# FUNERAL RITES PARTICIPATION AND HEALTH SERVICES UTILIZATION IN RURAL GHANA.

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# HEALTH SERVICES UTILIZATION IN RURAL GHANA

## Abstract

Conventional health care services (CHCS) have failed to meet the health needs of many people in rural Ghana. Relevant literature highlights poverty, underdevelopment and inequities in allocation of resources as largely accountable. Currently in vogue and as a solution to these inequalities is the concept of comprehensive primary health care (CPHC) which implies community participation or "health by the people". Since its adoption and implementation, the CPHC strategy to health has not been successful in most of these rural communities, an issue that poses a new challenge to both "experts" and "students" of utilization studies.

In this study, funeral rites participation (as a sociocultural phenomenon) is used to examine the character and levels of use of CPHC services among the Dagaaba in the Upper West Region (UWR) of Ghana. Using a qualitative-ethnographic design to gather data, special emphasis is given to inter- and intra-gender variations in utilization patterns. The process of data analysis, like that of data collection, derives from grounded theory. This theory is especially suitable for determining health explanatory models of lay and professional people as well as for identifying which cultural beliefs and social norms influence healthcare practices.

Lack of viable economic activities in the UWR cause many able-bodied Dagaaba men to migrate. Over 50% of these migrants work in the mines where they fall victims to and die in epidemic proportions from new occupational accidents, injuries and diseases. The effects of such migrations and epidemic mortality of these men on the community's economic and

social life are issues of great concern. Apart from the nutritional consequences of the socioeconomic deprivations, funeral rites, performed following death, have their impact on health. As part of a complex network of symbols and actions associated with life, health and illness, death rites redefine identities and inhibit the health seeking behaviour of participants of these rites. For instance, the symbolic structural and functional readjustments made, like "widow inheritance", in order to reach a new equilibrium and ensure continuity in the family inhibit the utilization behaviour of both the widow and the "heir". For them, the dead are actually not dead. Rather, they are transformed into a community of spirits (the "living-dead") policing and exerting influence on their behaviour in the human world.

Within the context of this belief system, the Dagaaba conceptualize and articulate the causes of most illnesses in terms of spiritual dysfunctions and/or relational fragmentations. Consequently, solutions to them are viewed in the context of spiritual renewal and relational reintegration. Healthcare is thus seen as a collective enterprise having little to do with the clinical reality of the individual and everything to do with the corporate interest of the community (the philosophy of N'taan be). In light of this, the study contends that to understand and facilitate utilization of CPHC services in the region (especially among the Dagaaba) we must depart from conventional models that explain services utilization in terms of macro-structure and micro-psychology. We must develop meso-models that identify with the meanings local people attach to ritual symbols and utilization actions.

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A.D.B

# Table of Contents

## Chapter One

## Introduction and Perspective



## Chapter Two

## Dagaaba Social Structure and Institutions



## Chapter Three

## Theoretical and Methodological Issues

## Chapter Four

## Manlarla Cosmology and the Health Care System

## Chapter Five

## Manlarla Funeral Rites and Health



## Chapter Six

## Ritual Participation and Utilization of Health Services

## Chapter Seven

## Analytical Interpretation of Utilization Data

## Chapter Eight

## Understanding: The Key to Common Ground

# List of Tables

# List of Figures

# CHAPTER 1

# INTRODUCTION AND PERSPECTIVE

> *The most acute of all issues...seems to be the issue of wholes and parts, the quest for patterned structure, or for the definitive and functional analysis of component elements. It is in a sense the old issue of Aristotle's forms versus Democritus' atoms, but it is stated today in terms of evolutionary holism, the indivisibility of the "living system".* (G. Murphy, 1949:444)

## 1.1 Subject Matter and Nature of Study

Every research inquiry has some problem it seeks to solve. In other words, there is a practical or theoretical reason why such a topic of study is preferred. The low utilization rate of primary health care (PHC) programmes designed to combat a chronic situation of poor health in Ghana in general and rural communities in particular is, at best, a complex problem. Perhaps, nowhere else in the development process of the country does a sphere of encounter cut across so many disciplines and so much subject matter. While there are widely differing schools of thought on the factors generating low propensity in rural Ghanaians to use health services, and the best way to address it, there is remarkably little empirical research on any of them to legitimize their long-term validity.

