally informs the chief or headman of the village by presenting an amount of palm wine or rum. He also informs the heads and members of the other lineages. Later, he sends his representative and other emissaries to present other people with drinks as a reminder (*nkae nsa*) or to formally inform them about the funeral rites. In the past the *nkae nsa* consisted only of an amount of palm wine (drink that seeps from a felled palm tree). It was first taken to the chief of the village to announce the death, and heads of the other lineages too were presented with similar drink (Busia 1968). During the post-burial ceremony of those days, people were expected to make reciprocal donations in such items as foodstuffs, pots of palm wine, and bundles of firewood to the bereaved lineage to help defray the costs. Structural changes have been vast and have seen a huge shift. Nowadays, the reminder usually consists of a bottle of schnapps (gin, sometimes even imported) and two thousand cedis (about 50 US cents in 2003). The essence of the reminder is an expectation of a reciprocal monetary donation, known as *nsawa*, to the bereaved lineage during the post-burial funeral event. Lineage members usually decide the

timing for burial and post-burial events, which kinsmen and kinswomen (as well as neighbours and friends) attend from far and near.

Overseen by the lineage head, duties are allotted. Women typically engage in such household chores as cooking to serve mourners with food. Young women and girls sweep the houses in which the main activities take place, such as the room in which the corpse is laid in state and other places where visitors are housed. Men usually see to the purchase of drinks, which these days are made up of cartons of beer, Guinness, schnapps, and the locally distilled, vodka-like *akpeteshie*. Men in the kin group, usually helped by other men in the community dig the grave, erect sheds and do other manual jobs. This means that the brothers, sons, nephews or grandsons of a man or woman generally act as the gravediggers. This group may also include sons-in-law or brothers-in-law. Generational considerations are always at work in this respect. Ideally, younger men dig the grave of an older man; where there are only a few young men in the kin group, their friends and other volunteers readily undertake to help, either for free or for a token fee of a bottle or two of local rum.

Akan custom stipulates that the father (or his successor) is responsible for the funerary rites of his child (Gilbert 1988). The grown-up children (or the mother's brother, *wɔfa*, of very young ones) must provide the coffin in which their father or mother is to be buried (cf. Chukwukere 1981). In addition to the coffin, the children also provide the funeral garment (especially the shroud) and toiletries used in decorating the body after it has been washed in preparation to be laid in state. It is considered a big disgrace for the children of the deceased not to be able to bury him or her. Where the deceased child was a married woman, her husband cooperates with her father and the woman's matrikin for the enactment of the rites. It is common for conflicts to erupt involving all three sides related to the deceased—the spouse, the matrikin, and the father of the deceased. Such disagreements can occur at the death of a woman as well as a man.[24]

Funerals are typically performed on weekends because it is the free period from work schedules, and people can travel from places of work to the funeral venues. Margaret Lantis (1940) has assigned a reason relating to Akan beliefs about omens. She suggests that funerals and other practices of the Akan (Fanti) are performed based on beliefs about the days. According to her, the seven days of the week are possibly derived from "some sort of horoscope complex" that divides the days into male and female (ibid: 154). The male days are Sunday, Wednesday, and Friday; the female days are Monday, Tuesday, Thursday, and Saturday. Both categories have their

[24] See Gilbert (1988) for conflict about a dead rich man in Akwapim in the late 1970s.

peculiar characteristics, prohibitions, and prescriptions. Marriages, funerals, and other ceremonies of life-crisis nature must take place on female days. It is believed that if a funeral is held on a male day, then more deaths will occur in the family. The notion of bad omen extends to administering (herbal) medicine, especially internally such as enema, in the nostrils, or orally. People usually remind or advise others not to administer the medicine on a male day.

There are four stages of a typical Akan funeral— preparation of the corpse when it is washed without wailing, pre-burial mourning when the body is laid in state, the burial, and post-burial mourning, which includes a public ceremony when people express their condolences through donations (Opoku 1978). In the past before someone died, water was poured down the throat of the dying person with the words that he or she should not permit any evil to befall the living relatives and all women in the household should bear children (see Rattray 1954: 149). Rum was poured down the deceased's throat ostensibly to enable the corpse stay the process of decomposition if the person died far away from home.[25] Funerary rites followed an almost continuous process in those days. There were no hospitals and no refrigeration for embalming, and the colonial authorities insisted on an early burial before the body decomposed and became a health hazard (Arhin 1994). Social changes in Ghana have seen many transformations in the organisation of funerals. In the recent past, because rural-urban migration was minimal, when someone died almost all family and kin members could be contacted within the vicinity and the necessary arrangements were made for burial and other rites within days. This was done, however, in a way unlike the immediate disposal of those who suffer abominable death.

It is difficult today, due to migration, to get all family members informed; they may be scattered all over the region, in other regions of the country or even abroad. Also, the schedule of work may not allow some family members to come home early enough; the best option is to preserve the corpse and wait for their arrival. The funeral rites may be delayed also because lineage members take time to find the money for the event. A 69-year-old woman who died in a Fanti village was locally embalmed for two

[25] Rattray (1954: 149) observes that the idea of embalming was not unknown in Ashanti, among whom he conducted an extensive study in the 1920s. The author recounts an example of the Ashanti way of embalming when, for example, a great man was killed in war or died far away from home. In that case, the intestines would be removed through the anus and the abdomen stuffed with some leaves, while the corpse was placed on a rack and smoked over a slow fire. There are many other ways, including wrapping the body with a beaten stalk of the plantain tree (which I witnessed in one instance myself) or pumping cement mixed with water as enema into the body of the deceased.

days while the kin members looked for money for the event. She was buried on the third day when some initial amount was secured from members of the lineage. The main funeral rites waited until a year and a half later, when a bulk sum for the rites was gathered from her children and other kin members. The long periods characterising most funeral rites are easily used to gauge the life and status of the deceased as well as that of the family or lineage. The availability of hospitals and mortuary facilities today enable dead bodies to be prepared at the hospital and kept there for weeks, if not months or even years[26] before burial and funeral rites.

Libation is offered from the moment of death to the end of the rites. Libation is offered as soon as the individual 'gives up the spirit' (Busia 1968). This usually continues intermittently until the beginning of the funeral rites a few days, weeks, or even months later. Most deaths occurred at home in the past. Today, a very good number of deaths occur at the hospital, and libation cannot be enacted at the point of death. But before the corpse is taken home from the mortuary of a hospital, libation is offered. When death occurs at home, libation is offered before the corpse is taken to the mortuary while preparations are made for the funeral. Libation is thus an important part of mortuary rites, whether in traditional or Christian burials. Before the coffin is lowered into the grave, libation needs to be offered if it is a traditional burial. If it is a Christian burial libation is offered before the corpse is washed. But at the graveside the officiating priest, minister or pastor and other church members pray in the Christian way. Either way, both performances express and ensure man's continued relationships with the sacred.

It is the desire of every Akan to be buried in his or her native village. Like the Nyole (Whyte 1997: 92) who live in towns, death, burial and mourning rites tie people in Akan society to their 'real' homes. They come home for funerals and their bodies are brought home for burial and funeral rites. Thus, death (yours or that of a close family member) brings you home. In the past, this was so strong that the Kwawu, for instance, who worked in the capital city, Accra and died were never buried there. 'The person has been brought home' (*yɛde no aba fie*) is constantly used for those who died elsewhere and were brought down to be buried in their village of origin. In this regard, home has both a spatial and symbolic sense. The link between home-coming and mortality is anticipated when fatally ill people are removed from the hospital, a shrine or the premises of a spiritual church and

[26] I heard a story that because of disagreement [my informant said 'litigation', very common in such times of death] between two families the body of a rich man had been kept for more than 10 years at the mortuary of a hospital in Accra.

brought home to die. People make considerable effort to arrange the transportation to return the corpse to its home in the lineage house (*abusua fie*). Today, this practice is waning; people who died working in Accra are sometimes buried there. Even the funeral rites, which used to be performed only at the native village, are nowadays performed at the place of burial and not the home village.

The body is usually washed on Friday, in the early hours of the morning. It is then elaborately dressed up to be laid in state and for a wake to be kept till next morning. Although funeral rites in Akan-land are very much public, washing of the corpse to be laid in state is exclusively private. It is usually the preserve of close kin members who take pride in ensuring, if possible, that an outsider does not see the nakedness of their deceased relative. Many families prefer to conduct much of their own affairs concerning the washing of the corpse. Elderly women in the neighbourhood often help to wash the corpse of people in other lineages, but grown-up women of the bereaved lineage keep a close watch.

The ideal, however, is for women of the bereaved lineage to do the washing without recourse to the services of an outsider. Two reasons may account for this. First, there is usually the fear of petty gossip about the deceased. The second reason is to do with fears associated with sorcery or bad medicine. If someone was guilty of causing the death, he or she may fortify himself or herself by securing body parts (hair, cut nails, etc.) from those who wash the dead body for the medicine of fortification. People washing the corpse of their own lineage member clearly minimises social relations with others in the community. But many are ready to sacrifice social relations to avoid rancour and ill-feeling due to gossip and evil machinations by others, which could generate a worse crisis. After being washed, the corpse is elaborately decorated and laid in state in a similarly decorated room. The lying-in-state is a very important period for two major reasons. First, it allows mourners to file past the corpse and to pay ‘their last respect’, as it is usually said. Secondly, it allows the bereaved group to show off their wealth and to ‘display’ their reputation as good organisers.



PHOTOGRAPH 1: A corpse lying in state as mourners file past it.

Burial usually takes place on Saturdays at the cemetery (*amusie*, from the verb *sie*, to hide). In the past, it was common for people to be buried in the home (cf. Rattray 1923). This seemed to involve lineage elders and others in good standing in the group. In contemporary times, this practice has declined, although traces remain. Cemeteries are usually situated a few hundred metres at the outskirts of the village or town. There is usually a royal cemetery where chiefs are buried and a separate one for the public. The graveyard is usually referred to as public cemetery. In the public cemetery each church has its own portion of land where it buries its dead members. A portion of the public cemetery is also reserved for the burial of those not Christianised. It is usually called *Amamfo amusie*, which roughly translates into public cemetery. Much prestige is associated with a Christian burial. It is generally viewed as a disgrace for a Christian to be buried at *Amamfo amusie*.

In times past funerals made it possible for the coffin containing the corpse to be carried on men's shoulders through the vicinity to the cemetery. There was no motor hearse to carry it to the cemetery (this still occurs in the villages). Carrying the coffin was sometimes also used to discover who had killed the deceased by witchcraft, sorcery or other spiritual means. It is not practised any more, but it was seen as an important mechanism for redress. The carriers became possessed by the ghost of the dead person. They could not move if a witch or sorcerer who may have caused the death lived in a house nearby. The so-called culprit was often detected. Both Margaret Field (1960) and K. A. Busia (1968) offer an interesting explanation about the so-called culprit. They claim that the culprit was thought to have been found

only because someone became jittery or that a fetish priest explained the possession as due to acts of witchery. Banishment or jeering at the perpetrator was the suspect's punishment.

Akan funerals are a vehicle for maintaining and authenticating social order. They show in a pertinent way that the Akan have a social system where social balance and the well-being of individuals, the lineage, and the whole community are linked to the practices of individuals for other individuals and for the group. Although noted for their grandness and emotional qualities, Akan funerals can sometimes be more underpinned by the "politics of reputation" than the religious function (van der Geest 2000: 103). The role of the lineage in this 'politics of reputation', as in the whole idea of funeral rites for the dead, is immense. A prestigious funeral event is always viewed to have been performed to the satisfaction of all, and the lineage in particular obviously finds glory in it.

'*Ayie*': removing the sorrow

Funerary rites mark the completion of the immediate rites when a person dies. The rites are the immediate ones because there are others, such as the fortieth-day and the one-year anniversary, although they are less elaborate. For the living (mourners), the rites enable them to come out of their mourning and sorrowful state. They come back to the state of normalcy, which the death altered. A major point in Hertz's theory was that death rituals enabled the living group members to come out of the mourning period (he says the liberation of the living). Both Hertz (1960) and van Gennep (1960) emphasize the transitional or processual nature of death and its ritual practices in many traditional societies. Van Gennep discusses the ways in which the theme of transition dominates funeral symbolism. He developed the three-part structure and significance of most rituals in man's life, which he phrased "rites of passage". He identified the three phases in the rites of passage as separation, liminality, and reintegration. Victor Turner (1969), building on the insights of van Gennep, has taken it further, especially concerning liminality, which he defines as 'between and betwixt'.

The liminal and ambivalent stage after death is a period in which the borders between the spirits and the living become temporarily fuzzy. All mourning rites— those preceding burial and the post-burial ceremonies— are public. Yet, death brings about a period when the mourners are conceptually cut off from the rest of society. They have conceptually been polluted by the death, even though it is only their member who is affected physically by his or her demise. Subsequently, Akan burial and funeral

events are an enactment to indicate the completion of the period of separation when the group is in a liminal state, and after that the affected group can be reintegrated into the society. The Akan word for funeral rites is *ayie* (to free/ to pick out of something). *Ayie* can thus be understood to free the deceased as well as the living members from the status caused by the individual's demise.

Funerals are important for prescribing socially recognised mourning behaviours and to facilitate grief resolution (Romanoff and Terenzio 1998: 697-8). When it is the death of an elderly person, people take consolation that the deceased lived a long life. Consequently, mourners wear white, especially for the thanksgiving service on the Sunday during the funeral period. The grieving is not expected to be intense. Indeed, the death of an elderly person who has lived a life of emulation is synonymous to the level of joy at the arrival of a child as a new member of the lineage. At the birth of a newborn child, both mother and child dress in white clothes for about six months. Hence, the brochure containing the programme for the funeral event of an elderly person usually reads: "A Celebration of Life".

In contrast, the grieving is intense when a young person dies. Claude Levi-Strauss (1973: 232) has pointed out that death, in every society, is natural because it is inevitable. It is also anti-cultural because it is a loss for both the close kin members and the community as a whole. This is important considering Durkheim's works in social theory on sentiments expressed during funerals. Wailing becomes the expression of the attachment that is now physically severed. Grief and sorrow are real in the lineage at a member's death in Akan society; the tears are demanded by social custom and a token of genuine grief (Rattray 1954: 151). This will better be understood when put in the perspective of Hertz (1960) about why people feel a sense of loss at the death of a member of the group.

According to Hertz, death destroys the social being grafted upon the physical individual to whom the collective consciousness had attributed recognition of status and roles, which now must shift or be completely obliterated (ibid: 77). Not much grieving characterised the deaths of the AIDS patients in Kwawu, which means that not much of their social being was seen to have been grafted on their physical lives (or was it that they had been drastically reduced—a form of stigmatisation?). On the one hand, when a person dies, society loses in him or her much more than a unit, for society is "stricken in the very principle of its life, in the faith it has in itself" (ibid: 78). On the other, it is the individual alone who is affected physically by death. People feel obliged to shed tears and feel the sorrow of parting with the dead kin member or friend. A collective representation and

solidarity with the group are generated when people 'weep over the corpse' or 'weep at the memory of it' if it has already been buried. Not to weep is seen as being untouched by the loss and thus being hard-hearted, which the Akan abhor. Any hard-heartedness is seen as evidence of acrimony between the deceased and the other party, which the Akan eschew too, particularly when it is extended into death. Weeping is also thought to be therapeutic. Thus, one of the major characteristics of an Akan funeral is its power to alleviate grief.

A. R. Radcliffe-Brown's (1932) assertion (among the Andaman Islanders) that funerary rites are dictated by traditional norms is important for the role of funerals in the lives of mourners in that society. For him, funerals are the means by which the society acts upon its members, compelling them to feel emotions appropriate to the occasion. For Maurice Bloch (1982: 218), in many societies death is seized upon as an opportunity to create an ideological construct of social order that is legitimate. This helps to understand the Akan funeral rituals. People advise others to attend more funerals as a show of solidarity; it also expresses reciprocity or the anticipation of it. The usual advice is that when one attends funerals, "other people will get to know you and do similarly when you are bereaved too". When they were convincing me to attend funerals with them, my relatives would usually remind me to show solidarity by evoking the Akan saying: "*Wo nyɔnko da ne wo da*" ('A friend's day is your day', which is close to the English maxim—'A friend in need is a friend indeed').

The serious nature of death in Akan society is expressed in the colours worn for the funeral rites. Colour symbolism is an important status marker and appropriately signifies the event. As already mentioned, white clothing is usually worn at the funeral of an elderly person and for the thanksgiving church service on Sunday. In Akan colour metaphors, black and white are unambiguous (McCaskie 1992). White is the colour of success, victory, joy, and spiritual purity; it is usually worn after successfully giving birth to a child. Black (and other dark colours), on the other hand, connotes negativity; black is used for death and funerals because it expresses sorrow, regret and mourning. Red symbolises the life and death aspects. It has a volatile mix of feelings, of strong emotive sentiments such as impurity, danger, anger and defiance (ibid: 233). It is also associated with war and witchcraft (cf. Rattray 1954).

An important Akan disposition towards the colour red helps to understand its relation to death and the state of mourners.[27] *M'ani abere*

[27] At other times, red symbolises freshness and good health, such as when the blood of an animal killed in ritual is bright red. Also, women and girls in their private conversations

('my eyes are red', that is, bloodshot) is a common locution that signifies the dangerously anarchic confusion characterising an emotional state which combines aggression, sorrow, rage and despair (McCaskie 1992: 233). When a young person dies, one practice is for people to tie a plain red cotton cloth around the wrist, the head or the neck during the mourning period. In Kwawu, every *abusua panyin* as head of the lineage and the chief mourner hangs a piece of red cloth around his neck to signify his[28] status and it also symbolizes the state of *anibere* he is in. When lying in state every corpse is decorated in white apparel in which it is buried. This ostensibly indicates that the deceased, even though overpowered by death, has in turn conquered the phenomenon because it cannot visit again. The mourners, however, wear black, brown or red because death is negative and leaves people in a state of anxiety and confusion.

At the moment of death, close kin members must wear dark clothes with minimum activities of joy, such as having birthday parties, to mark the period of separation. At the end of the funeral rites, the mourning clothes should be discarded (except those of the widow or widower that last until the first anniversary) and the lineage head advises members to go back into their usual daily lives, signifying (re)incorporation into the society. Funeral rites have thus been seen as cultural devices to facilitate the preservation of social order and provide stability to the group. In accord with the dominant concern for them, Akan funerals are the key idiom of reference for institutionalised relationships, concerning who to make funeral contributions to (Chukwukere 1982: 63).

The descent group's prominent role at the death of its members is given concrete expression at the post-burial rites. The head of the lineage or the wider clan sits in the front row under a shed[29] with other male elders of the lineage and watches over proceedings. The spatial arrangement of mourners at the funeral grounds follows a pattern of order. Members of the bereaved *abusua* sit in the front row under a shed specifically made for the occasion in the vicinity. In the sitting arrangement, all the women of the lineage are seated behind the men.

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with each other sometimes speak of how red their menstrual blood had been, and this is taken for a good sign of fertility.

[28] Men usually become lineage heads; a woman assumes the office of *obaa panyin* and is usually in charge of women's affairs in the lineage.

[29] In Kwawu, funeral rites are organised at a place built with concrete cement and asbestos roofing as a permanent structure at an open space for that purpose. At other places, canopies made of tarpaulin are erected; in the villages the shed is made of bamboo poles at four corners with palm fronds for roofing.



PHOTOGRAPH 2: Male lineage elders usually sit in front, while women of the group and others sit behind them at funeral events.

People who arrive at the funeral grounds are expected to greet by shaking the right hands of most members of the bereaved lineage, at least those sitting in the front row to express their condolences. This differs from the casual everyday greeting when people exchange regards. Greeting by a hand shake is generally with the right hand, and such greeting at any gathering is from the right to the left. I presume that the emphasis on the right is because the left hand is regarded as unclean, used for filthy things such as cleaning oneself after toilet.

There is a significant aspect about clanic and totemic identification that concerns funeral rites. Like Zande clanship and totemic differentiation (Evans-Pritchard 1961: 116), there is a complexity about Akan clans and totems. Many elderly Akan talk with pride about their clans, totemic animals and what they stand for; but many others, especially the youth, only vaguely know about the clans.[30] It may be assumed that clanic identification is of little importance in the lives of its members beyond creating a context for relatedness, however vague, among members from distant localities.

The religious significance and collective representation about Akan clans show strongly at funerals. The clan of the deceased must be in attendance, the head of the lineage seated in front of the group with the staff of the clan's emblem or totem. As Claude Levi-Strauss (1963: 5) has

[30] For example, many people do not know that the Amoakare and Adaa clans in Kwawu were created as offshoots of Aduana, which had grown too big, in order to facilitate further chances for marriage; an Aduana woman is today deemed fit to marry an Amoakare man. They no longer make monetary contributions into a common clan's coffers. Also, the dog (ɔ*kra* or *kraman*), the totem of Aduana, is said to have been in front of the group with fire in its mouth as they emerged into the world; thus, the *Aduana* pride themselves with the invention of fire.

explained, totems express a homology of relationship between social groups and the natural species and give the group their identity and recognition in the Durkheimian sense of enhancing group solidarity. Through the presence of the matrilineal group, the deceased is recognised as a legitimate member of the social group. Because funerals were not performed on their behalf, those who died of AIDS in Kwawu missed out on their clanic identification.

The funeral event is the best place where the children, grandchildren, and great grandchildren of the deceased are introduced to the other members of the lineage and people take great consolation in their presence. Even where the deceased did not have children, his or her long life is assumed to have produced many friends, which expresses the idea that the deceased was 'amicable' and 'loved by all'. A well-attended funeral event, with its high level of sociality, often also emerges as courting grounds. There are many instances where a marriage, so important for the Akan in terms of procreation and legitimate children, has been established after the couple met at a funeral event.

Funerals as social events

Another importance of Akan funerals for the welfare of the living in terms of removing sorrow concerns the social aspect. Akan funeral events have always been and still are big social occasions and a sign of status for the deceased and the lineage. They provide the context for the family or lineage to affirm its prestige and to celebrate its excellence at organising such events (van der Geest 2000). The status of both the deceased individual and the lineage thus depend heavily on it, which means that status, in terms of the individual's social standing, and the type of death are closely connected here.

When a funeral is to be held, kin members and other people do not go to the farm, or they are sure to return early enough to attend. Those working outside their home villages or towns, sometimes in other parts of Ghana, come back to their hometowns to attend funerals, demonstrating kinship and other ties (cf. Gilbert 1988; Bartle 1978). For the purposes of this study, I view the sociality about Akan funerals as part of the mechanism to help the living lineage members come out of their sorrowful state.



PHOTOGRAPH 3: Such socialising is very common at Akan funerals

In their study of how death is celebrated in various societies, Huntington and Metcalf (1979) have pointed out that the importance of funerals is equally placed in organising the society of the living. They contend that the continuity of the living is more palpable reality than the continuity of the dead. Consequently, it is common for life values of sexuality and fertility to dominate the symbolism of funerals (ibid: 93). The two authors were concerned with celebrations of death. In a cross-cultural approach, Huntington and Metcalf demonstrate the varieties in forms of mortuary rituals in various societies, including Borneo, Madagascar, ancient Egypt, and Renaissance France; they conclude that although death is universal, there is no simple explanation of death-ways as universal psychology. They used their findings to consider American death rituals and they argue that American death-ways are not irrational and strange than they appear to some social critics (p.3).

Funeral rites among the Akan have become the costly public displays of the sacred 'send-off parties', whereas the birth of a child, the entry of a new member into this world (which should ideally have brought 'joy to the world'), is much more subdued. It is treated as a private affair and marked by a brief, relatively simple ritual performance.[31] Perhaps, the somewhat wanton revelry at Akan funerals is to be understood. A joyous mood is required to counter the sorrow about death. Brass band music, rhythms from amplified sound systems, and gospel music by church members characterise many an Akan funeral. People are allowed to dance intermittently during the proceedings of mainly announcements of donations at the post-burial ceremony. Food must be prepared and served to mourners for the duration of the event. A variety of food may be served— kenkey (a fermented boiled

[31] See Margaret Thompson Drewal (1992: 51) for similar observation among the Yoruba.

maize meal) and fried fish, rice and stew (these days packaged in small plastic containers called 'take away'), and candies. The food may be served at the deceased's home or at the family/lineage house or at the funeral grounds. Funeral occasions are usually associated with feasting.

Akan funeral events these days attract much concern, regarding revelry and what many see as the questionable behaviour of mourners. People worry that funeral grounds today are fast becoming avenues for lax sexual behaviour which invariably increases the incidence of HIV infections. Other problems, including adolescent reproductive health and teenage pregnancy, rape, and defilement of minors are fast being associated with funeral celebrations. Ideas of revelry and sexual laxity are not new; in the past, sexual abstinence was not enjoined on those taking part in the funeral rites. Relatives were enjoined to have intercourse with their wives on those occasions, although it did not apply to the wife of the deceased (Rattray 1954: 150). Other sexual themes were apparent. Food was prepared after the burial for the couple who lost their child. Husband and wife were enjoined to 'eat', which has a double meaning because to eat (*di*) stands for both commensality and copulation. The worry today is about the level of sexual laxity and the rate of offences associated with sex during funerals.

Akan funerals produce sociality and social relations but are also associated with drunkenness and frivolity. As far back as in the colonial days, frivolity at funerals in most parts of Akan-land was a matter of concern to the authorities. In June 1912, the Commissioner in the Central Province was worried about drunkenness at funeral celebrations and submitted a report to the Secretary for Native Affairs. The letter said that gin drinking at funeral customs had largely superseded the practice of indulgence in palm wine[32] on funeral occasions. The Commissioner felt that the effects were "more deleterious but over indulgence in palm wine, which also has intoxicating effects when drunk fermented as it always is, and other stimulants has long been considered a fitting and necessary feature of funeral customs". When a funeral custom was being held in a village, men of all ages from the Chief downwards had been seen in varying stages of intoxication, the Commissioner claimed (ADM 11/1/43).

Earlier in April 1912, an official letter from the Colonial Provincial Commissioner's Office on the discussions of drunkenness at funerals, which had been ongoing in the Colonial Offices for some time, did not seem to see

[32] Palm wine seeps from a felled palm tree. The whitish juice is used to distil the stronger and more potent vodka-like tasting *apketeshie*, nicknamed 'Kill-me-quick' or 'Don't mind your wife' as just two of its numerous sobriquets. *Akpeteshie* may also be distilled from cane sugar made into molasses. Because it is cheap, *akpeteshie* is one of the favourite drinks at funeral ceremonies today.

any problems with people enjoying themselves for a brief period. The letter expressed the view that drunkenness at funerals was being "slightly exaggerated", and called attention to the fact that "the natives use a funeral custom as *one of the few occasions when they give themselves up completely to a short period of thorough enjoyment*" (ibid, emphasis added). But it was obvious that minds were already made up in other quarters of the Colonial office. A few months later, in September 1912, there was a letter from the acting Secretary for Native Affairs (who signed the letter). It expressed misgivings about expenses and drunkenness at funeral celebrations, and called for a circular to be sent to all chiefs on the procedures for conducting funerals and to "restrict the consumption of liquor and reduce extravagant expenditure" (ibid).

Today, things have not changed; funerals turn into merry-making without the shedding of tears at the memory of the departed. It is common to see men and women very drunk at funeral grounds or indulging in sensuous interactions. This reminds me of a scene I witnessed at a funeral occasion in one of the Kwawu towns one day in August 2003. A Kwawu man had attended the funeral ceremony of a friend's relative with his wife from the Ga ethnic group (in the Accra area of Ghana). As the tipsy-looking husband and two of his friends chatted up a young local Kwawu girl, the man's wife who had been conversing with friends dashed to the scene, fuming with anger. She had no case with the girl, as it were, who slipped quietly out of sight; the onus of the wife's anger was on her husband. Without a word, a dirty slap went from her to the man's face. "Be very, very careful, you [name]; you and your friends had better be very careful with what you are doing," she warned the men. Turning to her husband again, she shouted: "Did I accompany you all the way from Accra to let you look at another woman's vagina?"—a question that drew both giggles and chagrin from onlookers.[33] Funeral events are seen as grounds for women especially to 'fish' for men. Beer bars open and are almost always filled with drinkers. Some women virtually 'pull' men into the bars to buy them a drink. Sometimes, weeks before the event some women estimate how well an upcoming funeral will be attended and make preparations; they sew new clothes and buy shoes and bags. Most women in the society also attend funerals to flaunt their wealth and material possessions—expensive and

[33] It was apparent that those who giggled saw the scene as funny. But the majority countenanced a repressed disapproval—first, that the woman slapped her husband in public; secondly, for her to have complained publicly at her husband's 'escapades' with another woman; and thirdly, for being too profane and mentioning the female genital organ in plain words and not euphemistically, viewed as the way well-mannered people communicate such words in public generally in Ghana.

glittering jewellery and wax print cloths, especially the one known locally as *Me ba wo aborokyire* (My child is abroad), as a status marker. This cloth, a brocaded material, is said to be imported from abroad and is more expensive than the locally made ones. It was the funeral cloth in vogue in 2003.

Akan funerals also contain various status markers. It greatly depends on a deceased person's high status and the availability of money in the family. Whether or not the funeral rites can be prolonged over many days, weeks, or even months after death in order to organise an elaborate funeral with many mourners in attendance is often dependent on the deceased's or the lineage wealth and his or her status (although this is not usually the criterion). There are distinctions for the funeral rites involving commoners, lineage heads, and chiefs.

The death of a chief was kept secret in the past for a period of varying length until his burial in the royal mausoleum. Many people were killed to accompany and serve him. Gold dust was put into his coffin to enable him pay for the fee and be ferried across the river of death. The chief was then buried at midnight because he was not to be seen to die (cf. Rattray 1954). In contrast, ordinary humans were buried at the public cemetery, with less or no gold dust, and they were buried in the daytime with no killings. Today, people are not killed to accompany a dead chief on his spiritual journey. But other practices have persisted, such as different amounts of money spent on the funeral rites of chiefs and ordinary people, which indicate variations in status as well as continuity and change.

The Colonial Provincial Commissioner's office noted the considerable variations in the expenses on funerals in 1912, which ranged between 40 and 150 pounds sterling for a head chief; that of ordinary people cost between ten and 50 pounds sterling. But the records also noted that sometimes "a wealthy local man, even though not a chief, was capable of attracting more spending on his funeral than many of the chiefs," (ADM 11/1/43). Nowadays, a huge sum of about twenty five million cedis (about 2,906 dollars in 2003) may be spent on the funeral of a chief or a rich person and it is usually viewed as a prestigious event; the funeral of an ordinary person may cost a few million cedis. Three of the many funeral rites I attended in the field involved royals— two chiefs and a queen mother—and were particularly remarkable. Each of the three funeral events occurred more than three months after the deaths. They were big occasions that were celebrated with great pomp. The two chiefs were aged 73 and 63, and the queen mother died at 90 years. Since all of them were members of Christian churches, Christian burials and funeral rites were performed alongside the

traditional rituals such as drumming and the firing of muskets. Other chiefs in full regalia attended from many surrounding areas.

The social significance of Akan funerals is expressed in the frantic efforts to complete business activities on Fridays in order to attend the event. In Kwawu, when around 3 pm on Fridays, ambulances blow their sirens through Nkawkaw as a gateway to towns and villages on the Kwawu scarp, it signifies the occasion as much as it creates a traffic jam. Funerals in most Kwawu vicinities are characterised by huge crowds and heavy traffic. Because many Kwawu towns have single main roads, they are usually blocked to ease congestion. Cars are redirected to use a bypass to allow people to walk about; where there are no bypasses, the traffic jams can be imagined. People seem satisfied with the great number of mourners who attend the event: *ebae oo* (it was well-attended) is the usual post-event comment with smiles for many days. But there is also concern about the economic aspect of funerals. The economic and social concerns are taking precedence over the religious (customary) importance of funeral rites (see Arhin 1994; de Witte 2003).

Funerals, transfer of property and economic significance

It is a fixed principle of the Akan social structure that at death every member of the group must have an heir and successor (Fortes 1969: 173). This is also part of Akan religious thought. A successor is named for the deceased as part of the funerary events. The transformations recorded about Akan funerals have not affected this. From R. S. Rattray's recordings of Ashanti culture in the first two decades of the last century to this day, the naming of a successor and heir takes place at the end of the mortuary activities. The successor (*odiadefo*) is chosen and announced on the day the funeral expenses are calculated, that is, on the Monday immediately after the rites the previous weekend, as already mentioned. If he or she is present (and not residing elsewhere too far away from the community) the inheritor or successor is shown to the lineage members.

The purpose of inheritance and succession is to quickly fill the gap and resume normal duties again. Thus, continuity resides in the status and property inherited from the deceased (ibid). Such an observation has been made by Max Gluckman (1970: 66), who sees the persistence of the social structure in the replacement of a dead man by an heir among the Zulu. Succession and inheritance play a major role in the social ordering of the Akan, and funerals are the context for enacting the society's customs about them.

Lineage property has to be inherited only by a member of the matrikin; in contrast, self-acquired property can be given as a gift to anyone the deceased so wishes. The Akan inheritance and succession system stipulates that property and status are transferred from the mother's brother (*wɔfa*) to sister's son (*wɔfase*). It is, however, a more complex principle than the usual examples given in anthropological explanations. When a man's brothers are available, a consideration of generational seniority stipulates that the line of brothers must be exhausted before the right to succeed passes down to the next senior genealogical generation of sister's sons.

There are gender issues about inheritance. A man inherits from another man, when it is said that he has taken over his 'gun'. A gun (*otuo*, pl. *atuo*) was in the past, and still is, a symbol of authority and economic importance. Guns are important for hunting and protecting farms from pests. When negotiating marriage in the past, lineage elders had good reasons to refuse giving their girl to the suitor if he did not own a gun. Guns thus indicated status and were used as an important instrument of recognition. Women inherit from their mothers, sisters or female cousins, and are said to have taken over the deceased's 'hoe'.

The inheritance of a man's 'gun' or a woman's 'hoe' does not mean it is the instruments of production that are passed on; the successor also inherits the deceased's social and political status. Although men inherit from fellow men and women from fellow women, a woman may inherit from a man if she is the only suitable candidate. Inheritance by women is not as complex as that of men, for rarely do men inherit from women. Is there any reason behind this? An elderly woman informant asked back: "How would the man take the woman's place among other women in the community, or how would he wear or use her clothes and other possessions?"

As among the Lodagaa (Goody 1962), succession and inheritance among the Akan take place only after death and the funerary rites. A potential successor or inheritor may already be known but he or she can never assume that role until after a person's death. The deceased's property is also not distributed among lineage members until after the first anniversary, when the room in which they were kept and the boxes are 'opened for the first time after his death'.

During the post-burial ceremonies two tables on which are locked boxes for collecting monetary donations (*nsawa*) are placed separately in front of the bereaved *abusua* as well as representatives of the community. A mourner entering the funeral grounds first finds the "*oman*" table, which belongs to the Town Development Committee (TDC), and monies collected are used to develop the town. The contribution for town development (*oman*

*to*כ) is two thousand cedis (about twenty five US cents in 2003). After the *oman* table is the *abusua* box for collecting the *nsawa* to the group. The *nsawa* ranges from the smallest amount of two thousand cedis to the biggest sum one can afford. This is different from contributions generated within the *abusua.* In my mother's lineage of the *Aduana* clan, it is stipulated for members to pay five thousand cedis (or more if one chooses) when a lineage member dies. All members of the extended family and the clan make monetary payments to the bereaved family to financially support the organisation of the rites. It is not usually binding on people to pay both the internally-generated contributions and the *nsawa*. Also, the bereaved parent(s), spouse, or the children usually have their own box for collecting donations.

At the funeral grounds, people usually get to know the clan they are to pay nsawa to. In their own lineage they are informed about how the cost of the funeral is to be defrayed, such as selling the farm of the deceased. Thus, one function of funerals is that one gets to know the people one cannot marry. As an old woman explained to me, one cannot marry someone with whom he or she pays contributions into the same lineage coffers, which means they are related by 'blood'. Every major donation is announced to bereaved members by a male elder and the group acknowledges it with a murmur-like '*hɛɛ*' in appreciation. Another form of informing about donations is done by someone who makes announcements in a public address system fixed at the funeral grounds (in Kwawu, it is usually done by a popular man nicknamed 'Kwawu Announcer'). Lineage elders inform the announcer and he announces it to the crowd, which is expected to say '*hɛɛ*'. Women of the bereaved lineage are asked (by the head or other male elder) to 'return' the good gesture with hand-shakes to a major donor who sits elsewhere at the funeral grounds.

There is an aspect about Akan funerals and their economic importance that does not concern the transfer of property or the funeral donations to the bereaved lineage. It involves the financial input in organising the event and can been considered as part of the transformations about contemporary mortuary events (see de Witte 2003; Arhin 1994). But it also marks the persistence of funerals. Both Kwame Arhin (1994) and Marleen de Witte (2003) express levels of concern about the monetary aspect in organising Akan funeral events today. De Witte is of the opinion that dealing with death and the mortuary practices surrounding it has become a very lucrative business among the Akan. She is not alone with these sentiments.

The commercialisation of funerals provokes much worry and public debate in the media. Like de Witte, many people feel that making money out

of death evokes negative sentiments of avarice and selfishness. As de Witte (ibid: 532) has noted, money is an evil that dries up the emotional attachment and compassionate values of bereavement. An average Akan funeral today costs about three million cedis (about five hundred US dollars in 2003), but families usually go for an extraordinarily elaborate event and spend more than 10 million cedis. Some decades ago, Margaret Field (1960: 33) suggested that a major part of people's earnings from their cocoa farming was spent on funerals (among other endeavours such as litigation, sponsoring young relatives' education, and travelling distances to visit medicine men). Funerals continue to attract a huge expenditure. The huge spending may be for fame and self-aggrandisement, but people are also convinced that it must always be grand and expensive to honour the deceased (cf. Arhin 1994; Witte 2003; van der Geest 2002).

In a study of funerals among the Ashanti, Marleen de Witte (2003) has observed that planning and organising the event is like running a business; it involves an intricate game of accountancy. If the organisers are not careful, it can easily end the lineage in a big debt. A number of factors may account for a loss in organising the funeral event. The Ghanaian value of hospitality expects the bereaved family to host well the many people who travel from far and near to mourn with them. Huge sums of money are needed to cater for the food, accommodation, drinks, music and other logistics. Although it is seen as callous to expect the tearful and sorrowful bereaved family to combine the almost incompatible roles of mourning the dead and hosting a feast for the thousands of sympathisers, this is exactly what happens. The lineage may also opt for an expensive coffin and other items for reputation. Again, every Akan may have some mourning cloths, but usually lineage members wear new ones for each funeral occasion in the group. Some bereaved families use the funeral occasion to solicit for funds from all quarters, although many end up with less than they had spent. The *nsawa* to help defray the costs may also be far below the expenditure.

There may be misgivings about recent trends and the commercialisation of Akan funerals, but there is an "economically useful" aspect (Arhin 1994: 318). Other people use the occasion of a big funeral to sell their wares. It is common to find dozens of sellers, mostly women, selling everything from candies to cooked food or herbal medicine at funeral grounds. Others use the occasion to print T-shirts with the deceased's picture (whether with permission from the family elders or not) to sell, making money out of the situation. At one funeral event in Kwawu, a man selling such items initially bragged about how many pieces of shirts, head bands and handkerchiefs with the deceased's picture he had sold by eleven

o'clock in the morning. When I wanted to know how much he had sold he was evasive, as are most people about their money. "Later!" he said.