Nevertheless, low utilization rate of health services remains a matter of increasing concern in the country both as a major source of mortality and morbidity, and as a serious flaw in developmental efforts to achieve maximum human resource potential. Initially, discussions on low propensity of rural Ghanaians to use health services were associated with the problem of policy "insensitivity" to equity. In other words, the health care system was "commercialized", "urban-centred", and oriented towards "high-technology and curative

medicine". By implication, such a healthcare system was considered to have closed its "gates" to a large number of potential users.

Between the latter parts of the 1960s and 1970s, therefore, various Committees[1] were instituted by the government of Ghana to examine this problem and make recommendations for its redress. Commenting on the curative and urban orientation of health services in the country, the Easmon Committee observed that rural communities were neglected, while preventive emphasis of health was not taken seriously. For instance, the Committee noted that only 20 of the 565 physicians practising in the country at that time were in preventive health based in the cities. For this neglect, it argued that one adult in every three, and an appalling high number of children in rural communities died from preventable conditions (1969:2). Similarly, Sai et al. (1972:125) noted that not more than 20% of Ghanaians could be offered any service given the "nature" and "distribution" of hospitals and clinics in the country, while Cole-King et al. (1979:219) estimated that "only 32% of Ghanaians were receiving environmental sanitation services".

Allocation of financial and human resources was equally characterized by inequity. For example, Ewusi (1978) observed that while the Greater Accra Region (GAR) had about 9.4% of Ghana's population, 47% of all total government doctors practised there. Similarly, Fosu (1986) observed that some 67% of physicians and 86% of pharmacists were in towns of over 20,000 which contained only about 18% of the country's population. This maldistribution of human resources between rural and urban communities was mirrored in financial imbalances stemming from a favour for urban, hospital care. For instance, Ofosu-Amaah (1975) revealed that over a third of the health budget for the 1974/75 fiscal year went to Korle-Bu Teaching Hospital alone in the GAR (in Senah, 1989:258).

Arguing in terms of the commercialisation of what is considered to be the "bona fide right of all", Senah criticized the policy of health care financing. He argued that the policy was insensitive to the financial constraints of many potential users (1989:256). Inspired by Kunnes (1985), Senah emphasized that the payment of hospital fees was not only a health hazard but also a psychological barrier to health care for the poor, who are disproportionately concentrated in the rural communities of the country.

Given these rather appalling disparities and barriers, low propensity of rural inhabitants to use health services was explained in technological, geographic and economic terms. To generate and sustain equitable access to health services in the country, therefore, the Committees recommended that a new orientation was required, especially at the level of health policy makers. Thus, by the end of the 1970s this new policy, designed to generate an effective, high quality and affordable primary care in rural communities, was initiated by the country's Ministry of Health (MOH) with assistance from the World Health Organization (WHO) and other non-governmental organizations (NGOs).[2] This policy is the primary health care (PHC) programme.

The PHC approach represents a concept of integrated health services developed with the understanding that health and the possibility of its improvement, is related to a whole range of social, political, economic and cultural factors. This is emphasized by inter-sectoral collaboration and community participation, principles of which are incorporated in its definition as:

> An essential health care made universally accessible to individuals and families in community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of both the country's health system, of which it is the nucleus, and of the overall social and economic development in the community (WHO, 1978:34).

This strategy was thus adopted in Ghana as a dominant approach to health problems partly because of the existing maldistribution of resources (material and human) and in part from *de facto* recognition that "high technology, hierarchical, and facility-oriented" health care was neither generally affordable nor culturally appropriate for health improvement and socioeconomic development of rural people. The assumption, then, was that a less hierarchical, non-bureaucratic, and culturally sensitive health programme would encourage effective utilization and generate opportunities for sustained social and economic development.

The concept and principles of PHC were discussed and adopted in a WHO/UNICEF Declaration of 1978 at Alma Ata in the then Soviet Union (ibid.). The Declaration was made against the background of experiences and limitations of the conventional health delivery system (over-centralized and top-heavy, cure-biased, and hospital-based) that tended to yield less than maximum positive impact on the health status of broad masses of the people the world over (but especially in developing economies). Therefore, in Ghana, like other developing countries, PHC was organized on the basis and principles of equity, inter-sectoral collaboration and community participation within the framework of decentralized structures (Ghana, 1985:57).