The danger of bad (AIDS) death

In Akan society, bad death does not motivate funeral rites; for instance, funerals are not organised on behalf of children. Adults who die from long-lasting illnesses are usually buried without any elaborate ceremony. Their bodies have to be quickly disposed of. Today, those who die of HIV/AIDS are often treated in such manner. Thus, bad death affects the single most important ritual connected with death in Akan society—the post-burial funerary rites. Funeral rites are necessary as a device to fulfil the religious and social orders, but when bad death occurs they may not be performed because such demise goes against societal norms. This ends in a multiple loss because apart from religious and social fulfilments, funerals have economic and political (traditional authority) significance.

The significance of Akan funerals for the welfare of both the living and the dead makes the fate of those whose funeral rites cannot be performed indeed pitiable. It also means that conceptually, the living lineage members do not have the chance to 'free' themselves quickly from the sorrow. The question then is, if funerals properly send the dead off, why are they not performed irrespective of the death and to help alleviate the sorrow? Answers to this question seemed vague. Sometimes, people merely explained that "it is not done" or "it is against the tradition" to organise the funeral. Others feel that the suffering of those who have been long ill is already too much that their corpses need to be disposed of without delay. It seems to me that such has been the tradition all along. I am not suggesting that it should be abandoned. I am only trying to point out an example of how the Akan can be strict adherents of tradition.

Every death shakes the fabric of society. The sorrow aside, the vacuum left by the deceased and the role he or she played in life need to be filled to ensure continuity. These important cultural categories were missing about the AIDS deaths I witnessed. No one was chosen to inherit from any of the HIV/AIDS patients who died. There was only one instance in which someone was named to replace a deceased AIDS patient. The patient's junior brother is said to have elected himself to replace the deceased man. It was just informal, only among some of the siblings. Although it indicates some recognition to the deceased in the family, it falls short of the 'proper' way of succession and inheritance where the chosen person is formally

announced to most of the lineage members after the post-burial funeral events.

There are many ambiguities about funerals. Funeral rites may occasionally be performed on behalf of those who suffer abominable deaths. For instance, whether the 'drawing spirit home' ritual is performed or not after a motor traffic accident, the deceased from this unfortunate incident may have one of the well-attended funeral ceremonies. However, this does not negate the death as bad. Another ambiguity lies with Christian burials and the notion of bad death. In an article on the notion of dying peacefully in Kwawu, Sjaak van der Geest has noted Christianity's role in the changing notions of good and bad deaths. He points out that the firm establishment of Christianity in Kwawu society has made its impact on the experience of good and bad death (2004: 906). Indeed, Christianity has gained firm roots in Ghana ever since it was introduced during colonialism. It has assumed a dominant role in people's lives. Churches today play an influential role in most social and cultural gatherings, in weddings, and in crusades they organise to 'win' new converts. Burials and funerals are an important area in which church involvement is dominant (ibid; Debrunner 1967).

Most church members attend the funeral rites of deceased colleagues. Christian burials and mourning rites can be heavily attended and prestigious. Mourners sing hymns and other gospel music to the accompaniment of drums and dancing. It is obvious, too, that funeral grounds have become avenues for many churches to 'win souls' by converting others into their fold. In this context, the religious significance of funerals lies in both traditional religion and Christianity. A prestigious funeral is therefore a major reason why people convert to Christianity—in order to have a 'fine' funeral (Gilbert 1988).

As already mentioned, bad or good deaths in the way they are conceptualised in traditional thought seem not to concern the churches. For their adepts who pay their tithes (*ntosodu*) or annual fees, a good death is when the church buries them and is present (even if it is only a group from the church) at the funeral (cf. van der Geest 2004; Debrunner 1967). A bad situation is when the deceased's church is not present at the funeral grounds. This is felt the more when no other church is willing to bury the deceased. Two of the patients who died of AIDS during my fieldwork were buried by the church they belonged to because, ostensibly, they had been good church members. But they were the only two deaths out of the ten I witnessed directly in the Kwawu area.

Notwithstanding the church's involvement in burials which traditionally would be conceptualised as bad, the traditional notions about

bad deaths persist. As already indicated, whether there will be funeral rites or not, and whether the burial is hurriedly performed is usually decided by lineage members. But the attitude of mourners also counts; many are not motivated to attend the event of someone who has been long ill. Many bereaved families have always been guided by this fact. Funeral rites are thus a social category dictated by tradition or norm. The jural authority of the lineage over the individual, and the group's central role in funerary rites are indicative of that.

4. CHIEFS, ANCESTORS, AND WELL-BEING

One important aspect of the holistic and encompassing nature of the Akan matrilineage is in the smooth running of every Akan village or town, largely centred on the chief as the ruler of the community. Maintenance of order in the community starts with the selection to the high office of the Akan chief. The chief is not picked at random from any group of people or even from just any lineage. He is selected exclusively from a royal matrilineage. This is usually the group whose ancestress and other ancestors first found the village and are thus the custodians of the land. Chosen exclusively from the royal lineage also means that prescriptive and elective qualities combine in the selection of the chief. The candidate counts on both his ascribed and achieved statuses. Once in office the chief represents the whole community. When a chief is removed, another is picked from the same royal lineage to replace him, which reflects the persistence of the matrilineage. My concern here is with the political power of the chief, which he derives from his ancestors, as much as it is with his religious authority, also derived from the ancestors (Gilbert 1994).

Studies of traditional Akan political organisation have shown the importance of descent in the existence of the office (e.g., Rattray 1954; Busia 1968). The high premium on the traditional political system through which the traditional governing of the people in a settlement is enacted is felt at all levels of the society. In fact, the concept of office, mainly based on matrilineal descent, is manifested in all domains of Akan social life (Fortes 1969: 139-145; Kallinen 2004).

The Akan chief does not wield only secular powers. He has sacred powers and the two are tied to each other. The chief's political power and commitment to his people embraces a religious authority to seek from the ancestors the welfare and protection of the community. Ancestors as the dead elders of the lineage give backing to the chief and he seeks their favour for the good of the people. Seeking the ancestors' favour also mirrors an Akan value of respect for seniors and expectations of their support to younger ones. For instance, there is the norm that parents cater for their children, older siblings help younger ones, and grandparents show immense indulgence to grandchildren.

The religious aspect of chieftaincy is grounded in mythology and ritual, and serves socio-political ends as much as the spiritual. As Benjamin Ray has demonstrated through his study of the symbolic importance of the chief's role in Bugandan royalty, the religious ideology of a society is always a dominant one. Ray looks at rites and myths surrounding the death

of Buganda kings and royal ancestors for an understanding of the symbolic aspect of kingship and the ideology of sacredness on which it was based. He has expressed the view that social anthropologists have been turning their attention away from the symbolic dimension of royal cosmology, which leaves unexplained the complex of royal ritual constituting the ideological foundations of kingship (1977: 56). This chapter looks at the Akan chief as a positioned character, a living person and at the same time a representative of the (dead) ancestors for the protection of society. His ritual role as a mediator between the people and the ancestors, especially royal ancestors, is important in traditional religious practices. In religion a practical picture of authority can be viewed.

Tales about the beginning of Akan chiefship often merge into migration stories. People attribute the origins to heroes and leaders in the long pre-colonial migration to the present abode. Chieftaincy in Akan society has had its own problems, notably with colonialism which caused transformations in the chiefship. Some of the transformations have been radical, such as brought on by state-level organisation during colonialism and after; these have made the chiefs no more the absolute rulers of their communities. Other changes have been slow (less radical), such as chiefs being Christianised and Western-educated. For instance, it is quite recently (from the 1970s onwards) that communities choose chiefs who are Western-educated. The chiefly office has persisted, with the chief's ritual role and the associated religious ideologies almost intact. A discussion of the ritual role of the chief in this chapter explores the changes that have occurred in the office and why it has persisted; there is also a look at some of the challenges faced by chieftaincy today, notably HIV/AIDS.

Descent, chiefly status, and society

Descent and lineage connections strongly characterise chiefship among the Akan. The ethnographic literature from the beginning of the twentieth century to even more recent accounts emphasize lineage connections for the smooth running of the chiefship and the various communities. The foremost prerequisite for becoming a chief is to belong to the royal family. Succession rules allowed for a choice among a number of eligible heirs in the royal lineage; thus, genealogical ties within the royal lineage determine a person's eligibility (cf. Rattray 1929; Busia 1968; Fortes 1969). The chiefship or the lineage headship is always hereditary.

In the past, one had to be a royal and a brave warrior who protected the people in tribal war(s) or who was well versed in the sacred knowledge

and history of his people to become a chief. There are no tribal wars nowadays; thus, belonging to the royal lineage and being the closest heir to the throne are arguably the most important criteria. A struggle for the position, which today throws many communities in Ghana into chieftaincy disputes, arises mainly where there are two lineages which contest the office. In the ascription of political authority and elements of political office among the Edo of Benin, age overshadows kin-group alliance (Bradbury 1965: 96). In contrast, among the Akan one's place within the kin group is stressed, backed by age. The Akan chief is ideally expected to be middle-aged.

Inheritance and succession to political office is usually from mother's brother to sister's son, that is, it is transferred from an uncle to his nephew. A chief's son can never succeed his late father because they do not belong to the same lineage (cf. Rattray 1929). The queen mother's role is crucial in the selection of a chief. It is she who has to first select the candidate from the royal lineage. Upon approval by the lineage elders in the ruling council, the chief is then installed. Although her selected candidate is usually approved, the queen-mother has to select a different person when the earlier candidate is rejected. Michelle Gilbert (1994) has viewed the Akan queen mother's authority to select a chief and to remove him when necessary based on women's role as reproducers of society and repositories of oral tradition. "Women physically reproduce society, so it is said that they 'know' genealogy; thus the Queen Mother 'legitimises' the king by selecting him" (ibid: 102).

The selection of a candidate can also be characterised by lobbying or propaganda. To be fully assured of being selected, the candidate must have the support of the kingmakers as elders in the royal lineage and other lineage heads. Sometimes, even the role of the *nkwankwaafo*ɔ, the royals in the lower rungs who are not eligible for any office, is crucial. Their support is necessary and often sways kingmakers' decision. There is also the scare from wealthy men. Instances abound in many Akan communities where men who are not the closest heir sometimes attempt to or indeed usurp the position through monetary inducements.

The importance of lineage connections aside, moral support from the lineage members is absolutely necessary for the ruler. This support is marshalled when disputes arise about the chief. Problems have to be quickly resolved; it is believed that unsettled crises produce rancour which may motivate people to resort to bad medicine or witchcraft against the chief and other members of the royal household. It is thus important for his safety

both spiritually and physically, lest he attracts ill-will and machinations against him.

The Akan chief in pre-colonial times exercised executive, legislative, judicial, and more importantly, religious authority in the society. He was the judge of the traditional court of last resort, commander-in-chief of the army, and the chief priest for the veneration of ancestors for the protection of society. The chief was indeed a primus inter pares in ensuring social order in the world of the living. Traces of these roles remain, notably in the rural areas. Transformations caused by colonialism later ensured state-level organisation, the establishment of a national army and a police force. These have drastically reduced the role of the chief and made him redundant in those respects, especially in the urban areas. But the chief is still seen as the 'defender of the society'. This role starts with the chief's promise to the people at his installation. Every Akan chief must swear an oath to his people, part of which goes somewhat like this:

> If I am called upon in the morning, in the afternoon, in the evening, or even deep in the night, I will never turn my back to my people. Should I do that, I forsake my elders and revered ancestors whose wrath I then incur on myself.

This oath, so solemn that it can sometimes draw tears from the eyes of women of the royal lineage and others of the community, signifies a promise of commitment to the people. I have witnessed instances of such oath-taking, and my observations were collaborated by some chiefs and elders. The oath is seen as a covenant with both the ancestors and the people.

The chief's throne is a stool. As the occupant of the stool as a symbol of office, an Akan chief is the embodiment of the 'spirit' (*sunsum*) of the community. Thus, the Akan hereditary statuses, tightly woven into the religious system, also ensure the legitimacy of the chiefs. Busia (1968: 26) has drawn attention to the spiritual relationship that is created when the chief is installed. Every chief has to be lowered three times on the blackened stool of the most renowned of his ancestor chiefs. Blindfolded, he touches one of the stools, the name of whose previous occupant the current chief uses in his own reign. For Busia (ibid), this is the period when the chief is brought into an especially close relationship with the ancestors.

Apart from the stool as an important symbol, every Akan chief uses the prefix *'Nana'* as a title of honour and respect.[34] He is in charge of other

[34] '*Nana*' is also used for the supreme God, the deities, and as already mentioned, for ancestors and grandparents or a younger person who is named after an elderly person. Apart

stools of his predecessors as part of the state regalia, which include gold dust and ornaments, as well as the sword or staff of the community or clan's emblem. The stool is a sacred vehicle of the presence of ancestors, and as both the source and symbol of politico-ritual office, it embodies an ancestrally-ordained authority to the kingship down to the head of village (Fortes 1965: 138). Akan social organisation is dominated in many aspects by this type of traditional authority, which in Weberian sense, is characterised by divine sanctions. The chief works closely with lineage heads whose authority in the control and coordination of the affairs of their groups is viewed as sanctioned by their dead forebears. The lineage heads are each in charge of his group's ancestral stools and are the links between their kin members and their lineage ancestors, while the chief is the overall representative before all the ancestors of the community.

In terms of traditional authority the chief as a power holder is also a caretaker of a world that belongs to the ancestors. The Akan chiefship is conceptualised to be a sacred office and so the chief is sacred (Gilbert 1994). As the people's representative before the ancestors and vice versa, the chief must be sacred to be morally eligible in the presence of the revered beings. On the occasion of *adae* and other festivals when ancestors are propitiated, no funerals may be held and no news of death may reach the ears of the chief (Bartle 1978: 81). Death pollutes the chief as a sanctified person who represents the ancestors in society.

The sacred nature of the office is carried in the person of the chief (Busia 1968: 36). It is important that the chief is without blemish physically and morally. The Akan view of the chief's well-being is foremost in the idea that there should be no mark (scar) on his body (*dɛm biara nni ne ho*). In the past the chief was not circumcised; this applied to all eligible candidates even generations below. Elders of the royal lineage kept close watch to make sure eligible heirs were not circumcised. Circumcision is highly regarded in Akan society, but it contrasted with chiefly values. It was obvious that circumcision was good only for the ordinary male citizens; the chief as a 'whole' person was then above all men. This was also because in the past slaves were marked by a scar as a sign that someone owned them. A slave was of a lower status and for a chief to have a major scar was to reduce him to the status of a slave. Today, circumcision is no longer considered due to social changes. As a lineage elder explained to me, the availability of hospitals ensures that male infants are circumcised a few days after birth. Thus the eligible persons would already have been circumcised.

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from '*Nana*', the chief usually also has an appellation, such as *Otumfo*ɔ (the Powerful) and *Odeefo*ɔ (the Merciful).

There are specific rules or taboos regarding the chief's conduct. Such rules are seen as reflecting the sacred nature of the chief and the chiefly office. A manifestation of the ritual necessity of isolating the chief to maintain his sacredness is the fact that he eats alone. His food is prepared by his head wife (or, if the chief had only one wife and is widowed, a trusted woman in the lineage such as his mother). To be sacred also meant that the chief's body should not touch the bare floor. The ground is viewed as polluted with evil spirits, human contact, and filth. When a chief falls down, a sheep is slaughtered to appease the gods and ancestors. The chief should not be an ex-prisoner. The criterion of physical wholesomeness excluded the blind or the crippled from becoming a chief. A chief would be removed should he become blind after installation, just as if he became impotent, suffered from leprosy, madness, fits, or was maimed in a way that disfigured him (Busia 1968: 22). All these combine with moral and other qualities such as wisdom (*nyansa*), good ideas (*adwen pa*), humility (*ahobrase*), generosity (*ayamuyie*), manliness (*aboduru or akokoduru*), intelligence (*nimdee*) and a broad outlook (*anibie*).

The highest political authority in Akan-land is the *Omanhene* (king, or paramount chief). The *Omanhene* rules the major Akan chiefdom, made up of towns and villages (including his capital village or town) and usually described as the state (see Busia 1968; Rattray 1929). He exercises political power through divisional chiefs and other lesser chiefs as the rulers of the towns and villages that form the chiefdom. The Akan chiefdom is made up of divisions. These divisions or "wings", expressed in military functions because of war in the past, are usually made up of groups of villages and towns.[35] Every Akan chief's political authority transcends the cleavages between the lineages that form the village or town over which he rules, and it transcends a number of vicinities if he is a divisional or paramount chief.[36] Seen as the 'father' of the community, every chief is to be informed about any important visitor in the vicinity; the visitor has to formally present him or herself to literally be under the chief's protection. In this way, the chief will be seen to be 'aware' of the visitor's presence and will be responsible (indirectly) for any mishap that befalls the visitor. Such a norm trickles

[35] The Kwahu South District has about 26 towns and villages that form the Kwawu state—about 17 of them situated high on the Kwawu mountain range. The seat of the Paramount Chief of Kwawu is at Abene to the west, with the district administrative capital, Mpraeso to the east. Nkawkaw is to the south and is arguably the most socially and economically vibrant Kwawu town. The divisions include *benkum* (left guard), *nifa* (right guard), *kyidom* (rear guard), *gyaase* (body guard), *adonten* (vanguard), *twafo* (advance scouts), and *ankobea* (home guard).

[36] See Kallinen (2004) for more on Akan (Asante) political hierarchy.

down and pervades levels of the society that a visitor has to be introduced to the head of the family or larger lineage.

The chief's judiciary role saw his court as a centre for adjudication of various cases. Meyer Fortes (1969: 155-157) notes the opposition and sometimes the interpenetration of cases identified with polity and those related to kinship. As he rightly points out, *oman*, the body politic, is counter-posed to *fie* as the household and family sphere. While the former is institutionally focussed on the chiefship, the latter is associated with the lineage and household headship. A further distinction occurs in matters (*asem*) found in these separate spheres, between what Fortes refers to as things of the law (*mera*) which go to the chief's court and *amammera*, commonly translated as "custom" and settled at the lineage level. To use Fortes' example, while disrespect to one's lineage elders is a breach of *amammera*, it is actionable in law when shown to a chief. Incest is both a heinous transgression of *amammera* and a criminal sin punishable by law.

There are two broad categories of wrongs. R. S. Rattray (1929) was the first to refer to these as "Sins or Tribal Taboos" (*Oman Akyiwadie*) and "Household Cases" (*Efisem*). *Oman Akyiwadie* fall directly and compulsorily under the jurisdiction of the political authorities either at the chiefdom or national level. The wide range include murder, dishonourable suicide, incest and other sexual offences, witchcraft accusation, invoking a curse on any holder of high office, and violations of taboos enjoined on the whole community (Fortes 1969: 155). Household cases concerned marriage and divorce, lineage and personal property, inheritance of kinship statuses, insult and assault. They were handled at the lineage level, unless the two parties did not belong to the same parental family or lineage (ibid: 157).

The chief also physically ensures ordered behaviour among his subjects. An archival record shows a case in 1923 in which a paramount chief barred women in his area from travelling to another place because they indulged in "undesirable character" with men in the other area (ADM 11/1/1639). When I was a secondary school student in an Akan town, the chief of a nearby town was said to disguise himself and go to a dance hall late in the night. With a whip hidden in his clothes, he would beat and drive the teenagers out of the place. Ensuring community welfare in the past also concerned Akan female initiation rites (*bragoro*), overseen by the queen-mother. Women in Akan culture are seen to represent the beauty, purity, and dignity of the society. It was believed that women should be properly trained to bring up good children. Upon first menstruation, girls were secluded and given lessons in sex education, how to relate 'properly' with men, and about marriage. Such rites are not practiced any more and are

viewed apparently as outmoded, this shift partly attributed to Western education and Christianity.

The Akan chief does not reign unchecked. The role of the queen-mother and the lineage elders who form the ruling body was crucial in the chief's removal (locally, de-stooled). They are capable of bringing de-stoolment charges and proceedings against him for grave offences such as constant drunkenness and gross incompetence. The chief is also under close scrutiny by his subjects. He rules over his subjects, but they keep a careful watch on the way traditional authority is exercised (Busia 1968: 106), which can be viewed as an African 'checks and balances'.

So central was (and still is) the chief's role as defender of the people that his death remained a secret for some time until close to the funeral rites. A new chief may be installed before the funeral or after (in one case, a new queen-mother was paraded as the funeral of her predecessor was ongoing).[37] It should not be obvious that the mediator for the people and society is himself vulnerable to death. Because the chief should not be seen as overpowered by death, a euphemism is employed in announcing his death—he has metaphorically 'gone to the village'. Unlike the Shilluk, the Akan never resort to regicide. The Shilluk killed their king before his body and powers became weak so that the world would not fall to decay with the decay of the man-God if he died on the throne (Evans-Pritchard 1962). In contrast, the Akan chief must reign till his death on the throne. When traditional rulers are laid in state, their effigies are laid in state too in a room or space leading to where the real body is. The effigy is buried at the cemetery in the daytime when the corpse is 'carried' to the burial place for interment. The real corpse of the chief or queen mother is buried after midnight, in the royal *nsamanpow mu* (royal mausoleum or a special, reserved thicket). At times it may be buried in the lineage or deceased's house.[38]

Ritual, ancestor reverence, and well-being

Rituals are a major part of Akan social organisation, where the Akan chief leads in supplication to the ancestors to protect the society. The Akan social system embraces lineages, the ancestors, and the gods to whom the people

[37] When a chief was buried before a new one was installed, it was explained that replacing him before the burial meant that there were two occupants on the stool (since the deceased was not seen as 'completely gone'). However, sometimes a new one is put in place before the burial in order that he 'buries his predecessor'. I guess there is some transformation here, which may have interesting revelations.

[38] This was quite common in the past but waning these days because it is regarded as superstitious, although traces remain.

appeal for material and spiritual well-being. Ancestral role in protecting the society is conceptualised in a way that ancestors of each lineage watch over kin members (ancestor chiefs are there for the society generally). This expresses a contested area of operation, a division of labour between them. The holistic Akan society is based on cosmological ideas of a division between the world of the living and the world of the dead, which are at the same time united.

About two years before my fieldwork, the Odekuro (village headman)[39] of Amanfrom, a village located near Nkawkaw, led in a ritual performance at a spot on the main Accra-Kumasi highway that traverses the vicinity. The ritual was to appeal to the ancestors and gods in the area for their intervention because too many lorry accidents occurred at the spot. Fetish priests and priestesses in the area performed the ritual near a small river. Sheep and fowls were slaughtered, and כ/כ (mashed yam) and eggs were offered to the gods and ancestors. It was a supplication to the deities and ancestors to ward off any evil by malevolent forces. They were appealed to for forgiveness if the mishaps were retribution for wrongdoing by any member(s) of the community. Since then, informants happily told me, the accidents have abated.

Early studies about the sacred by Emile Durkheim and Marcel Mauss viewed ideas about the sacred as projecting the social order; to Mircea Eliade, the sacred was unaffected by time and space; Arnold van Gennep and Victor Turner associated it with rites of passage, transition and liminality. Recent discussions by Maurice Godelier (1999) and others have emphasised the social relations aspect. In his pioneer analysis of gift exchange, Marcel Mauss (1990: 20) asserted that the first group of beings with whom men established a reciprocal relationship were the spirits of the dead and the gods. Those spirit entities are the true owners of the things of the world. Godelier (1999) brings up powerfully the idea of creating or enhancing social relations in his critical review of Mauss's magico-religious views about gift exchange. Both ideas aptly fit into the Akan context. Even where no material benefit is thought to arise, religious offering and sacrifice have other compensatory functions for the Akan. Life itself and other

[39] An *Odekuro* ('headman' or overseer of, usually, a village) is in charge of the village that is not autonomous but under a town or another village. Many villages have been established by the royal lineage of a town. Nkawkaw, for example, used to be the 'village' of Obomeng but has outgrown the latter in size. It is governed by a chief who is still under the Obomeng chief. Amanfrom, also a 'village' of Obomeng, is still ruled by an overseer. Busia (1968) explains that the *Odekuro* is selected as head of the village from among the lineages that form a local political unit, which is different from Arhin's (1994) explanation that the *Odekuro* is the one whose ancestors first settled in the vicinity. For Amanfrom, its *Odekuro* assumes that office because his ancestors first settled in that village.

benefits arising from belief in the establishment of appropriate relations between the one who does the sacrificing and some spirit entity or extra-human power pervade Akan thought.

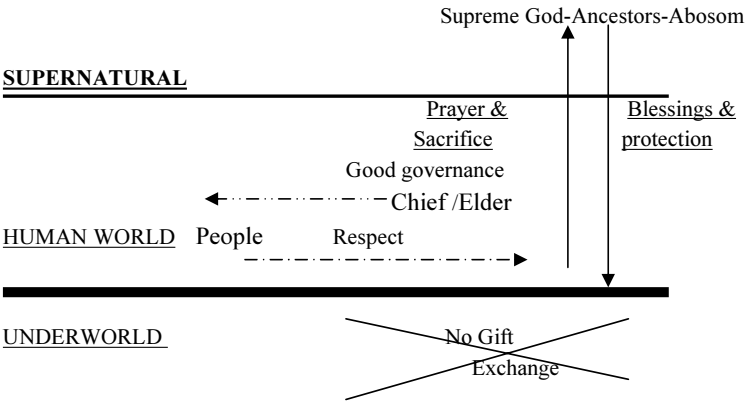


FIGURE 3: Sacrifice, exchange, and worlds—gift exchange between humans and the revered beings

For social relations as much as the religious significance sacrifices and libation are offered in Akan-land. As can be seen in Figure 3, the relations created in both the human world and that of the supra-human realm are of two kinds, and both are for the good of society. Between chiefs and their people as humans exchange is on a same-level, horizontal relationship. The chief must ensure good governance and show respect and affect to his people; in return he wins respect and affect, and material gifts from the people. In contrast, humans sacrifice animals to the sacred beings above, from whom they receive in return blessings and sacred protection down here on earth. Even where the sacred beings do not directly reciprocate, the relationship still compels humans to show loyalty (Sahlins 1972: 206). As Mauss (1990 [1925]) and Godelier (1999: 10-20) have shown, gifts obligate and hold the receiver indebted to the giver. The Akan supreme God, the ancestors and the deities give the great gift of life, which humans cannot create. So, it is alright if they acknowledge their gratitude with sacrifices in items that are comparably low in value but satisfying as a sign of loyalty.

Sacrifice to ancestors express descent, locality, and origins as important concepts in the social organisation of traditional societies. Akan veneration of ancestors is shaped largely by requests for life and well-being, against illnesses and premature deaths. These are tied to cosmological ideas, social relations, and concepts about their origins and survival in time and space. As Michael Jackson (1977) has pointd out in his discussion of

sacrifice and social structure among the Kuranko, descent and locality are strong concepts about sacrifice to ancestors. Descent "essentially defines modes of relationship between predecessors and successors", and locality encompasses values based on co-residence and local contiguity (p. 44). For him, the complementary principles of social organisation, such as lineage and locality, ancestors and the earth, or descent and territoriality can be viewed as a distinction between temporal and spatial modalities of structuring (ibid).

Two approaches have generally been used in the study of ancestor veneration in traditional African societies. One approach is to treat it as a system of beliefs, a body of thought that is closely associated with religious philosophy; the other has been to view it as a reflection of social relations (Mendonsa 1976). According to Eugene Mendonsa (ibid: 57), African ancestor worship has most commonly been dealt with in the latter fashion. To me, such an assertion seems to downplay the close connection between social relations and cosmological ideas. As Meyer Fortes has pointed out, ancestor worship is grounded in kinship and descent relations, but largely conceptualised in the sacred realm:

> There is general agreement that, wherever it occurs, ancestor worship is rooted in domestic, kinship and descent relations, and institutions. It is described by some as an extension of these relations to the supernatural sphere, by others as a reflection of social relations, yet again as their ritual and symbolic expression (1965: 122)

Several authors have noted the Akan chief's role in the enactment of rites and rituals for the protection of society, although it has not been fully explained. K. A. Busia (1968), for example, has written much about the chief enacting rituals through libation to the ancestors. In such rituals, the chief calls for long life and fertility in prayer to the Supreme God, the gods, and the ancestors. Busia, however, failed to connect it to a request against bad death, which threatens the way ancestors are produced, the way they protect the society and reproduce it.

Three major types of divinities exist in traditional Akan religion in terms of closeness to humans and an apparent importance to man's needs. The Supreme God (*Onyame*), the deities (*abosom*), and the ancestors (*nananom nsamanfo*) form an important part of the cosmological order. Of the three, *Onyame* is far removed from humans due to man's own actions; in an Akan myth *Onyame* once lived close to human beings but moved away to avoid being hit by the pestle of an old woman as she pounded her favourite

local dough of *fufu* from boiled manioc and plantain. He[40] delegates issues concerning man's needs to his deputies, the deities. The deities, who embody the vegetation,[41] are sometimes indifferent too unless implored. In contrast, ancestors as former human beings are close to and interact more often with people.

Ritual prayer is almost always in supplication to ancestors for their attention, even though *Onyame* and the deities are usually mentioned first. *Onyame* is always given his due as paramount in Akan religion (Akyeampong 1999). Akan belief in the supremacy of *Onyame* is expressed in the recognition of rainwater as highly consecrated and a direct gift from the sky (early anthropologists such as Rattray made reference to the Akan God as a Sky God). In front of the chief's palace or in the compounds of the palace and other royal homes stands the three-pronged pole of the *Nyamedua* tree (*Alstonia Congensis*, see Rattray 1923) that holds a pot into which consecrated rainwater is collected for ritual purposes.

The blackened stools of the ancestors, kept at the royal palace and lineage homes, embody the spirits of both royal forebears and ancestors of the lineages. They are the sacred artefacts that unite and are a reminder of cosmic, mythic, and historical origins. These artefacts are thus the "living theatres where the past may be repeatedly revived and encountered anew in the present", as Ray (1977: 65) explains about kingship and royal ancestors in Buganda. One of the major occasions for the Akan chief's role as a ritual figure and a positioned actor is during festivals (*afahyɛ* sing. same), which are usually events of reverence and thanksgiving to the gods and ancestors.

Spiritual beliefs and everyday life in Akan society are mingled during festivals (and in funerary rites) when ancestors are not regarded as dead and forgotten but are personified and addressed as living beings (Busia 1968). In this sense, it is not enough by way of explanation that an ancestral spirit is primarily "a *name attached to a relic, the stool,* standing for ritual validation of lineage ancestry", as Meyer Fortes (1965: 129, emphasis added) claims. Instead, the stool signifies the 'dwelling place' of the ancestor. When invoked on particular occasions, the ancestral spirit is believed to dwell in

[40] *Onyame* is symbolised as a male. His day name is Saturday and as a male, *Kwame*. He is sometimes referred to as *Onyankopon Kwame*. See the Glossary for a list of Akan day names.

[41] Natural bodies such as peaks, rivers, trees, the sea and the land are important in traditional religion because many deities are believed to reside in these forms of the vegetation. The traditional Akan religion is thus largely reflected in the landscape, although a god is regarded as invisible, omniscient, omnipresent and omnipotent (Field 1940: 138). The state god of the Kwawu resides in the *Buruku* rock projection near the town of Kwawu Tafo; it is consulted on occasions such as the traditional festival, *Akwasidae.* People visit the shrine for spiritual assistance in curing illnesses and to avert other misfortunes.

(or possesses) the stool, which then embodies the spirit and is more than a mere relic.

Land and its produce—that is, the harvests from farms and other products on the land—are a major catalyst to the performance of ritual to the ancestors. Most Akan towns have been established around market activities, where people from the villages (*nkura,* sing*. akura)* bring their crops for sale. Physical efforts may result in good harvests; however, much is seen to rely on the magnanimity and spiritual intervention of ancestors. As true owners of the land, they have to be constantly propitiated for allowing the use of it. Like the Zulu king (Gluckman 1969), the Akan chief is the 'owner' of the land only inasmuch as he is a custodian for the society that includes the ancestors.

Rituals then portray the relationship between ancestors and the gods on one side and humans on the other—the benefactors and the beneficiaries— underpinned by association between the two. As Sara Berry (2001: 90) has pointed out, such a relationship reaffirms the plasticity of social boundaries, which encompass the living as well as the dead. It also portrays the permanence of social ties and responsibilities, which cannot be broken even by death.

There is a time and place for appealing to or thanking the ancestors. Spontaneous actions do occur, such as when the community wins a court case and thanking the ancestors and gods becomes a spur-of-the-moment occasion for libation not far away from the scene. The rituals involving the chief are very much public, in contrast to other rituals by other people such as a prayer in one's room and hence inherently private. This emphasizes Gilbert Lewis's (1980: 21) point that not every ritual has an audience, although there is always a public aspect to it because it is usually taught and learned. Sacrifice may be made in response to special situations or in emergencies. The outbreak of an epidemic may necessitate sacrifices to the ancestors, *Onyame* and the deities.

Ancestors are usually appealed to on many special occasions, dominated by festivals specifically reserved for the purpose. *Akwasidae* and *awukudae*, *odwera*, and ceremonies of the first-fruit harvest are all celebrated to propitiate the ancestors. *Odwera* was originally the feast of the dead (ancestors) and closely connected with first-fruits, cleansing the nation from defilement, and purifying the shrines of ancestral spirits as well as the state gods (see Busia 1968: 29). Citizens could be called upon to work on the farms attached to the chief's stool and to pay tribute of first fruits for the annual *odwera* ceremony (Fortes 1969). Sheep, fowls, and sometimes a cow are sacrificed, and offerings of eggs and mashed yam made during the *adae*

ceremonies and *odwera*. The sacrifices at these ceremonies are communal and therefore not under individual obligation. Today, *odwera* is more popular among the Akwapim (Gilbert 1994) and in some parts of Brong Ahafo. It is no longer celebrated by the Ashanti or the Kwawu, who concentrate instead on the two *adae* ceremonies that follow each other every twenty-one days based on the traditional Akan calendar in which the year is divided into forty-day periods (*adaduanan*).

R. S. Rattray placed the *adae* ceremony first in order of importance of the ceremonies that deal with the "propitiation, solicitation, or worship of ancestral spirits" (1955: 92). The *adae* festival is a day of rest (from *da*, to sleep), which is set aside for communion between the living persons of the community and the ancestors. The day is always marked by commensality. The ancestors are fed with food sacrifices and rum in the stool room (*nkonguafieso*), where their blackened stools as the repositories of their spirits are kept (cf. Rattray 1955; Busia 1968; Akyeampong 1999). In addition to the food, palm wine or the locally-distilled rum, *akpeteshie*, or more recently, the factory-manufactured or imported schnapps (reflecting socio-cultural changes), is offered in libation. The living members of each lineage then eat a communal ritual meal prepared from the sacrificed animals and others secured specifically for the occasion. Thus, the *adae* rejuvenates the ties among humans, and between the living and the dead, which symbolises them at peace with each other.

Libations are such a significant part of the traditional religion that they are incorporated into some state functions, although some people see this as not portraying Ghana as a Christian country. Libations always start with prayers first to *Onyame*, to the deities, and to ancestors for life and longevity, health, prosperity, and protection from especially sudden and unfortunate death. Even before the advent of Christianity in Ghana the people were not agnostic; their religion subscribed to a belief in an almighty God. The chief of a Kwawu village recounted a typical prayer in libation, including the request against bad death:

Onyankopon Kwame, nsa
Asaase Yaa, nsa
Abosom a mo etwa yɛn ho ahyia nyinaa, nsa
Nananom nsamanfo, nsa [here, names readily remembered are mentioned]
Yɛrefrɛ mo ndɛ a, ennyɛ biribi…
ɛyɛ ….[give the reason/occasion for the supplication]
Onipa bone deɛ, owuo nto no, efiri sɛ obi nnטכ nsa nnhyira ne tamfo
Nananom nsamanfo, adeɛ a ɛyɛ yare bone, mo mpa mfiri yɛn mu
Atofowuo, ɛne asɛm bכne nyinaa mo mpa ngu…

Onyankopon Saturday, drink [here is drink for you]
Earth goddess, drink
All ye deities that surround us, drink
Ancestors, drink
If we are calling you today, it is not for any evil mission
It is because….[give reason /occasion]
To the evil one, death; because no one buys drink to bless his/her enemy
Ancestors, that which is dangerous illness, prevent them from us
Abominable death and all misfortunes should be away from us

So long as the centre (the village or town) represented by the chief was stable, and so long as relationship with the ancestors was stable too, social order was enhanced and trickled down to the subjects.

The need to cleanse the society

The Akan value of life is such that it is not just illnesses that must be combated in order to restore health; life must be protected by rituals to cleanse the society of evil and prevent illnesses. It was the duty of the Akan chief in the past to cleanse the society from time to time. Cleansing ensured that the society was rid of witches and any malevolent forces that may seek to disturb the peace. The chief's role in ritual for preventive measures was of immense importance in the pre-colonial period. According to my centenarian informant, during outbreaks of epidemics (*oguekuro,* lit. destroyer of towns) such as smallpox, the chief and his fetish priests led in preventive rites. A day was set aside, and a gong-gong [the metallic traditional information device] was beaten at the instruction of the chief to inform all people.

The whole community erected stakes of plantain tree stalks at the outskirts of the vicinity. All inhabitants dumped their garbage on these stakes, which were ritually burned to cleanse the society of the epidemic. Most of these rituals to cleanse the community have become defunct. The ritual survivals are not elaborately enacted any longer except in festivals which may in most cases be appreciated more for their social relevance than spiritual. The transition can undoubtedly be attributed to Christianity and Western education, which frown on such ideas and practices. The establishment of Western medical services is another factor; illnesses are treated at hospitals, wiping out the need to ritually cleanse the society as an important therapeutic remedy (cf. Twumasi 1975; Senah 1989).

Cleansing the society was mainly to rid it of witch activities. The chiefly office has its own problems with regard to witchcraft and sorcery (bad medicines), used either to kill the chief through illness or to force him

to abdicate 'of his own volition'. This makes it an office which attracts spiritual 'workings' against it due to envy. Thus, when some chiefs seek (good) medicines for their personal protection, it is to fortify and enable them to lead the society. As the saying goes, if gold rusts what will iron do; if the defender of the people himself is vulnerable to evil forces, what is the fate of those he leads? Some chiefs try to fortify themselves with medicines usually secured from medicine men or fetish priests, which was rife in the colonial times (see Field 1960; 1940).

Witch-hunting and witch cults, more prevalent in Akan society in colonial times, were the major modes of cleansing the society. Many of my older informants corroborated Field's account that sometimes the chief secured the help of medicine from other places outside his territory. It was the practice that in every year, many Akan chiefs invited a powerful witch doctor/fetish priest to cleanse their communities of witches (see McCaskie 1981; Asiamah 2000), suggesting an underlying politics of power between the chiefs and medicine men. Cleansing the society of ills and witch activities was seen to maintain the social and cosmological order because witches were rid of their powers to destroy life. Because chiefs (and fetish priests) must protect the society and life, they enter into a struggle with witches and their destructive powers.

Chiefs gave backing to the witch cults that increased in many Akan areas in the first decades of the twentieth century. Many so-called medicine men who claimed to detect witches and rid them of their evil powers were treated with respect by the chiefs. In Kwawu many witch-finding cults emerged between the 1930s and 1950s, which included Senyo Kupo, Kunde, and Tigare (or Gare fetish). Tigare was both popular and notorious because its officials were said to use intimidation and violence to catch those they branded as witches (ADM/KD 29/6/69). Their preoccupation to rid the society of witches was also associated with the cults' tendency to acquire great riches in those days. The archival records from the 1940s indicate that chiefs were involved in monetary gains from the witch cults and were notorious in the eyes of the colonial authorities. The records say a prominent Kwawu chief "received two shillings from the two [shillings] and six pence initiation fee charged from each applicant, and presumably shared with other chiefs" (ibid).

The oft-cited Tigare, an importation from the northern part of Ghana, was very popular and powerful at its base at Nkwantanang village near Kwawu Pepease. People travelled from far and wide, the railway line established from Accra to Nkawkaw in the mid 1920s serving as an easy means of transport. They submitted themselves under Tigare's protection or

confessed that they were witches and wanted to be rid of the evil power (ibid). Due to the part chiefs and native tribunals played in witch-hunting, in 1927 the colonial government enacted the Native Administrative Ordinance (NAO) that gave the Gold Coast Native Tribunals (made up of paramount and other big chiefs) the authority to try witchcraft cases for the first time. The colonial government was asserting its authority by giving the native courts the power to handle witch cases as a way to reduce the powers of smaller chiefs and medicine men and their means of making money. The paramount chief of Akyem Abuakwa, Nana Ofori Atta, a lawyer, guided the drafting of the ordinance to enhance the power of paramount chiefs by extending their jurisdiction while withdrawing official recognition from the courts of village headmen and fetish priests (Gray 2001: 348).

Prior to the enforcement of the NAO, there had been a petition from the Provincial Council of Chiefs, which reasoned that "it is impossible for the ordinary person to find out witchcraft, except by certain Native Doctors, who, by extraordinary medical skills and experience have the means of discovering it" (ibid; ADM 11/1/886). But the colonial government stepped in for order because instead of cleansing witches of their powers in order to protect life, the witch cults were destroying life by causing death to those they caught as witches. Many of the so-called witches died because they were forced to drink a poisonous concoction at the poison oracle. Others branded as such and unable to withstand the humiliation committed suicide; thus the cults' activities caused disorder instead of pursuing and maintaining the social and cosmological order. The colonial government's way to ensure order was that if complaints against a particular shrine were judged to be too serious or numerous, the cult was banned altogether by the authorities (Gray 2001: 341). There was popular support for the shrines, especially from some chiefs although there was disdain from those who were accused of being witches. Under the colonial administration's policy of Indirect Rule, the chiefs were expected to be the government's top informants about life in their communities. They virtually cooperated on this; regarding information about the ruthless shrines, however, the chiefs were often uncooperative (ibid; ADM 11/1/886).

Witch-finding was banned by the colonial government in 1930 but Tigare and others continued to flourish until about the late 1950s. However, when more local people converted to Christianity the power and significance of the witch cults further waned. Their activities against witches in those days, and now that of spirit churches, may be viewed as efforts to maintain the cosmological balance.

Colonial transformations and the persistence of chiefs

Before the arrival of the British colonisers, Akan chiefs were the principal holders of power and authority in the society. Chieftaincy in Akan society probably met its worst period during colonialism. Margaret Field (1960: 25) has suggested that unlike in Nigeria indirect rule was unsuccessful in Ghana due to the absence of a ruling class of invaders with foreign blood. There are many conflicting views about Akan chiefs and indirect rule, the policy of the colonizers where chiefs ruled their own subjects but were under and answerable to the colonial masters. The policy is seen to have been a tool to manoeuvre for control in many African colonies.[42] Field (ibid) claims that attempts to introduce indirect rule from Nigeria to Ghana only resulted in chieftaincy embroiled in machinations for de-stoolments by eligible people with clanic identity and equal standing for the office.

According to her, chiefs found it hard to serve their own electorate with the European concept of chieftainship (ibid). Other scholars seem to say differently about indirect rule and chieftaincy. The chiefs were said to have been used against the educated elite when agitation for independence started (see Busia 1968; Debrunner 1967). The Reverend Hans Debrunner, a missionary, observes that in the long run the chiefs paid dearly for allowing themselves to be used for indirect rule. For him, as top informants about life in their communities chiefs were a great asset for the colonial administrators. Chieftaincy eventually "lost much of its political influence and appeal, and destoolments became frequent" (ibid: 315).

The vast literature on chieftaincy in traditional societies, mostly in Africa and the Pacific, shows that the legitimacy of a chief is tied to exchange, ritual knowledge, and kinship advantages. As A. F. Robertson has noted about chieftaincy in Ghana, originally chiefs existed with their traditional councils made up of elders of the lineages. However, in the colonial era, chiefs and the traditional councils yielded much of their authority to District Officers; in the run up to a post-colonial state in late 1950s, the Local and District Council System was established (1971: 131).
Colonialism indeed caused many transformations in which Christianity and post-colonial central state politics affected the chief's power and authority (Busia 1968). Much of the secular authority of the chief in most of these societies was lost but they maintained their ritual roles. Meyer Fortes and E. E. Evans-Pritchard (1969) have noted that chiefs retained their 'ritual

[42] See Richards (1969) and Gluckman (1969) for accounts of how the colonial government manoeuvred chieftaincy for its own good in the Bemba and Zulu societies respectively.

functions' because "the mystical values of the political office [was not] entirely obliterated by a change of religion" (p.21).

Chieftaincy in Ghana has survived and persisted in the face of state-level organisation in the post-colonial period for a number of reasons. Exchanges of respect and affect, and gifts (food and other material substances) between Akan chiefs and their people are still important. Sacrifices to the ancestors and gods on behalf of the people were and still are closely tied to the chief's position, both as a sacred figure linking his subjects to the ancestors and as the embodiment of the society. Thus the legitimacy of the Akan chief continues to be connected to his ritual authority, political role, and also by exchange, kinship and descent alliances. Today, the chiefs rule through their cosmological knowledge (and knowledge of history) and their role in rituals, by which their authority is maintained.

Land was largely controlled by the 'stool' and 'sub-stools' (as metonyms for the chief and heads of the lineages respectively) in pre-colonial Akan society, where chiefs and lineage heads were in charge. As already mentioned, this ensured (and still ensures) social relations from the chief downward through lineage heads in each village into a hierarchy of kinship ties.[43] Customary land law recognised the usufruct right of the member of the lineage or the community (Ninsin 1989). Concerning stool lands, the colonialists viewed customary law as an inferior and undeveloped legal system. Crown lands were created alongside the lands vested in the hands of the chiefs and lineage elders. Later in post-colonial Ghana, the government under the Conventional People's Party (C.P.P) sought to "weaken the economic base of the politically most powerful chiefs" by converting most of their lands into state lands (ibid: 167). Subsequent governments, even though more liberal than the C.P.P, have since then sought to assert the state's supreme dominion over all the lands of the nation (ibid).

Nevertheless, chiefs have maintained a prominent position with regard to the control over land. This is mainly due to their unique position—their office and close attachment to the ancestors as the mystical and 'real' owners of the land. The chiefs' authority derives from the ancestors who exercise real power over the land, and that power is thus transferred to chiefs (Berry 2001). Such authority, in the Weberian sense, is the power behind power and legitimised by the sanctity of tradition. Kwame Ninsin (ibid), who considers the helplessness of the peasantry in the land issue in

[43] For more on the land tenure system in pre-colonial and colonial Akan, see Rattray (1929) and Busia (1968). For the post-colonial period, see Ninsin (1989).

Ghana since the 1950s, observes that the chiefs' influence over land has continued because of their continued political relevance and influence in the political economy of Ghana. He notes that the ease with which the ruling classes secure lands under communal land tenure has effectively restrained successive regimes from initiating wholesale land reforms for the needs of the peasantry (ibid: 166). This also shows the extent of chiefly control over land. Even today, sometimes the lands which the government demarcates for public structures must be paid for with a token fee of drinks to the chief in question.[44] Drinks 'paid' to chiefs are usually used to thank the ancestors, reinforcing their recognition as the true owners of the land.

The impact of colonialism, Christianity and Western education resulted in changed attitudes towards some traditional practices and ideas viewed as superstitious. In effect, the traditional ideologies have completely been obliterated or transformed considerably. Requests to the gods and ancestors have undergone considerable changes and are continuously under review. In the past, it was common to use palm wine (*nsaefuo*) or the stronger *akpeteshie* in libation. Today, schnapps that have been manufactured by a company in Ghana, or even those imported from abroad (*aborokyire nsa*) are in vogue. There are always variations in such requests (cf. Minkus 1984: 115). Conditions of life have changed, and the requests reflect that; appeals for employment, success at school or examinations, to go abroad, and freedom from motor accidents are often made, reflecting modern concerns (ibid).

Concerning Christianity, many Akan chiefs these days attend church services as thanksgiving after celebrating traditional festivals. Easter is one event that combines Christian and traditional practices. The Kwawu celebrate Easter with such pomp that it has now become popularly known in Ghana as 'Kwawu Easter'. In every other year, Easter coincides with *Akwasidae,* celebrated every forty two days as the major traditional festival for revering the ancestors and gods of Akan societies (Bartle 1978).[45] Such an occasion brings a double celebration, one Christian and the other

[44] The present Constitution of Ghana (1992) reinforces the principle of stool land ownership. It created the Office of the Administrator of stool lands to oversee the management of stool land revenues (see also Berry 2001: 99), and states categorically that the Office of the Administrator is responsible to establish a stool land account into which rents, dues, royalties, revenues or other payments will be collected. Ten percent of the revenue goes to the Office of the Administrator for administrative purposes; twenty five percent to the stool for its maintenance; twenty percent is to the traditional authority, and fifty five percent to the District Assembly of the area of the stool land (The Constitution of the Republic of Ghana, Art. 267(1-6).

[45] For more information on how the Akan traditional calendar is counted and operates, see Bartle (1978).

traditional. At the end of the traditional enactments in offerings and sacrifices to ancestral spirits and community gods, many chiefs attend church services as the climax of their activities. This should hopefully not be seen as 'serving two masters'. Having rendered unto Caesar the things that are Caesar's (if that can be equated with traditional state affairs), the chiefs go to church to render unto God the things that are due the Almighty. Protection of the society is then doubly assured through magnanimity from both sides.

Western education is another factor for the transformations. Although I am not aware of any state directive to that effect, for some time now, from about the 1970s, an increasing number of chiefs have been Western-educated. Communities choose the Western-educated candidate to be their chief because it is thought that an educated chief will bring development to his community (cf. Berry 2001). Today, many chiefs have been professionals—lawyers, top civil servants, chartered accountants, educationists, and engineers; they usually cease their professional practice once they assume the traditional office. It has become a symbol of status for a village or town to have an educated chief. Most of the chiefs, highly educated in the top schools in the country and abroad, are also practising Christians who attend church regularly and not just after festivals.

Chiefs and their post-colonial challenges

The chiefs face many challenges today. Post-colonial state administration means that the chief does not hold an all-embracing position as in pre-colonial times. The modern court system, established during the colonial period, took away a considerable part of the chief's authority as a traditional arbitrator. More so was the introduction of the more recent tribunal system and local government administration in the 1980s under the erstwhile military government, the Provisional National Defence Council (PNDC). In many rural areas, chiefs have continued to be arbiters in conflicts involving their subjects.[46] As mentioned earlier while family disputes (*efisɛm*) are handled by lineage elders, community conflicts or litigations (*manso*) between members of two contending lineages go to the traditional ruler for arbitration at his palace (*ahemfie*).

The tribunal system was introduced in Ghana to speed up legal cases that had piled in many courts in the country, and it now handles many of the

[46] On a trip to a village in the Afram Plains to meet with one of my informants, my supervising professor, Karen Armstrong, my principal informant Ernestina, and I walked into arbitration being handled by the Chief of Pitiku, Nana Danso Ababio I at his palace court.

disputes that would have been settled at the palace. The introduction of the tribunal system and, more especially, the District Assembly system that allows people to represent the village in local government politics, are seen by sympathisers of chieftaincy as an attempt to usurp the powers of the traditional rulers. But the chiefs continue to negotiate and renegotiate new realities and changing material and ideological structures. They are barred from active party politics, just as civil servants, members of the Police, Army, and other forces are. The ban on chiefs is stipulated in the 1992 Constitution of Ghana that states categorically: "A chief shall not take part in active party politics" (Article 276:1). The explanation seems to be that the chiefly office is so sacred that it should not dabble in 'the dirty game of politics', the usual maxim in Ghana. From another perspective, since a chief stands for the unity of all his subjects, participating in politics is likely to bring rancour between those who support the chief's party and those who do not.

The changes are not found in state-level politics alone; many others are identified in informal, face-to-face interactions. Chiefs may sometimes feel uneasy about people who go about as 'big men' who usually belong to the ruling lineage or are in a rival one and eligible to the throne. They may have their own hidden agenda, being interested in the chief's position or agitating for their favourites as a replacement. There may also be the threat from wealthy people (*asikafo*) who do not belong to the royal lineage and are thus ineligible to the throne, but who want to assume authority as eminences grises in the society. They may finance projects in the community, often in an attempt to win respect and indulgence from the people; this equally threatens the chief's position and command in the community (see McCaskie 1983).

Akan social rank and status even before the colonial period entailed the accumulation and control of wealth through gold, land and slaves (see, e.g. Rattray 1954). In the past wealth was also used as one of the pillars of social order in nineteenth century Ashanti, where consumption and investment involved a wealthy entrepreneurial class who assumed the status of 'big men' (McCaskie 1983, 1986). Although wealth was expressed in the stool (office of the chief) having gold and other resources from which political power radiated, the chief was (and still is) not necessarily rich. As Arhin (1994) has commented, in the early twentieth century rank was expressed in private individuals acquiring private wealth, which gives further credence to McCaskie's (1983) point on the widespread accumulation of wealth in Ashanti around that period. Chiefs' uneasiness about wealthy men has long existed and continues to do so. But in

contemporary Akan society, some chiefs create problems for themselves and attract criticism and hostile feelings from others. Some chiefs sell stool lands and misappropriate the community's funds, putting their people into insecurity and despair that they agitate for the ruler's de-stoolment.

It is for society's good that the chief performs rites in association with fetish priests and medicine men to prevent misfortune. There usually is an apparent cordiality between chiefs and fetish priests. But the mutual cooperation can sometimes turn sour and produce a glaring agonistic relationship. An inherent conflict may be discerned in their paraphernalia and way of dressing for public occasions. Chiefs and queen mothers wear the expensive hand-woven *kente* cloth or velvet with gold ornaments around their necks, wrists and sometimes ankles. Similarly, on public occasions when they are not engaged in any performance or ritual dancing, fetish priests and priestesses in ordinary attire wear such 'kingly' apparel. When their ritual knowledge and clairvoyance (*sunsun mu adehu*) win them much popularity, fetish priests can assume for themselves an air of importance to the uneasiness of the chief. Margaret Field recorded years ago:

> When a very popular shrine is run by a private practitioner it is not always pleasing to the local chief. One big chief, with an air of great righteousness, set the police on the track of a successful and by no means anti-social practitioner, accusing him of witch-finding. But he let fall elsewhere his real reason, 'He is making himself into a chief' (Field 1940: 148).

As a symbol of unity among his subjects, the chief still attracts respect and deference from the people from whom he enjoys a strong emotional attachment, although lately traditional healers are enjoying popularity in the society with their claims to cure AIDS. The chief's position in Akan society is still crucial because he gives meaning to the people's well-being. The characterisation of a chief in the Pacific as an index of political integration and the legitimacy of the state (see Lindstrom and White 1997: 18) can similarly be made about the Akan chief. Chiefs in Akan society are closer to their people than the government (*aban*), often referred to figuratively as 'the person' sitting there in Accra. This leads to the view that African societies have weak centralised state authority (e. g., ibid). Despite the challenges, chieftaincy among the Akan continues to show dynamism. Chiefs in Ghana generally have been agents of social and cultural change in that they and their institution have undergone transformations, while they have helped to transform the political and socio-economic life of the country.

The chiefs have turned on the wheel of change about themselves by leading their people to actively participate in the development projects of their communities. Counting on their status as members of the royal lineage (and therefore on kinship relations), such efforts by chiefs have also endeared most of them to their subjects, and their office is often free from machinations by opponents. For the good of their communities, chiefs respond favourably to changing material and ideological circumstances; if the government is unable to institute development projects in the community, the chief tries to help by soliciting funds from elsewhere. The Asantehene, for example, has instituted an educational fund through appeals to Asante citizens living abroad to help finance needy school children. The Bronghene and many others are engaged in other endeavours for development in their areas as examples of the chief's continued role for the good of the community and society.

Due to the AIDS scourge today, chiefs have actively been involved in campaigns to fight the disease by creating more awareness. Health personnel and educators usually consult chiefs before they undertake educational campaigns in the chief's community; chiefs also use the occasion of durbars and other parades to speak about the AIDS scare. The Okyenhene (the paramount chief of Akyem Abuakwa, an Akan subgroup) has been participating in an annual walking exercise to create HIV/AIDS awareness on every AIDS Day on December 1, since the year 2001. When in that year's AIDS Day commemoration at his town at Kyebi, he agreed to undergo a voluntary HIV testing,[47] he made history as the first chief to do so, which also is an instance of leadership by example.

The Akan chief is thus a combination of roles—he is a social worker, a counsellor, a traditional priest, and the spiritual link between his living subjects and the ancestors. In this way, the society is conceptually assured of protection, and protection of the society ensures order and stability for continuity; all are connected to cosmological balance and the maintenance of it. The people can count on their chiefs for well-being and the spiritual protection of the society by the ancestors, while in the area of therapy the fetish priests and other medicine men provide their medical needs. The chiefs know there are more challenges ahead. Ghana is still counted among the world's poor countries, and there are many amenities that government cannot provide in many communities. There has always been the need for chiefs to find, through their own efforts, the means for providing those amenities for their people. They have actively been involved in health education and in campaigns about immunization of children against polio,

[47] See story in Daily Graphic newspaper on December 3, 2001.

for instance. And now, they are confronted with another problem, a disease—HIV/AIDS—in their communities.

5. THE HIV/AIDS THREAT

A staggering 33, 000 AIDS deaths occurred in Ghana in 1999 alone (GAC 2003); in 2003, another 30, 000 deaths from the disease were recorded. The estimated number of people aged zero to 49 years living with the disease in 2003 was around 560, 000. The specifics about HIV/AIDS as a big threat in Akan society and in Ghana generally reveal a grim picture. The most vulnerable group is the 15 to 49 age category with a prevalence rate of 7.0 per cent; moreover, this group also forms the bulk of Ghana's labour force. As in other sub-Sahara African societies (Webb 1997), in Akan-land and in Ghana the disease afflicts mostly the youth, the future leaders. In recent years, a drop in Ghana's prevalence rate (from 3. 6 per cent in 2003 to 3.1 per cent in 2005) was quite encouraging but the reality is that new infections are recorded daily in the country. It is feared that there may be more than the current 550, 000 cases in a population of around twenty million.[48] Not all infected people report to the hospitals for testing although many regional and major district hospitals have HIV-testing and screening facilities.

Ever since HIV/AIDS burst onto the public health scene in the mid 1980s, the effects of the disease in Africa have been overwhelming (Bosompra 2001). Poverty, migration, the need to feed the household or family, and attitudes to fertility consistently raised important questions in early research on AIDS in Africa. About the mid 1990s, 'African sexuality', as Douglas Webb (1997: 29) puts it, began to dominate the cultural variables because of the heterosexual mode in the spread of the disease in Africa. Many have read racist undertones into this and other aspects of such inquiries; a particular construction of the disease in Africa has been created (ibid).

HIV/AIDS is constructed through various cultural practices and categories among the Akan. Like any experience of illness in the society it almost always expresses broader abstractions and relate closely to many other cultural categories. In the cultural epidemiology of HIV/AIDS, social processes usually categorise patients as not of moral worth. The disease is associated with 'negative' sex relations—multiple partners or lax sexual behaviour, unprotected sex, as well as premarital and extramarital sex in Akan society.[49] There is more to it than meets the eye; therefore, this chapter goes beyond ordinary descriptive accounts of HIV/AIDS. I show the conscious cultural models involving the practical factors for risks and

[48] Figures are according to United Nations estimates. Internet source: http://www.un.org/

[49] Akan society frowns on premarital and extramarital sex despite the commonality (cf. Bleek 1976), although it is less so today than it used to be (even as recently as in the early 1970s when I was a teenager).

insecurity associated with HIV infection and such less conscious cultural categories as witchcraft, conceptualised to operate mostly in the lineage group. There is another aspect to issues about the matrilineage. An HIV/AIDS illness and many of the factors leading to infection (directly or indirectly) may reflect the holistic and encompassing nature of the matrilineage; it also shows its contradictions. These themes are visible in the everyday lives and lineage organisation of the Akan.

Grace B's burden and infection

Grace B, 27, was burdened as a major breadwinner in the family at quite an early age. She was still a teenager when her father abandoned her mother for another woman. The father had moved to another town outside the Kwawu area; there he had married the woman he had had a relationship with long ago, leaving Grace's mother to care for their five children alone. As the first child, Grace was expected to help when she completed the junior secondary school at about 18 years. This meant that it was not possible to further her education even if she had wanted to; she was forced to work and help her mother in the upbringing of her other siblings. As a farmer, her mother had been struggling to care for the children. Life in the village was so unbearable. Grace had been forced to live with a distant relative at Nkawkaw in her early part of schooling. Soon she left for Koforidua, some twenty kilometres south east, where she lived with one of her mother's friends to complete school. At Koforidua, Grace sold vegetables for the woman and through that her education was financed. After her schooling, Grace was expected to be on her own. She decided to live in Koforidua and continue with trading, using the money her guardian had given to 'see her off' for living with her.

Grace traded in petty items like candies and biscuits. She did not earn much from her sales, nevertheless, she had to support her other kin members back in the village. Her status as a positioned individual, a contributor for the family's upkeep was significant. Her support for the upbringing of others expresses the matrilineage's encompassing nature and individual members' chance to help and be helped for the good of the family, which is usually paramount. For instance, a household survey in this study showed that 24 out of 96 migrants (or 25 percent) who were traders or wage earners at Nkawkaw gave monthly or occasional financial support to kin members back in the village. Only 14 percent (14.6 percent) did not remit to other kin members. The bulk of the respondents (58, or 54.1 percent) did not give any answer on remittances in the survey questionnaire, which does not mean

they do not remit to kin members back home. Rather, it may be linked to an Akan value—the obligation to help other kin members is seen as a virtue and to mention it could be taken as bragging about it, which is usually frowned on.

Supporting others indicates the pulls of matrilineal descent on the individual and the burden to be of help to other kin members. Having left school and with an opportunity to earn money from petty trading (even if her earnings are minimal), Grace was seen as better off than someone who is still in school or with no means to trade. Anything from her was eagerly anticipated. Grace, then a beautiful woman of about 22 years, started a relationship with a 'rich businessman'; it was also obvious that she 'roamed around' men and did not stay at one place, as the Akan say. After some time Grace started to feel ill every now and then. She returned to the village to complain to her mother and went to the Holy Family Catholic Hospital at Nkawkaw, where she was tested as being HIV positive in January 2003. Like all such patients, she became the hospital's outpatient and reported for the counselling sessions organised every other Thursday.

The hospital also organises visits to interact with the HIV/AIDS patients in their homes and to check on their medication. It was during one of those visits on a bright Wednesday afternoon in April 2003 that Grace told what she termed as her "whole sad story" to the team of hospital personnel.[50] Grace had cohabited with the rich businessman but separated from him because "he was a womaniser". It was not long after the separation that she was diagnosed as being HIV-positive. She never told the man about her status, although he still pressures her to come back. Grace, however, assured the hospital team that because of the counselling she had decided not to go into relationships with men any more. She had come back to settle fully in the small village of a few huts and about fifty inhabitants, and was not expecting the men to visit her there. It was a remote village, Grace mused, but it was the place where she had lived as a child until she started schooling initially at Nkawkaw and later at Koforidua. Like among Haitians, as found by Paul Farmer (1992), there was the pattern of people having left the village to the urban area where they got infected and came back to live in the village. Radstake (1997) records a similar pattern in Ashanti.

[50] I accompanied the team on their rounds to a number of villages and towns that day. It was a tiring day, which started with some problems in getting a vehicle and other logistics for the journey. Someone whispered that sometimes the team has to run around for a vehicle, fuel and the signing out of other logistics; it is just cumbersome and it "shows the highly bureaucratic way of doing office work in Ghana". She, however, observed that it is worse in government hospitals.

When we met Grace B in her home at the village where she was currently living, she did not look ill. She was exuberant, full of smiles and grateful that we had visited. Behind those smiles, however, the patient was to reveal her 'real' post-diagnosis worries to us. She was almost always confronted with financial difficulties. It is, however, not the financial problems that concerned Grace. She was bitter about her mother's attitude towards her. In the open space of the compound, however, she could not tell us anything about it; she invited us into her own room, quite far away from her mother, her younger brother, and sister. Hardly had we sat down in her room, when Grace started to pour her heart out. She first assured the visiting team that everything was fine with her health and she still had some of the medicines she had collected during the counselling session the previous Thursday. Grace's greatest problem was that she had had no peace in the home ever since she revealed her status to her mother some weeks back.

Grace was disappointed with her mother's attitude towards her: "Ever since I told her that I had been tested as HIV positive, she insults me at will. One day, she even cursed me for my lifestyle that resulted in my infection," Grace revealed. She said her mother even went further to tell her brother and sister about her status. "She told them that I got it because of the kind of lifestyle that I had led. But I haven't done it for my own sake alone." With tears in her eyes, Grace further poured her emotions out: "You all [meaning her mother and Grace's siblings] have benefited. I had to look for money and some property to make life easier for us. This compound and the few houses we have been able to build have all been through my efforts," she pointed out as she tried to force back the tears in her eyes. Grace said her mother insults her at the least chance. She was convinced her mother had revealed her status to her younger brother and sister on purpose. Grace was bitter that her mother had not been sympathetic, considering her efforts and help in the family until her infection.

Her mother's castigation and the contempt from some of her siblings aside, Grace was faced with another problem. She revealed that to us thus: "When I didn't know my status, not many men proposed to me. Now that I have been tested as HIV-positive, surprisingly many potential suitors are emerging and proposing immediate marriage. I have been saying no, even though I know they must be unaware of my status. But my mother comes in here too." Her mother has been insulting her for the negative answers to the men. "My mother has been trying to put pressure on me to agree and marry a certain rich man. The man is so rich, and my mother thinks I could go ahead and marry him without telling him about my status." Her mother's prodding had confused Grace and she wanted advice from the health team.

As expected, the health personnel advised her to ignore what they viewed as her mother's unfortunate behaviour and advice. Grace now loathes her own mother, whom she calls an evil person.

The family still lived together in the same remote village near Nkawkaw. For her living, Grace works on the farm she used to keep when she schooled at Nkawkaw. As a migrant without her lineage group in the Kwawu area, she grows cocoa on someone else's land. As the usual practice for migrant farmers in Akan-land, she goes into '*ebusa*' terms. The inclusive nature of the group sees migrant and tenant farmers as 'outsiders' who have no direct access to lands unless they go into the traditional '*abusa*' system whereby the land owner receives one-third of the produce. She also has a vegetable farm specifically for the household's consumption. Grace faces many other challenges. The undulating dirt-road from her village to the main junction on the Accra-Kumasi highway, an apology of an outlet for vehicular use, makes drivers plying the route charge quite high fares. Lorries and taxis are not regular and sometimes Grace has to walk the more than 10 kilometres from her village to the main junction. She gets so tired that on the next counselling day if she is not able to find a vehicle, she abandons the trip to the hospital altogether. Even when she can get a vehicle to transport her, the fare of five thousand cedis (about sixty five US cents in 2003) is unbearable to her. But she is determined to face life boldly in her predicament.

The HIV/AIDS illness disorder

Before I left the field in mid March 2004, Grace looked quite ill and weak. She could not do much as a farmer. HIV/AIDS has become a major illness disorder, which also expresses how illness is constructed in Akan society. Any physical disorder that weakens the body or that renders someone immobile disrupts the coherence of meaning in everyday life. In folk medical discourses, illness is a disturbance in the health balance because it blocks one's chances to be productive. The Akan view a good balance in health as an individual's ability to perform duties and roles; illness is thus a problem for cultural categories. To better understand illness as a disorder in Akan conceptions is to consider the etymology of its local (Twi) name. Illness is *yadeɛ* (usually, *yareɛ*)—from *yaw* (pain) and *adeɛ* (thing), making it a thing of pain (cf. Ventevogel 1996).

Various physical symptoms such as bodily pain, discomfort, weakness, psychological disturbance—anything that prevents the individual from pursuing his or her everyday activities (or which seriously minimises

the pursuit of them)—all indicate illness. Because AIDS always leaves patients' bodies weak and emaciated, which prevents them from working, its status as an illness should then become obvious in Akan conceptions. In biomedical terms HIV (human immunodeficiency virus) is the infection caused by a virus that attacks and destroys the human immune system. It shows no symptoms of illness on the affected individual in the early stages of infection. It is explained that generally people infected with HIV may take as long as ten years before they develop AIDS (Acquired Immune Deficiency Syndrome) as the full-blown disease when opportunistic infections can easily set in (Webb 1997). Obviously, because of the long period it takes for an HIV-infected person to show signs of illness, known as the latency period, in Ghana the disease is simply called AIDS without any reference to HIV. AIDS has no Akan word. Instead, it is described in the idiom of gonorrhoea (*babaso*); it is referred to as *babaso wiremfoɔ* (enigmatic gonorrhoea).

Douglas Webb (ibid) explains in his discussion of HIV and AIDS in southern Africa that the retrovirus that causes AIDS and has been known since 1986 enters the blood stream through contaminated blood, seminal and vaginal fluids. Once in the individual's blood stream, the virus targets the CD4-T lymphocyte cells, a vital component of the immune system that fight against diseases in the individual's body (ibid: 3). Webb makes a pertinent correlation between two contrasting environments and the span of time from initial infection to eventual death. According to him, the environment in many traditional societies has high levels of pathogens (which cause disease). This makes the process of immune deficiency in such societies considerably shorter than the average ten years after which HIV develops into AIDS in advanced societies.

Webb asserts that there is an average of six years between the time when HIV develops into AIDS in many sub-Saharan African societies and two years between full blown AIDS and death; eventual death usually results from the combined impact of opportunistic infections. The most common infections—tuberculosis (TB), diarrhoea, vomiting, and herpes zoster— combine with various oral and skin lesions such as candidiasis (ibid: 4). The picture in Akan society subscribes to almost all of Webb's claims. All the AIDS patients I saw also suffered other ailments. Feverish conditions, diarrhoea and loss of appetite, TB, skin rashes, pains and weakness in the legs characterised the problems and suffering associated with the affliction.

Two major strains of HIV are identified in Ghana— HIV-1 and HIV-2— which fits the pattern in most African societies. HIV-1, found in many

other parts of the world, is more prevalent in Ghana and accounts for a bigger percentage of infections. HIV-2, mostly confined to West Africa, takes up the rest of the infection in Ghana. There can, however, be a double infection of both strains.[51]

The experience of HIV/AIDS in Akan society is foremost a disorder for the individual; it is also a social disorder because it affects other kin members. Medical anthropology often recognises that illness indicates both a biological and social disorder, which also conveys psychological and emotional feelings. As Rene Devisch has pointed out in his study of rites to heal infertility among the Yaka, illness first concerns the subjectively and culturally informed experience of the ailing person. It also concerns the way it is given shape and interpreted in terms of the meaning and core values of the culture (1993: 30). The illness becomes social in character when the sick person, kin members and co-residents of the community acknowledge the disorder.[52] Among the Yaka, the ailing person and his or her 'therapy managing group' interpret the specific way in which the individual's state of health or style of behaviour deviates from the norm. They then "mark out or stigmatize the deviation with regard to the interests of the group" and to what extent the individual's illness threatens them (ibid: 161). Similar ideas pertain in Akan society.

The social definition given to the HIV/AIDS affliction—that is, both as an individual biological disturbance and a social disorder—is important in Akan illness construction. Grace was being cared for by other kin members because they acknowledged that she was weak. Her illness is consciously or unconsciously marked out as one that cannot allow her to work and be able to support others as she used to do. She must now be supported, which again shows mutual support in the family. Grace had been attracted to the big towns with urbanisation and promises of better conditions to be able to cope with the vagaries of 'economic' circumstances in Ghana today (Brydon 1999: 367). Because she has become ill and weak, it is not just her own chance to support herself financially that is blocked; that of others who had been benefiting from her are blocked too.

Individual goals are becoming strong in Akan society but one still has to contend with family/lineage values. Individualism is gradually taking hold in many aspects of life in Akan society, promoting self-help efforts and declining importance of kinship and community ties (Berry 2001). There is clearly a struggle between individualism and holism (although it does not

[51] See The MEASURE Project and the Ghana AIDS Commision report 2003.

[52] However, as Kleinman (1980: 75) points out, although it is rare, there are instances when illness may also begin with others labelling the individual as ill even when the person himself or herself has no subjective complaints.

mean a complete take-over of one by the other). Matrilineal expectations persist strongly, and individual goals are pursued with 'helping back home' still on people's minds (cf. Bartle 1978). Thus the problem with the Akan lineage system is the constant presence of the group's values in the lives of individual members. The disease is a cause of economic hardship to both the individual and kin members. It usually threatens and produces strife in families; not surprisingly, stigmatisation, condemnation, and abandonment are recorded more in the close family setting in Akan-land.

The precarious nature of HIV/AIDS in Akan society and the imminent death that awaits many is expressed in the grim picture portrayed by recent increasing figures. The first four cases of HIV/AIDS in Ghana, diagnosed in the Eastern Region in March 1986, had by the end of that year risen to forty two as the officially reported number. The highest levels of HIV/AIDS prevalence in Ghana are largely found in Akan areas, notably in the Eastern and Ashanti Regions. In 1999, Ghana's growth rate of 2.7 percent increased to 4.6 in 2001. The initial figure of 42 infections in 1986 increased to an unbelievable seven thousand seven hundred and fifty two infections in 1999, the peak year so far as shown in the table below.

1986	**1987**	**1988**	**1989**	**1990**	**1991**	**1992**	**1993**
42	112	646	2331	2013	2442	2699	2371
1994	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
2330	2578	3295	3833	4854	7752	6289	3857

FIGURE 4: Table showing the year (in bold) and number of HIV/AIDS cases recorded in Ghana from its inception in 1986 to 2001.
***Source of figures*: World Health Organisation, Regional Office for Africa—WHO Country Cooperation Strategy: Ghana 2002-2005. Internet page: www.afro.who.int**

Not surprisingly, Ghana has taken up the fight against HIV/AIDS at the highest governmental level just as other African countries like Kenya (Akwara et al. 2003). A medium-term plan developed with the World Health Organisation's (WHO) Global Program on AIDS in late 1988 saw the setting up of the National AIDS/STI Control Programme (NACP) in the Disease Control Unit of Ghana's Ministry of Health (MOH). The national programme is aimed at the prevention, management, and control of HIV infection in campaigns through the mass media. It indicated a major step in the fight against the disease.[53] But not much seemed to have been felt in terms of awareness in those years; increases were recorded in the next years.

[53] See *The MEASURE Project* and the Ghana AIDS Commission report 2003.

When the disease began to spread alarmingly, the Ghana AIDS Commission (GAC) was formed a few years later in 2001 to coordinate all HIV/AIDS related activities in advocacy, monitoring, evaluation and resource mobilisation. The Commission is placed directly under the Chairmanship of the President of Ghana (GAC 2002: iv). As with any new institution, GAC seemed to have its own teething problems, and its activities were quite on a small scale. Meanwhile, the growth in infections continued. For instance, in 2003 the official total number of infections was 350,000 but unofficial sources quoted the high figure of 720,000. The rate of 3.6 percent that same year is said to have dropped to the current 3.1 percent, but the projection is that if current trends continue within the next ten years there will be nearly two million AIDS cases by year 2012.

The worst scenario for Akan areas was reflected in the Ghana AIDS Commission Report of 2003. In late 2002 Koforidua, the Eastern Regional capital close to Nkawkaw became the leading district with a high prevalence of HIV/AIDS in the country. Koforidua overtook Manya Krobo, the non-Akan group farther east in the region, which had been the leading district in the 1990s (GAC 2003). Corresponding to such increases are the quite high figures at Nkawkaw ever since the Holy Family Hospital started screening people around 1992. At the time of my fieldwork, the yearly figures below had been recorded:

1993	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003 (J-M)**
97	272	190	106	101	81	68	86	74	144	25

The gloom surrounding HIV infections and AIDS deaths is unprecedented. The pre-colonial and colonial disease pattern in Akan society was quite grim. Margaret Field (1960) gives a good idea of the sordid pre-colonial health picture, although as a psychiatrist she seemed to have concentrated more on mental disorders and their relation to venereal diseases. According to Field (ibid: 87), in 1918-1919, the influenza pandemic almost decimated whole villages. My fragile-looking centenarian[54] informant recounted how in the colonial period, chicken pox, smallpox, and influenza surfaced to co-exist with leprosy, piles, fever, rheumatism, and many others.

[54] By her own reckoning, the white-haired old woman informant must be more than 120 years old. She had just been married when Yaa Asantewaa (the queen-mother of Ejisu) led the Ashanti war against the British in 1900. She told me Kwawu myths and first-hand information about historical events.

In his study of health, disease, medicine, and socio-economic changes in colonial Ghana from 1900 to 1955, David Patterson (1981) notes that medical (hospital) intervention was effective only with yaws, traumas, and other conditions requiring surgery. Other diseases such as syphilis, gonnorhoea, and malaria were still endemic. Cholera had never occurred in Ghana then (ibid: 83, 106). In 1971, however, a severe and widespread outbreak of cholera in the Akan areas especially took the lives of about 13, 048 people,[55] seen as a huge figure in those days. The folk explanation in many towns and villages for that countrywide outbreak was that witches had 'bought' the disease and spread it in the society. Individual witches were said to use the disease as a weapon to kill kin members.

The epidemiological situation of Ghana, similar to other sub-Saharan African societies, is predominated by many communicable diseases such as tuberculosis and cholera, as well as sexually transmitted infections (STIs) — syphilis, chancroid, and gonorrhoea. HIV is an STI and closely linked to other such diseases (Webb 1997). It is claimed that untreated STIs become an easy means for HIV transmission; thus, STIs are crucial in HIV epidemiology (ibid: 136-137). The problem with HIV/AIDS is that it is incurable while malaria, for example, can be remedied. Malaria is indeed endemic in Ghana. The whole of the country is identified by the World Health Organisation (WHO) as a major zone prone to malaria. According to the WHO, almost the whole of Africa is home to the most deadly species of the mosquitoes that transmit malaria. Hence, it is topmost (together with TB and HIV/AIDS) on WHO's programmes on the many diseases it is trying to eliminate in the world.[56]

Malaria really accounts for many childhood deaths and morbidity. It is estimated that about three million cases are recorded annually, with more than 38, 000 deaths.[57] But, as already mentioned the consolation with malaria is that it can be treated if detected early enough. In contrast, HIV/AIDS has no cure and worse still, there are increasing numbers of infections and deaths. The devastation caused by HIV/AIDS in sub-Saharan Africa has been compared to the Black Death in Europe in the fourteenth century or the influenza outbreak in India after World War I (Caldwell et al. 1989). It has become the "greatest public health challenge" in the world today (ibid: 185).

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[55] Source: World Health Organisation. Internet page: http://www.who.int (16/3/2006)
[56] Found in the WHO homepage. Source: www.who.int/malaria
[57] See latest figures by the health authorities in Ghana, as reported by the Ghana News Agency. Source: www.ghanaweb.com (a private Ghana Homepage on the internet). (14/3/2006).

The HIV/AIDS hazard: risk factors

Since the most common form of infection among the Akan and in Ghana generally is heterosexual contact, sex dominates the discourse on risks for HIV transmission. Discussions on risks, however, did not start immediately after the disease first surfaced in Ghana; a non-prioritisation of the issue seemed to have occurred. It was not until 1998, twelve years after the first AIDS case in 1986 that questions of people's perception about risk of infection were seriously explored. Only a third of men and women (32 percent) felt then at risk of being infected with HIV.[58] The attitude seemed unchanged during my fieldwork in 2003. Many respondents still feel that only those residing in the urban areas were at risk. Because the first cases in Ghana were recorded among sex workers, the common assumption initially was that only prostitutes and their customers were at risk.