To sustain these principles, the MOH in Ghana developed a three-tier structure (see Table 1.1) that serves as the framework for implementating and managing the programme.

Table 1.1: Structure of the PHC Programme in Ghana

| Level | Structure(s) | Management Team |
|---|---|---|
| Level C | district hospital | district health management team (DHMT) led by a district medical officer (DMO) |
| Level B | polyclinics, health centres, health posts | medical assistant, community health nurse/midwife, health inspector, and field technician |
| Level A | community clinics | community health nurses, TBAs, environmental workers & community development workers |

From the structure, Level C is the district level in which the district hospital, overseen by the district medical officer (DMO), serves as the lynch-pin that knits together the services and facilities provided by other departments and units of the ministry. A composite district health management team (DHMT) provides the inter-sectoral and inter-disciplinary setting essential for the implementation of the programme. An intermediate structure, consisting of a satellite system of polyclinics, health centres and health posts and designated Level B provides out-reach health care facilities within easy "accessibility" of communities. Given the thrust and components of the PHC programme, community mobilization and active local participation is considered necessary for systematic and sustained implementation. This is recognized and emphasized by the designation of the community as Level A of the three-tier system.

While equitable access to health services has since been the cornerstone of this new orientation, the increased utilization rate (or the utilization magic bullet) anticipated among rural potential users has proven to be an elusive goal (or a misdirected shot). Adjei et al.

(1984) suggest that only moderate gains have been achieved by the PHC programme. In terms of progress, they observed that 64% of Ghanaians now have access to healthcare services within one hour travel time, an improvement reckoned to be twice that of 1977. However, the team noted that between 50 and 70% of deliveries still take place at home, with over half of such deliveries performed by "untrained" traditional birth attendants (TBAs).They also observed that less than 50% of mothers are protected from tetanus, while more than 40% of children with diarrhoea are not treated. Finally, they lamented that 11% of rural and peri-urban children are seriously malnourished, while *kwashiokor* is still as rampant as it was 50 years ago. The view that PHC has failed in terms of maximizing utilization was also upheld by the country's Director of Medical Services. He said: "progress of the primary health care programme has been very slow" (Ghana, 1984:8).

This lack of congruence between equitable access and effective utilization poses a new challenge to both "experts" (policy makers and programme implementors), and students and observers of utilization mechanics. Within the general framework of this incongruence, two things can be deduced. First, that accessibility of healthcare services in rural Ghana is only partially granted. Second, that access is not to be equated with the use of services. While use of healthcare services clearly demonstrates that access has been achieved, accessibility does not always guarantee effective utilization. In other words, physical availability of healthcare services (as implied by "the within one hour travel time") does not always guarantee use of them. The question is, "What factors influence the propensity of rural Ghanaians to use healthcare services?"

The propensity to use healthcare service is a complex function of many different variables. The incidence of disease, the availability of services (in qualitative and quantitative

terms), the costs of services (in terms of time and money), beliefs about the efficacy of such services, service personnel and client relationships, family and social networks, age and sex differences in morbidity (Cartwright, 1967; Freeman et al., 1972; Freidson, 1970), and patients' perceptions of ill-health, healthcare and death are all determinants of service utilization. For these reasons, utilization of health services has generally varied from country to country, region to region, locality to locality and, even, within one locality, from one social group to another. Uneven impact of general causal factors on different geographical regions and/or social groups as well as unique causal factors of specific regions and/or social groups may have confounded to generate variability in propensity to use healthcare services. As Mishler (1981:84) suggests, even though "illness rates are generally higher for lower socioeconomic classes, health services are less available to them than to higher socioeconomic classes". In other words, social groups (and even individuals within them) vary in their dispositions to seek medical care for various reasons.

In Ghana as a whole, while propensity to use health services has been generally low, utilization rates tend to vary from region to region, community to community and, even, within each community, from one social group to another. Factors and forces of varied dimensions (general and local) operating *in situ* and/or *in solo* may have accounted for the lack of congruence between "accessibility" and "utilization" in Ghanaian rural communities. It is this lack of congruence between accessibility and utilization of healthcare services among the Dagaaba in the Upper West Region (UWR) of Ghana (see Figure 1.1) that provides intellectual stimulation and thematic structure for this study.