Social research theories for the risk of AIDS have always tied HIV infection to mother to child transmission, unprotected sex in gay and heterosexual relationships, and intravenous drug use (Small 1997). Dominating the discourse on risk factors in Africa are heterosexual contact, low use of condoms, poverty, and migration (Caldwell et al.1992; Hunt 1996). These are equally structural issues that confront the individual as she or he confronts life. Douglas Webb (1997: 80), considering the epidemic in South Africa, attaches some of the risk factors to migrant labour flows, economic relations, and apartheid structures. Except for the factor of apartheid, the others arguably fit the Akan situation well. In this regard, I am in agreement with Webb (ibid) that the conditions which create high risk situations are institutionalised. Poverty is widespread in Akan society; indeed Ghana is ranked as a poor country with more than a third of its population living below the poverty line.[59] But the country knows it is helpless against poverty. Hence, migration and labour flows are important and accepted way of life for better living conditions.

To avoid poverty in the villages, people migrate to the cities (cf. Bartle 1978). Three major sociological problems are associated with migration to the cities. First, it significantly affects economic and social structures in the villages, left almost bare with homes occupied by the elderly and children while farms are increasingly abandoned. Secondly, because many migrants do not find jobs they take to street vending, selling anything from dog chains to wrist watches. Street vendors are increasingly becoming a

[58] See The MEASURE Project and the Ghana AIDS Commission report 2003.
[59] The 2005 Human Report of the United Nations Development Programme (UNDP) rates Ghana 138th in human poverty among a group of sub-Saharan Africa's poor, and in an overall 175 countries in the world.

nuisance, aggressively pushing their wares into cars; worse still, some are often run over and killed by vehicles. Thirdly, the common assumption that migration increases social problems is given credence by the increasing incidences of armed robbery and pick-pocketing in Ghana today. Girls may even be more vulnerable; they may become commercial sex workers or engage in sexual favours for money to survive. The risk of HIV infection also becomes high. Because people generally adopt negative attitudes towards an HIV/AIDS patient, stigmatisation becomes a risk factor when infected persons keep their status secret and go about their normal sex life.

Inconsistencies that marked earlier explanations about the origins of the disease and risk groups may have led to the apathy and a level of ignorance in Ghana. I suggest that because HIV/AIDS was initially traced to Haiti (Farmer 1992), homosexuals (Small 1997), and Africa (first to monkeys and later among sex workers), it prevented people from seeing the reality. A group discussion with some lay people in the early stages of my fieldwork revealed individual theories. For example, some people think that the disease has been created in American laboratories in order to curb promiscuity and rampant sex among Black people. A male school teacher with Marxist ideas vehemently blamed the United States. His accusations and attribution of the origins of the disease to the US comes close to the conspiracy theory Farmer (1992) found among Haitians:

Perpetual Crentsil (PC):	What are your ideas about HIV/AIDS?
Teacher:	You see, let me tell you, the Americans created it all— to wipe out the American Blacks so that the Whites alone would live in that country. They injected some of the Blacks in their prisons with the virus and set them free into their families. But the Whites had forgotten that the Blacks engage in relationships with other Whites, and through that things got out of hand and the disease spread all over the world.
PC:	[jokingly] I'm not convinced by your 'theory'.
Teacher:	I'm giving you the bare facts [shouts slightly]! You see, when the Americans saw what they had done they quickly used it to their manufacturers' advantage— in the sale of their condoms.
PC:	Are Ghanaian manufacturers not currently producing most of the condoms in the country?
Teacher:	Don't you realise things? How long did it take the local manufacturers to get onto the scene [market]? The American companies had by then already made their profits [as he looked visibly indignant about my prodding, I was about to discontinue the conversation

when we got to the junction where we had to part ways into our homes].

The danger about the teacher's ideas is the potential to translate into lax behaviour about sex. A survey by the Ghana AIDS Commission in early 2005 found that teachers showed high levels of ignorance, inappropriate sexual behaviour, and denial of the existence of the disease.[60]

Risks, campaigns, and behavioural change

Educational campaigns about HIV/AIDS in Ghana have increased in order to create awareness and reduce the risk of infection; indeed many people have become aware of the existence of the disease and its modes of transmission. Getting people to change their lifestyles has been a major campaign message to fight the spread of the disease in Ghana as in other sub-Saharan African countries (see Webb 1997). Unprotected sex between men and women and the activities of commercial sex workers top the risks and factors for the spread of HIV infections. Hence, educational campaigns call for change in sexual behaviour through the adoption of healthy sexual lifestyles—sexual abstinence or 'safe' sex.[61] Non-governmental organisations (NGOs), community-based organisations (CBOs), the churches and other civil society organisations are helping with community outreach campaigns. They undertake to support people living with HIV/AIDS (PLWHAs); they counsel them, organise peer education and training workshops, and are engaged in advocacy, radio talk shows, home visits and condom promotion. As Peter Redfield (2006: 3) has pointed out in an article on the Medecins Sans Frontieres (Doctors Without Borders), the activities of such NGOs play a central role in defining secular moral truth through humanitarianism.

The educational campaign strategies used to create awareness about HIV/AIDS have their own shortfalls; they are often public (mass) campaigns than interpersonal, face-to-face communication, except at the hospitals during counselling. On the streets in major towns and cities of Ghana are billboards that read conspicuously: 'AIDS is real'; 'Stop AIDS, love life'; 'AIDS has no respect for anybody' 'We are all at risk';

[60] See the story in the Daily Graphic newspaper of 4 January 2005, which appeared while I was in the country for a short holiday.
[61] This is consistent with findings from other developing countries such as India (see Asthana and Oostvogels 1996).

'(A)bstinence or (B)e Faithful or (C)ondom use'.[62] Small posters on HIV/AIDS and behavioural change are occasionally seen in the villages.

As in other African societies, abstinence is one of the strongest messages being preached by the churches and other religious bodies; it is seen as the best practice, which also holds the key to sexual or reproductive health of the youth and the future. The many 'Virgin Clubs' formed by Christian Churches and organisations reflect similar ways of combating the disease. Christian associations and churches are making their young members promise to abstain from premarital sex until matrimony, which is close to the traditional Akan norm of no sex before puberty rites and marriage. But how many people adhere to this or even see it as necessary? Many clubs and associations embark on processions with music and dancing to educate and create awareness. Others organise walking several kilometres with placards, thus making an ordinary human activity (walking) an extraordinary event, and through that they hope to change ignorance into knowledge. But how often are these organised and how many of the people who take part are serious about the goal?

Advice to people to be faithful to their partners does not seem to be as popular as condom use. The need for people to protect themselves, as the campaign message on using condoms in the fight against the disease goes, seems popular among the youth. However, there is the worry that condom culture is still low (cf. Frimpong-Nnuroh 2002). In Kwawu, many said they did not use condoms, although they are in relationships. One woman mused: "How would it feel like using condoms? Will it be enjoyable? I'm sure it will hurt me." Some men claim that 'flesh-to-flesh' is more enjoyable. But when considering factors for the low condom culture, we need to move beyond questions of people's pleasures and other sentiments. Instead, we need to associate it with women's reproduction and manipulation. As Radstake (1997: 107) has pointed out, for many women unprotected sex is a way to commit a man to them by giving him a child.

Also, many people do not seem to favour condoms because of shyness when purchasing them. Until recently, to walk into a pharmacy shop and ask to buy condoms was one of the daunting tasks for the youth especially. Condoms (locally called rubber) were in the past meant for birth control alongside others such as the foam and IUD in family planning programmes that targeted married couples (see Bleek 1976). Sexuality is not openly portrayed, and to buy condoms is invariably to show that you do what everybody knows exists but does not mention. These days the old paradigm

[62] The last message may be viewed as the basics for behavioural change; an important guideline that should also be as simple as ABC, as often said in Ghana.

of low condom culture is being supplanted. People are resorting to condoms, but it is more on such festive periods as Valentine's Day, Christmas and Easter when there are reports of shortage of condoms. Thus the change is only sporadic and can even be more dangerous. Controversy surrounds condom use with regard to some Christian organisations. For instance, the Catholic Church in Ghana, like the world over, has been against promoting condoms as one of the safest measures. The position of the church is echoed by many who are of the view that condom use encourages promiscuity.

Big-time NGOs long involved in campaigns for good reproductive health, such as the Planned Parenthood Association of Ghana (PPAG) and the Ghana Social Marketing Foundation (GSMF) nowadays give free condoms to revellers during festive occasions. This may look outrageous to the Christian ideals of the churches. It could be that the NGOs are only being guided by the reality that the current behaviours and attitudes of the youth especially make sexual abstinence only a mirage. There is no need to leave things to chance, is there? Such may also be the view about truck drivers, generally seen in Ghana as a high risk group. Based on this, the GSMF has made drivers one of their main target groups and the campaign message to them, 'Drive Protected', is on stickers distributed to them to affix on their vehicles.

Many such organisations engaged in campaigns face such problems as lack of logistics and difficulty in reaching many of the rural areas. Sadly, some NGOs capitalise on the dire AIDS situation to make money for themselves by embezzling funds from the Ghana AIDS Commission and other international donors. For instance, it was reported in mid 2003 that 114 CBOs embezzled 1.4 billion cedis (about US 160 million dollars) belonging to the Commission; many such negative attitudes have attracted concern and condemnation in the media.[63] Other bogus organisations even give unreliable addresses as points of contact (GAC 2003). These may be the few bad nuts; many more are involved in community development to the benefit of rural dwellers and genuinely and actively campaign against the disease.

In general, poverty is directly associated with some social problems, and it has a relationship with HIV infection. Poverty has been a dominant motif in the HIV/AIDS discourse as a concatenation of factors that result in and increase HIV infection. Many studies about HIV infections have shown that poverty starts a vicious cycle when people migrate to cities and neighbouring countries and indulge in unprotected sex. The eventual loss of

[63] See the editorial comment in the Ghanaian Times newspaper of 25 October 2003, and a story in the Daily Graphic of 26 July 2003.

human and economic resources to both the individual and other kin members when patients cannot work due to weakness from AIDS was clear. Many of the HIV/AIDS patients I came into contact with became infected in urban areas. The story of Grace B is one about the necessity to move out of a rural area into an urban one in the search for a better way of survival for her and others and becoming HIV-infected. It is also a story about women's sexuality, like that of Eva Abe.

Eva Abe's illness

Eva Abe was about 35 years old. She was quite educated and worked as a civil servant. She was married to a businessman who was quite rich. The man had married Eva in the customary way. He had presented drinks and other items as part of the bride wealth to Eva's lineage members, as 'proper' Akan marriages are established (cf. Rattray 1929). Marriage (*awareɛ* in Twi or *awar* in Fanti, from the adjective *ware* or long) literally means 'a long journey' because it is expected to be long-lasting. Akan marriages conjure rites that are calculated to integrate the wife into her husband's family. This is established by the man (through his family elders) paying the bride wealth to the woman's family. So, the woman is always the one who is married by the man and not the other way round, although it can be said that a woman 'agreed to marry a man'. Eva Abe's husband had paid bride wealth to her family, making the union a recognised one. They established their own neo-local home.

I do not know whether they had children. Eva, who initially agreed to have an interview with me, later refused it. The social worker informant who first told me about Eva and the fact that she was infected by her husband did not know either. The social worker could not find out from the patient. Eva never revealed anything about her husband's infection and finality, even though he predeceased her. Moreover, Eva had already become aware of the reason I (or the social worker, whom Eva got to know was my good friend) wanted such information from her. It became apparent that it would be useless to attempt any information from her. Such is the secrecy about the disease, as Radstake (1997) found too in Ashanti.

According to my social worker informant, Eva knew that her husband was going after other women. Eva initially complained to her kin elders. She could not complain to the man directly, although she indicated her worries about the husband's behaviour to him on countless occasions. One day, Eva packed her belongings. She left her matrimonial home and went back to her lineage home. Eva's own people were not happy with her action

obviously because the man was taking good care of her. They impressed upon her to go back to her husband and promised to talk to him about the problem. They never talked to the man. As my informant put it, "they could never take up such an issue with the man", which marks an important point about Akan marriages. Since marriage as an achieved status brings respect to both women and men in Akan society as among the Nyole (Whyte 1997) people are encouraged to marry but are usually not encouraged for divorce.

The prestigious nature of the marriage institution among the Akan is such that it is not easy to institute divorce proceedings, especially if it comes from the woman. Previously, it was not easy for a married woman to initiate divorce from her husband. This persists even today, although it is fast disappearing. Even where a husband is guilty of some misbehaviour, such as frequently beating up the wife, it may still not be easy for the woman's family to institute charges against him and bring about divorce proceedings, especially when he is rich. The usual feeling is that because men pay bride wealth and 'look after the wife or wives and the children', they have control over women in marriage. A woman was in the past not given her share of the lineage land if she was married, perhaps to make the husband look after her. In present-day Akan society, divorce and women's refusal to remarry is on the increase, which marks significant structural transformations and a changing gender balance. Reflecting increasing female-headed households, such women own (or are awarded their share of) family lands, which they work on single-handedly or with their children from the estranged marriage.

As a paid worker, Eva was quite economically independent. Many married women in contemporary Ghana try to be independent by taking paid jobs or trading. But the effort to be self-reliant may see women in conflict with their husbands or even the mother-in-law. The complaint is always that work outside the home takes the married woman away for long hours from other family responsibilities. I do not think Eva faced such a problem from her husband or in-laws, although I could not find more from her. Eva's case makes visible the many shortfalls in Akan marriages and the matrilineal organisation. Eva's husband predeceased her; he died two years before my fieldwork. I did not get Eva's story from herself since she was so evasive, if not antagonistic towards me, but the informant who told me about Eva's story was of the opinion that Eva was still too scared to say anything that would offend her late husband's family. Even though she had been infected by her late husband, Eva never talked about his womanising or the cause of his death to anyone. The middle-aged social worker saw that as unfortunate because it does not help matters.

A similar situation of a husband suspected to have infected his wife occurred to a couple from the northern part of Ghana who resided at Nkawkaw. The man is said to have contracted the disease; after testing HIV-poisitive he was advised to bring his wife for testing. She tested positive too. There was nothing she could do other than to be sent back to their home town to die. Her husband took her back to northern Ghana, and was back at his work as a junior clerk in a company at Nkawkaw. The woman deteriorated quickly and died less than two years later during the latter part of my fieldwork. She thus predeceased her husband, who continued to receive counselling at the hospital at Nkawkaw. Stories often circulate about women who had been infected by their husbands or partners. Most of those men may have later died or they outlive the women. The stories are the sordid experience of women like Eva Abe, worried but helpless against her husband's womanising which eventually caused her infection.

Women, sexuality, and HIV infections

Eva's and the other married woman's stories are good examples of HIV infections caused by regular partners who are thought to have engaged in extra-marital affairs. The stories also give credence to the view in Akan society that many married women are infected by their husbands. Women's helplessness over their own sexuality attracts considerable attention when considering HIV/AIDS in Africa and other traditional societies. The discourse on women's sexuality and HIV/AIDS also takes on a discourse about an aspect of Akan married life. Polygyny, widely practised in the past, is changing rapidly and being replaced by monogamy, especially in urban areas. There are many instances of women's helplessness regarding the polygamous or promiscuous relationships of their husbands. It is not common to find a married woman having an extra-marital affair because the society frowns on it. In contrast, as in Togo (Moore and Williamson 2003), in Akan notions men are capable of marrying more than one woman. Many married men also have girlfriends and are sometimes wayward with one-time intimacies, which greatly risk infecting their wives. In fact, the incidence of HIV/AIDS is higher in women than in men. Records in Ghana indicate that HIV/AIDS in women aged 20 to 29 is higher than in men of the same age group.[64] Such a pattern is portrayed in many traditional societies.

Women also have little control over their own sexuality. There is increasing worry about men's domination over women in relationships,

[64] See also World Bank report 1999.

which is closely tied to women's sexuality and HIV infection in traditional societies. Many women in such societies have few or no opportunities for economic survival except commercial sex or sexual favours. The view, although not statistically proven, is that men's appetite for pre-marital and extra-marital intercourse is a major contribution to women's increased prostitution and HIV infection. Similar views are expressed in India (see Asthana and Oostvogels 1996). The lack of control over their sexuality and the increasing high levels of women's infections in many sub-Saharan African societies are strongly associated with their low status (see Caldwell et al. 1992). In Botswana, a major factor for women's HIV infections is their low status in society and the "lack of power in negotiating sexual relationships" (MacDonald 1996: 1325). Ghana has similar problems. For instance, because many men enjoy 'flesh-to-flesh' their wives and girlfriends have to accept it if they do not want to lose their husbands and boyfriends.

Caldwell et al. (1989) have tried to analyse how sexual attitudes and ideas increase the rate of infection in sub-Saharan Africa. While they caution that African sexuality is often misrepresented because it is viewed from a Western perspective, one of their central arguments is that Africans do not attach any religious moral value to sexual activity (ibid: 187). Critics of Caldwell and his collaborators point out the major flaws in their thesis (e.g., Ahlberg 1994; Heald 1995). Beth Ahlberg criticises Caldwell et al. because "their analysis is ahistorical" (1994: 222-229). She notes that the arguments by Caldwell et al. do not take into consideration African societal taboos and prohibitions about sexuality in the pre-colonial society. For her, the colonial and Christian view of African customs as primitive when Christianizing the 'natives' became counter productive because it wiped out many practices that ensured strong moral values about sex. A similar argument could be made for the Akan.

Christianity and Western education viewed traditional Akan practices as primitive or superstitious, and many of those practices were abandoned. Beliefs about witchcraft have persisted, but others were not able to survive the assault. Puberty rites for girls are one such social practice that has almost faded. Sex was (and still is) not seen as a child's play in Akan society; it was recognised mainly for procreation. Sex and pregnancy before puberty rites were heavily frowned on (cf. Bleek 1976). If they occurred, purification rites were performed to cleanse the culprits and to pacify the gods and ancestors. Because it occurred usually in marriage or in a relationship expected to produce children, sex merely as a form of enjoyment was not encouraged. Individual enjoyment was not to be put

above society's increase and community good. Sex-related crimes were heavily punished. Incest (*mogya fra*, lit. mixing of blood) saw the culprits killed or banished from society; sex in the bush or bestiality rarely occurred.

Marriage has always been an important institution and a mechanism to ensure ordered behaviour among the Akan. Anthropologists usually claim that marital unions tend to be relatively weak in matrilineal societies. Schneider and Gough (1961), for instance, claim that matrilineal societies differ from patrilineal ones in terms of marriage and sexuality. The recruitment into the corporate group through matrilineal descent gives women in such groups a level of prestige and a leeway in sexual relationships than their counterparts in patrilineal ones. The Akan as a society which values high fertility of their women, nevertheless, recognised birth within marriage or in an approved cohabitation.

The order about sexuality was extended to establishing a marriage. Arranged marriages were the norm in the past, just as betrothals (*asiwa awareɛ*) where a girl was promised usually to an older future husband. This was a mechanism to minimise promiscuity, especially on the part of the girl and to ensure future possible marriage and procreation. A legal marriage is established by the man's family giving *tiri nsa* (lit. head drink) consisting of liqour, a sum of money and some items as the bridewealth to the woman's family; it thus strictly involves members of the two families. Romance and love were not necessarily understood to be a major part or a prerequisite to marriage. Before a marriage was established, the man's family investigated the woman's group and vice versa. They made sure no negative traits—stealing, murder, and suicide had ever been recorded and no dangerous or contagious diseases (leprosy, mental disorders, TB, etc.) existed in the lineage group of the prospective partner. Families/lineages were thus promoting the general good health of the society; an Akan marriage then was a health promotional agency. This, unfortunately, has virtually stopped.

The marriageable age for girls in the past was around 16, when puberty rites had been performed upon first menstruation. Menarche was the sign for initiation (the *bragoro*, nubility rites) and the readiness to marry. For boys, marriage was around 20 years of age and when they were financially and psychologically ready. In a society where sex is viewed as important only for procreation and pre-marital sex is heavily frowned on, asceticism before nuptiality was necessary and admired for the communal good. A 75-year-old woman expressed these sentiments about sexuality in those days and in contemporary times:

> As girls in the past, we indeed fancied boys and even referred to them as our lovers (*mpena*). We danced together and even exchanged handkerchiefs as we socialised;

> but that was the farthest things could go. There were no thoughts of sex with them and we were never intimate. A girl had to wait until a boy's family approached her elders and asked her hand in marriage; the marriage rites were performed before the couple had sex to start a family. Today, what happens? Girls who haven't even experienced their first menses (*bra a edi kan*) take boyfriends and do what was in the past reserved for married people.

Deviant sexual behaviour (and teenage pregnancy) before marriage commonly occurs these days, although it attracts criticism (cf. Bleek 1976). Girls go for rich men even if they are married men, and some mothers back their daughters in such relationships obviously because of monetary considerations. Older people and adherents of traditionalism consider the moral degradation among the youth and at times blame Western lifestyles and ideologies that have infiltrated, adulterated and eroded many aspects of the indigenous practices seen to express morality. Girls nowadays are trapped between customary expectations and the claims of modernity, of "processes that destabilize and decenter as much as they control and contain" (Piot 1999: 23). Many young girls (sometimes less than 14 years) have sex with boyfriends in casual relationships. The old ways are seen as 'Colo' (colonial times) and to depart from them is to be abreast with modern times and 'civilised'. Young unmarried girls who have many partners or 'sugar daddies' (much older men) in the cities are often viewed as immoral; and they may actually be at greater risk for HIV infection. As Bleek (1976: 153) has noted, there is enormous discrepancies in so-called "attitutes" and actual practice in aspects of sex relationships.

The Akan were strict about sexual portrayals, especially in the presence of the opposite sex or in communication between older people and children. Metaphors and euphemisms were used in reference to the female and male sexual organs. The vagina is euphemistically called *Akosua Kuma* (Akosua as the day name of a girl born on Sunday, while *Kuma* is a person's name literally translated as The Little/Less). The penis was referred to as a 'stick' (*dua*) or a man's 'manhood' (*ne barima*).

Until recently, homosexuality was not common in Akan society. For instance, Bleek (ibid) found few mention of homosexuality in a study about sexual relationships and birth control in the 1970s. It was heavily frowned on because homosexuality was equated with the decision not to have children; given Akan high regard for procreation, it was unthinkable for someone not to marry from the opposite sex in order to have children. Men whose mannerisms were seen to be feminine were ridiculed with the name Kwadwo Basia (lit. male born on Monday Female). These days newspapers report about homosexuality among young men in the cities, with worries

about HIV infections. Western attitudes and values are blamed and claimed to be 'copied blindly' in many communities. There are worries about scant dressing and profane lyrics in music; video films and television programmes deemed too sexually-explicit and a dangerous importation of foreign cultures are seen to be corrupting traditional Ghanaian society.

Today, when people are helpless and have to live with sexual language among peers HIV/AIDS is also transforming sexual euphemisms. Sex education in schools, viewed as a threat to the moral fabric of the youth a few decades ago, is to be reintroduced with education on HIV/AIDS included in the school curriculum.[65] AIDS advertisements on television that would have been deemed outrageous in the past are constantly shown. One such advert is about condom use in a conversation between two male colleagues; it ends with the phrase, 'If it's not on, it's not in (*ɛnnhyɛ a, yɛnnyɛ)*'.

'All die be die': Apathy about HIV/AIDS

There is great worry in Ghana, as in other parts of Africa, that despite all the education about the disease there has been little or no change in lifestyles. This makes the fight against HIV/AIDS in Ghana a daunting one. There are calls by many well-meaning Ghanaians on people to adopt 'decent' sexual practices and lifestyles. The campaign messages continue but little impact seems to be made.

Some people do not even believe the official figures for the rate of infection. One man argued to me: "They say 200 people get infected daily in Ghana. If that is true wouldn't all of us have died by now?" Many people are not ready to discuss anything about HIV infection and AIDS as a scary disease. People are adamant or display a seeming apathy about the eventual AIDS death. Some say in a carefree way in pidgin English that 'all die be die' (*owuo biara yɛ owuo*), an Akan maxim which roughly translates into the idea that any type of death is death. Such apathy based on the above maxim was recorded in Ghana by Awusabo-Asare et al. (1999) a few years ago.

Such apathy is buttressed by an incident when I visited one of my informants at a small village. As I discussed with the elderly woman about my visits to HIV patients, she called to one of her grown-up sons. "Come and listen, and be advised— AIDS is real." Her son came to us, and was soon followed by his 'brother' (mother's sister's son—MZS) in funeral

[65] Story appeared in *Accra Daily Mail* newspaper of 26 August 2003. Source: The newspaper's internet homepage: http://www.accra-mail.com/ (14/5/2006).

attire and apparently drunk. After listening to us for some time, the drunken man retired to a seat behind us. Suddenly, he burst out: "For how long will you three be discussing this thing about AIDS? Are you all afraid of death? How long does it last to die? Why are you so worried about how death comes? All die no be die?" Without waiting for a reply, he answered his own question: "All die be die." He then called to his 'mother' to give him some food to eat if she had any, because he was feeling so hungry. Such a seeming stoical attitude toward death (or what looks like people's helplessness as far as HIV/AIDS is concerned) has been recorded in many parts of Africa and has been connected to the failure to control the epidemic on the continent (see Caldwell et al. 1992a).

John Caldwell (2000: 124; 1993) has tried to explain such an attitude toward death, using the health transition theory which says one reason for bravery in the face of death relates to a limited progression. People are insensitive to the risk of death in agrarian societies with family production and high mortality. They become sensitive with a transition to a more urbanized, non-farming economy or industrialization, and low mortality (2000: 124). The early society (apparently of the West) was insensitive to death partly because it was less avoidable. Over time in the West death came to be regarded as a very bad outcome. In many African societies, including Ghana, recent research suggests that the high level of mortality is still an important reason for careless attitudes (ibid).

In Ghana, what many see as carefree behaviour on public holidays, during Christmas, Easter, and Valentine's Day continues to occur on these festive occasions. The celebrations are fast becoming notorious for wild band music, drunkenness, near-naked dressing, and unrestrained sex. It is feared that things are getting out of hand; hence, in the Easter of 2003 the Kwawu traditional authorities announced that 'indecent dressing' would not be tolerated. The police detained momentarily the youth who flouted that directive or were engaged in excessive drinking and what was deemed indecent sexual behaviour. But the element of excessive sexuality was never lost; free condoms were given by some non-governmental organisations to people as a way to prevent HIV infection.

Valentine's Day, thought to be an imported holiday, is seen as fast invading the moral fabric of the youth, to the chagrin of many. The concern is about its rapid growth into a day associated with sexual "nonsensicalities", as one writer termed it in a newspaper article.[66] People worry that the 'love concept' in Valentine's Day in Ghana today is being portrayed as one of eroticism and unrestrained sexual behaviour, a far cry

[66] See article in *The Mirror* weekly newspaper of 15 February 2003.

from the agape (Christian love) that the original St. Valentine intended. In fact, in the celebrations of both 2003 and 2004, condoms were short in pharmacies and drug stores in many places, including the Kwawu area. At Nkawkaw and other urban areas of Ghana, people queued with partners for hotel rooms "to have fun", as someone put it.

Closely attached to apathy is ignorance, which in an era of the threat posed by HIV/AIDS, is equally dangerous. Many people seem to view the disease as distant from them. In a big house at Nkawkaw, most of the girls aged between 14 and 17 have boyfriends. Some of the teenage boys in the house are the errand boys between these girls and their boyfriends. They do not think that they are at risk because they equate a physical healthy-looking body with the absence of HIV-positive status. Indeed, most men and women in the rural areas seem to feel they cannot be at risk.

The sense of vulnerability, many told me, should lie with people in the cities like Accra and Kumasi and "those who travel outside Ghana". They seemed to feel no danger in their own villages, seen as safe from the disease. But the prevalence rate of about 3.6 percent in urban areas in 2003 was almost comparable to the 3.4 per cent in rural areas. Many who become infected in the cities and towns come back to their home villages. A significant variation in age groups occurs in both urban and rural areas. The HIV prevalence rate of 4.5 per cent falls in the 25 to 29 age group, followed closely by the 30 to 34 category (4.4 per cent), and the 35 to 39 years group (3.9 per cent).[67]

Is HIV/AIDS a spiritual illness?

There were many instances when patients' HIV/AIDS cases were thought to be spiritual. The biomedical explanation of biological (physical) causation by a virus has nothing to do with the spirit world. Yet people continue to assign spiritual causation. Thus, people's explanatory idioms encompass symptomatic manifestations and aetiological concepts about supernaturalism. Many such instances of people attributing their HIV/AIDS statuses to the work of witches and other spiritual agents do occur among the Akan and in Ghana generally (e.g. Awusabo-Asare and Anarfi 1997). HIV/AIDS is also showing Akan ways of classifying illnesses.

Medical anthropology continues to portray how people explain their illnesses. Our understanding of how patients in Akan society construct their illness will better be understood in relation to the concept of explanatory models developed by Arthur Kleinman (1980). He defines an explanatory

[67] Source: Ghana AIDS Commission. Website: http://www.ghanaids.gov.gh/

model as the ideas employed by lay people and professional practitioners alike to interpret aetiologies, diagnosis and types of prognosis that may seem appropriate (ibid: 104-105). HIV/AIDS in Akan society attracts explanatory models from both the professional point of view and the local understandings; the latter models usually include supernatural causation.

Like many traditional societies, the Akan classify illnesses into two main categories, natural maladies and spiritual afflictions (Warren 1979). Ailments caused naturally or physically are usually talked of as 'ordinary' (*kɛkɛ* or *hunu*) and they include colds, coughs, and feverish conditions. Sometimes, an illness episode is considered merely as 'a lesson' (and not dangerous). The brief tummy upset and diarrhoea suffered by a young man of about 25 years who drank heavily one Saturday evening and suffered the ailment the following morning was viewed as a lesson to him. Co-tenants in the rented house where he lived advised him to chew and swallow *ka me we* medicine, made from a number of herbs pounded into a ball and dried for the cure of many ailments, including stomach ache and diarrhoea. After the ailment, the man was heavily teased (mostly by young women in the house) for having been taught a lesson. In Akan society, sexually transmitted diseases such as gonorrhoea and syphilis are hardly attributed to spiritual causation, perhaps because they respond to treatment. In contrast, spiritual illnesses (*sunsum mu yareɛ*), conceptualised to be caused by witchcraft, sorcery or curses are those that persist or are life threatening. HIV/AIDS as a persistent and life-threatening illness easily lends itself to be attributed to supernatural causes.

While Christopher Taylor (1992) has pointed out that outside influences have transformed many medical beliefs in traditional societies, he has also emphasized that some indigenous ideas persist as a reflection of central cultural elements and values. E. E. Evans-Pritchard (1976[1937]) has demonstrated about witchcraft and magic among the Azande that attributing supernatural causes is rife in African notions about illness aetiologies. It has a long history, and Evans-Pritchard showed decades ago that the Azande attributed a slow and wasting illness to witchcraft. Such attributions show the nature of the belief, how it is related to causation, rules of conduct, divination and the art of healing as a coherent ideology for a people (Fortes 1953: 18).

Of the more than 30 instances of patient episodes I got to know in Akan society, including those from informants who had closely been associated with events, six were attributed to witchcraft, five to sorcery, three to the wrath of angry ghosts, and none to the gods or ancestors. That the bulk was not attributed to any of those spiritual entities notwithstanding,

ideas about HIV/AIDS as a spiritual disorder are quite rife. Newspapers in Ghana usually have stories about witchcraft and HIV/AIDS, and many people are apparently convinced about them. One such report was about a 15-year-old girl who confessed at a spiritualist church that she was a witch and had devoured an HIV/AIDS patient with her group. She herself was dying of AIDS after the incident, and was reported to have died not long after her confessions.[68] Apparently indignant with my inquiries about AIDS and witchcraft, one of the taxi drivers with whom I often travelled told me almost rudely in the face one day that the disease is '*abonsamfo*כ *yareɛ*' (witches' disease). "So, please, stop your unbelief," he advised me.

In her study of illness episodes and visits to shrines for cure among the Akan (Ashanti), Margaret Field (1960) noted that fear and anxiety often gripped the afflicted, for which they gave various explanatory idioms concerning supernatural causation.[69] Akan ideas about spiritual illnesses as the work of malevolent agents express a worldview of human existence which is holistic—the world of humans in their earthly existence encompasses the physical world and the spiritual kingdom. Illness and the idea of evil forces as causal agents thus make the cosmology of the Akan 'human-centred', where the lot of individuals is thought to be affected by power inhering in others. Almost all life-threatening sicknesses and deaths happen with personalistic interpretations and with reference to the power to destroy others.

Deaths from strange illnesses are also attributed to angry deities and curses, in which the powers of ruthless gods are feared to have been invoked. There is one such deity in Abidjan (the capital city of neighbouring Ivory Coast), I was told. Many Ghanaians who had lived and died there or shortly after coming back to Ghana were said to have been cursed, that deity having been invoked. Many others attribute the causes of their ailments to sorcery, as exemplified by Kwaku B's story.

An HIV-positive woman's suspicions

A middle-aged woman who was HIV-positive decided to abandon the hospital medication she had been receiving for her ailment. She consulted a spiritualist instead for help in remedying her situation. At her home, the HIV-positive woman made an important revelation. She decided to abandon

[68] The story appeared in the P & P bi-weekly newspaper of 26-29 February 2004. Many patients believe they had been bewitched (cf. Awusabo-Asare and Anarfi 1997).

[69] Similar ideas of a sense of insecurity and uncertainty during illness episodes have been portrayed by Whyte (1997, among the Nyole of Uganda), Devisch (1993, among the Yaka of Zaire), and Taylor (1992, in Rwanda).

the hospital medication because she was not getting cured after several attempts. Her decision to go to the spiritualist for healing was based on revelations made by the man of God that her ailment was to be countered spiritually. She was indeed convinced that hers was "not a hospital illness".

One bright afternoon in May 2003 when I accompanied the Holy Family Hospital team on their visits to HIV/AIDS patients in their homes, it was also a hellish experience for the team. The woman was adamant in her ideas and very uncooperative with the hospital personnel who had called on her in their usual home visits to check on drug supplies to patients and advise on nutrition. The woman was quite blunt with the team; she had been told by a spiritualist in a neighbouring town that her illness was not for nothing. The spiritualist explained to her that there was more to her illness, and the only hope for cure was by prayers and spiritual healing. The spiritualist had revealed that her problem is "from home", which expresses suspicions about witchcraft. Someone from her own lineage [she said "house"] is envious of her exploits in life. She had apparently planned to live permanently at the spiritualist's church premises in a town several kilometres away from her village.

The middle-aged woman told the visiting team almost rudely in the face that they had better not waste her time telling her about hospital drugs. With such stern words, she went back into her room, slamming the door behind her and leaving us all standing helplessly in front of her doorstep. She was in no mood to discuss anything further with the team. We turned back quietly and went away. The little information I had about the woman indicated that she had a farm and combined it with trading. I do not know how successful she was. Nevertheless, her case makes interesting revelations.

Witchcraft suspicions and accusations in Africa are usually marked by experiences of modernity, monetary and labour economies (Parish 2000). The central trope of the moral economy of witchcraft is usually the maximising individual in the market economy in a community which is marked by norms of collective survival (Austen 1993). In a capitalist society those who gain wealth do so through a dangerous appropriation of scarce resources as "limited goods" among peasants. The situation of an individual or a family can be improved only at the expense of others (Foster 1965: 293). Among the Akan, Western education and a boom in the cocoa economy boosted witch suspicions and accusations in the colonial days. Margaret Field (1940; 1960) reveals that people were envious of others' exploits in schooling and in wealth.

In contemporary times, these ideas of acquisition of wealth and witchcraft (or sorcery) persist, more so because of the expansive markets and the labour economy. Jane Parish (2000) has drawn analogies between witch accusations or suspicions and the capitalist market economy among the Bono Akan. Entrepreneurs both at home and abroad fear that witches would harm them or their finances, and they seek protection from shrines.

The 'dark side of kinship': blood ties, HIV/AIDS, and witchcraft

As the middle-aged woman's story indicates, witches are believed to use illness (in her case HIV/AIDS) as a tool to harm others spiritually. In Akan society, when a sick person (or a member of his or her group) thinks that the illness has been caused by a witch, suspicions and accusations often occur within the clan or kin group (cf. Rattray 1954). The threat to life, brought on by the illness episode seen as perpetrated by the witch, is thus not external to the immediate group and surroundings. The discourse on witchcraft in illness aetiologies has long been recorded among the Akan. In her study of people's visits to shrines when ill or faced with life's problems in the 1940s, Margaret Field suggested that people are usually beset with a feeling of insecurity when they fear that envious machinations are being perpetrated against them from within the kin group.[70]

The Akan explanation that a witch can only kill within her own kin group buttresses the anthropological view that witchcraft is the "dark side of kinship" (Geschiere 1997: 11). As among the Yaka (Devisch 1993: 14), health and prosperity among the Akan largely derive from the branching out of the uterine side of life, with the father's line supporting. Paradoxically, witchcraft and destruction in situations such as illness also come mainly from the matrilineal group. Danger is thus not from outside; rather it is within the kin group, conceptualised to be closely-knit by a common blood. I remember in the late 1960s many children died from measles and whooping cough during a Christmas period in a Fanti town. Most mothers had taken their suffering babies to a spiritual church for healing. The pastor of the church made an important announcement after the deaths. A divine revelation had been made to him; all the mothers who lost their babies from the two diseases that period were accountable for the deaths. That is to say, they devoured their own babies.

[70] Similar ideas are found in Victor Turner's (1996 [1957]) work among the Ndembu. He recounts many incidents of accusations and suspicions of witchcraft or sorcery following a death or in scheming for the matrilineally-inherited village headmanship among kin members that threatened the peace of the community.

The Akan theory is that witchcraft within the kin group works like an owner and the object owned. The analogy of an owner and the object owned is drawn in Akan conceptions about the jural right over the individual. Since by virtue of the blood (and the womb) a person belongs to the matriline, lineage ideas determine the individual's place in the group—as the 'bona fide property' of the matrikin. This also gives the witch (or witches) in the kin group the right over the individual, and to 'kill' him or her as and when they want. One informant drew the analogy of chickens in a pen:

> It is something like when you have a poultry farm. You know you have some chickens and you kill some to eat when you feel like it—at any time. They are yours and you decide when you need to enjoy them.

Both witchcraft (in the lineage) and HIV infections have an interesting (if not strange) relationship with blood. Witches 'suck' dry the blood of their victims 'in secret', that is, unseen by the human eye; similarly, HIV cannot be known unless by a blood test. Since by Akan conceptions the blood belongs to the matrikin and has only been given to the individual to ensure his or her existence, it would not be an affront for witches from an individual's own family to 'drink' his or her blood. However, the Akan explain that not every family or kin member is a witch and the few who are witches should not be allowed to decimate the group.

Moreover, not all witches in a family kill. It is said that some are more interested in feeding on the refuse dump and leaving kin members alone. Occasionally, it is even said that a witch may use his or her witchery to 'protect' his or her children. These are the 'good' witches, even though there is the fear that eventually the witch herself (or himself) or someone else from the family is likely to bewitch ego. It is even explained that sorcerers, cursers, wild and hovering ghosts, and other evil spirits can get access to the individual because the witches from his or her own kin group failed to protect him or her. So, by their activities in the kin group witches challenge, reject and destroy the kinship order in a group expected to be more closely-knit and to protect members.

6. IN SEARCH OF THERAPY

All the HIV/AIDS patients I interacted with sought one form of therapy or another for their ailments. Usually, a form of medicine is used one at a time or different medicines are administered simultaneously. People's search for therapy for HIV/AIDS as a persistent illness always portrays the pluralistic nature of the medical resources in Ghana, expressing also shifts from one resource to another. But people do not merely fall on one form of therapy when the other fails. As Leith Mullings (1984: 49) has emphasised, patients and their kin devise treatment regimens that make selections from among many possibilities. There is, however, no clear-cut and systematic set of thinking about which medicine to use; it rather comes in a piecemeal shift in relation to particular cases (Jahoda 1979: 102). There is an apparent flexibility in changing therapies.

Arthur Kleinman's (1980) study of the medical practices of patients and healers in Taiwan has enabled him to show that people seek therapy in one or more of the three sectors he classifies as the professional or biomedical care at the hospital, the popular or self-therapy, and the folk or traditional healing. The Akan medical system can similarly be grouped and, like the Taiwanese system, it shows the different forms of practices inherent in them. Based on their explanatory models which allow them to make sense of the illness, people are able to go for the therapy deemed appropriate. This is also true of the Akan. The effort to restore health leads people to try remedies on their own or to consult indigenous healers or Western practitioners for medicines. HIV/AIDS strongly portrays such a pattern.

The Twi name for medicine, *aduro* (pl. *nnuro*), can refer to all sorts of concrete substances. Indeed, *aduro* is a generic term for items as varied as herbs, Western drugs, (shoe) polish, poison, and any concrete substances used in sorcery (*aduto*, bad medicine). The distinction is only made in reference to the source of the medicine or what it is used for. Traditional or herbal medicine is *abibiduro* because it is found locally, in contradistinction to Western medicine, *aborɔfo duro*, viewed to come from the place of the Whiteman.[71] Like the Nyole (Whyte 1997), the Akan conceptualise that all these substances can transform the condition of the things they affect, including human lives, for better or for worse. Thus, medicines heal, kill, or

[71] *Abibiri* refers to the Black race or something indigenous to Africa. *Obibini* is a Black person (*abibifoɔ*, Black people). *Oburoni* (pl. *aborɔfoɔ*) is a White person, and sometimes, *aborɔfoɔ* (or *aborokyiri*, abroad) is used generically to describe anything associated with the Western world.

make people feel sick (or suffer) when they come into contact with them. For the purposes of this study, my concern is with medicines that heal.

In this chapter, I present the various therapeutic resources used by the HIV/AIDS patients in and around Kwawu in response to their ailments. Any health-seeking behaviour in traditional societies is dependent on a number of factors, including the accessibility of various therapeutic resources, financial resources, and the illness condition (Webb 1997). This leads to a discussion of ownership in the three sectors of health care and the problems associated with each, especially with regard to HIV/AIDS. I give separate discussions of each for a better differentiation, but I also portray the kind of relationship between the two dominant ones—biomedicine and traditional healing. The effort to combat HIV/AIDS as a personal and usually a social disturbance often offers the pretext for social control in the process of administering therapy. In these attempts, the lifestyles of individuals are usually regulated, and the sick person and/or others are under pressure to live within certain conditions to combat the illness.

As a cultural construct that threatens individual well-being and social cohesion in the family, HIV/AIDS produces many decisions and practices in response. This reinforces Allan Young's (1981: 318) assertion that people are forced to be pragmatic when they feel threatened by terminal illnesses. The sick person may embark on the search for therapy on his or her own in response to the ailment. He or she may be accompanied by a kin member who takes an active part initially, usually as an obligation and an expression of what Meyer Fortes (1969) calls kinship amity. As Arthur and Joan Kleinman (1991) have pointed out, illness (and healing) reveals a particular moral domain, and in it the relation of the psychological to the sociological are exposed.

A driver's search for therapy

A 35-year-old driver was taken seriously ill with what was described as general bodily pains. His wife took him to the hospital, where he was given a number of drugs and injections. The ailment subsided. However, it resurfaced not long after. This time, his wife took him to a fetish priest at a shrine in a nearby village where it was divined that 'someone' was responsible for the man's ailment, suggesting supernatural causation. The man's family blamed his wife for "assuming undue guardianship of their *dehyeɛ* ['freeborn' kin member] and taking him to places". The wife, in turn, accused the man's mother of being a witch and 'doing' her own son. The sick man himself was said to have often wondered why he was not getting

cured. At the time I got to know his story, the driver had been admitted at the hospital for some time, where he was being treated for chronic malaria and pneumonia.

He had decided to submit himself completely to the medication and care at the hospital. In a lengthy conversation with me one day, my taxi driver informant (let us call him Kofi O) said the sick man's family had contemplated to 'take him elsewhere', which means they would resort to traditional healing. But the hospital personnel became aware of the plans to take the patient away even without the recommendation of the doctor in charge. It is not uncommon for a patient (or the kin members, if he or she is a child or very weak) to arbitrarily 'discharge' himself or herself without the doctor's knowledge or against his or her advice. But on this occasion, based on the doctor's advice the sick driver decided to continue with the treatment at the hospital. This is indicative of the authority doctors in Ghanaian hospitals usually have. As Arthur Kleinman (1988) has asserted, social control facets of healing systems all become part of the effort for therapy. These controls are more prevalent in non-Western societies due to the different types of expert practitioners and the authority exerted through the application of technical interventions. For, sicknesses as a social phenomenon confront members of the social system (or at least the family) with two major concerns, involving *bafflement* or 'why me?' and *control* in the sense of what to do to restore health (ibid: 124).

Kofi O said when his friend's illness started it was initially taken for a mere headache which could easily be treated with painkillers. They were with their colleague drivers at the lorry station. It was not a particularly busy day; buses and taxis queued for long hours to take passengers to their destinations. Kofi O's friend suddenly complained of headache. He looked for a painkiller— panadol or paracetamol. My informant readily gave his friend the pack he had bought the previous day at a drug store. Kofi O always carried painkillers on him "because of the tedious nature of the work", which is driving a taxi. He takes the tablets when he feels tired or has a headache. In Ghana, painkillers can easily be bought as over-the-counter drugs. Like in many parts of Africa (van der Geest et al. 1996), this is so common in the country that sometimes even more complex drugs which require a doctor's prescription are secured as over-the-counter purchases without much scrutiny. This means the lay use of Western drugs is usually not under the control of medical officers. Kofi O's friend took some of the painkillers and went back home to rest. The following day, the sick man was back at the station; however, he was there to inform his friend

that he was going to the hospital. He had decided to visit the hospital following discussions with his wife and mother earlier in the morning.

The contemplation to take the sick man elsewhere (an Akan circumlocution when witchcraft and other supernatural causes are suspected in illness situation) was the result of a fetish priest's divinatory revelations, made to some kin members who made the inquiries as the patient lay in hospital. If he has been bewitched, then there is cause for alarm. Any desperation on the part of the family should be understood. Synonymous with Zande notions (Evans-Pritchard 1996 [1937]), in Akan society witchcraft is believed to cause nothing but evil and such situations are not to be joked with. The ruthlessness of witchcraft is acknowledged and feared by almost all who believe it. Moreover, the sick man was said to be the major bread winner in his maternal family; he had made preparations to renovate their dilapidated house. Kofi O narrated this story with apparent trepidation. "What will they do now that their sole caretaker is ill; they are already devastated. They greatly fear that he may die," my informant went on. "How serious is your colleague's illness," I inquired. "It is quite serious. They [his family members] are desperately hoping that he gets better; they are worried that if he dies that will be the end of them. Who else will care for the family members, especially his aging mother," Kofi O wondered.

Meanwhile, Kofi O, with whom I often travelled to visit HIV/AIDS patients, suspected something else and was planning not to visit the sick man again. As we drove in his taxi back to Nkawkaw after I visited some HIV/AIDS patients in some of the towns and villages on the Kwawu scarp, Kofi O suddenly asked me: "From the way he [the sick man] has lost weight, don't you think that maybe he has AIDS?" He revealed that his friend's thighs are no bigger than his own arms. "In fact, I strongly suspect AIDS. He likes women too much. His condition is so scary," Kofi O told me with a hopeless expression on his face, shaking his head in despair. Incidentally, when I requested that we visit his sick friend together, Kofi O felt quite uneasy. "No, please! If I should go there with you, the man will realise that I have told you things about him, since he does not know you," he pointed out. He explained further that he had only confided in me about his friend's story. In subsequent discussions with Kofi O on a number of occasions in which he mentioned his friend's full name and where he lived, I recognised the name as one of the people who had recently become an out-patient and was receiving counselling at the Holy Family Hospital at Nkawkaw. But I dared not reveal to Kofi O what I knew about his friend, for obvious reasons.

Therapy at the hospital

The driver's story shows the role of family members in looking for therapy for their sick kin, even if it is only by suggestion. Sometimes, kin members move to different locations of many hospitals to care for their sick relatives when people decide to use Western medicine because they perceive the malady as a 'hospital illness' capable of being cured there. The story also demonstrates the significant role of Western medicine in the therapeutic needs of many in Ghana.

Western medical services are the major therapeutic resource for many HIV/AIDS patients. Western medicine in the sense of hospital care was the sole therapeutic resource they relied on. This was notable in their post-diagnosis period, although many others resorted to other forms of therapy soon after their diagnosis or much later. Consistent with other findings in Ghana (e.g., Anarfi 1995), all patients who are diagnosed as HIV-positive usually become out-patients of the hospital where they were tested. In Kwawu, all the patients I interacted with got to know their positive status after tests in the hospital where they had reported sick and almost all who tested positive became out-patients of the Holy Family Hospital at Nkawkaw. It is obvious that since the disease has no cure they viewed the hospital therapy as the only resource to manage it.

The health care system and other social services are severely limited in Ghana. Like in Malawi (Hatchett et al. 2004), there is a lack of facilities in many rural areas of Ghana, and medicines and other basic supplies are lacking or inadequate in areas with medical services. Western medical services started in Ghana during colonialism. Although it was acknowledged that it would not be an easy task, the colonial authorities were concerned to expand biomedical care throughout the country. In the 1940s, the then Eastern Province Commission had cause to observe:

> It will probably always be impossible to provide in rural areas a complete medical service owing to the widely dispersed population living at low economic levels, but it is generally agreed that a service of some kind is essential in order to relieve suffering (ADM/KD 29/6/345).

Western medicine was seen as a necessity, the lack of access to which would be the greatest barrier to health. Philip Curtin (1992) has pointed out that in many parts of Africa the health care policy introduced during colonialism was shaped by the assumption that it would solve the medical woes of the people.

Although available in colonial society, Western medical services in Ghana did not start immediately as a public service, at least not in the sense of the locals having access to it. It was only after about six decades of colonialism that the first public hospital, Korle-Bu Teaching Hospital, was built in Accra in 1924 under the then Governor, Sir Gordon Guggisberg. By the first decade of its establishment, many diseases were being treated in the few hospitals and clinics (Patterson 1981). According to colonial sociologist and psychiatrist, Margaret Field (1960), by the 1930s the many venereal diseases and other illnesses such as yaws could be treated at the hospitals. Today, many illnesses are treated at the many hospitals in the country.

Ghana's professional sector care is structured as a three-tier system aimed at covering the whole of the country in terms of preventive and curative care. At the base of the system is primary health care (PHC) which caters for people at the community or rural level; at the secondary or intermediate level, regional and district hospitals are expected to provide the health needs of people. At the highest level are teaching and major hospitals in regional capitals and major cities. In addition to the two teaching hospitals, the Korle-Bu Hospital in Accra and the Okomfo Anokye Teaching Hospital in Kumasi, there are nine regional hospitals, 62 district hospitals and 862 health centres and clinics, as well as a host of mission hospitals and other medical facilities.[72]

Despite these numbers, researchers and health authorities acknowledge lapses in the provision of health care in the country; there is an uneven distribution with many rural areas completely lacking medical services (Bonsi 2001). The lack of access to hospital care in the rural areas usually strengthens the common claims that Western medical services in Ghana are unable to satisfy the needs of the population (e. g., Ventevogel 1996). A survey of medical facilities conducted in the Kwahu South District in this study showed that Nkawkaw, a sprawling township of 45,000 inhabitants, has only one major hospital, the fairly well-equipped Holy Family Catholic Hospital. Smaller private hospitals, clinics, drug stores, and the Atibie and Kwahu Tafo Hospitals about 20 kilometres away on the Kwawu scarp seem woefully inadequate for the many dispersed villages and towns in a district of about one hundred thousand inhabitants. Patients at Amanfrom, a typical Kwawu village without hospital, clinic or a health post, have to walk for about two kilometres to Nkawkaw or board a taxi as the only means of transport at a thousand cedis (about 11 US cents in 2003) for biomedical

[72] From World Health Organisation, Regional Office for Africa—Country Cooperation Strategy: Ghana (2002-2005) records quoted from Health of the Nation (Ghana)—2001. Internet: www.afro.who.int/ (16/4/2006).

care. Not surprisingly, people constantly say: "It is God himself who protects us," in reference to how they manage life and their health. The unavailability of hospitals in rural areas is obviously a major contributing factor to patients' failure to report again after an HIV-positive test. Many patients who test positive do not attend follow-up treatment. In most cases, they cannot even be traced to their homes because they give false addresses.

Ghana has been experiencing an adverse economy for some time now. This is mainly the result of a huge drop in the earnings of the top traditional exports—cocoa and gold—and what many see as mismanagement of Ghana's resources in the three decades after independence in 1957. This forced the nation to resort to the International Monetary Fund (IMF) and the World Bank's financial measures in the 1980s. The country adopted the Economic Recovery Programme (ERP) and later the Structural Adjustment Programme (SAP); despite these conscious efforts, the economy has not considerably improved. The government had been subsidizing much of the health costs at the public hospitals, but cancelled that in the early 1980s and introduced the 'Cash and Carry' system that requires patients to pay for prescribed drugs at the hospitals' pharmacies or private ones in town.

In effect, it is clear that many patients feel overburdened. To ease the financial burden on patients, in the latter part of 2003 the government finalised plans to introduce the National Health Insurance Scheme (NHIS), formally launched in March 2004.[73] Sadly, only the 'core poor' people who are unemployed and who "do not receive any identifiable support from anywhere for their survival" are exempted from making contributions.[74] Exempted too are children under five years, old people above seventy years, and those under eighteen years whose parent or parents or guardian pay their contributions. Surprisingly, people described as the 'very poor' or 'poor' and are unemployed but receive identifiable and consistent financial support from other sources are expected to contribute seventy two thousand cedis annually (about nine US dollars in 2003). This also applies to low income earners who are unable to meet their basic needs. Middle-income earners are to contribute a hundred and eighty thousand cedis per annum (20.9 US dollars), while the rich should pay four hundred and eighty thousand cedis annually (55.8 US dollars).

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[73] Nigeria launched a similar scheme in June 2005. See story on the official website of the Office of Public Communications, State House, Abuja. Source: http://www.nigeriafirst.org/ (15/4/2006).

[74] See the National Insurance Scheme document on the website of the Republic Of Ghana. Internet: http://www.ghana.gov.gh/dexadd/NHIS.pdf. See also the Daily Graphic of 18 February 2004 for a full-page advertisement on the scheme and its proposed minimum benefit package.

While these figures may seem reasonable, the concern lies with the unemployed and low income earners. The national daily minimum wage was 9,200 cedis (a little over a dollar) in 2003. As already mentioned, conservative estimates of sales from a farmer's highest proceeds in 2003 were about 400,000 cedis (about 46.5 US dollars) at the end of the major farming season (March to September), and the basic school fees per pupil per term were about 32,000 cedis (3.7 dollars).[75] How are the people expected to contribute to the scheme without jeopardising their financial standing? No wonder, many people do not seem interested if they have to contribute so much. Others who could readily afford the money were adopting the usual 'wait-and-see tactics' by many Ghanaians as happens in any effort to diffuse an innovation in the country; yet others were then making plans to save towards it.

To worsen matters, although the scheme covers 95 per cent of the treatment of some diseases (malaria, diarrhoea, hypertension, diabetics, asthma, and upper respiratory tract infections), it leaves out chronic renal heart failure, heart and brain surgery, orthopaedic gadgets, and the supply of AIDS drugs. This means the cost of anti-retroviral drugs and treatment for HIV/AIDS are not included in the benefits provided under the scheme. There seems to be no explanation for this, and health authorities always advise such patients to ensure good nutrition and continue with regular medications to slow down the process of the disease. Anti-retroviral AIDS drugs such as azidothymidine (AZT) slow down the replication of the virus (Webb 1997), but were unavailable in Ghana in 2003. Even if they were readily available in Ghanaian hospitals and pharmacies, poverty would bar many from getting access to them.

Hospitals and clinics rank highest among the first places patients go to for treatment after being diagnosed as HIV-positive (Anarfi 1995). As Hotard et al. (1998) have noted in an article on the education to prevent the spread of HIV/AIDS in Ghana, many patients do not attend follow-up treatment because they cannot afford the cost, and public assistance for treating the disease does not exist. Many clients cannot afford to buy the foods necessary to stay healthy and prevent wasting (ibid). In late 2003 an official announcement that anti-retroviral treatment of HIV/AIDS was to start in four of the nation's hospitals was refreshing. The treatment was estimated to cost fifty thousand cedis (about US $ 7 in 2003) per month, and in January 2004 Ghana actually introduced free anti-retroviral drugs to patients (South Africa started in April 2004). Unfortunately, only 600 out of

[75] In 2005 it was announced that basic school fees were to cease in Ghana in 2006. See story in Daily Graphic newspaper of 8 July 2005.

the targeted 6,000 patients could benefit yearly from the United Nation's Global Fund-assisted programme.

Because it cannot be cured from the biomedical perspective, HIV/AIDS threatens the credibility of biomedicine. For this reason the best way against the spread of HIV/AIDS is generally agreed to be counselling. As in many African societies such as Uganda (Ntozi 1997: 3), in Ghana counselling of HIV/AIDS patients is mostly done in hospitals. In the effort to prevent others from getting infected, the health personnel of hospitals take up the campaign and education in workshops and community outreach exercises, which means that these activities are mostly undertaken within the professional sector. Workshops and seminars are organised for doctors, nurses, and other hospital personnel to upgrade their knowledge about the disease in order to be able to counsel patients. Hospitals continue to form AIDS associations to help patients feel a sense of belonging to a group. I do not think the idea for this is because of stigmatisation by the public; nevertheless it seems it is aimed at helping the patients to overcome stigmatisation, if it should occur to them.

The hospital at Nkawkaw is financed by the Catholic Church, and the HIV/AIDS unit enjoys part of this sponsorship. The unit also relies on NGOs for more sponsorship in the training of counsellors to educate people in the communities and in schools about the disease. The campaigns usually involve organised groups too—from the churches, associations of seamstresses, tailors, and hairdressers. Much of the education, however, occurs in the face-to-face counselling at the hospital as happens in other hospitals. A typical HIV/AIDS counselling session at the Holy Family Hospital starts at nine in the morning and ends around one o'clock in the afternoon. The session takes place under a shed in front of the Social Welfare Unit, quite inconspicuous from 'public eyes'. The shed has quite new-looking corrugated iron roof and is different from other sheds at the hospital with slate roofing, which also suggests that unlike the others it might have been built a few years ago. There are about five counsellors, made up of two personnel of the unit and three volunteer social workers. Some engage in taking the weight of the patients in comparison to previous weight levels to determine improvement or deterioration in a patient's physiological statistics. The rest of the time is spent discussing patients' problems, how to improve their nutrition, and more information about HIV/AIDS.

On my first visit to the session on 20 February 2003 I was quite impressed to watch the thirty one HIV patients listening attentively to an advice to lead their normal lives but to be mindful of maintaining good

nutrition and to "do well to abstain from sex in order not to infect other people". Four new clients (as the patients are referred to ostensibly to avoid stigmatisation) had joined the group, and six were absent (minus many others who had not reported to the counselling session after one or two attendances and could not be traced). Mr. Evans Osei Baah, in charge of the unit, advised: "As human beings, you will have the urge for sex, but try to remember your statuses and control those urges so that you do not infect others; in short, lead exemplary lives." Discussions with some officials later indicated that I was not alone to worry about how many of the patients would heed the advice to abstain from sex, especially those who did not look sick.

At the end of every counselling session, each patient is given some drugs— paracetamol, multivitamins, tissol, and garlic tablets to help boost the immune system. Apart from these basic drugs, patients are given other antibiotics that can help prevent opportunistic infections. The patients are each given fifteen thousand cedis (almost two US dollars in 2003), regardless of where he or she lives to help defray their transport costs because most of them are peasant farmers without any other means of income. They are also given a kilo of corn-meal and powdered milk to cook porridge, eaten in Ghana usually at breakfast.

The monies and items to the patients are the result of networking involving the unit and some NGOs for sponsorship in cash and in kind. The Catholic Relief Services, The Adventist Relief Agency (ADRA) of the Seventh Day Adventist Church, the World Vision International (WVI), the Planned Parenthood Association of Ghana (PPAG), Friends Foundation, and the Ghana Midwives' Association form part of the networking. Although the Holy Family Hospital partly finances the HIV/AIDS Unit as a section under it, the unit is quite autonomous with its own AIDS Committee. Apart from its financial constraints, the unit is under-staffed. It had only one full time person in 2003, assisted by a national serviceman and a number of volunteers on counselling days.

HIV/AIDS and self-therapy

Because their illnesses started as what they perceived as common ailments, almost all the more than 20 HIV/AIDS patients I interacted closely with engaged in self-therapy. Usually experiencing their illness as feverish conditions, headaches, or bodily pains most of them tried Western forms of readily-available medicines. The medicines in self-therapy were usually suggested or given out by a kin member, a friend or a neighbour. Most

HIV/AIDS patients initially try easily accessible pain killers and antibiotics— paracetamol, panadol, chloroquine, and teramycin— most of which are bought from drug stores without a doctor's prescription.

A wide range of self-treatment, constitutive of the popular sector of Ghana's medical system, is practised in Akan-land in the effort to counter illness on one's own, that is, by lay knowledge outside of expert practitioner advice and supervision. Many lay people with knowledge of herbal treatments or common Western drugs usually advise the sick person about those medicines. Thus, as with the Yaka (Devisch 1993: 28), self-treatment with well-known folk remedies is rather commonplace and frequent. Many families have knowledge of medicines, including herbs for colds, boils, and stomach ache. Self-treatment thus takes different forms and securing the remedies is quite easy.

None of the HIV/AIDS patients used herbs, which are the more common lay remedies. The use of simple herbs for the treatment of headaches, colds, and feverish conditions is common in Ghana. Ginger (*kakaduro*) is a common but important additive to many liquid preparations for enema to alleviate stomach problems and to free the bowels, and leaves of the neem tree are well-known for feverish conditions. Access to most herbs is very easy; they abound in the bush near the neighbourhoods, and both lay people and expert traditional healers can simply pick them. Moreover, sellers of medicinal plants and recipes can be found at most marketplaces and at lorry stations. There is a growing number of pharmacies and small privately-owned drug stores in many towns and cities where people easily buy Western drugs and local but Western-packaged medicines.

Drugs purchased from the pharmacies and drug stores are for the particular ailment, but usually left-over drugs for a similar ailment may be used. Access to complex drugs secured as over-the-counter purchases without much scrutiny and used arbitrarily without a medical doctor's guidance is seen as a problem with the system in traditional societies. Several authors attribute this anomaly to the failures of state policies (see van der Geest et al. 1996: 164). These failures force people into "self-help culture of medicine and create space for the development of an informal medicine market". One cannot but agree with this view. In Ghana patients, family members and neighbours easily buy Western medication and exchange it across a broad interpersonal network for as long as the drugs last. This crystallises Arthur Kleinman's (1980) assertion that the popular sector of health care, which comprises the lay, non-professional, non-specialist domain, is the largest sector in a society. It is also common for

people who purchase remedies at the drug store to use other types of treatment for the same illness. Eventually, they may not even use the drugs they have purchased. Although the drugs are usually individually owned, belonging to the one who purchased them, others in the family or household have access to them in time of need.

Kleinman (ibid: 51) has claimed that in many cultures, self-treatment by the individual and his or her family is the first therapeutic intervention resorted to by most people. Such an assertion is generally true with the Akan; however, there are many significant instances when friends and close neighbours are the first to offer help in self-therapy, as the driver's story indicates when he took painkillers from his colleague driver and friend, Kofi O.

People do not merely recommend lay remedies. They question why the onset of the illness at that particular time, what action on the part of the sick person may possibly have caused it, and what is to be done to restore health. This is usually their starting point in their attempts to understand the illness as they initially apply medicines on their own. Allan Young's (1982: 275-277) claim that the philosophical questions people ask as they attempt to find a remedy for the illness turn them into "metaphysicians and philosophers" is very true when fit into the Akan perspective. We can follow Young (ibid) and view the effort for therapy as a huge ideological practice. I would add that among the Akan people tend to try medicines on their own for some time because they usually do not straightforwardly deem an illness episode as dangerous or spiritual. The services of an expert practitioner, be it the biomedical doctor or the traditional healer, is resorted to only when self-treatment does not yield the expected results.

The problem with self-therapy in this age of HIV/AIDS is that because in the initial stages of their ailment, many patients respond well to treatment it is easy not to go for early HIV testing and biomedical advice. The fact that Western medicines are easily purchased from a pharmacy for the particular ailment or the left-overs of already purchased drugs are exchanged among family members and friends adds to the problem. Self-treatment with initial good results may give the false hope that all is well and the patient may go about his or her normal sex life. The danger associated with this can well be imagined— the risk of infecting other people.

The role of traditional healing

Before they were diagnosed as being HIV-positive, most of the patients tried traditional healing. It is understandable that when people first experience a recurrent ailment (headaches, feverish conditions, etc.) they will try other therapeutic resources when hospital medication does not achieve any results for them. Using traditional healing is more consistent with cultural and social beliefs often grounded in supernaturalism. Traditional healing[76] as an unofficial source of therapy has existed in Akan-land for ages. Oral accounts about healing in pre-colonial Ghana indicate that traditional healers and fetish priests were important in providing treatment for the sick. As in many parts of Africa, traditional healers in Akan society represent a broad spectrum of practices, including those engaged in herbalism and spiritualism. A wide range of individuals refer to themselves as diviners, fetish priests, and faith healers (most of these, however, engage in spiritual church healing, discussed in the next chapter).

The importance of traditional healing (and its medicines) is expressed in terms of the scale of its use; it is estimated that about two-thirds of the population rely on traditional healing (cf. Osei 1978; Ventevogel 1996). Western medicine in Ghana was a major transformation, marking a new variant of medical resources in Akan-land. It augmented the society's medical outlets because traditional healing, in terms of both the folk and popular sectors, was never supplanted despite attempts by colonial authorities to completely erase folk medicine. Official documents described traditional healers as 'insincere jujumen [*juju* means fetish or evil spirit in the Hausa language] living on the neurosis of the illiterates' (see Senah 1989: 245). Consequently, there was a campaign of enlightenment to persuade urban dwellers, the educated and opinion leaders to shun traditional healers (ibid). But the practice has persisted.

It is a general view that in Ghana and other African societies where HIV/AIDS has a great impact on the limited health care resources traditional healers should be involved in the care and treatment of patients. In the absence of a biomedical cure, it is understandable that traditional healing is attempted for remedy. Many workshops and seminars are held to sensitise traditional healers about HIV/AIDS and how they should counsel their clients on the disease. The role of the traditional healer in educating and

[76] Traditional healing is healing by practitioners of herbal or native treatment and magico-religious (sacred healing) acts and concepts. It is differentiated from traditional medicine, which, in the sense of this study is made up of concrete substances. Medical anthropology variously refers to traditional healing, folk medicine, alternative treatment, etc. I mostly refer to traditional healing.

creating awareness about the disease is highly recognised. South Africa seems to have gone further; in 1997, the national HIV/AIDS programme in that country enlisted the services of three traditional healers as consultants to mobilize other such healers on sexually transmitted diseases and HIV/AIDS (see Baleta 1998: 554).

In Ghana, the Ghana Psychic and Traditional Healers' Association was formed in 1961 under the initiative of the first President of Ghana, the late Kwame Nkrumah, to give official recognition to folk healers. In the late 1980s, the Ghana Federation of Traditional Medicine Practitioners (GHAFTRAM) was formed to reflect the use of herbs in healing. The continued high use of traditional medicine was also the reason why the government established the Centre for Scientific Research into Plant Medicine at Mampong-Akwapim in the Eastern Region in 1973. Collaborated by the World Health Organisation, the Centre was established for research into medicinal plants and to offer herbal care along hospital lines. It thus merges the two dominant sectors and aims to serve the many rural communities without biomedical care. It has two departments. There is a clinic section with an out-patient's department (OPD) and medical officers and nurses trained along biomedical lines to administer treatment with Western-packaged herbal medicines. The other is the research section, which conducts studies into the medicinal qualities of plants.

Traditional healing was recognised by the WHO in 2000 as an important part of the therapeutic resources for managing HIV/AIDS due to its wide use in many rural areas of Africa. Indeed, the WHO has been advocating the inclusion of traditional medicine in national AIDS programmes since the early 1990s (UNAIDS 2000). The advocacy for collaboration is laudable. In many parts of Africa where supernaturalism and illness aetiologies are intricately linked and where psychic and spiritual healers are the first point of call for many patients, the role of traditional healers in preventive and curative measures is substantial. The literature on collaboration with traditional healers in HIV/AIDS prevention in many sub-Saharan African countries draws an important correlation between healers' expertise and the information on HIV/AIDS. Findings often reflect the stage of the epidemic in a society whenever African healers' knowledge, attitudes, beliefs and practices about sexually transmitted diseases (STDs) and AIDS are explored (ibid). The view is that traditional healers must be involved in the campaign against the spread of HIV/AIDS due to the amount of information exposed to them, their pre-existing belief systems about health and disease in general, and STDs and AIDS in particular (ibid).

Well before HIV/AIDS surfaced, the WHO's interest in the possible use of traditional healers in formal health care systems in traditional societies had increased (Ventevogel 1996). Rene Devisch (1993: 26) has viewed this as a recognition which marks an increasing cultural emancipation for African healing. For him, the attention being paid to the potential role of traditional healers is a rediscovery and revaluation of African healing arts on the international scene. Policies regarding collaboration with African traditional healing and biomedical health care programmes were a major option enunciated by the WHO African Committee in 1974. That year's technical discussion (in the twenty-sixth session of the WHO) was under the topic: 'Traditional medicine and its role in the development of health services in Africa' (UNAIDS 2000: 9). This stance was restated by the WHO in 1977 in what has become known as the Alma Ata Declaration, which came up with the primary health care (PHC) concept to support the use of indigenous health practitioners in government-sponsored health programmes (ibid). Many African countries adopted the PHC idea; Ghana embraced it in 1978.

Many AIDS patients visit traditional healers based on Akan belief systems and illness causation. People are usually encouraged to seek alternative medicine and are actually accompanied by kin members to the shrines of the healers. As Awusabo-Asare and Anarfi (1997) found in their post-diagnosis study of persons living with HIV/AIDS in Ghana, those who visited traditional healers both for treatment, consultation, protection or prayers did so because they believed they had been bewitched. When people feel that they are bewitched, fetish priests and herbalists engaged in mysticism are the best people to remedy the situation because powerful fetish priests or medicine men see beyond this world.

The ability to identify the cause of the illness is of utmost importance in this form of healing. Many traditional healers in Ghana rely on divination and their cosmological knowledge or clairvoyance for aetiological explanations of the illness. The usual form of divination is with a fowl, slaughtered and left to struggle to death. If it ends lying prostrate, it is a bad sign—that the healing will fail; it then becomes necessary to slaughter another fowl until the animal lies facing upwards as a good sign that healing will be successful. The general belief is that to be able to determine which illness is spiritual and which is not makes one a good healer. People often attach more importance to fetish priests and other psychic or mystic healers for their medical advice than to herbalists who engage in physical treatment with herbs. The high regard is understandable. Diviners and fetish priests are seen as possessors of special eyes to perceive what ordinary eyes cannot

see; they have esoteric knowledge for diagnostic or prognostic purposes to protect life.

A traditional healer's aetiological explanation of witchcraft, for instance, as a magical theory of spiritual malevolence is always acceptable to clients because they know it is coming from someone who 'sees things'. As Philip Peek (1991: 194) has noted, their "non-normal mode of cognition" and the means of "acquiring normally inaccessible information, which is synthesized by diviner and client(s) with everyday knowledge" give such specialists immense authority and respect in the society. Explanations based on clairvoyance enable people to make sense of the illness. As seers and therapists, they give meaning to the illness complaint and the remedy given is usually deemed the appropriate intervention. But it sometimes creates tension and conflict among kin members or neighbours when accusations or suspicions of witchcraft and sorcery are directed at particular individuals.

In this study, only one fetish priest told me he once had an HIV/AIDS patient he was 'treating' but the sick man went away unceremoniously after some time. Another, an herbalist, still had the patient he had been treating. The sick woman was diagnosed at a hospital outside the Kwawu area. The patient was shown to me. That was in late January 2005, when I visited the research site during a short visit to Ghana.

HIV/AIDS and traditional medicine

The HIV patients at the Holy Family Hospital are usually given a liquid herbal medicine at the end of the counselling sessions, which marks an important collaboration. It is a fusion of herbal treatment with professional sector care in the hospitals, although it is also a grey area. The liquid herbal medicine prepared by some herbalists is brought from Kumasi, and it boosts the patient's appetite. The man who brought it was ready to discuss the financial problems involved in transporting it to Nkawkaw and other places. Apart from this, he was not prepared to discuss anything else about its composition, or to even tell me where and how to contact those who had prepared it. It was quite disappointing but I could understand him. Like the fetish priests who do not easily allow non clients to watch proceedings in their shrines, I saw it as a way to protect their 'treasure'.

Such practitioners doggedly protect their practice this way. When a practice is not patented, refusing access to information about it seems the surest way of protecting the formula from being copied. The liquid herbal medicine at Nkawkaw is not the only example of the use of traditional medicine at hospitals to manage the disease. There is similar information in

other hospitals. For instance, the Centre for Scientific Research into Plant Medicine, as the only herbal hospital in Ghana, used to administer a similar liquid herbal preparation to HIV/AIDS patients. It had encouraging results because it boosted the patient's appetite. They regained strength, and since they no more looked sickly they "went about their normal sex lives", said an official of the hospital. This increased infections in the area and the hospital discontinued administering the herbal medicine.

The attention on traditional medicine for the management of HIV/AIDS has been increasing in recent years. In March 2004, the WHO welcomed South Africa's commitment to traditional medicine. A report by the world health body's Africa Regional Office said the outfit had developed generic and disease specific research protocol for the clinical evaluation of traditional herbal medicines for HIV/AIDS, malaria, hypertension, diabetes and others.[77] The interest continues about HIV/AIDS and the use of traditional medicine in traditional societies. In Ghana, discussions continue about traditional medicine's efficacy to manage HIV/AIDS. The claim always is that many herbal preparations are capable of reversing the health status of HIV/AIDS patients.

Ideas about traditional medicine for the management of HIV/AIDS have been the focus of attention for some years now. Early in 2001, during a meeting of the WHO's Africa regional expert committee on traditional medicine in Harare, Zimbabwe and later in Burkina Faso, the Regional Director, Dr. Ebrahim Samba, referred to promising signs in the management of HIV/AIDS through traditional medicine.[78] That was not the first time attention had turned to the role of traditional medicine for the management of HIV/AIDS. It started during the first conference on AIDS and Traditional Medicine in Dakar, Senegal in 1999 (UNAIDS 2000). The debate on traditional medicine for the management of HIV/AIDS seems to have been given a boost recently in 2005. Nigeria's National Institute for Pharmaceutical Research and Development (NIPRD) was considered as a candidate for a WHO Collaborating Centre for research in traditional medicine.[79]

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[77] See story on the WHO's Africa Regional Office webpage. Internet source: www.who.afro.who.int/country_offices_press/2004/pr20040330.html (16/3/2006).

[78] See story on WHO homepage. Source: www.whoafro.org/press/2001/pr20011119.html (2/12/2004).

[79] Story on WHO site: www.afro.who.int/country_offices_press/2005/pr20050407.html (16/3/2006).

Caution: 'No herbal cure for HIV/AIDS'

As concerns increase about the growth of HIV/AIDS in Ghana, many traditional healers are crying Eureka and claiming to have found a cure for the disease. In the early 1990s, Nana Kofi Drobo, a prominent fetish priest of a popular deity in Ghana, claimed to have found cure for the disease. He hit the news headlines at an international conference in Kumasi, where he proclaimed his exploits. His herbal research drew the attention of the international community. Unfortunately, he died two years later. Ghanaians could not comprehend the circumstances that led to his death,[80] which attracted conflicting stories that he committed suicide or that he was murdered by some agents on behalf of some highly influential people. The police were investigating the cause of his death. HIV/AIDS is attracting all sorts of such claims. Nana Drobo's claim to have a cure for the disease is not an isolated one, and his death has not ended other such claims.

Many such announcements by fetish priests and other traditional healers are made in Ghana but none has so far been proven; that is, the efficacy of the medicine has never been established scientifically. As I have discussed elsewhere, most of the healers feel reluctant to come out and prove the efficacy of their medicine. During an earlier fieldwork in Ghana for my master's thesis, a fetish priest explained the reluctance. He connected it to bureaucracy in Ghana; "…among us herbalists in the country, we know some potential herbs that can be mixed to treat the disease. But should you [the herbalists] announce it just now, the authorities [perhaps in reference to those of the Ministry of Health in Ghana] will ask us for proof, and that is another matter," he claimed (see Crentsil 2001: 127).

Despite the apparent support for collaboration with traditional healers by the WHO, and calls in Ghana to the authorities to give traditional medicine a chance to try its efficacy with HIV/AIDS patients, there are always cautions about its use and claims. The upsurge in claims to possess the medicine that cures HIV/AIDS forced the GHAFTRAM, the body representing herbalists in Ghana, to openly caution people in August 2003.[81] In an interview with the Ghana News Agency (GNA), the President of GHAFTRAM, Dr. Anthony Normeshie stated categorically that there is no herbal preparation that cures HIV/AIDS. He declared officially on behalf of the organisation: "Our preparations cannot fight the virus, it can only control the infections associated with the dreadful disease."

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[80] See story in People's Daily Graphic newspaper of Wednesday, August 26, 1992.

[81] See story by the Ghana News Agency on 25 August 2003. Source: a homepage on Ghana. Website: www.ghanaweb.com/ (16/3/2006).

The President was convinced that many herbalists have little or no knowledge about HIV/AIDS, which makes it difficult for the practitioners to counsel or educate their clients. The Ghana AIDS Commission (GAC) was to assist 35 members of GHAFTRAM to carry out a thorough research into the formula of their herbal preparations, he revealed. The President, according to the GNA report, said GHAFTRAM would only accept the GAC's offer if they were granted patent rights or the necessary compensation was paid to them. He appealed to the government to assist herbal practitioners to improve on the efficacy of their products and help cut down costs on the importation of anti-retroviral drugs. The statement by GHAFTRAM seems to have minimised the controversy surrounding claims by some herbalists to have a cure for HIV/AIDS. But the claims continue.

7. SPIRITUAL CHURCH HEALING AND HIV/AIDS

Many HIV/AIDS patients resort to spiritual church healing. Healing by spiritual churches is a significant part of the continuum of traditional healing from herbalism to prayers and fasting—anything outside of biomedical care. Most contemporary spiritual churches in Ghana make spiritual healing one of their primary activities (cf. Mullings 1984). Because of the strong Akan belief in supernatural illness aetiologies and how insecure people feel, spiritual churches give hope to adherents who feel a sense of chaos in their lives. Almost all of such churches claim to heal many afflictions—barrenness, mental disorders, epilepsy, and other persistent or life-threatening illnesses, including HIV/AIDS. Most of these illnesses are believed to be caused by witches and other malevolent forces. Hence, it is believed that they can be cured only by prayers and a pastor's divine gift. The various churches in Ghana and other religious bodies have been important players in the sponsorship, education and creation of awareness about HIV/AIDS. But it has also been necessary to caution some spiritual churches about pronouncements that the disease as a punishment from God due to people's sins with sex. Many see such pronouncements as stigmatising HIV/AIDS patients.