### 1.1.1 The Upper West Region (UWR) of Ghana

The UWR, which takes its name from the geographical location, had existed under various names in the past. It was known as the Black Volta Administrative District in the 19th century. Early in the 20th century it was renamed the Northwestern Province. In 1932, the Province was merged with two others (Gambaga and Tamale) to become the Northern Territories (NTs). However, in 1960, the Northern Region was carved out of the NTs and what remained became known as the Upper Region. On 14th January, 1983, the Upper Region was divided into two: the Upper East Region (UER) and the UWR (Ghana, 1983:1).

The UWR is not only the youngest, but also the least resourced. It has been neglected for many decades. And since it was declared a region, little has been done concretely to change that situation. Five districts - Wa (also the regional capital), Nadowli, Jirapa-Lambusie, Lawra and Tumu (see Figure 1.2) - constitute the administrative structure of the region. As can be observed from the map, the region is bounded on the north by Burkina Faso, to the west by the Black Volta River, to the east by the UER and to the south by the Northern Region.

With an area of about 18,476 square kilometres, the region falls within latitude 11 North and 9 South, and longtitude 2 30' East and 3 West (Ghana, 1994a:8). The landscape is generally flat and about 300m above sea level with central plateau ranging between 1,000 to 1,150ft. It is drained by the Black Volta River and its two tributaries - Kulpawn and Sissili. The soil is mainly sandy loam with underlying hard iron-pan and a strip of alluvial along the river banks (ibid.).

The UWR is characterized by a single rainfall pattern which falls between May and October (wet season) with an intensity of 100 - 115cm/annum. Humidity ranges between 70

and 90% but falls to about 20% between November and April (dry season). During this time of the year, the north-east trade winds or tropical continental airmass (harmattan), blowing from west to east, is cold, dry and dusty. Even though diseases are endemic and play havoc with lives throughout the year, they are particularly devastating during the peak of the dry season (ibid.:10).

Farming is the major pre-occupation in the region. About 68% of the working population are engaged in it (Ghana, 1987b:44). In spite of this, food production in the region is poor with resultant seasonal famine and, sometimes, malnutrition rises to over 60% in some localities. The poor food stock of the region is supplemented by earnings from the remaining 32% of the population who work as civil servants, traders, hunters, tradesmen and miners in and/or out of the region (ibid.:47).

According to census figures of 1984 (the latest census, though outdated), the UWR had a population of 438,008 people. The estimated population for 1994, as projected from year to year, was 529,113. Out of the 1984 figure of 438,008 people, about 53% (278,149) were females, while 47% (250,904) were males. The illiteracy rate is very high. Only about 10% of the people are literate, with slightly over 95% of females being illiterate. Also, the region is predominantly rural. The statistics of 1984 indicate that 390,459 (89%) people lived in rural communities, while only 47,549 (11%) lived in urban areas of more than 5,000 people (Ghana, 1987b:19).

These features of the region, with serious health implications especially for the most vulnerable groups (the aged, women and children), have changed only very slightly over the years. For instance, amplified by lack of safe water and inadequate nutrition, infectious disease rates tend to be very high. This is especially evident in the region's high infant mortality from

such preventable diseases as diarrhoea, measles, neonatal tetanus, whooping cough, and malaria (Ghana, 1994a; Unicef, 1990:17). But the region does not only wrestle with poverty and ill-health. It also faces a more demanding set of conditions (economic underdevelopment), a set of expectations (massive migration), and a set of challenges (adaptation to premature mortality). These conditions expectations and challenges, while disrupting patterns of community life, leave an indelible influence on the utilization of modern healthcare services in the region.

### 1.1.2 Modern Health Institutions and Services in the UWR

Currently, there are 52 health institutions in the UWR providing both curative and public health services (Ghana, 1994a:34). Out of this number, 30 (58%) are established by the Ghana government and run by the MOH, while 22 (42%) are owned and run by Missions (Christian and Islamic), other NGOs and the private sector (see Figure 1.3). While 10% of these institutions are hospitals, 87% are health centres/health posts and 3% are clinics (ibid.). The population served per institution varies from 8,208 in Jirapa-Lambusie district to 15,267 in Lawra district (ibid.:48). Using the guidelines of a PHC review of 1991, which prescribed an institution per 10,000 people, the UWR with a projected population of 529,113 people will require 53 health institutions. Thus, with the physical availability of 52 health institutions, it appears the region has enough facilities to meet national health targets.