Researchers and writers on Christianity and spiritual churches in Ghana seem to have concentrated on the history and political role during colonialism, notably in the run up to the country's independence in 1957.[82] Much of the discourse on Christianity in Ghana has focused on the conflict between traditional religion and Christianity during colonialism (e.g. Debrunner 1967), conversion (e.g. Middleton 1983), and in recent times the growth of syncretism (e.g. Meyer 1995). Paul S. Breidenbach (1976) discusses healing in a spiritual church in Akan society.[83] In a study of the Twelve Apostles Church of Ghana, Breidenbach has shown that healing in these churches is as important as worshipping. The Twelve Apostles church engages in healing, which they call *edwuma* (work) or *sunsum mu edwuma*

[82] The literature on Christianity in Ghana mirrors a larger picture of the development of Christianity in Africa. Some of the literature has been on religious ideology (e.g., Comarroff 1985), the conflict between it and traditional religion during colonialism and conversion (e.g., Horton 1975; Hasu 1999), and the growth of separatist movements (e.g., Walker 1979).

[83] I am aware of the healing exploits of Islamic institutions. Muslim healers engage in divination and give preventive and protective medicines to patients and clients. There are also some hospitals established by the Ahmadiyya variant of Islam. In this study, however, I concentrate on Christianity because spiritual churches give the kind of symbolic healing the patients I met resorted to. It thus more accurately expresses the argument I am trying to advance about traditional healing, supernaturalism, and beliefs about illness (HIV/AIDS) causation.

(working with the spirits) as an important aspect of its activities alongside their worship sessions. Many kinds of mental and physical disorders are cured (1976:137).[84]

There seems to be no study of HIV/AIDS and spiritual church healing in Ghana. There are even few in-depth studies examining religion and HIV/AIDS (Takyi 2003). Kofi Awusabo-Asare and John K. Anarfi (1997) examined the health-seeking behaviour of persons with HIV/AIDS in Ghana, and found that a number of patients contacted spiritualists [spiritual church healers] for healing. They, however, only mentioned it without further description.

This chapter discusses the attempt for therapy by HIV/AIDS patients from spiritual church healing as an important therapeutic resource in Ghana. I concentrate on healing by the churches of the Holy Spirit or what is commonly called spiritual churches (*sunsum nsɔre*). The chapter also explores the history of such churches, their perspective on life and well-being, on HIV/AIDS, as well as their popularity in Ghana today. There are different forms of spiritual churches; they include the Pentecostal, Charismatic, Revival missions, all with different historical backgrounds and quite distinct characteristics. For ease of reference (unless it becomes very necessary to specify), I lump them together as spiritual churches without further description. These churches believe in the gifts of healing (or faith healing), based on their understanding of the Bible and Jesus' healing exploits during his days on earth. As Birgit Meyer (1995: 252) has noted, such churches are springing up all over both rural and urban areas of Ghana, "appropriating Christianity at the grassroots" because their messages appeal to the poor who have lost some hope in life.

Kwame K and spiritual church healing

Kwame K is about 43 years old. He had lived in a neighbouring African country and had acquired what people in his village saw as a huge wealth. He was back living in Kwawu-land, looking quite ill. As my informant put it, all his money after 'the toil in a foreign land' has almost run out. Kwame K was said to have spent a huge amount of money looking for healing at hospitals and from traditional medicine-men. Eventually, he was introduced to a spiritual church.

[84] Healing is done on Fridays; Sundays are for worship sessions called *asɔre* (or, *kyapor*, a corruption of chapel in the Fanti dialect of the Akan language). Both the worship and healing sessions take place at the premises of the church, called the garden.

I got to know the full story about Kwame K's quest for therapy at a spiritual church in early 2004. At the time, he had become a full member of the church, situated in a quiet suburb of Nkawkaw. Kwame K had been introduced to the spiritual church by one of his classificatory sisters (mother's mother's sister's daughter's daughter, MMZDD), a member of that church and a close friend of the pastor and his wife. It was said that Kwame K's sister recommended the church because "the pastor is good". Kwame K had been drinking heavily, I was told. Signs of this may be his pale face, the reddish, bloated mouth and drowsy-looking eyes. In Akan society, drunkards who spot the descriptions above and look pale or bloated and tawny are talked about that 'alcohol has taken a photo of them' (*nsa etwa no photo/mfoni*), which usually also implies spiritual causation. His sister was worried about the drinking habit and that "these things" [the drinking and signs of illness] need spiritual remedies.

It was not easy to know whether my informant and others who knew Kwame K were aware that he was HIV-positive. I assumed that at least my informant was unaware of that, since she spoke only about the man's heavy drinking habit. Many members of Kwame K's close kin were said to be worried that the sick man goes to a drinking spot for a 'quarter' (of a pint[85] as measurement for sale) of the local gin as the first thing after washing his face and brushing his teeth. The local gin, *akpeteshie*, with its many sobriquets, is popular not just for such occasions as funerals. It is also enjoyed on ordinary days when men want to socialize. They usually call for and share a bottle or two of the vodka-like drink, acknowledged for its potent intoxicating qualities.

But when people (often men) make it a habit of drinking *akpeteshie* everyday, others begin to worry. This worry usually stems from the idea that such heavy drinking is caused by witchcraft. Therefore, it is common for drunkards to be thought of as bewitched. People, however, do not usually pinpoint or directly accuse witches. That is the job of the strong spiritual church pastor (or, in traditional religion, the witch finder, the fetish priest or other person well-versed in that field). As Margaret Field (1960) pointed out long ago, only drunkards accuse others of bewitching them into the drinking habit. Sometimes, however, people directly accuse others as withces during a quarrel or in the form of innuendos after a death or a life-threatening illness episode.

I had only chanced on the details of Kwame K's story. As I walked with one of my informants to a fetish priestess's house one day in January

[85] One-quarter of a pint is about 0.14 of a litre in British liquid measurement, and 0.1 of a litre in the American system.

2004, we met Kwame K on a footpath at about six o'clock in the morning. It was quite cold. The morning sun's rays were almost invisible, as usual, blurred by the hazy harmattan weather when the north-east trade winds blow white dust from the Sahara Desert downwards to cover West Africa from November to late February each year. Visibility and recognising him became better as the man neared us from the opposite direction. My middle-aged woman informant stopped to exchange greetings with Kwame K. In most of our rounds when we needed to walk a distance, she would only shout out the greeting and walk past an acquaintance without stopping for the response. Moreover, when she had commented that the weather was quite cold that morning, I had expected her to move on. She did not; instead, she engaged in a long conversation with the man. She later told me that their conversation had centred on the man's views about the church's healing sessions. There was to be a special prayer session at the church premises that day and when we met him, Kwame K was on his way to the early morning's activity.

I had walked a few metres away from my informant and the patient as they talked, but I retraced my steps to say hello to the man. I caught his eyes and said immediately, 'Good morning'. He did not return my greeting. He nicely ignored me by continuing to direct his discussions at my informant. This indicated that he was not ready to give me audience. I felt slighted, like most Akan people would, that he ignored me by refusing to respond to my greeting. I quietly moved away from them and waited for about five minutes when my informant finished her discussions with the man. As we walked on to the fetish priestess's place, I mentioned how Kwame K had been impolite by ignoring my greeting. To ignore someone's greeting (when there is no conflict) is usually viewed as against Akan mores. My informant had noticed it too, and agreed with me. However, she defended him thus: "Please, don't be upset. Anybody in his situation will always behave out of the way [against tradition]. The worries about his drinking and deteriorating health have taken the better part of him." I agreed only half-heartedly and never mentioned that it was not the first time the man had ignored me.

I first saw Kwame K at one of the counselling sessions at the Holy Family Hospital in June 2003, about seven months before our encounter on the footpath. I immediately recognised him at the counselling session as an acquaintance years ago. I remembered we used to live in the same area in Accra in the late 1970s when I spent some of my secondary school vacations with relatives in the capital. At the counselling session, I had caught his eyes and nodded but he did not nod back. I cannot tell if he recognised me too or if he even noticed the nodding.

Kwame K sat at the extreme end of the gathering. I decided to go to him at the end of proceedings at the session. That day's counselling session ended well ahead of time. In my enthusiasm to contact Kwame K, I did not engage in discussions with other patients or the health officials as I usually did. I made my way towards the man. As I approached him, he got up and went away through the open space at the back of the shed under which the counselling session is organised. I did not see Kwame K again at the sessions, which I attended almost regularly. I had thought he had left town until I met him that day on the footpath in January, when I also learnt about his quest for healing at the spiritual church.

From then on, I watched Kwame K pass by the house where I stayed on his way to morning devotion and the church services on Sundays. Further discussions with my informant revealed that Kwame K had become convinced his problem was spiritual and there was the need for prayers and divine intervention. Although there was no chance to find out from Kwame K himself, his devotion to the church activities as I watched him attend worship sessions convinced me about this. This was confirmed when I visited the church with my informant one Sunday morning. I saw Kwame K; he sat in a corner at the rear of the shed roofed with new-looking corrugated iron sheets, which suggested that it had been recently built. He actively clapped, sang, and danced as the other members did. The pastor then asked everyone to pray openly and implore God to pluck the wings of Satan and his agents, the witches. When these evil forces are overpowered, every problem, every load of care will be removed, the pastor said. In such open prayer sessions, people usually close their eyes. I stole glances at Kwame K praying frantically.

HIV/AIDS, faith healing, and the salvation metaphor

Kwame K's case and that of the middle-aged woman who decided to go for spiritual church healing because a spiritualist said hers was not an illness for the hospital further express the fact that HIV/AIDS is being taken to various avenues for therapy. Healing by spiritual churches has long been a therapeutic resource in Akan society and in Ghana generally. Such healing is often referred to as faith healing. Faith (or spiritual) healing is healing in the spirit by the pastor using various methods such as placing the hand on the adherent (Theron 1999). Faith healing[86] greatly allays people's fears and

[86] Jacques Theron (1999) makes a distinction between faith healing and divine healing. According to him, faith healing is one done by a pastor for specific needs of people, while divine healing is closely attached to salvation and the atonement of sin as a healing by the

anxieties during illness or when they believe themselves to be bewitched. The symbolic ritual of prayers may go along with the use of concrete objects such as incense, candles, and olive oil as religious artefacts in 'ritualised' therapies to heal illnesses that are perceived to be caused spiritually. Usually, the form of faith healing by the spiritual churches in the context of putting a hand on the head or shoulder of the adherent may also include anointing him or her with olive oil in prayer sessions. Anointing is thought to heal a particular illness or to prevent misfortune. This kind of healing is often ministered and perceived as divine or miraculous.

Healing in most of these churches may take place during worship sessions or after, in the premises of the church. Apart from the session at the church where Kwame K had been worshipping, and the middle-aged HIV-positive woman's decision to join a spiritual church for healing, I did not witness directly many such healing incidents involving HIV/AIDS patients. Nevertheless, many stories and newspaper reports abound about the resort for spiritual church healing by some patients. There are usually two forms of healing in these churches. Healing may be performed in a mass deliverance session or personally. In the mass deliverance type, prayer is said to 'bind' (*kyekyere*) or 'cast out' (*tutu gu*) the devil, when there are no symptoms of illness.

Personal healing concentrates on the sick or those afflicted with other misfortunes. As Opoku Onyinah (2001: 129) has pointed out, personal healing is usually performed for people who report chronic or persistent illnesses, into which HIV/AIDS falls. When they seek spiritual church healing, the patients' positive status may already be known to them. As both Kwame K's and the HIV-positive woman's cases indicate, they had obviously been informed about their HIV-positive status at the hospital. Yet, they resorted to spiritual church healing. Thus, it is obvious that such individuals usually resort to spiritual church healing after they have tried other therapies to no avail.

The major emphasis of the healing exploits of these churches is on both curative and preventive remedies. Faith healing is important for these churches and their adepts. This may be due to the fact that of all the miracles in the Bible that Jesus Christ performed healing forms the bulk of them, even though Jesus was no trained physician or healer. Whenever he successfully healed people (and he never failed)—whether it was the ten lepers, the woman with the haemorrhage, the blind man at Bethsaida, or those possessed by evil spirits— Jesus' major explanation was that their

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Christian God. It is directly linked to and interpreted in terms of Jesus' death on the cross. See Theron (ibid) for more on Pentecostalism and their healing ministry in South Africa.

faith had healed them (e.g., Matthew 15, 21-28). It was only where there was a lack of faith that Jesus was prevented from healing, as in his own hometown where he had to comment (ostensibly in disappointment): "A prophet is without honour in his own country" (Luke 4, 24). It would not be out of place then for HIV/AIDS patients suffering from a disease with no cure in biomedical terms to put their faith and hope in prayers and other church rituals. It seems logical that where human attempts for healing have failed, God, conceptualised as the ultimate healer, should be approached as a last resort.



PHOTOGRAPH 4: A worship session at a spiritual church.

There is a belief in the healing power of prayers. Prayers for healing usually involve adepts and become 'ritualised' therapy in the sense Steven Feierman and John Janzen (1992: 171) have identified in traditional healing. According to the two authors, ritualised therapy entails heightened emotional impact and symbolic means for healing—such as prayers, singing and dancing. Consequently, in Ghana prayers become part of the traditional therapeutic measures and the symbolic healing is usually performed amidst singing, dancing, and the more recent 'deliverance' sessions. The Ghanaian spiritual church healers who offer words of knowledge (mostly as revelation) in the attempt to ascribe causation of the illness, place their ability under the aegis of God's power (Onyinah 2001: 137).

Healing generally builds the faith of those who receive it (Theron 1999). It is obviously this faith that makes the HIV-positive patients resort to spiritual church healing, perhaps looking for a miracle or divine intervention in their lives. To many of the churches and their members, the way to be spiritually alive in the world is prayer-centred. Most of these churches engage in what seems to be their incomprehensible shouts that are referred to as 'praying in tongues' (originally expressed in the Bible by the

Apostles on Pentecost Day). Many of the worshippers become possessed by what they claim to be the Holy Spirit. People relate their dreams and visions, and give their personal testimonies usually of how they have been saved or how an imminent evil to them may have been averted (Onyinah 2001: 125).

The healing mission of spiritual churches, and more especially the hope by HIV/AIDS patients for divine intervention may start from the message of salvation preached by Christianity when, like Western medicine, it was introduced in the nineteenth centry during colonialism (Debrunner 1967). Christianity dominates in the southern and central parts of Ghana (Islam prevails mostly in the north). It was among the Akan that Christianity was first introduced in the country; hence the Akan are highly Christianized. They were highly religious even before Christianity, and like the Nuer (Evans-Pritchard 1951), the Akan use the friend metaphor in reference to the local God (*Onyankopɔn*, the Greatest Friend), seen as someone who can be relied on for solace. This may account for people's religious zeal and the huge belief in divine intervention in the face of adversity, such as an HIV/AIDS affliction. This may also account for the popularity of Christianity in Akan society. Freedom of religion is upheld as a constitutional right, enshrined in Ghana's current constitution of 1992. No recent official figures on religious affiliation seem to be available, but Christianity is thought to constitute about 63 per cent of Ghana's population of about twenty million; Islam accounts for 16 per cent, while adherents of traditional religion total about 21 per cent (Pobee 1991).

When the missionaries first began their evangelising work on the Gold Coast (Ghana's name before independence), they found themselves face to face with the firmly rooted folk religion (Wyllie 1976: 199). Christianity has played a major role in the socio-economic and political spheres of Ghana's social system. The mission churches saw the need to establish schools as nurseries to educate and train African elites to take up ministration for the spread of Christianity. The healing exploits of spiritual churches today add to the pluralistic nature of Ghana's medical system.

In their proselytizing efforts, the mission churches proclaimed the existence of a true Christian God, portrayed in the skin of a Whiteman, who alone can save. There was the need for this salvation through a personal search for grace and spiritual perfection in order to go to heaven—to enjoy a future bliss there (ibid). This tying of Christianity to individual salvation (this is part of the individualism Dumont (1986) points out) is contrary to the encompassing nature of the Akan mtrilineage. Christianity was initially also viewed as a threat to the social order surrounding the people's

traditional religion. Consequently, Christianity was not readily accepted and converts could not openly proclaim their adherence to the 'new' religion (Middleton 1983). In Kwawu, for example, the Tigare cult had gained ground that Christianizing was virtually retarded. A powerful fetish priest, Atia Yaw, held sway even beyond the Kwawu area; he forbade his adepts to attend church services by the missionaries (Nkansah-Kyeremateng 2000).

We only have to consider some of Christianity's early converts to appreciate its tumultuous beginnings. If it arrived as a high culture to open the eyes of the natives of the Dark Continent, Christianity had to settle with converts of ambiguous or low status in Akan society (Middleton 1983). Most of the converts were princes (who as the sons of chiefs and not their nephews had no hope of a traditional office), ex-slaves who became free if they could escape to missions, and widows. Others were deserted or divorced women, orphans, those who had wittingly or unwittingly broken taboos, and those with six fingers and saved by the missions from starvation or abandonment because they were regarded as a curse in the family (see ibid: 4). The uncertainty did not pertain only to conversion. The converted Akan Christians had to make radical adjustments in their belief systems and lifestyles because most of the Christian values were in direct contrast to the traditional beliefs (Akyeampong 1999).

Ideas and practices of the folk religion could not find a place in the Christian ideology of spiritual perfection as a prerequisite for salvation (Wyllie 1976). Monogamy, for example, was in direct opposition to the polygamous attitudes of most Akan men. Concerning Akan cosmology, the Christian explanation of heaven, a place of rest after death where all men are equal obviously contrasts with the Akan notion of *asamando*, where spirits of the dead dwell and reproduce the society through reincarnation. Again, the Christian idea of Jesus Christ as the only saviour and mediator between humans and God gave no place to the Akan notion of supplication (by the chief) to their ancestors, to *Onyame* and other superior beings.

Viewed this way, salvation was not a glorious thing for traditional religion because Christianity meant that the people had to abandon their own beliefs, seen to have been bequeathed to them by their ancestors and which they had lived with for ages. Traditional Akan religion does not preach salvation in the Christian sense, even though the folk religion stresses harmony in a person's social relationships for the good of the community. Consequently, Christianity, like Western medicine and education in Africa, brought a salvation theme that easily lent itself to a negative understanding of the relationship between the administrators and the natives. Was it that Western medicine was to save the diseased bodies of

the natives and education was to show them the light to knowledge and save them from dangerous superstition, while through Christianity their diseased souls would be saved?

The missionaries would not accept that the Christian God and the Akan god, *Onyame*, could exist side by side; instead, they portrayed the native God and gods as idols. As it were, the alien missionaries had presented an alien God they were trying to impose on the natives. This was an inadequacy in the approach of the missionaries because they alienated themselves from the natives who then began to desire a church less alien. A rising spirit of nationalism had begun during the last decades of the nineteenth century when the people agitated for political control of their own lives. This sense of nationalism was carried into the religious lives of the people, and many saw the need for a black man's church that would emphasise their African identity (Wyllie 1976).

African spiritual churches erupted in Ghana in the early 1900s, given impetus after a visit by the Liberian 'Prophet', William Wade Harris in 1913 (Walker 1979; Mullings 1979). Some of the new churches were the result of schism and break away from a mother church of the older missions introduced during colonialism; others were founded by an individual. Whatever form it took, it was an indigenisation of Christianity because they combine many Akan (African) practices. Drumming and dancing, and the belief in witchcraft and the power of healing go alongside the Christian ideas of salvation and the power of the Christian God. The churches are often referred to as 'spiritual' or 'spiritist' or 'spiritualist' because of their invocation of the Holy Spirit (Mullings 1979: 66).

These churches also occupy a middle ground sinse they incorporate some traditional practices with Christian ideals. They use the Bible to preach based on ideas about the Christian God and his son, Jesus Christ, but they also characterise their worship with drumming, singing and dancing, which are close to fetish performances (*akɔm*). For this reason, classical Pentecostals as the earlier variant of spiritual churches were initially ostracised by the mission churches around the 1970s for their unorthodox beliefs and way of worship (Onyinah 2001). In practical terms, spiritual church healing expresses concrete salvation from illnesses and worries of this world, including HIV/AIDS.

Spiritual churches, witches, and HIV/AIDS

It is not just individuals, such as those afflicted with HIV/AIDS, who assign the disease to the work of witches. In Akan society today, it is common to

hear stories and read some newspaper reports about a spiritualist associating the disease with witches. The 15-year-old girl reported in a newspaper to have killed and eaten an AIDS patient with her group made the confession to a spiritualist. It could even be that a spiritualist may have first suggested it to many of the patients who believed that their ailment was the work of the witch and sought spiritual church healing.

One of the strong messages of spiritual churches in Ghana is against the Devil and his agents, the witches. The discourse on witchcraft and witch activities is a dominant leitmotif in the preaching and form of worship in these chrches. When I attended a worship session at a spiritual church in one of the Kwawu towns for the first time in more than twenty years, this discourse was much the same as earlier. On that day in June 2003, the leader and preacher of the church opened the service with a piece of information that also sounded as a caution. “A few days ago,” he said, “there was an announcement on one of the FM radio stations that witches all over the world were coming for a conference in Ghana—in [name of an Akan town]. Did anybody hear that news?” Members of the congregation were briefly quiet, meaning that they were hearing it for the first time from the pastor. I had heard it; there was rumour in that town that Ghana was about to host a world conference of witches. A ten-year-old boy confessed to having witch powers; he was to take part in the conference but his good judgement made him reveal the impending clandestine activities of the witches. But I did not say it at the church because as a first time visitor I wanted to practise the Akan outlook on modesty, which expects such visitors to be in the background as much as possible.

A murmuring from the congregation indicated that people were shocked and worried at the news. The pastor admonished members of the church to be prepared to fight against witches with prayers. “It shows that those people [witches] are on the rampage. The world exists dangerously, always under threat from their activities. We need to defeat them with prayers and God’s power,” he stressed. This was followed by a lengthy prayer session in which everyone prayed aloud.

Spiritual churches’ promises of salvation, to ensure wealth to adherents, protection against witches, and an idea of a full and enjoyable life here and now on earth, as against the older Christian denominations’ futuristic ‘reward is in heaven’ discourse, is appealing to many. It is therefore common for people to move from one spiritual church to another in search of the ‘real’ promise and protection (or cure). My main contact person (and cousin) Ernestina was baptised a Presbyterian. But she left some years ago for the Pentecost Church. She is still a member of that

church and attends worship session every Sunday morning, but she also attends a spiritual church on a different day. Except when she travels for her trading activities, she goes to the spiritual church every week "just for prayers". Many like her see witch ideas as real and that the true weapons against witches are prayers and fasting. Hence, praying and fasting form a major part of worship in spiritual churches, and for people who fear being bewitched the best insurance is to belong to a spiritual church or a prayer group.

In an article on Christianity in a Ghanaian town, John Middleton (1983) has suggested that spiritual churches have become a threat to the traditional mission churches because they continue to win new members. For him, this is due to the changing roles of the ministers of the older denominations whose message of piety and a future heavenly bliss has *become stale* (ibid: 13, emphasis added). The spiritual churches promise miracles in people's lives here on earth, which seem more attractive to adherents.

The presence of spiritual churches portrays variation in Christianity in Ghana, but their activities come into direct confrontation with the ideology of the earlier missions in many ways. They promise salvation, healing, and well-being to adherents, in contrast to the mission churches which seem to emphasise salvation and spiritual uprightness. No wonder spiritual churches seem to be winning more converts. Indeed, it would be a more concrete act for their well-being when the sick get healed (or hope to be healed, from HIV/AIDS) and are free from hardships than to belong to the older denominations and hope for a futuristic bliss. People are suffering here on this earth from poverty, illnesses and other misfortunes they want to come out of. No wonder many shift camp to these latter-day prophetic churches whose leaders or pastors also preach with some sophistication. Even if they are Akan and speak Twi or Fanti fluently, they tend to preach in English, some with obvious difficulty but others with admirable ease and gestures; an interpreter translates into the local language after every sentence or two.

The singing, dancing and playing of drums by the spiritual churches is interpreted as an expression of happiness for being God's children. It is also a defeat for the devil. People must 'celebrate' God openly than in silent prayer. This openness has encouraged some of the mission churches to incorporate Pentecostal-oriented prayer groups in their worship in order to prevent their members from leaving (Meyer 1995). In the Catholic Church in Ghana, for example, the Catholic Charismatic Renewal was formed in the 1970s to give a spiritual boost and more prayer-oriented worship in the

church. Many have understood this as the church's uneasiness from the scare of the spiritual churches and the number of converts flocking to them.

Some spiritual churches are indeed doing great evangelising, bringing the word of God to many souls. Yet, the activities of others draw much consternation. They are viewed as dangerous to social order and their claims to have spiritual powers against witches often create conflict and confusion. For example, in 1987, a man who was referred to as Jesus Christ of Dzorwulu (a suburb of Accra) formed a cult whose members were simply unkempt with unwashed bodies and hair. Most of the adherents had also severed relations with their families, obviously because they believed them to be witches. Those adherents lived with and followed the leader wherever he went. This and other activities of some spiritual church leaders cause great disaffection in sections of the society. Reports and stories are rife that on the pretext of praying exclusively for people against witchcraft, some pastors trick female members of their church into giving them sexual favours.

In the discussion on witch-hunting and chiefs, I argued that because witches destroy life created by the superior beings and for which the chief must seek protection, chiefs (and fetish priests) enter into a struggle with witches. Similarly, spiritual churches' promises of life, wealth, and salvation enter into a struggle with witches whose ability to cause death means a failed promise by these churches. The early churches preached that evil power emanates from the Devil, who was portrayed as a black caricature with horns growing from his head. The devil rules in his evil kingdom from where he controls his agents, a strong ideology with the spiritual churches too. But spiritual churches go further with a belief in witches as the cause of illnesses. It is not surprising some pastors associate HIV/AIDS episodes with witch activities.

The discourse on witchcraft was a huge topic in the colonial days. In the late 1930s, the Executive Council of the Gold Coast passed the Native Custom (Witch and Wizard Finding) Order. The order ceased to see witchcraft as a crime (as perceived by the native chiefly courts), making witch-finding illegal (Gray 2001). But the prohibition of witch-finding did not go down well with the native authorities and fetish priests, nor did it hush public debate on it; rather, it intensified it. As big-time players in witch-finding and cleansing, chiefs also came in direct opposition with the ban. Having lost some of their political power through indirect rule to the colonial administrators, the ban meant that the chiefs had further lost the power (or the opportunity?) to protect their societies and the people. It was not surprising then that much of the protests about the ban came from

chiefs. In 1931, the then newly-formed Christian Council, the representative body of the churches (minus the Catholic Church), may have dealt the chiefs' case a blow.

The Christian Council had joined the discussion on witchcraft by holding an inquiry into the phenomenon, and its report on the subject accepted that Christians could disagree in good faith on whether witches existed or not. However, it argued that many of those who believed themselves to be witches were hoodwinked (ibid: 358). The report further counselled compassion for people accused of being witches:

> Even witches (if any such there be) are the children of God; that, therefore, they deserve not only condemnation but pity and compassion; and that it is the duty and privilege of Christians to lead the world into new ways of pitiful compassionateness, following the footsteps of Him who was known as the friend of publicans and sinners (ADM 11/1/886).

But the next point in the Christian Council's report only confirmed that even as Christians, people did not totally abandon their belief in witchcraft. For, the fifteen-point report said in its final part, sub-titled 'Our duty':

> Finally, we desire to remind ourselves, and the Christian Council and the Christian people of the Gold Coast that, whether in fact witches and wizards exist among us or not, no Christian need be afraid. If we are afraid we shall be weakened by our fears. If we put our trust and confidence in our Heavenly Father and in his son Jesus Christ our Lord, then even though our bodies suffer, our souls are safe with him; and no power, not though it were the power of the devil himself and all his angels, shall be able to pluck us out of our Father's hands (ADM 11/1/886).

Spiritual churches generally see social problems on two levels. First, misfortune is foremost the result of wrongs perpetrated by the lesser evil forces such as witches. Secondly, misfortune may be attributed to wrong relations between humans and God when men sin and incur his wrath; this thereby distances him from humans. The distancing from God consequently allows or provokes the action of supernatural beings. God himself may come in to punish people, or he allows Satan and other evil forces to sow havoc in the world. It should then be understood why HIV/AIDS is being associated with a (religious) slip in piety. As among Malawians, many in Ghana see all the troubles in the world to come from the Devil, who tricked the first humans (Adam and Eve) to commit sin and continues to lead people astray (Englund 2004). As Harri Englund (ibid: 300) has pointed out, this is why in Born-Again cosmology of the Pentecostal Christians the first birth in

the flesh has to be complemented by a second birth which is achieved through baptism in the Holy Spirit.

Is HIV/AIDS a punishment from God?

When HIV/AIDS first surfaced, the popular discourse by the spiritual churches for some time was that the disease was a punishment from God. It is not uncommon to hear a preacher proclaim that 'God has sent it because of man's waywardness'. God himself is usually implored to send his divine intervention. And there seems to be a transcendental hope for the better. It may not have been overtly expressed, but as Grace B's story shows there are instances when illness and a slip in Akan moral values become contiguous, particularly in the eyes of others. A similar slip occurs here, although this time it falls within Christian ideals and not traditional religious values. Since God himself is capable of punishing people for their sins, an illness or other misfortune may be seen as divine retribution.

The discourse on HIV/AIDS as punishment from God is not confined to Ghana (or the Akan). In Nigeria, many Christian leaders believe that AIDS is a divine punishment (see Orubuloye, Caldwell, and Caldwell 1993a). Such ideas seem to have subsided in Ghana these days, but it is common for some pastors and lay people to express similar views when pressed. Patients may be looked down on not because of their illness and incapacitation but because they have offended God and brought his anger unto themselves. For the churches, the sins commonly committed but which greatly annoy God are fornication, adultery, and licentiousness. These are all sex-related sins which the churches vehemently preach against.

It then becomes clear why some churches initially condemned those who were infected as having 'sinned and come short of the glory of God'. Because the major mode of HIV infection in Ghana is through sexual relations, patients afflicted with the disease are looked on as 'sinners' who are paying the price as fornicators or adulterers. It may partly be for this reason that some spiritual churches insist on an HIV test before they conduct wedding ceremonies between couples in their church. Other pastors encourage persons living with HIV/AIDS to attend their church. Later, following periods of prayers and fasting, they would claim to have successfully healed the patients of the disease.

Because some of the preachers equate HIV/AIDS with sexual promiscuity and the disease as a punishment from God, religion is another context for stigmatizing people living with HIV/AIDS (Takyi 2003). Ironically, many of these pastors are themselves not without blemish; many

are viewed as false prophets who preach what they do not practice. They admonish their adherents to live uprightly and avoid sin, but many are seen as lustful, promiscuous and guilty of impropriety. They are usually accused of exploitation of their congregation, false miracles, and ostentation. Thus, sometimes the threat to social order is found in religion, in the practices of others in the sacred arena where practices are meant to replicate social order and render it impervious to chaos and change. Many pastors are said to indulge in occult powers associated with fetish priests and even start their church activities and so-called spiritual and healing exploits with powers secured from shrines. One fetish priest shrugged off the powers of spiritual churches: "Their so-called powers are most of the time derived from us. They contact us for powers to start a church, and later they proclaim themselves to be so powerful. But it is all from us [fetish priests]."

When a spiritualist is thought to be powerful, the church he or she leads usually attracts a large congregation. A large number of members is usually important for monetary contribution (locally called collection) during the worship. A collection may be solicited two or even three times before the end of the worship session. Many churches (including the older denominations) also organise a special collection at the end of every month called Kofi ne Ama (male born on Friday and Saturday-born female). On such occasions, those born on the various days of the week, from Monday to Sunday, are called one after the other to donate. The various sums are totalled and the winners, second, third, in descending order to the last are mentioned amidst applause and jubilation. This is apart from the church harvest performed every year when members donate monies, foodstuffs and other itmes sold in the church; the proceeds are kept for financing various church activities.

Some leaders are suspected to amass wealth from contributions by the congregation. The money-making tendencies of most pastors cause much concern to many people. Although the income level of many adherents in these churches is fairly low, some church leaders and their families usually live in luxury. Many have a car (sometimes two or more) and own properties such as land and houses. Even the church building may have been built on a land belonging to the pastor. What happens should the church collapse is anybody's guess. People often observe sarcastically that one of the easiest and quickest ways to enrich oneself in Ghana today is to establish a spiritual church or form a non-governmental organisation and claim to work against HIV/AIDS.

The church leader, founder and pastor of many spiritual churches is usually one and the same person. There is always a tendency for such a

person to assume a 'Jack of all trades' status. He (or she) is usually the sole treasurer, the secretary, keeper of the ledger, a one-man executive board, and even the clerk, all at the same time. It is usually easy to embezzle funds in such churches. But many other church leaders usually have Elders or Deacons as their lieutenants. The person at the helm usually assumes the title of Reverend, Pastor, Apostle, Bishop, Archdeacon, or Archbishop. And new titles could emerge from the fast-growing number of such churches, which made someone joke to me one day: "Very soon, we will have in Ghana the Pope of a spiritual church."

The need for deliverance, prosperity gospel, and HIV/AIDS

Because of their belief in witchcraft and the power of the Devil to make people sin and bring hardship unto themselves, spiritual churches see the need for their members to be delivered from the 'powers of darkness', a metaphor for the devil and demons/witches. Both leaders and adepts of such spiritualist churches have strong beliefs in the 'deliverance' of people from Satan and witches. Such churches, which also indulge in prayers and incantations for deliverance, are on the increase today (Meyer 1995). Their promises of salvation to adherents, and to ensure wealth and protection against witches continue to win for them new converts and a large following (Sackey 2003). Some have their premises turned into a permanent abode for patients. The emphasis on prayer subscribes to the view that illnesses associated with powerful demons need more time to be combated (Onyinah 2001).

The church leaders themselves seem to encourage patients to live permanently at the church premises. There is the obvious notion, both among the adherents and leaders of these churches, that to have many patients living at the premises is an indication of the pastor's healing powers or clairvoyance. Many such healers may genuinely be able to 'see things' spiritually and reveal them. But others are seen to be false prophets who only create fear in individuals or conflict in families, for their own gain.

Despite the public distaste the attraction to the 'born again' churches is obviously based on the concept of Prosperity Gospel in spiritual churches today. All over Ghana today, the so-called prosperity gospel has become popular (Meyer 1995). The prosperity gospel proposes that God's children, as 'born again' Christians (who usually belong to the spiritual churches), will have material wealth, be free from illnesses and the worries of life on earth. The prosperity movement is worldwide, with similar promises of "spiritual resources", in the words of Simon Coleman (2004: 427). For

instance, it is also popular in Sweden, where many young people flock to such churches (ibid). In Ghana, the concentration on promises for individual successes, health and wealth should understandably be attractive to many, given the deprivation and sometimes abject poverty experienced by people at the grassroots level—at the lower rungs of society. The message of prosperity catches on well since the churches argue that the relations between humans and God cannot be complete in a period of disorder (from poverty and illness). God is just and did not create humans to suffer.

The prosperity gospel brings up a number of issues. Like their healing and way of worshipping, the construction of religious uprightness by spiritual churches is in stark opposition to what dominates the message of the older mission churches. All churches exhort their members not to love money or be envious of the wealth of others. But the older denominations seem to stress more than their spiritual church counterparts the need for Christians not to be consumed by the acquisition of worldly riches. Instead, people should strive to be rich in spirit for a future heavenly bliss. Hence, piety, humility and spiritual worthiness are dominant discourses of the older denominations. The 'born again' churches employ quite different teachings on wealth and consumption. Like the older churches, they denounce material acquisition and ostentation; most of their songs express this theme. Paradoxically, they promise prosperity that associates the accumulation and display of wealth with God's blessings.[87] 'Born again' churches are becoming the fastest-growing Christian congregations in Ghana, but their activities and convictions about prosperity allow talk among Ghanaians about the superficiality of their belief. This also reinforces the lamentation that many churchgoers are only nominal Christians (Meyer 2004: 106).

If in times past deflections to spiritual churches whose ideals are closer to Akan beliefs indicated that the converts desired a sense of continuity with their traditional 'faith', today that continuity seems to be linked more to witch beliefs, averting misfortunes, and prospering in life. Hundreds of prophetic spiritual churches have sprung up and have spread throughout many towns and villages of Akan-land. Their names most often indicate their activities—healing church, spiritual church, revival church, prayer ministry, gospel church, miracle church, etc.

In the current HIV/AIDS situation, one must acknowledge the significant role these churches and the older denominations play in creating awareness about the disease in Ghana. They and other institutions engage in workshops and seminars to sensitise the public. Jeremy Liebowitz (2002) has noted the contribution of such churches and their related institutions in

[87] Daniel Jordan Smith (2001: 589) recounts similar notions in south-eastern Nigeria.

HIV/AIDS education in Africa. He characterises them as faith-based organisations (FBO), embracing "places of worship [churches] and their members as well as any organisation affiliated with or controlled by these houses of worship" (ibid: 4). Pentecostal churches tend to have a less hierarchical institutional structure, and they usually have a network of interaction which is more across the board (ibid).

In a study of the impact of FBOs on HIV/AIDS prevention and mitigation in Africa, Liebowitz argues that those organisations have played a major part in delivering intervention, encouraging open discussion, providing services, and changing behaviour. For almost a decade in the 1990s, Uganda hit international fame for its successes in reducing the prevalence of HIV/AIDS in the country. Liebowitz points out that the activities of the FBOs in Uganda provided communities with resources and hope in the struggle against the disease (ibid: 1). Pentecostal churches and many of the institutions affiliated with the houses of worship have significant advantages in delivering certain kinds of interventions.

In Ghana, young men and women continue to become members of spiritual churches and prayer groups. A few decades ago, John Middleton (1983: 14, among the Akwapim) suggested that this was a sign of rebellion by the youth against their elders. In my opinion, the youth join those churches as insurance against becoming victims of evil forces, to prosper in life, and to have a fitting funeral as a symbol of status. As Liebowitz has suggested, FBOs have regular and closer contact with their congregations and they could use that as a platform to increase campaigns. That is, these churches could do more through intensified and sustained campaigns to deliver their adherents and other members of the public from becoming HIV-infected. In this way, they will better ensure people's prosperity in a life without HIV/AIDS afflictions. In sum, spiritual church healing broadens therapeutic resources and gives more options in HIV/AIDS patients' attempt for therapy. The hope in divine intervention calms the heart of the afflicted, even HIV/AIDS patients who may have been told that their illness is incurable. Ultimately, however, it is one's lineage which takes care of the HIV/AIDS patient. Thus, the real consolation is that when illness strikes, there are people to care for the afflicted person and to help in the effort to regain health.

8. A TRADITION OF CARE AND CRISES IN CARE

Many HIV/AIDS patients are mainly cared for by their kin members. Caregiving expresses one of the most important periods when the encompassing nature of the Akan matrilineage becomes visible. Care for the sick member also portrays the emotional (psychological) support much needed in the experiences of the HIV/AIDS patients (cf. Radstake 1997). Caring for the sick person tries to restore health, and it also leads to the sense people make of the illness or illnesses generally. Thus, the social meaning of the illness is largely expressed through caregiving. The level of care shows how serious the illness is viewed, expressed in the constant support to HIV/AIDS patients by members of the matrilineal group when they act as therapy managers. It also expresses the tradition of care in Akan society based on amity and altruism when the sick individual has other members of the group to rely on for support. Some of the patients were abandoned or not cared for by close family members, which is unfortunate and a contradiction about the matrilineal group. In instances when they were abandoned, the tradition of care in Akan society is such that the patients never completely lacked someone to care for them; neighbours readily gave support.