According to the director of health (DOH), health services in the UWR are centred on five broad concerns. These are maternal and child health and nutrition, disease control, environmental health, health education, and medical care. Each of these has a variety of accompanying activities. Under maternal and child health, for example, the broad objectives

are the reduction of maternal and infant mortality and morbidity rates and the increase of birth intervals to an average of 3 years. To do this, the DOH said, "expecting mothers are encouraged to pay regular visits to the health centres, while supervision of traditional birth attendants (TBAs) is intensified and post-natal services are provided during out-reach activities". In connection with disease control, the DOH explained that "surveillance systems have been set up in hospitals to monitor the occurrence and spread of diseases including measles, diarrhoeal and parasitic diseases, AIDS, and leprosy". Activities of environmental health are focused on water and environmental hygiene through clean up campaigns, while those on health education are centred on teenage pregnancy, and drug and alcohol abuses (1994: Interview).

### 1.1.3 The Problem and its Conception

As demonstrated in the sections above, the UWR appears to have enough health institutions and personnel to effectively deliver various health services to the people. In spite of this, many inhabitants of the region still contract several preventable diseases and either die from them or become incapacitated in their socially and economically productive life. For instance, the DOH suggests that malaria, anaemia, malnutrition, diarrhoea, pneumonia, and infective hepatitis remain devastating in terms of morbidity and mortality in the region (1994: Interview). These illnesses, according to Dr. Francis Banka (coordinator of the PHC programme in the region), are either preventable or controllable with prompt attention (1987:4). From the coordinator's statement, it could be said that most people in the region become victims of these illnesses because of either inattention or late attention to their occurrence. Why are people in the region inattentive or pay little and/or late attention to their

health problems? Why do they feel reluctant to go to health institutions available in the region when they are sick? These are important questions that can be answered only by data arising from the inhabitants themselves.

In 1981, I studied the social significance of funeral rites in a community in the region. I worked in the same locality in the mid-1980s as a coordinator of a PHC programme. Quality of health in this community was generally poor; perhaps the poorest in Ghana (Ghana, 1993a). Yet efforts by the government of Ghana, with assistance from international agencies[3], to alleviate suffering and improve productive life in this community were rarely utilized. From a sociological point of view, "utilization is seen as the professionally or officially desired culmination of a social process by which one is brought into contact with medical institutions after one has come to believe one is ill" (Freidson, 1970:292). The rate of utilization is, therefore, expressed as the proportion of people in need of a service who actually receive it in a given period, usually a year. For example, the proportion of children at risk who are immunized, the proportion of pregnant women who receive prenatal care or have their deliveries supervised by trained attendants, or the proportion of people requiring medical treatment who actually go to health care centres.

Within the framework of this definition of utilization, the DOH maintains there is low utilization of health services in the UWR. For instance, he says "less than 15% of pregnant women in the region receive prenatal care, while only 10% of deliveries are given professional supervision". The DOH also lamented that in the out-patient-department (OPD), utilization rate for 1993 was 0.23 visits per person per year" (1994: Interview). This means that about 1 out of 4 persons attended the health institutions' OPD once in 1993. From the 1993 regional health report, the magnitude of the DOH's concern about utilization of health services in the

region was brought home to me. Below are tabular illustrations of the PHC rates of coverage and immunization performance for the five districts in the region.

Table 1.2: Primary Health Care Coverage in the UWR (1993)

| Target | Wa District | Nadowli District | Jirapa/ Lambusie | Lawra District | Tumu District | Regional Average |
|---|---|---|---|---|---|---|
| 100 | 19 | 10 | 14 | 28 | 12 | 17 |

Table 1.3: Immunization Performance by Districts, 1992-93

| Vaccine | Target | % Coverage by Districts | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Wa | | Nadowli | | Lawra | | J/Lambusie | | Tumu | | Region | |
| | 1993 | '92 | '93 | '92 | '93 | '92 | '93 | '92 | '93 | '92 | '93 | '92 | '93 |
| BCG | 100 | 72 | 81 | 28 | 52 | 72 | 67 | 72 | 80 | 43 | 59 | 61 | 71 |
| DPT3 | 100 | 36 | 55 | 28 | 47 | 46 | 58 | 46 | 57 | 29 | 47 | 37 | 54 |
| OPV3 | 100 | 38 | 86 | 24 | 41 | 45 | 56 | 47 | 59 | 31 | 43 | 37 | 63 |
| Measles | 100 | 43 | 89 | 29 | 52 | 43 | 54 | 44 | 55 | 40 | 62 | 40 | 67 |
| TT2 | 100 | 27 | 22 | 12 | 13 | 8 | 14 | 9 | 15 | 17 | 32 | 17 | 19 |

Source: Ministry of Health Regional Report, Wa, UWR (1994a:12, 41).

From the tables, both the PHC rate of coverage and immunization performance in all five districts of the region remain very low. The sample district, Nadowli, has the lowest rates of PHC coverage (10%) and immunization performance for most vaccines. These appalling rates of PHC coverage and immunization performance, the DOH says, "are not due to lack of professional personnel or support resources", but that "the communities are difficult" and

"the people don't come". Why are the communities difficult? Why do few people in the region use services provided by cosmopolitan health institutions? Are inhabitants of the region comparatively in good health? Are health services inappropriate? In short, what accounts for the low propensity for health services in the region? To proceed systematically, it is important to first understand the statistical health profile of the region.

### 1.1.4 Some Background Statistics

While health conditions in Ghana as a whole leave much to be desired, rural UWR is especially bad. For instance, life expectancy at birth by 1988 was estimated at 45 years for males and 48 years for females in the region (Ghana, 1989). The national averages for the same period were estimated at 57 years for males and 61 years for females (WHO, 1991). Infant mortality rate (IMR) by 1987 was 103 per 1,000, twice the infant mortality rate of GAR which was estimated at 51 per 1,000 live births (op.cit., 1989:65). The national infant mortality rate is estimated at 87 per 1,000 live births (ibid.). Child mortality rates (CMRs) and under five mortality rates (U5MRs) are even worse. While GAR had 48.9 per 1,000 child mortality rate and 97.8 per 1,000 under five mortality rate, the UWR registered 132.3 and 221.8 per 1,000 for child mortality and under five mortality rates respectively (ibid.).

The difference in maternal mortality rates (MMRs) is equally striking; 1,400 and 450 per 100,000 deliveries in the UWR and GAR respectively (ibid.:66). The national maternal mortality rate is estimated as 650 per 100,000 deliveries (ibid.). These figures could be higher as rates certainly apply to mortality occurring within health institutions. But, this is not to speculate that the maternal mortality gap between the two regions (GAR and UWR) could be narrowed if it was possible to include all out-of-institution births. On the contrary, it is

more reasonable to project a wider gap between them because of differences in hospital births. For instance, it is reported that while about 72% of all births in the GAR are delivered by doctors and trained nurses/midwives, only about 13% of all births in the UWR takes place in health institutions (Ghana, 1988:69).

Similarly, differences in the level of tetanus toxoid coverage have been noted. While 60% of births in the GAR are preceded by tetanus injection, less than 30% of births in the UWR are protected from tetanus (ibid.:70). Similar morbidity and mortality statistical trends are observable between the UWR and the other remaining eight regions of Ghana. The implication of these differences in morbidity and mortality statistics of infants, children and their mothers is quite clear. The UWR seems to be a rougher and more "unhealthy" or turbulent environment to live in and die than the rest of the regions, including the GAR.

The men of the UWR face a similar, although not identical, health profile. The people in the region, who are 70% Dagaaba (Ghana, 1987a; McCoy, 1988), practise labour-intensive hoe-cultivation in a two seasoned climatic environment (wet and dry seasons). During the dry season when there is very little economic activity in the region and during which period village life is bleak, drab and insecure, Dagaaba able-bodied men migrate to locations in and around Bibiani, Dunkwa, Nkwatia, Obuasi, Prestea, Tarkwa and Wiawso (see Figure 1.4) to take up jobs in the mines as unskilled underground workers. Motives for such migrations are varied. But for most migrants and their families, the need to supplement food and meat supplies is the overwhelming reason. As I have indicated elsewhere, these are sometimes insufficient for subsistence.