Arthur Kleinman's (1980) study of the medical (cultural) practices of patients and healers in Taiwan a few decades ago led him to discuss the family's role in caring for a sick member. Two years before Kleinman's study, John Janzen showed the part played by kin members in seeking the health of a sick member in Lower Zaire. In his study of the search for therapy, Janzen developed the concept of the therapy managing group who care for the sick person among the BaKongo of Lower Zaire. He characterises the therapy managing group mainly as a set of close kinsmen [and kinswomen] who help with the management of illness or therapy for a kin member (Janzen 1978a: 4).

As HIV/AIDS continues in Africa, many studies are focussing on informal care for patients. Community-based care or home-based care by professional and semi-professional people has dominated HIV/AIDS studies for some time (e.g., Radstake 1997). Attention is increasingly being focused on the involvement of family members as lay people in the care of AIDS-afflicted persons. This form of care is informal because it largely involves lay, kin members. It is important in African societies where the family is a traditional social security mechanism.

Among the Akan, the family or larger lineage often encompasses the individual whose welfare is a concern to the group. Traditional ideas and

practices as an important part of the everyday activities of the lineage make informal care by kin members significant in the attempt for therapy. Care, here, subscribes to everyday usage as the process of looking after a sick individual and providing his or her needs to help restore health. It is distinguished from curing (or healing), which is directly in the area of prescribing or giving medicine and other advice by the expert. It is also different from home-based care as the provision of basic medical, nursing, psychological and sometimes spiritual support by health workers at home but devoid of such daily household activities as bathing and feeding the patient (cf. ibid).

This chapter shows the important role of the Akan matrilineage in the care of a sick member with HIV/AIDS. For the Akan, one is born into a lineage, lives his or her life in it with support and care from other members of the group, and one will hopefully die within that lineage. The symbolic nature of the matrilineal group is portrayed, for example, in the identity individuals derive from it; its real (or practical) nature lies in economic and other practical support to members. The practical aspect is even more visible in caring for the sick member. Meyer Fortes and others who studied the Akan missed this, although they recognised the corporate and encompassing nature of the matrilineage in other areas—inheritance and succession to office, and death rituals on behalf of deceased members. Margaret Field's (1960) study of the search for therapy at shrines recorded many instances where kin members accompanied patients to seek remedy, although she did not focus directly on caregiving.

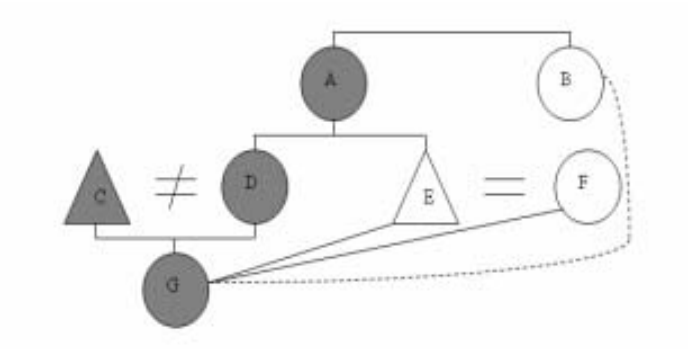
Caring for a chronically ill person is usually a stressful task (Parkenham et al. 1995); there are many problems associated with the giving (or not giving) of care, which indicate some of the contradictions about the Akan lineage group. Many instances of these problems emerged as conflicts closely associated with the care of HIV/AIDS patients. So rife were the conflicts, yet they could easily be missed or glossed over by a Western observer and even the unsuspecting native. They were expressed mainly as disappointments and disagreements. Sadly, the importance of care among the Akan has not received much attention, perhaps because caregiving is informal, unpaid and regarded as 'expected' of the family and other kin members. Yet, the work involved in caregiving is substantial, if not overwhelming.

Caring for Abena Bea

When Abena Bea fell ill at 28 years she was cared for mainly by members of her matrilineage. There were a number of her close kin members— both consanguineal and affinal (see Figure 5). But her matrikin formed the bulk of caregivers. The principal carer was her classificatory grandmother (mother's mother's sister, MMZ). The 80-year-old grandmother (B) bought food for Abena Bea from the monies that the patient's maternal uncle (mother's brother) gave for her upkeep. The old woman usually bathed (or cleaned) Abena Bea and occasional cooked for her or collected the food prepared by other members of the family for the patient. The maternal uncle's wife (F), a social worker, gave the patient some medical care and administered injections for curing the tuberculosis Abena Bea developed. The uncle's wife occasionally also prepared food for the patient.

The part played by her maternal uncle's wife was significant and widened Abena Bea's network of carers. It also lays bare a fact about Akan marriages; when she steps into the marital home, a woman also enters into relations in the husband's group. In fact, Abena Bea was never short of carers. Her biological grandmother was dead, and so too was her biological mother. But Abena Bea was free to go to her mother's 'sister' and therefore her classificatory mother (actually, mother's mother's sister's daughter, MMZD) who had succeeded the patient's deceased mother. The classificatory mother would have cared for the patient, but she worked with a firm in Accra and could not do so. She agreed with her 'brother', Abena Bea's maternal uncle, to find someone to care for the patient.

After discussions in the family, the onus fell on the octogenarian (B). She had been a farmer but stopped going to the farm a few years ago due to her old age. She was thus free at home most of the time. Although very old, she was quite agile. The old woman was delegated to assume major responsibility in caring for Abena Bea, which also indicated the severity of the patient's illness.



Abena Bea (Ego, G)

FIGURE 5: Matrilineal organisation of Abena Bea's (G) carers (therapy managers)

Legend: A is Ego's grandmother, and B is her classificatory grandmother (her grandmother's sister). C is her father, while D is her mother. Ego's maternal uncle (*wɔfa*) is E, with F as her aunt-in-law. Lines from B, E, and F show sources of care to Ego (that is, her therapy managers, and the dotted line indicates the major caregiver). The sign = means marriage, while ≠ stands for divorce. Dark symbols mean deceased.

Abena Bea had lived at Koforidua (the Eastern Regional capital) where she said she worked with the regional branch of a public corporation. She was schooled at a village near Nkawkaw. She said she had not been lucky in marriage, which she often alluded to and regarded as a misfortune: "All the men I married maltreated me." It was not clear whether she had been 'properly' married to the men. She would not tell me about that aspect of her life. It seemed her kin members were not aware of any such marriage. When I broached the issue one day, some of the women were mute and the look on their faces convinced me there was something that had better not be discussed.

Abena Bea had been in a number of relationships and she had a child, a daughter who lived in Accra with the patient's sister. She suspected her infection occurred about fifteen years ago at Koforidua. Her diagnosis was conducted at Atibie Hospital on the Kwawu scarp, where her status was revealed to her about seven years ago. Her status was confirmed at the Nkawkaw Hospital a few months later. When she felt ill intermittently at Koforidua, Abena Bea came to her home village to be among her kin members and to look for cure. She had been experiencing feverish conditions and headaches, and in Kwawu she tried several medications on her own (she would not mention specific ones but simply said "almost all medicines"). Her mother was alive then and urged her daughter to go to the

hospital. It was after quite some time, when she finally decided to go to the hospital that she was diagnosed as being HIV positive.

Her mother had died in middle age a few years ago from heart failure. Abena Bea did not think that her status had anything to do with her mother's death. The patient had also not been fortunate with parental 'pampering', as the Akan say, as she grew up. Her parents were divorced long ago when she was almost a toddler. Her father did not look for her and he did not encourage her to go to him. In a conversation with me one day about what she termed as her "sordid life", Abena Bea explained that her father had a bitter conflict with her mother and the family. Abena Bea did not give details of the conflict, but said that was the main reason why her father completely abandoned her. He was dead too from stroke, having predeceased Abena Bea's mother. When he was alive and was informed about Abena Bea's ill health, he was said to have claimed that Abena Bea's mother's people had kept her all along to themselves. Now that she was ill, what was he to do with her? All these deaths and abandonment notwithstanding, Abena Bea did not lack others to care for her.

One Wednesday afternoon when I visited Abena Bea, whose condition always fluctuated, she asked me for a 'lift' (free transport) to the counselling session at the hospital at Nkawkaw the following day (Thursday) because she did not have money for transport. She also needed a readily available means of transport close by since she had become quite weak and felt excruciating pains in her legs. She would not have been able to walk on her own (or even when supported) to the roadside or the lorry station some five hundred meters away for transportation.

Abena Bea had told one of the many social workers who visited such patients at home about the pains and bodily weakness two days before her request to me. She still wanted to be present at the counselling session. The old woman who cared for Abena Bea was herself feeling ill and had gone to their family home the previous day to find treatment. I offered to collect any medication from the hospital for Abena Bea, but she explained that she had not attended the counselling session for quite some time because of the weakness. She wanted to be there to say hello to the people. Since I lived at Nkawkaw, I left early to Abena Bea's place some ten kilometres away in order to help her prepare for the journey. I found that she had been helped to dress by a couple who were her co-tenants in the rented house where she lived.

I gave her the lift in a taxi I had 'chartered', as I usually did when I had to travel around. In Ghana, one can pick a taxi and have it to oneself for some time, which is referred to as a 'charter'. On the other hand, the taxi

can just drop the person at a place and the driver does not have to wait. 'Chartering' attracts a higher fee than the other option, 'Dropping'. Considering Abena Bea's condition, chatering was the better option. Chartering a taxi is usually considered the safer alternative when someone has some pressing transactions to make and feels the need to have a readily available means of transport at hand. It is always difficult to find another readily available taxi. When business is brisk, allowing the taxi you took to go away is risky.

After the counselling session later in the afternoon, I took Abena Bea back to her hometown on the scarp and gave her 5,000 cedis (less than 60 US cents in 2003); she in turn gave me her sister's telephone number for more information about herself whenever I found it necessary. It was obvious that she had built a great trust in me. She would talk heartily whenever I visited her, which I did several times later. Abena Bea looked weak, yet she was always in high spirits and looked elated to see me or others who visited her. She never ceased being thankful to those who visited her and offered her monetary support. Abena Bea also paid glowing tribute to her 80-year-old caretaker grandmother, her maternal uncle and his wife, as well as the couple as her co-tenants. "Please, do thank them wholeheartedly on my behalf," she told me one day. "But for their support, I would be gone [would have been dead] long ago."

She often suffered from diarrhoea and loss of appetite but her condition always improved. Abena Bea attributed this positive sign to the medication from the Holy Family Hospital, which, as mentioned earlier consisted of antibiotics and other Western drugs, as well as the herbal liquid preparation given to all such patients to boost their appetite. One day when I visited Abena Bea she exhibited great courage, or so it seemed. She said she was taking her situation with hope and a positive outlook for the future. "I am taking everything in good faith. I know I must be strong and positive-minded to be able to move on in my life and prolong it. I also do not want people to get into my situation. That is why I agreed to reveal my status to an audience recently," she pointed out.

Having people around to give care, however, does not always assure the terminally ill person psychologically. Behind Abena Bea's positive outlook lay a suppressed anxiety and fear. On many occasions, after talking with me for some time, she would relapse into silence and a pensive mood. Her countenance always expressed mixed feelings of moodiness, long brooding, or a happy and amicable disposition. This display of different states of feeling happened frequently in the latter stages of Abena Bea's life

when her voice was barely audible. I always shared jokes with her because to see her in a state of despair saddened me.

There was yet another problem; this involved her grandmother carer. Beneath the care Abena Bea enjoyed from the old woman was a huge sense of frustration felt by the elderly carer. This was clearly manifested one day when I met the old woman at a funeral in one of the Kwawu towns. After exchanging greetings and other pleasantries with her, I asked about how Abena Bea was doing. The cute old woman answered sarcastically: "She is still around." The old woman then actually revealed her frustrations. "Do you know something? She [the patient] is giving me only worries and fatigue. She is so weak that I have to carry her around for everything she needs to do. I am indeed tired. As you can see, I am an old woman. I don't have much strength in me."

Because Abena Bea often lost her appetite, she would sometimes not eat the food the old carer or someone else in the family had prepared for her. "She would ask for something else and I have to walk all the way to the centre of town [about four hundred metres away] to buy her the kind of food that she wants," the elderly carer explained one day. A long silence ensued between us. I actually did not know what to say to the poor old woman. I had kept quiet, trying to imagine and analyse the level of her frustration. All of a sudden the old woman broke the silence. She asked me: "They say the disease has no cure, and that when patients get to this stage it means that the end is at hand. Is it true"? I replied that according to (biomedical) doctors, the disease has no cure yet (and I stressed the yet to indicate that there could be in future). The old woman was pensive for some time and commented thus: "And she won't die quickly for me to have my rest? I have really suffered enough caring for her for so long [for about two years]."

These comments may at first sight seem strange indeed. Is she a wicked old woman who wishes death for a fellow human, more so, her own 'grandchild'? Indeed, such utterances may only indicate the frustration those who give care to HIV/AIDS patients go through. As Moore and Williamson (2003: 624) found in their study about the problems associated with the treatment and care of HIV/AIDS patients in Togo, sometimes out of frustration relatives make comments that seem cruel about the afflicted ones. Somehow, however, one may understand the logic in the old woman's argument. As can be inferred from her questions and comments, if the disease cannot be cured or even minimised and the patient is bound to die, why would death not come quickly to relieve the patient and her of all the suffering they were going through?

About two months later, Abena Bea died. This happened when I had travelled to another place. I was told about her death upon my return by informants who were concerned about the old carer due to a stroke she suffered a few days after the patient had died. I went to see the old woman. We had become so close all this time and I always received greetings from her through some of my relatives. At their family home, I found the old woman looking indeed sick and worn out. She had cared for a patient and not long after she had become a patient, being cared for by some other kin members.

During my visit to the old woman, I learnt that because of money Abena Bea "would go anywhere that a man called her to". This suggested that Abena Bea did not keep a stable relationship with men, and it was said that she would not listen to advice from older people in the family. I do not know if that was really the life Abena Bea had led or whether it was an attempt to save the face of the family by emphasizing the fact that she was advised against her lifestyle. In many of our numerous conversations, Abena Bea always bemoaned the fact that all the four or so men in her life "disappointed" her although they had promised to marry her. Or, was she the one who was trying to hide things from me? I cannot tell.

On quite a different note, one of the women present during my visit commented that if Abena Bea's ghost would appreciate how the old woman devoted time caring for her, she [her ghost] should help the elderly woman to recover fully. "But if her ghost is causing the old woman's illness, then she [ghost] indeed is a wicked one." No wonder many people avoided visiting the patient, the woman commented.

Matrikin as therapy managers

Abena Bea's story is an example of how the Akan matrilineal group seeks the welfare and well-being of its sick member by way of caring for him or her during an illness episode. This is more prominent when it involves a persistent and life-threatening illness such as HIV/AIDS. It also shows the plethora of carers for the afflicted person. The majority of Abena Bea's therapy managers came from the matrilineal group. As the process of care for the patient shows, a network[88] of carers is usually created and springs

[88] Network in social analysis expresses lines of contact between people in any setting (McQuail 1984). The history of network analysis in a community studies is traced to the 1950s, probably in the US, when hanging around in street corners and ringing doorbells in surveys, community researchers found close ties in kin relations, friends, neighbours, and workmates (Wellman 1982: 61).

into action almost at the same time that the illness surfaces, although it does not usually last after the illness episode.[89]

The network of carers is context-bound in terms of spatial and temporal characteristics— it is confined to the group and the vicinity, as well as to the duration of the illness. It is also invariably a network of close social relations. The social relationship created between a person and members of the matrilineage in their social milieu is very important in the holistic Akan society. The Akan nuclear family is always responsible in many aspects of the individual's life, and together with the extended family they care for the sick person as part of the lineage organisation. But usually mothers, sisters, aunts, and female cousins care for the HIV/AIDS patient at home (cf. Radstake 1997).

The Akan household is full of consanguineal and affinal kin and there are often people to care for the sick person. As Maud Radstake (1997) has pointed out, for practical support in care giving the household is more relevant. Kin members usually see the ill state of their afflicted member as a family or private issue. So, even where neighbours are always close by and can give immediate help or care, kin members who may live far away from the afflicted person usually arrive from their places of residence to take over as carers for their sick kin member.

To better understand the prominent role of the matrilineal group in caregiving we need to move beyond notions of amity about kinship. Instead, we have to place it in the context of the moral obligation to seek the welfare of a member in times of need, and criticism from other members of the society. Family members do not expect non-kin members to assume greater responsibility than them because failure to assume a prominent role in caring for a sick kin member is viewed as strange and often attracts castigation or insinuations against the particular family.

Hence, members of the matrilineal group take it as their primary duty to provide close personal support for the sick kin member before all others in the community. In many holistic African societies an individual's illness dysfunction is perceived as a dysfunction of the whole family or clan (Janzen 1978a). Close kin members view it almost as a status to be the prime source of patient care; thus, caregiving is usually spontaneous. As among the BaKongo (ibid), in Akan society kin members as the therapy managers take up such duties as bathing, feeding and massaging the patient.

[89] See Kathryn Staiano (1986: 62-64) for similar ideas about network formation in the quest for therapy in Belize, even though her work does not study the lineage role in the care of a sick member.

The level of care in Akan society is usually determined by the type of illness; if the illness is chronic or life-threatening, it may require that a carer is always close by, as Abena Bea's case portrays. An almost twenty-four hour support is necessary if the sick person is very weak and needs to be helped around for almost everything. It also portrays the extent to which the illness is perceived as a threat and the level of anxiety associated with it (Desjarlais et al. 1995). A mild illness or a merely recurrent one does not require intensive care.

It is in this context of care that the sick role can be analysed as a way of defining and mobilising rights and duties in Akan society. The sick role in the latter stages of the HIV/AIDS patients' lives was prominent in Kwawu, when the patients' weak state further burdened the carers. It greatly also emphasized who was ill, and who was not; who needed care, and who gave it. Kinship as a relational idiom expressed by a genealogical bond that is not voluntary but automatically binding means that one is born into an Akan kin group as an ascribed social frame of reference and not an achieved one. The matrilineal group 'owns' its members and they constitute severally and collectively the primary "social value" for the group as a whole (Fortes (1969: 187). It is only logical that they should care for the illness-afflicted member. HIV/AIDS does not give any hope of being successfully combated. Nevertheless, members must have concern for one another, and the obligation on the family to be there for the sick member was just too great. Yet, many cared for their sick members without stopping as part of the moral obligation on them to support a less fortunate member.

Within the activities of the informal carers, the holder of juridical authority, such as head of the lineage or the mother's brother is important; but the father or the mother of the patient may equally be influential in decisions about the sick person. Such a person may also have other kinds of authority such as being the financier of the therapeutic measures, and thus he or she greatly influences decisions about the illness, the course of therapy, and who should take care of the sick person. In contrast to curers and therapists as specialists, caregiving as an informal set-up in the lineage group has no institutional hierarchy in the strictest sense. Among specialists where everyone is trained to take a specific job, disagreements may be less rife or easily suppressed. In contrast, in informal caregiving confusion and conflict easily develop over who is in control of decisions about the sick person. Sometimes, in a neo-local home the father or husband may take decisions about his wife or their children without the opinions of members of their matrikin. Carers may decide to give or withhold their support without succumbing to the dictates of the commanding individual, even the

head of the lineage. Such circumstances make caregiving indeed a very tricky affair.

Kinship and domestic ties as important constructs in the lives of individuals ensure enlarges the number of carers in the vicinity. Bilateral relations, expressed in filial, sibling, and affinal bonds and interaction are grounded in the familial domain where the day-to-day activities including caring for the sick are performed. I argue that what is crucial and contributes greatly to the range of carers are marriage and residence pattern. For instance, a sick married woman living virilocally is likely to be cared for initially by people from her husband's lineage. When things do not improve, members of the man's kin group know that they do not have any jural authority over the sick woman. As the illness worsens, her matrilineal kin members are expected to be informed and they are expected to act quickly by delegating someone from amongst their group to join the husband's group in care. Or they completely take their sick member away from the husband's home, which usually occurs if there is conflict between the two sides. Generally, however, people from both houses are expected at least to visit her, even if she and her husband have set up their own neo-local home. But often for fear of being bewitched, a spouse may implore the partner not to tell his or her own kin members about the illness or the whereabouts of the sick person or where therapy is being sought.

Gender roles affect the level of care a patient enjoys from others. As with many illnesses, and especially terminal ones, when HIV/AIDS enters a household among the Akan it is usually women who provide the bulk of care in the home (cf. Radstake 1997). Caregiving by females occurs in spite of other tasks that women and girls perform since the bulk of domestic responsibilities in an Akan home usually fall on them. The sexual division of labour assigns women with most of the household chores—cooking, washing, fetching water, and firewood. In many Akan farming communities where subsistence cultivation is the dominant occupation, women and girls go to farms just as men and boys do. Thus, caring for an AIDS patient in the family considerably increases the workload of the female caretaker.

The fact that lineage members care for and interact more with the patient does not give everyone equal access to the patient. Interaction is level-specific. Close kin members usually have more interaction than other members in the extended family or affines. Mothers often care for their children, even grown-up men; sometimes, the ascribed status of a mother and the achieved status of a wife come into a direct opposition. For, the mother and the wife of a married man each wants to assume more responsibility in caring for the sick man, which often produces conflict

between them. Mothers, wives, sisters or female cousins usually care for the sick person than brothers and male cousins. Fathers give the least care. Women usually look after their husbands, fathers-in-law, mothers-in-law, fathers, brothers, sisters and cousins. All in all, the Akan matrilineal group remains the central caregiving unit. But concerning the care for HIV/AIDS patients, some insurmountable conflicts arise that reveal dark spots in the group.

'They don't care': blood relatives and strife in HIV/AIDS care

Family conflict and disagreements associated with HIV/AIDS care in Akan society may not have attracted much attention; however, they are quite rampant and sometimes they cause a deep schism in the family or the larger lineage group. There are many instances where patients may have been neglected or not cared for adequately. Such conflicts may not be visible initially; one becomes aware of the situation only after a close watch (or by luck when disagreements and tensions can no longer be suppressed and they explode). Patients usually accuse others of neglect or that they have not been shown affection. Some of the HIV/AIDS patients were not happy with the level of care to them. Some patients are actually abandoned by their family members, quite against the encompassing nature of a group which emphasises unity.

Victor Turner (1996) used conflicts to show the contradictions in a group. His analysis of village life in Ndembu society has demonstrated how crises threatened the peace in the social life of individuals and kin members. Many illnesses and deaths were attributed to people having perpetrated the deed through witchcraft or sorcery among the Ndembu. Discussions about conflicts between or among kin members during an illness experience in many African societies usually concentrate on suspicions and accusations of witchcraft (and sorcery). The crises I present here have nothing to do with witch suspicions and accusations; yet, they were quite problematic and formed an important aspect of the process of care. The Akan stress local contiguity and close relatedness in a social space, which expresses ties of various degrees. But relating with others can also produce cleavages, particularly during an HIV/AIDS illness episode. It is often taken for granted that caregiving is always characterised by affect and altruism on the part of those who take care of the sick person. As both Maud Radstake (1997) and John Anarfi (1995) have pointed out, caregiving is not a straightforward altruistic behaviour by other kin members towards the patient suffering from HIV/AIDS.

Caring for the HIV/AIDS patient and the altruism associated with it usually also throws a burden on the carers, especially the elderly who themselves are frail and need to be cared for. Many of the carers of HIV/AIDS patients often become frustrated with worries, usually due to conflict between them and the afflicted person. While patients complained about the form of care (or the lack of it), some carers in turn accused the patients of thinking only about their own welfare without considering the effort by the caregivers. Such accusations and counter-accusations was a major part of the disagreements between carers and HIV/AIDS patients. The patients' complaints were seen as a result of the psychological imbalance due to thoughts about the imminent death, a viewpoint the patients never accepted. They were convinced they would have been treated differently were they not ill with an affliction for which there is no hope of survival. One of such patients, Smart A, often complained about the quality of care to him and argued that "since it does not cost anything to show love and since it will not be long when the end comes, they have to give better care". This was his main concern in his pathetic story. For clarity as the only narrative, I have decided to italicize Smart A's story.

Smart A narrates his pathetic story

Hmm!... [There is a long pause]. *How do I even start it? In fact, I don't know…Hmm* [a shorter pause], *my sister, εyε asεm o* [it is indeed worrisome]. *I used to work…I mean I used to have a nice job and could afford nice things in life. But now, I am not only reduced to the status of a child; I am treated like nobody in the family. The best I get is poor quality food such as koko sakora*[90] [maize meal porridge with very little milk and sugar] *for my breakfast. For my lunch, I may have banku* [a thicker or heavier maize meal] *or some other food with little fish and pepper (chilli) sauce. I used to work in many urban areas, including Accra; I was well-to-do and could buy anything that I wanted. But now, look at me—a pitiable sight.*

I don't mean that there is no-one to care for me. I mean that they don't care about me. I have a very cordial relationship with my family. Depending on who is available, whether it is my mother or one of my sisters, she cares

[90] '*Sakora*', slang probably from the Hausa language, means bare or bald. '*Koko Sakora*' became popular among secondary school students in Ghana in the 1970s and 1980s to describe the maize-meal porridge served with little or no milk and sugar. That was the period when, due to the country's dismal economy, provisions such as milk, sugar, and soap were scarce and often rationed. It was common for many schools to go on demonstrations and destroy school property in protest against 'poor quality food'.

for me. They would cook for me and also help me to turn round in bed. Whoever is around also fetches water for me, either to drink or bath with when necessary. But to tell you the truth, my sister, I now lack someone to wash my clothes. Maybe, I should go back and marry the woman I was with before I became ill. At least, she too knows her status and she will not feel bothered to handle my clothes. We will also be there for each other [he laughs slightly].

It is obvious that nobody in my family wants to wash my clothes because of my status. At least, they are aware of everything about me now, and for how long will they be washing my clothes? No one else outside this family knows anything about my status. I do not want them to know. I used to be regularly sick when I was younger. That is what people think is still my problem. At least it feels good that people do not know about my status. And when I meet people and I have to explain things about my health, I try to throw dust into their eyes by saying that I have cancer.

I am always a sad man, as you can see. Because I lack money, I have to take [eat] *whatever is provided. Sometimes, it is just difficult because I may not have the appetite for the particular food that has been provided. And because my people* [the family members] *do not have alternatives, this creates problems between me and them. But they have to bear with me and try to provide what I feel like eating. You know that this kind of illness requires that one has nutritious meals to replace the lost energy. But I don't blame them. I recognise that my mother, especially, is doing her best. I must even be grateful to her, considering that my father doesn't care much. He seldom visits me and I don't think he even asks about my state of health.*

What is worse, as if I am not already going through bad situation, one of my brothers and a sister are now at loggerheads because of me. My sister visits me, but my brother doesn't. Then he blames my sister for trying to win my favour by talking behind his back to me. What a big problem!

Sometimes, I feel so bad because I used to work with the youth. Now, instead of being a good example to them, I am ill with [he hesitates]*; I don't even know what else to say. I have a positive attitude towards life in general and about my fate. I got to know my status* [when he was tested positive] *a few years ago. I was brave enough to ask the hospital staff to test me. This was after I suspected that things were not normal with my health. This was also after the girl I was with revealed in a letter to me that she had infected me. When her claims and my suspicions about my health were confirmed at the hospital, I took it in good faith. What else could I have done? I can't be angry with her, can I? The harm has already been done.*

A few months after I had been tested [as HIV] *positive, I started going to Nkawkaw hospital for treatment. The so-called treatment has in a way boosted my hope and confidence. If only the medication can sustain me and others in my situation until a real cure is found for the disease, I would be very, very happy. Now, one of my problems is that I often become ill with fever or coughing or pain in my joints. A few weeks ago, I was so ill that I nearly went away* [nearly died]. *It was so scary. But thank God, my health improved. And my confidence is back. Hmm, it's a big problem.*

Recently, something sinister nearly happened to me. I had a close encounter with a strange event. Some people in my situation may attribute that to the work of evil forces. It is their own problem if those people believe in such things. I don't see it that way. These things happen in life, and to me, they have natural causes. Period! If I believed in witchcraft and other evil forces, I would not even allow myself to be cared for by my people [matrikin]. *I don't have such problems with a belief in supernatural causes. The problem I have is that they don't care much about me.*

Rita N's bitterness

Rita N, a woman of about 35 years, lived in a family house with her sister, mother, and some of her nephews and nieces at a village near Nkawkaw and southwards in the Akim District. Her mother did most of the cooking. Rita N was very agile and usually did some household chores such as sweeping her own room. But when she became quite ill and very weak, which happened quite often, she was also lucky to have her nephews and nieces to go on errands and to clean her room. One of her cousins, a younger woman than Rita N and who lived a few meters away, cared for Rita sometimes. However, underneath the seeming plethora of carers, all of whom come from the matrilineal group, Rita N was very bitter about how others did not care about her.

Since her mother cooks food for the family, the patient always had something to eat. This is all she gets from her mother, Rita N said, adding that she [the patient] was not even worried about that. Rita N complained bitterly about her own younger sister:

> My whole problem is with my own sister, whom I initially trusted and who has let me down. The way she behaves towards me shows that she does not care anything about me. She does not visit me even to see how I am doing. Because of her attitude towards me, our mother too, who initially used to see me in my room, has stopped that. The only communication that my own mother has with me now is to send the

children to me with my food. And yet my sister is expecting me to leave my property to her—little does she know how things would be after my death.

Rita N intimated that she would disappoint her sister by leaving her [patient's] property to their cousin. She had already decided in a written will to bequeath her property to the cousin (mother's sister's daughter, MZD) instead of her own sister. Her reason was that her sister "does not show me any love in my predicament". The patient claimed her sister was only interested in the property she had been expecting to inherit after the patient's death. Pointing out that she was nice with her family members, Rita N said she decided to write her will and leave her property to her maternal female cousin because "she is the only one who understands me and shows compassion". Rita N was also happy with her older daughter, who provided her occasionally with money for food. With all others, said Rita N, I know they don't care.

When I first met her after one of the counselling sessions at the Holy Family Hospital at Nkawkaw in April 2003, Rita N told me her sister had opposed her second marriage a few years ago for the reason that the patient was barely out of the first one. In our first meeting Rita revealed an interesting part of her life. I had found her sitting pensively in a corner just outside the shed under which the HIV/AIDS patients met; she was elated that I went to converse with her. We indeed had a very lively discussion, first about my research and the purpose of it. Then, she told me about how she became ill. She contracted the disease in 1995, from a Ghanaian man she had married when he returned from abroad (London). She did not want to marry again after her first marriage did not work. But when the man proposed through some senior members of the church she attended, Rita got the impression he was a righteous man. "Moreover, he was quite elderly, and said he only needed a younger woman to spend life with after his wife died in London and he became lonely."

The man had also been made an official of the church. This and other facts convinced Rita that the man was genuine and good-natured. Not long after the marriage, the man left for London only to come back less than a year later, looking quite ill. Rita N said the man's family accused her of infecting their kin with the disease. A few months later, the man died. According to Rita, she was not allowed to inherit anything from the man's property; she had not tried to find out about the cause of death of the man's late wife.

One day, Rita N asked me for 'something small', meaning I should give her some money. Her mother did not have any money, and her sister who could afford it would not give her. She said she was broke because she

always needed to "buy all those drugs and food for herself and the family". I gave her 20,000 cedis (about three US dollars). Rita N did not have any appetite in those days; the only food she enjoyed was yoghurt and soft drinks, and she would use part of the money to buy them. A few days later, Rita N demanded 200,000 cedis (about 23 US dollars in 2003) from me if I wanted to have any conversations and interviews with her. It was obvious she meant it as a fee. Rita said she needed some financial support to put up their family house, part of which had collapsed. Rita N was said to be using her status to collect monies from organisations to feature at forums they organise. She had told me that in the past, many organisations used her "for their own campaigns and propaganda" without giving her anything. "Because of that, I have decided that I will not allow anybody to use me in that way anymore."

We agreed on a date to meet in Rita's home. I never witnessed first-hand Rita's description of her sister's neglect, which she was obviously so bitter about on all three occasions that I met with her. I never had the chance to meet Rita's sister because she had gone to the farm with their mother when I visited their home on the appointed date in May 2003. Thinking about it later, many ideas came into my mind. Going by Rita's story, was it a case of each party giving a dog a bad name and hanging it? That is, was Rita's sister punishing her by neglect because the patient went ahead and married despite the sister's advice and opposition? Or was Rita chastising her sister to show how bad the younger woman was and to draw sympathy unto herself? Will Rita's decision to 'show' her sister (as she used it, an Akan reference for being vindictive) in order to slight her achieve its purpose when the property goes to their cousin? There were no ready answers to the questions. However, concerning the last one, I could guess that the sister may indeed feel slighted since Akan ideas about inheritance and succession recognise close kin members and the senior in age as more eligible.

When I visited her at her village following the long-arranged meeting, I met Rita alone that day, which indicated to me that she may have been alone and on her own for long periods in the daytime. Only a young girl who Rita described as her niece (the daughter of her cousin) came to sweep her room and went away. I did not have the chance to speak to the young girl. She quickly ran off as soon as she finished with her assignment. Rita herself had given me quite a shock that day. She refused to have any audience with me—not even when I was ready to give her the money she had earlier asked for.

She was not ready to discuss anything about her status or views about HIV/AIDS. Her reason for the refusal was that she discussed our forthcoming interview with her "trusted" daughter who objected to the idea of her mother "going public", again, because it would "disgrace" the family. Rita N further explained: "I have previously been interviewed and I appeared in church crusades to talk about the disease and my status, but people have only used me for their own gains." She said her daughter thought enough was enough. It seemed Rita N had no other option than to abide by her daughter's wishes. "She is my all-in-all in this world. In my present predicament, she is the only one left for me in this world to continue my memory." Rita N's other daughter was HIV-positive too and predeceased her.

Rita N revealed that the programmes she had earlier had with a number of churches had been public and her daughter felt uneasy at her work place. "At this stage," said Rita N, "I don't want to do anything that will hurt her or put her to shame when I am gone [dead]. I am already nearing my end, but she has still her life to live," the patient pointed out. Rita coughed a lot in those days and she was to be admitted to the hospital at Nkawkaw the following week. I took Rita N's feelings in good faith and stopped the idea of interviewing her, although I was very much disappointed.[91]

Summary: kinship care and HIV/AIDS

The three case studies above are evidence that HIV/AIDS patients never lack others to care for them. The network of carers mostly from the matrilineal group amply displays the group's readiness to be there for its less fortunate members. This is generally so when people become ill in Akan society. The care of HIV/AIDS patients rests almost solely with blood relatives (in the matrilineage), usually by mothers and sisters. The pulls of matrilineal descent are strong. This ensures that carers see it as an obligation to care for the afflicted ones (cf. Radstake 1997; Anarfi 1995). The spatial proximity and nature of work has a direct correlation with caregiving. The Akan village (*akura*; pl. *nkuraa*) as an important space for production and reproduction of social and economic relations is also the place where the matrilineal group is mostly based. Most of them are subsistence farmers

[91] Later during the Christmas of 2004, almost a year after leaving the field, I was in Ghana for a short holiday. When I visited the hospital, I learned that Rita N died some months after I left Kwawu. Many more of the patients had died too.

who work on their own and can decide when to go to the farm and when to come back home. This ensures relatively easy access to the carers.

Even where some of the patients, such as Kwaku B in the opening story, are abandoned by close kin members other people care for the patient with relative ease. The close sense of belonging felt in Akan communities, particularly in small villages where the spatial closeness is more pronounced, is important. Expressed often by the reference to each other as *me nua* (my kin, brother/sister)) or *me nyɔnko* (my friend), this sense of community and close bonds encourage people to be there for each other.[92] Although there is no specific, real kinship tie or nomenclature when the Akan villager refers to a co-villager as *me nua*, it is the mere quality of co-residence that is emphasized. This placing of a person within the community (Jackson 1977: 47) brings on amounts of fondness even when it is not marked by blood ties. Caregiving in Akan society is thus very much socially mediated.

The perspective on social life equates a person's existence with social relations. Caregiving in this sense can be understood in terms of the Akan view of local contiguity, the sense of sharing and good conduct. The Akan know that local contiguity foremost establishes ties, although cleavages could and do occur. Local cohesion is therefore emphasised (Fortes 1969). People are encouraged to help others because a person's good behaviour or affability is regarded as high personality and it is often judged by his or her relationship with others.[93] A generous person or the one filled with altruism is a 'true person' (*nipa ampa)* or a 'good person' (*nipa pa)*. In contrast, a person (*nipa*) who is considered unsociable, selfish or wicked is 'not a person' (*ɔnnyɛ nipa)* or is a 'bad person' (*nipa bɔne*). At least as far as the illness episode is concerned people who have others' problems at heart and care for the sick are usually 'good people'. Hence, kin members who abandon HIV/AIDS patients and make it necessary for others to take over the care show a negative side of Akan kinship and values.

The high level tradition of care as expressed by the family or lineage has its own negative consequences. The lot of the patients, as exemplified by the cases of Abena Bea, Smart A, and Rita N is that they have to accept whatever is given them even if it falls below their expectation. It also results in immobility, the loss of freedom of movement and financial setbacks for the patient and kin members/carers, although it never discourages others to be there for the patient.

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[92] I was often referred to as *me ba* (my child) whenever my classificatory mother (MMMZDD) introduced me to her own friends.

[93] Charles Piot (1999) says similarly about the Kabre of northern Togo.

If people who test positive are usually shocked and sad, their kin members are equally shocked and often even outraged by the negative news (cf. Anarfi 1995). The patient's status is often viewed as having reduced the family honour, which may be why some kin members neglect HIV-positive patients or are indifferent to them. It is not surprising then that some patients initially keep their sero-positive status secret till the symptoms of AIDS are visible. But the initial shock and outrage are usually replaced by sympathy for the patient. Since the latter stages of an HIV/AIDS affliction usually leave the patient weak with an emaciated body, this stage necessitates more attention and support. As in Uganda (Ntozi 1997), it is therefore the stage when the patient's family in particular is expected to give physical, emotional, economic, and psychological support.

HIV/AIDS patients in Ghana do not typically go on admission at the hospitals unless they are chronically ill. Generally, patients detained at the hospitals are never accompanied by kin members. Usually in Ghana relatives (often mothers or sisters) of patients admitted at the major hospitals sleep on mats or on a piece of cloth on the cemented floor behind the various wards. The carers engage in daily chores— fetching or making warm water early in the morning to massage the patients, washing their dirty laundry, and buying food for them. Caring for the sick person is thus transferred from the home to the premises of the hospital. I did not observe such a pattern with HIV/AIDS patients.

The embeddedness of care, even by close members in the matrilineage, has its paradoxes. There may be compassion and love for the sick person; at the same time control and surveillance are rife. Smart A felt he had not been 'lucky' with the quality of care he expected because he was forced to settle with whatever was made available to him 'like a child'. Smart A often complained to me and I discussed it with some members of his family. They saw Smart A as having become too nagging because of his fear of death. Many patients were often lonely. Almost all of them were often found solitary; they lived in single rooms all alone. The nature of the work schedules reduced the network of carers usually in the day time.

When Smart A complained bitterly about his food, I could understand him. One day he even showed me the food for him, placed on a small table in his room. It was banku (a cooked maize meal) with a small portion of sauce. The process of HIV/AIDS in the body necessitates good food to boost the immune system. Where a balanced diet for the Ndembu is cassava mush and relish (Turner 1996) or millet porridge and relish of vegetables, fish or meat for the Bemba (Richards 1995: 15 [1939]), for the Akan it usually is fufu, made of cassava and plantain pounded together and eaten

with vegetable soup. Although people generally complain about lack of money for food, out of 112 respondents in the household survey conducted in this study 93 (representing 83 percent) have three meals a day, 16 (14.3 percent) eat two meals per day, and only three respondents (2.7 percent) have a meal in a day.

Smart A would better be understood and not seen perhaps as petty in consideration of how good nutrition concerns the Akan. It is an important topic since in local perceptions blood is vital for human existence and growth, and the major contribution to blood is food. Topics on nutrition usually centre on the abundance of food in the past and now the difficulty in securing it. Since there are few other ways of accumulating wealth in Akan villages except by acquiring sufficient food to cater for the big families of nuclear and extended kin members, a good harvest is a joy to all and an indication of 'good' work done.

Animal or vegetable foods secured from the bush or on farms almost unexpectedly attract particular interest and joy because of the element of luck in their discovery. A sudden find of snails or sprouting mushrooms, or crabs or fish caught in shallow rivers will be greeted with much excitement. It may be because people do not have money to buy always. It is also obvious that to have something that would nourish one's meal is important to people, not to talk about the luck associated with it, which the Akan view as good omen. This reminds me of the giddiness of a woman when one of my professors, Karen Armstrong (on a working visit to supervise me) and I accompanied her to her farm. Upon finding a big snail on a rainy day in June 2003, she exclaimed in Twi to me: "Your *Oburoni* (White person) teacher has brought me good luck." Commenting that her soup that day would be delicious, the woman laughed hilariously along as we climbed a hill to her farm.

Smart A's affableness was without doubt, although he was often in a state of fear, anxiety and moodiness. The patient often gave me answers in circumlocution; he never told me his exact age and often joked about it. One day, he asked how old I was, and when I told him I was a little over forty years, he said: "Then you are my senior sister—by some few years or months or even weeks." He then laughed quite heartily. Was he teasing me? I asked him, laughing too. "Maybe yes, maybe no… I don't know. What do you think [more laughing]? Just take it like that [laugh]. But the most important thing is that you are my sister," Smart A assured me. And I knew he had only been joking with me, affable as he was. I could appreciate his concern about loneliness, which he viewed as a "huge lack of sociality"; he always laughed and chatted heartily with me when I visited. Smart A even

prayed for me one day, asking God for his guidance in my work. He greatly feared stigmatisation and condemnation. Hence, while he willingly told me about part of his life "so that others would not fall into the same situation", he wanted to remain anonymous and even gave me the pseudonym I have used for him. After his death, I learnt that he had a wife with whom he had a child. He deserted his wife when Smart A met another woman he saw as "more glamorous," said one of his carers in a silent condemnation. I wept bitterly at the news of Smart A's death.

9. A SOCIETY IN TURMOIL

One of the central points in this study has been how HIV/AIDS is disrupting social organisation among the Akan. I have presented the economic, social, and emotional crises it produces. But more importantly, I have tied AIDS deaths to the notion of bad death and the non-creation of ancestors in Akan society. Thus the devastating nature is felt even after the death of the patient; the adverse effects of the disease extend from this life to the other world which, in turn, affects how the society is reproduced and reorganised. My concern has been the threat of the disease in Akan society, both in practical terms and conceptually. The devastation has not been analyzed as part of the total social system in any literature on the disease in Akan society.

Every society faces conflicts and is structured in relations that also cause problems. There are usually ways to manage the conflicts if they cannot be solved. In Akan society, a way to resolve personal conflicts is to discuss them in the lineage house, handled by the lineage head, or at the court of the chief. But when something out of the ordinary happens, such as a pandemic or an earthquake, it makes the internal contradictions more difficult or impossible to solve. As A. Barnett and P. Blaikie (1992) have demonstrated in their analysis of the impact of HIV/AIDS in Africa, with emphasis on Uganda and other southern African societies, the illness negatively affects various key sectors of national economies. Among the Akan, HIV/AIDS exposes many of the society's weak points. Two threats to Akan society are imbalances in the matrilineal group and the cosmological system. The disease is putting more stress on interpersonal relations and changing the situation with marriage and family formation, inheritance, and fosterage or caring for orphans. For example, instead of women being 'free' to go out for partners and procreate into the lineage, they do so with unease because of HIV/AIDS. Because ancestors are not created after an AIDS death, the lineage's chance to increase through reincarnation is blocked.

Customary practices about rights, duties and roles are the backbone of social organisation in traditional societies; a threat to these structures threatens the society itself. In an introduction to their edited book on African political systems, Meyer Fortes and E. E. Evans-Pritchard (1969) note the paramount value of respect for rights, the performance of duties, and the sentiments binding members together which must be upheld in traditional societies. If this is not done, they contend, the social order would be so insecure that the material needs of existence could no longer be satisfied in the common interest of the society (ibid: 20-21). When the authors assert

that if these measures are not followed productive labour would come to a standstill and the society would disintegrate, it is to show the high value attached to unity and cohesion in social organisation. It may be overstated when they claim the society would disintegrate if rites and practices are not performed. Nevertheless, circumstances about HIV/AIDS afflictions and the resultant deaths among the Akan vividly show that such an assertion is not far-fetched. A basic idea in illness experience is that all discourses about it are situated in idioms and symbolic practices embedded in narratives and stories about life and suffering (Good 1994: 24). As already pointed out, HIV/AIDS among the Akan is producing adverse effects beyond the individual's illness experience or even the problems caused to other members of the lineage such as caregivers. Akan society is threatened to its very structures by HIV/AIDS. The disease causes changes in the matrilineal structure and creates danger ahead for the society.

Rebecca's worries

Rebecca was a young widow of about 29 years when I met her in mid 2003. She was convinced that a man she lived with infected her about six years earlier. Rebecca was often caught in self-pity and regret. She also always bemoaned her inadequacies. "I used to be plump and beautiful. But now, even a fourteen-year-old girl is bigger than I am. I am so ill and cannot support myself any longer. I am so sorry about this situation." She was sad that she had to rely on her mother for care and financial support. If her mother did not have much to give, it meant Rebecca had to struggle on her own for food. One of Rebecca's greatest worries was that at her age she had to rely on her mother for money, knowing very well that soon the mother will also have to carry her in and out of bed.

Rebecca had tested positive at the Atibie Hospital when she fell ill in the beginning of 2003. Her status was later confirmed at the Nkawkaw Hospital. Informants at Nkawkaw said initially Rebecca's status nagged at her. She did not agree to anything about her status. Did Rebecca have doubts about it? It did not seem to me that was the case; rather, the health officials felt Rebecca was obviously overcome by anxiety about her status and the fear of imminent death. When I met her for the first time in a face-to-face interaction in early June 2003 during one of the health team's home visits, Rebecca exhibited traces of that anxiety. She always asked questions about what she must do to prolong her life.

Before being diagnosed as HIV-positive, Rebecca had been living in a small market town in the Afram Plains, on the other side of the Kwawu

scarp. There she engaged in lucrative trading. She lived with a man she was never married to. She had a child by him in a relationship the Akan call *mpena aware* (lit. lovers' marriage or cohabitation). Although common, *mpena aware* falls short of the ideal 'proper' marriage. The man died in early 2000. It was just before his death that Rebecca realised she had not been the only woman in the man's life. Because she was not formally married to him, Rebecca did not receive any form of property from the man's kin members. Usually, because of the child between them the father's kin members would have given some money to the mother for the child's upkeep, or a member of the man's kin would elect to look after the child. Rebecca said nothing of this sort happened. Her people were angry that she had been infected by the man, although there was little they could do. Rebecca's mother had assumed responsibility for the child's upbringing, perhaps out of anger.

Dying of AIDS, Rebecca clearly regretted having gone into such 'unrecognised' relationships. "If only we had had such education earlier, some of us would have been more careful before going into relationships with men," she said one day during one of the home visits by the health personnel. Although it was suspected that Rebecca was infected by the man, she had herself not been stable with men. She appreciated the counselling sessions at the Nkawkaw Hospital because they helped to educate her about the disease.

Like many others, Rebecca was obviously going through a big mental agony. In the subsequent number of times that I met her at the counselling session at Nkawkaw, Rebecca would sit silently alone in a corner. I never saw her laugh or converse with anyone as other patients did. Such psychological breakdown is likely to be pushing some patients to be secretive about their status. Others "assumed a very strange behaviour", as an informant put it. In the early stages of my fieldwork, a social worker revealed that many young people who tested HIV positive initially adopted a policy of '*me nkoa mennwu*' (I won't die alone). The patients decided to infect others through sex. "It is so disheartening that people should adopt this policy once they get to know about their status," my informant observed. The decision to wilfully infect others was abandoned later; my informant was convinced it was due to the counselling at the hospital. But the secrecy continues in other forms. One woman is said to have refused to tell her husband about her status, even though they were living as a 'properly' married couple. The social worker who told me about the story wanted me to interview the woman, in case that helps in changing her stance. The patient was said to have questioned whether her husband would

have told her if he had been in that situation. I never got the chance for a discussion with the woman. She always evaded me although I guess she was unaware I had heard about her case.

Changes in the matrilineal structure

Like Rebecca's case, many instances of individual illness experience also show larger processes concerning the negative effects of HIV/AIDS and the resultant deaths in Akan society. AIDS deaths are causing changes in the Akan matrilineal structure. Many orphans are being created, children are being raised by single parents or by others in the group, taken in by the orphanages or simply abandoned to their fate on the streets. The HIV/AIDS patients are cared for by old mothers and elderly women, the norms about inheritance are going against tradition, and succession is being skipped. Marital laws and practices are threatened, and the group, known for organising the popular Akan funerals, is no more able to do so (at least not the elaborate ones). Almost everything seems to go against the lineage group.

The increasing rate of AIDS deaths has seen an upsurge in the number of orphans in Ghana. In 2003 alone, unofficial estimates suggested over a hundred thousand orphans countrywide. As a result, more orphanages have been set up in the country. Orphanages in Ghana previously housed children who had been abandoned at birth or those from poor homes whose parents were dead and there was no one in the family to care for them. Hence, the concept of orphanages is not new; the concern today is the increasing number due to AIDS deaths. It has become a recent development to set up more orphanages most of whose inmates are children orphaned by AIDS deaths. Such orphanages are being established in other African countries like Zimbabwe, Malawi, and Tanzania (UNAIDS 1999). It is laudable to have some mechanism for addressing the problem of increasing orphans created by a disease. However, among the Akan where the matrilineal group is known for informal fosterage and adoption as part of its system of incorporating members, orphanages become a reversal of the order. There are two considerations; first, it suggests that families are not able to cope with the increasing number of orphans they should care for, and secondly, perhaps kin members are merely refusing to accept to take charge of such children due to the nature of death (a form of stigmatisation?).

The situation where orphaned children are not accepted (especially if they are HIV-positive) depicts Akan matrilineal groups as shirking their responsibility as 'informal orphanages'. They also conceptually cut the

blood ties with the orphaned children. Indeed, with the number of AIDS deaths women are increasingly compelled to raise the children left by deceased relatives. This is not to suggest that before AIDS entered Akan society, women were not forced by circumstances to look after the children of deceased relatives. The argument here is that the number of AIDS deaths is increasing the rate at which others are forced to raise orphaned children.

The many instances of abandonment and stigmatisation by kin members are consistent with findings from other parts of sub-Saharan Africa. In Akan society, they portray how much amity and the encompassing nature of the matrilineage is affected. It has become the practice today that many children who lost their parents to AIDS and have nobody else to care for them are forced to stop schooling. The removal from school gives no other option than work on farms in the villages. Considering the lack of prospects for better earnings in farming, many soon lose hope and go to the cities in desperation. There, they usually end up in menial jobs and in those lifestyles such as sex favours that risk infection.

Susan Reynolds Whyte has said among the Nyole that AIDS first became evident in Bunyole society not when local residents succumbed to the disease, but when Nyole working in towns fell ill and came back to their homes in Bunyole to be cared for and to die (1997: 92). A similar pattern occurs in Akan society. Most of the patients had lived in big towns and cities or even in neighbouring Ivory Coast and been infected there (cf. Radstake 1997). They then move back to their home villages, to be cared for by their matrikin, and to die. In the cities and towns, most of them had been positioned individuals who worked and contributed to the upkeep of other kin members. Back in the villages, their status soon changes, from being economically self-reliant to becoming economically dependent on others because they become so weak and unable to work. Their state of lethargy also necessitate that many AIDS patients are cared for like babies in the advanced stages of their illness when most of them always remained lying on their backs in their beds.

Sadly, their caregivers are increasingly becoming the elderly in the family, which is consistent with findings by Maud Radstake (1997). This is exemplified by the case of the 80-year-old grandmother who was forced by circumstances to care for her 28-year-old granddaughter. It was sad a woman at her prime age of 28 years was dying of HIV/AIDS, but it was equally worrying that in her weakness she was being cared for by an 80-year-old grandmother. It may be gratifying to have kin members to care for a patient. But at their ages, who should have been stronger to care for the other, all things being equal? Surely, an 80-year-old woman who needs care

herself should not be forced by circumstances to care for someone who would have been agile and given hope to a fragile old woman as she counts her last days on earth.

There are many more reversals of Akan norms and roles because of HIV/AIDS and the care of such patients. In Akan-land, grandmothers nurture their grandchildren, who are in turn expected to 'serve' the old woman as they reside together. Old people are not expected to perform some particular house chores— emptying the chamber pot in the morning, sweeping their own room and the compound or even cooking the family's meal. Younger people, usually girls and sometimes young married women in the household, often perform these tasks. So, instead of Abena Bea being at the service of her aging grandmother till death takes the older woman away, the old woman was forced to perform most of the household chores as she cared for her grandchild till death took the younger woman away. The case of Abena Bea is not an isolated one. Almost all the patients in Kwawu and other Akan areas were cared for by older people who also performed the household duties.

HIV/AIDS afflicts mostly the youth, which means that older people are left for considerations of inheritance. I did not witness a situation where an older person actually inherited from a younger one. If it happened, it would be a reversal of the norm; usually younger people are expected to fill the vacuum left by the older ones and not vice versa. But there were no successors and inheritors for any of the patients who died of AIDS, which is even worse. Since it is a fixed principle of Akan social structure to fill the vacuum left by a deceased with an heir and successor, failure to do so does not only go against the norm but also creates discontinuity instead of continuity in the lineage structure. The only exception with the cases in Kwawu was that of Smart A, whose younger brother elected himself to 'fill' his place. As already mentioned, this still goes against the norm because it was not after any funeral proceedings when the successor would have been announced and shown to many members of the group.

In the past, a man raised his own children and his nephews and nieces with ease. His nephew was given particular attention and nurtured to succeed and inherit from the older man. In an age of HIV/AIDS, it is likely that very few mother's brothers will look after an HIV-positive *wɔfase* or the one whose parent(s) died of AIDS. Even before HIV/AIDS surfaced, the transformations occurring in Ghana were affecting many aspects of the lineage organisation. The traditional inheritance rules that a man names his brother or his sister's son to succeed and inherit the considerably huge property he left behind was sometimes to the disadvantage of the deceased's

own children and wife, although local ideas did not see anything wrong with it; to many, it ensured that property remained in the matrilineal group. Since matriliny and virilocality (or even neo-local residence) make the wife and her children 'outsiders' in the husband's household, they were not expected to enjoy from his property, which may have been part of the lineage property the man may have inherited from his own *wɔfa*.

Around early 1970s, the writing of a will to show the person to whom the deceased wanted to leave his property became popular. A will as a legal document was obviously an attempt to solve the conflicts about inheritance, but sometimes the prolonged bitter legal battles only display that the situation is far from resolved. The Intestate Succession Law was passed by the State in 1985 (cf. Manuh 1997) and automatically grants two-thirds of a man's property to his children and widow if he died intestate, with the remainder to his family. These social changes, which have seen the will come into vogue and the promulgation of the intestate law, may have reduced the motivation to take care of other kin members outside the conjugal family. Weddings and civil (registered) marriages are a symbol of status, and it is believed that almost every woman would want to be wedded. Such marriages are usually viewed as insurance—a protective mechanism for the wife and children as outsiders.

Many deceased husbands today leave their property to their wives and children because of weddings, court marriages, and the writing of a will, which emphasize elements of patriarchal (reliance on men) relations at the expense of the matrilineage. Because the will and wedding give the legal backing and ensure that property goes to the children, the mother's brother is increasingly not required to care for his sister's son. Moreover, the *wɔfa* himself may have a wedded wife who would not like him to look after his sister's son, especially if his father died of AIDS and the child is HIV-positive. HIV/AIDS is reinforcing social changes in the lineage organisation, but in a very negative way.

A pertinent area in which the matrilineage is at a disadvantage concerns the fact that an AIDS death reduces the group's membership through someone else's action (a sex partner) but that person is not made accountable for the negative deed. Since in Akan society the disease is transmitted mainly through heterosexual contact, death from AIDS is 'perpetrated' by an outsider; danger always comes from outside (due to exogamy). If this is to be taken metaphorically as a homicide how is the culprit made to account for his or her 'sin'? In a paper on sin and punishment, I. Schapera (1955) pointed out how the Biblical Cain could not be killed but only banished because he was of the same blood with Abel, the

brother he killed. Murderers were killed for their crimes, and in some societies today compensate (blood money) is paid to the family who lost their member as a form of 'replacement'. But there is no such retribution for suicides.

Since homicides attract retributive justice, it would be quite satisfying that someone who caused the death of another person and a loss to the lineage should be legally punished. Or a redressive mechanism in the form of settlement at the village level should have been possible. HIV/AIDS is causing many changes and uncertainties in the matrilineal structure; yet, no arbitration can be organised between the perpetrator and the victim.[94] Even if it could, what will be the moral justification, as it were, in a 'crime' one may have been privy to against oneself throug unprotected sex? This is part of the ambiguity of an AIDS death. It is always a multiple loss to the matrilineal group—losing its member and thus their number reduced, financial loss that may lead to impoverishment, and changing practices about inheritance and succession. Having no chance for retribution may only add insult to injury (especially where someone wilfully infected another).

Cosmologies under threat

In this age of AIDS, the death of women in the lineage throws out of balance procreators of the society. Consider the notion of blood in the transmission of HIV and its relation in matrilineal ideas. What is the connection of blood and HIV/AIDS with its resultant death in the lineage? The Akan notion of an individual belonging to the mother's blood is significant in relation to mother to child infection (during childbirth or in breastfeeding). The transmission of HIV from mother to child during childbirth creates negative notions about matrilineal blood. A mother's blood, symbolising the lineage and which should have protected both mother and child, rather ensures their death when it is contaminated with HIV. An infection through breastfeeding symbolically turns the mother's milk that should nurture the child into 'poison' that kills. Consequently, there is the urgent need to make available antiretroviral drugs, such as nevirapine, which reduces the risk of mother-to-child infection. If such a medicine can help to produce healthy babies it will undoubtedly ensure a better future for the matrilineage.

[94] Professor Karen Armstrong, one of my supervisors, has initially advanced this line of argument. I thank her for that.

In traditional Akan notions, sex should produce babies who should grow into productive adults. However, this age of HIV infections ensures that for the most part sex produces babies who die soon after birth. Indeed, HIV/AIDS is creating imbalances in cosmologies. The important role of sex for procreation has already been undergoing a major transformation. Due to socio-cultural transformations, sex has increasingly become an act for mere pleasure, interest, curiosity, and self-affirmation especially among unmarried couples (Bleek 1976: 64-65). That the risk of HIV infection has further sunk sex into a dangerous zone has been recorded in many studies in other societies of sub-Saharan Africa. In Akan society, it also depicts the level of transformation about sex and how far it has moved away from life-giving device to death-threatening act. Obviously, many women go into marriage and other relationships with the idea to procreate into their group, but most of them are also unsure about what will be in store for them with regard to the status of their men and their lifestyles. HIV/AIDS is transforming attitudes towards marriage and female reproduction.

The blockage caused by (bad) AIDS deaths in the production of ancestors who in turn reproduce the society and protect it spells doom, but unfortunately that is what AIDS will be doing for some years to come. It seriously challenges cosmology. Since AIDS is killing many youths (bad death) in a year, one can argue that while ancestors in the Akan society are increasing at a slow pace hovering ghosts are being created with alarming rapidity. The society needs more ancestors to appeal to for its protection. Again, if one assumes that the reincarnated are dying of AIDS (when the disease can largely be avoided) the society is not seen to appreciate the gift of life sent by the ancestors.

Another pertinent point concerns cosmologies and the ambiguity of campaign messages. In an article on witchfinding and AIDS among the Chiawa of Zambia, C. Bawa Yamba discussed three paradigms (in the biomedical sphere, the Church, and traditional ideas or perceived tradition) in campaign messages through which people are expected to construct a cosmology for their daily lives (1997: 200). Within the biomedical paradigm, people in Akan-land, very much like in Chiawa society, are being advised to treat their sexually transmitted diseases (STDs) and use condoms. The Churches are advocating abstinence, while traditionalists are calling for the practices of old that regulated social life and were seen to keep social order.

As Yamba (ibid) has rightly pointed out, all these messages throw cosmologies into a state of turmoil. To explain further, treating STDs opens the chance for procreation; ironically, while a condom culture would avoid

infections, it would also block the chance to become pregnant. Similarly, abstinence does not ensure procreation, just as some of the traditional ideas. Marriage before sex does not solve the problem when the prospective marital partner goes into the relationship already having been infected or when the partner is unfaithful and engages in unprotected sex.

When people suspect their illness to be the work of witches, it gives credence to the notion that witchcraft is the 'dark side' of kinship as much as it threatens a part of cosmology since witchcraft destroys life. Incidentally, when someone dies of AIDS no one else is found guilty by law in Akan society; Akan witchcraft operates in a similar way. People suspect and find others 'guilty' of having caused another's death by witchcraft. Witchcraft challenges the cosmological order by its threat to destroy life, and so does AIDS.

Summary: dangers ahead

An illness such as HIV/AIDS among the Akan represents a disturbance of the balance of health, and healing is directed at correcting the imbalance. There is no cure for HIV/AIDS and while it challenges medical and human thinking, in such societies as the Akan it also produces a multiple disturbance—internally and externally—as a disturbance within the individual's body and outside it. The affliction and its death disturb the group with various kinds of irregularities. HIV/AIDS afflictions and deaths cause crises beneath the surface of social regularities and cohesion in the Akan social system, especially within the lineage structure. At the national level, it is draining the coffers of a country with a dismal economy. This has seen an over-reliance on foreign donors, and an over-stretched yearly health budget. Unfortunately, this will continue for some more years.

The sick person (often with other kin members) usually oscillates between the two prevailing but quite different medical traditions—biomedicine and ethno-medicine—in an attempt for a cure when the illness strikes. The shifting from one therapeutic resource to another or the simultaneous use of them is based on a belief system that incorporates ideas of spiritually-caused illnesses into their everyday lives. However, as may have become clear by now, everything about the financial drain and waste of time and energy aside, it ends in eventual death and failure.

The apathy and initial 'stoical attitude toward death' (Caldwell 2000), are likely to be contributing to the increased infections. Strangely enough, the stoical attitude becomes only a mirage. The look on the faces of those

who were dying of AIDS shows that when death is drawing near, the stoical stance melts and dries out.

When it comes to health, illness, healing and the care of the HIV/AIDS patient, the matrilineage emerges as the central unit. The pulls of matrilineal descent ensure that members of the matrilineal group are there to support the patient. Women give the most care or social support, which is often also found within the family (lineage). But the tradition of care is a heavy burden on others. The terminal nature of HIV/AIDS and its mode of transmission, in the face of folk beliefs about its causation are bringing up many contradictions about the lineage group. The illness is highly stigmatised in Akan society. One's matrilineal kin members are expected to embrace the patient even if others in the community ostracise the individual. However, this study has shown many instances where the patients' closest kin abandoned or failed to care enough for them. Unfortunately, as the disease continues the stigmatisation, abandonment and other negative traits are likely to continue.

The non-performance of the funeral will be a lost chance for the lineage to mourn and to receive condolences from which it could derive great consolation for the loss of its member. In Kwawu, if there were condolences to the families of those who died of AIDS they were on a small scale, and often attitudes towards the death and the family were close to contempt. I have already argued that funerals are one of the major contexts within which members of the matrilineal group have the chance to share costs (or generate profits) and feel the sense of belonging. Not to perform funerals means there is no occasion to create social relations and lost too are the opportunities to make formal contributions to the bereaved family and express solidarity. There would be no occasion to mourn and be mourned, very much important for the Akan after a death. When there is a bad death, people are not able to organise a funeral for reputation.

The status and prestige derived from a well-attended funeral event will be missed. In the discourse on funerals, an important point about these death rituals among the Akan was made; funerals are inevitably the occasions for summing up an individual's social personality. As among the Lodagaa (Goody 1962: 29-30) funerals in Akan society are a restatement of the roles and the general ways in which the deceased conducted himself or herself in life.

Prospects for business and other economic ventures are lost when there is no funeral event. In the discussion of the economic aspect of funerals, I pointed out that at such events part of the donations are made to the Town Development Committee coffers, through which the town (or

village) either fully or partially finances development projects in the vicinity. Not performing the funeral rites means there is no opportunity to collect such monies for community projects.

Libations to ancestors, *Onyame*, and the gods during funerals and other death rituals are gift exchanges with these superior beings. Through libations as offerings, as Maurice Godelier (1999: 29, 72) points out, society reminds itself of its existence; that is, society exists by recognising and being recognised by the superior beings they are indebted to for earlier gifts to man. AIDS deaths do not make possible that part of this exchange with the superior beings. The society does not have the occasion of funeral ceremony to interact with the superior beings—*Onyame*, the ancestors, and the gods—and to remind itself of its existence.

In this study, everyday life has been analysed as a commentary and debate on social order. There are the unquestioned basic assumptions that are the norms (*amamerɛ*) and rules (*mmera*) that constitute good behaviour (*abrabɔ pa*) that structure life in Akan society. Virtue was the ideal of people, and young boys and girls strove (or were expected to strive) to be as virtuous as possible to the honour of the lineage 'house' to which they belonged. In the past (and traces exist today), to be asked: "*Wo firi fie bɛn mu*?" (from which family/lineage 'house' do you come) was enough deterrence for any wrongdoing.

The stigmatisation associated with adultery and pregnancy before puberty rites was heavy (cf. Bleek 1976). A society in transition, in this period of HIV/AIDS, has become a society in turmoil. Unfortunately, this will be the situation for some years to come. It is also obvious that people are not taking a cue from the reverence accorded ancestors and to strive to achieve the status of an ancestor instead of the dreaded hovering ghost. If death is to come in any case it is logical to meet it in one's old age, which is the ultimate stage; death should not be helped to come early in life. If man's finitude is a continuing process, then it should end well and not worse. Unfortunately, the continuing infections will result in many more bad deaths in the future.

An HIV/AIDS affliction brings on concepts of selfhood and individuality, but it is also a major social fact. The financial problems an HIV/AIDS affliction and its death cause to individuals, families, and the state, the conflict and bitterness it produces among kin members, and the changes in traditional practices and the matrilineal structure portray the disease as associated with the social world. The failure of AIDS deaths (as bad deaths) to produce ancestors and thus blocking the chance to reincarnate and reproduce the group is one of the many ways in which it challenges the

cosmological order in Akan society. Indeed an HIV/AIDS patient's affliction and death cause holistic crises in a holistic society.

In sum, this study has used HIV/AIDS to show the insecurity people feel when illness afflicts an individual, which is also expressed in the desperate search for therapy as first demonstrated by Margaret Field (1960). The search for therapy and the various medical sources demonstrate the pluralistic nature of the medical system in Ghana and Akan society. Healing (or the effort for it) reinforces social relations and ideologies, and as others (e.g., Mullings 1984) have shown therapies are created within a given social structure or order, and they reproduce that structure or order. One of the important findings in Radstake's (1997) study of home care for people living with HIV/AIDS in Ashanti is that for some patients the hospital diagnosis was not the most likely or relevant explanation for their sickness. My own findings are consistent with hers since there were alternative explanations of witchcraft and curses as common themes in aetiology. AIDS afflictions have not necessarily increased accusations and suspicions of witchcraft. But its invocation should attract attention.

RECOMMENDATIONS

A number of recommendations arise from the findings in this study. Many of the recommendations here may sound quite radical, but the ill effects of the disease necessitate a radical approach. The serious nature of the impact of HIV/AIDS requires a holistic approach to the prevention, planning and education about the disease if any successes are to be achieved in Akan-land and in other sub-Sahara African societies. There have been calls to repackage strategies for education about the disease, and to shift from mere awareness creation to interpersonal dialogues aimed at influencing behaviour in a more pragmatic way. It seems reasonable to expect that where deaths from AIDS are common, people would be worried and would attempt to prevent infection by abstinence or protecting themselves. However, new infections indicate that campaigns to educate and create more awareness are not having the optimal effect.

1) There is the need to develop a health care strategy to deal with caring for and treating HIV/AIDS patients at home as well as at the hospitals. The current home visits are laudable but are too short; there should be more interaction and at shorter intervals. The home visits for educational campaigns could be made to all households and not just those in which there are HIV/AIDS patients. In view of its role in therapeutic decisions, I suggest that the therapy managing group could be a major area to focus Ghana's public health education and not merely on the sick individual (see also Janzen 1978a: 8, in Zaire).

2) Campaign strategies need radical changes in order to portray their urgency in sending strong messages about the seriousness of the disease. Alternative modes of educating people could be adopted, such as the use of traditional or supernatural concepts— 'bad' death and non-creation of ancestors.

3) There should be more posters and billboards about the disease. Owing to the high level of non-Western education in the rural areas, the posters should be more pictorial than textual. Again, as this study found, the posters seem to be concentrated in the cities and major towns. More need to go to the rural areas too.

4) It is important that pharmaceuticals make the medication for HIV/AIDS cheap enough for poor countries; in this way biomedicine would claim more control over other medical systems.

5) Traditional healers are an untapped resource of great potential, as I have suggested elsewhere (Crentsil 2002). They could be integrated into the

country's medical system, properly regulated and redefined to provide important outlets for networks dedicated to the campaign against HIV/AIDS in remote areas. After all, the model of the 'health care system' is meant to be universally applicable.

6) There seems to be a yawning gap between official statements and the reality, which may itself be contributing to the continued apathy and new HIV infections. For instance, people have doubts about the official figure of 200 infections daily, which was initially used in awareness campaigns against the disease. To give figures without further explanation will leave people always quizzing: "If that is indeed so, wouldn't all of us [Ghanaians] have died by now?"

7) To curb the activities of bogus NGOs, the government and the Ghana AIDS Commission should look for just one or two good and major NGOs in each district to coordinate the grass-root campaigning and education about the disease. The practice of giving money to just anybody who comes around proclaiming to work on HIV/AIDS has not helped. The desperateness about the disease should not make anybody accept half-baked plans. As the Akan saying goes, even if you are very hungry you do not eat with both hands.

8) The role of the media is important. There are many television and radio programmes on the disease. However, these programmes were in my opinion too short, shown only as adverts and some panel discussions. More could be done, even though television sets are more in the urban settings when the bulk of the population resides in the rural areas. My observations in the field were that even in the urban areas where many people have television sets, the majority choose to watch music and drama instead of HIV/AIDS programmes. Although not statistically proven, it is believed that people find HIV/AIDS programmes too boring. Soap operas on HIV/AIDS could be encouraged by the media houses. A few newspapers have columns devoted to monitoring issues about the disease. More of such HIV/AIDS watch desks could be established in the newsrooms to monitor the activities of all players in the campaign against the disease—NGOs, GAC, and other health authorities.

9) The family needs to reform itself as a socialising unit. Parents should be able to speak against their children's questionable lifestyles. In this period of risks of infection, the lineage needs to assume its role as what I call an informal 'health promotion agency' by conducting thorough investigations of prospective partners for their young members. This, in my opinion, could be a major deterrent to many young people who may be engaging in unhealthy lifestyles.

10) When I was in the field, discussions started on the possibility of instituting legal action against husbands who infect their wives. This is laudable, but I suggest that it should be extended; that is, anybody who wilfully (if it can be proven) infects another person should be made to face the full rigours of the law.

11) I support the churches' insistence on HIV test before they conduct marriage between couples, if that will make people sit up. I suggest that churches (the spiritualist ones and others) should make issues about the disease a major part of their preaching in worship sessions. More importantly, the logic of cause and effect exists as a guide in life. It is recommended that people take a serious view of attitudes and their effects of infection. If 'negative' sex—pre-marital, extra-marital, multiple partners, and unprotected sex—are high risk factors for infection the best way is to desist from them. I support abstinence by those who are not married (not merely because I am a Catholic). For married couples, being faithful should be a strong message to them. It is only when abstinence and fidelity cannot be practised that people would need to adopt the condom culture.

12) Many chiefs in Ghana are actively involved in AIDS campaigns; they and queenmothers could be encouraged to do more. Recent calls by chiefs for the government to institute policies that will bring back the nubility rites to prevent many sexually transmited diseases and teenage pregnancy is laudable. They should attract serious considerations. In this respect, elderly women too could be incorporated in health campaigns, especially on HIV/AIDS. In the past, it was such women who educated young girls on menstruation and to prepare them for marriage and motherhood. Chiefs could decree in their communities that the family of anyone who died of AIDS would be made to weed a community farm, the proceeds of which should help finance development projects in the area. Secrecy and confidentiality about the disease (see Radstake 1997) could be sacrificed in the name of effort to prevent new infections. Individuals know they will die one day but the group will still exist, formed by 'those left behind'. If AIDS stigmatises the afflicted, it should equally be a stigma for the family which loses its member to AIDS.

13) To the youth, they should appreciate their own culture and Akan norms. If people believe that witches and sorcerers cause illness, they should not place themselves in the path to be victims of these malevolent entities, as I have suggested elsewhere (Crentsil 2005). If people do not believe in supernatural causation, that is even better; then, they can take the practical steps to avoid the disease. It is a challenge to the youth of Akan and Ghana generally, as well as those of sub-Saharan Africa; they are not to

let themselves be consumed by wanton pleasures in this age of AIDS. Modesty, which is a metaphor of strong moral value in Akan society, is a personal and social value in many aspects of life such as in sexuality and way of dressing. It is also viewed as a good way to prevent the attention and evil intentions of witches and sorcerers. AIDS may involve personal acts, social interaction, daily life, and political economic relations. But people should control it by avoiding it; it should not control them.

GLOSSARY

Names of the days of the week in Akan

English	***Twi/Fanti***
Day	Da
Monday	Dwoada/Dwoda
Tuesday	Benada
Wednesday	Wukuada/Wukuda
Thursday	Yawoada/Yawda
Friday	Fiada/Fida
Saturday	Memeneda/Memenda
Sunday	Kwasiada/Kwasida

Akan day names (male and female)

English	***Twi/Fanti***	
Day	Male	Female
Monday	Kwadwo/Kojo	Adwoa
Tuesday	Kwabena/Kobina	Abena/Araba
Wednesday	Kwaku/Kweku	Akua/Ekua
Thursday	Yaw/Kɔw	Yaa/Aba
Friday	Kofi	Afua/Efua
Saturday	Kwame	Ama
Sunday	Kwasi/Kwesi	Akosua/Esi

Some Akan names/words (mostly in Twi)

English	***Twi***
God	Onyame, Onyankopon
Fetish	ɔbosom
Father	Papa/Agya/ɔse
Mother	Ena/Maame
Sister	Nua (baa)
Brother	Nua (barima)
Mother's brother	Wɔfa
Sister's son/daughter	Wɔfase

Letter sounding

dw = with rounded lips, as when pronouncing 'jaw'
ɛ = like 'e' in expert
gy = like 'g' in gym
hw = an explosive sound close to 'wh' in English

hy = like ‘sh’ in English
kw = like ‘qu’ in quick
ny = a nasal sound
ɔ = pronounced like ‘au’, as in authority
tw = an explosive sound close to ‘ch’ in English

ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ADRA:	Adventist Relief Agency
CBO:	Community-based organisation
DFID:	Department for International Development
ERP:	Economic Recovery Programme
GAC:	Ghana AIDS Commission
GARFUND:	Ghana AIDS Research Fund
GSMF:	Ghana Social Marketing Foundation
HIV:	Human Immunodeficiency Virus
IDA:	International Development Agency
IMF:	International Monetary Fund
NACP:	National AIDS/STI Control Programme
NHIS:	National Health Insurance Scheme
PHC:	Primary Health Care
PPAG:	Planned Parenthood Association of Ghana
SAP:	Structural Adjustment Programme
UN:	United Nations
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNDP:	United Nations Development Programme
UNESCO:	United Nations Educational, Scientific and Cultural Organisation
USAID:	United States Agency for International Development
WHO:	World Health Organisation

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www.who.int (website of the World Health Organisation, WHO)

APPENDIX

QUESTIONNAIRE ON HOUSEHOLD CHARACTERISTICS

Here are some questions concerning yourself and your family. Would you kindly underline the appropriate answer or give the correct information in the space provided?

1) Suburb……Your Town/Village of origin ……
2) Your name…… House No:……..
3) Tribe…….. Clan……
4) Religion: Christian/Muslim/Traditional religion/ Other (specify)……
5) Household Member List

Household Member	Related to head of Household as (A)	Sex: M= 1 F=2	Marital Status (B)	Main Work (C)	Education (D)	Read/Write (E)

A) 1. head 2. spouse (h/w) 3. child 4. maternal uncle 5. maternal aunt 6. other relative 7. no relation
B) 1. single 2. married (husband) 3. married (sole wife) 4. married (not sole wife) 5. divorced/separated 6. widowed * N.A (Not applicable)
C) 1. farmer 2. regular wage earner 3. casual labourer 4. business/trade 5. domestic/ housework 6. student/pupil 99. Other (specify)… * N.A. (Not applicable)
D) 1.none 2. non-formal 3. Primary (1-6) 4. Middle/J.S.S. 5. Secondary/ S. S. S. 6. post secondary/university 99 Other (specify)… * N. A. (Not applicable)
E) 1. read 2. write 3. both 4. neither * N. A. (Not applicable)

6) Who owns the house you live in? -- Self-owned/ Rented/Family house/ other (specify)……..
7) If you pay rent /other bills, how much does it amount to in a month? a) below 50,000 b)over 50,000 cedis
8) How many people sleep in a room? a) 1 b) 2-5 c) over 5
9) What is your monthly income level? a) below 50,000 b)50,000-100,000 (c)over 100,000 cedis (d) nil
10) Do you have any of the following items in your home? (Y=Yes; N= No)
a) Radio… b) Television set… c) Both… d) Neither… e) Tape recorder… Other (specify)……

11) What kind of fuel do you use for cooking in the house? a) wood collected b)wood purchased c)charcoal d) kerosene e) gas/electricity
12) Supplementary occupation: a) farming b) trading c) other (specify)……
13) If you have a farm, what crops do you mainly grow and for what purpose? Cassava/plantain/maize/yam: a) mainly consume b) mainly sell c) both d) other (specify)……
14) Who supplies/buys food for the house? -- Father/ Mother /Both/ Other (specify)……
15) If you are married, are you living with spouse in (a) husband's family house (b) wife's family house (c) rented/self-owned (d) separately
16) Do you have children/dependents? Yes No
17) If yes, who caters for them? -- Husband/Wife/Both/ Self/Other (specify)……..
18) How many meals do you have in a day? a) 1 (b) 2 (c) 3 (d) other (specify)……
19) Who decides what to do when you or a member of your family is sick? a) husband b)wife c) both d) head of family e)patient
20) Who has final authority in your family? a) husband b)wife c)both d) head
21) Do you have to give kin financial and other help? a) never b) occasionally (twice a year) c) monthly
22) Have you ever heard of HIV/AIDS? Yes No (If no, skip to 26)
23) If yes, from which source(s)? Radio/Television/Newspapers/Health officials/Friends/family/Other (specify)…….
24) How often do you hear about HIV/AIDS? Daily/Once a week/ Once a month
25) How do you find HIV/AIDS campaign messages such as 'AIDS is Real'; 'AIDS is a Killer', and on condoms? -- Alright/ Untrue/ No idea/ Too much about sex.
26) What is your age group? a) 1-14 b) 15-29 c) 30-44 d) 45-59 e) 60+