A review of the social background of mine workers indicates that by 1980 about 90% of the tens of thousands of underground miners (Iddrisu, 1981:11) were illiterate and semi-

literate migrants from either rural Ghana or neighbouring countries such as Burkina Faso, Cote d'Ivoire and Togo. Out of this, about 60% come from the UWR (ibid.). These human statistics of the mines do not seem to have undergone any significant alterations. For instance, Lentz and Erlmann (1989) suggest that Dagaaba probably constitute more than 50% of all underground miners in the country. Even with the economic restructuring and labour retrenchment of the early 1990s, this writer observed that Dagaaba numerical representation in the mines still stands around 40%.

The over-representation of the UWR in general and the Dagaaba in particular in the mines is a mirror reflection of a deficient development syndrome (DDS) perpetuated under colonial rule (Plange, 1984:36) and sustained since independence. Governor Guggisberg's[4] "Everyman in the Northern Territories (NTs) is worth his weight in gold....for the mines, for private enterprise and for the development of those schemes the completion of which are necessary to secure the progress of the Colony"[5] (in Kimble, 1963:27) best illustrates the point. The day-to-day impact of colonial rule of the UWR lay in what Thomas (1973) calls the "recurrent call for labour", which was sometimes compulsory and often unpaid. The preservation of the UWR as a "reservoir for the reserve army of labour" (Aidoo, 1982:642), regrettably remains unchanged since independence and is largely accountable for the region's underdeveloped status.

Continuous out-migration of Dagaaba able-bodied men due to general socioeconomic underdevelopment of the region not only creates what Onoge (1973) calls a "phenomenon of starving manless villages", but it also generates, sooner than later, a "phenomenon of streaming widows and orphans". Husbands and fathers of women and children exposed to new occupational hazards and diseases in the mines often return home dead or to die.

Unfortunately, reliable statistics of such status transitions of Dagaaba migrant miners are difficult to obtain. However, it would not be an unlikely speculation to emphasize that epidemics of occupational accidents, injuries, illness and death would probably be found to occur more commonly with Dagaaba miners (due to their numerical strength) than mine workers from other labour supplying regions.

Conservative estimates from elders of the three village communities investigated suggest that of all the deaths of males between the ages of 20 and 50 years in the past three years, 67% were associated with the mines. Reported mines-related deaths for the villages were approximately 60% for Loho, 65% for Nanville and 75% for Nyimbale. Out of these statistics, about 80% were active underground workers, while the remaining victims were surface labourers with mining companies. These reported statistics were supported while the writer was still engaged in data collection in the locality. For instance, between June and August 1994, 3 deaths occurred in Loho, 4 in Nanville and 3 in Nyimbale. Out of these deaths, 1 from Loho, and 2 each from Nanville and Nyimbale were reported to be active workers in Obuasi, Prestea and Tarkwa gold mines.

Shocking as these statistics may appear, I was told they represent only a tip of the iceberg because these figures were based on adult males who died. There was no mention of those women and children who died while living with their husbands and fathers working with mining companies. Nor were those who sustained injuries or contracted diseases accounted for in these figures. It is possible that for each of these reported deaths, several others were paralysed or incapacitated by job-induced illnesses. In other words, the true magnitude of the problem is likely to be drastically underestimated.

The implication of such untimely debility and premature mortality of able-bodied

Dagaaba men in pursuit of wealth and health for their families cannot be over-emphasized. The vital necessity of balancing short-term economic gains against long-term threats to quality of life offers them a major challenge. In other words, the social consequences arising from the premature death of these miners defy calculation. The region is not only deprived of their talents and energies prematurely, but their departure from this world also generates a population of survivors who are never able to pick up their lives as usual. For instance, women, children and older dependents left behind assume the primary responsibility of provisioning for themselves. The glassy look in the eyes of emaciated and malnourished children, and their equally emaciated, starving and physically weak mothers in pictures and newspapers, on television screens and posters, as observed by Akilagpa (1988:1), is but one of the associated micro-consequences of this undesirable double-edged macro socio-economic dagger. Such disturbing health realities from rural Ghana prompted a commentary from the British Institute of Development Studies (IDS):

> The basic health needs of the majority of Ghana's people require a health system which prevents their children from contracting easily preventable diseases, and dying from them; which ensures that their pregnant women have adequate antenatal and delivery care, widely and locally available; which gives adequate and accessible curative care for their common ailmets; which helps build them a healthier environment through appropriate sanitation measures; which is capable of controlling the communicable diseases rampant among them; which can utilize their own approach to health, disease and death to the best effort, and transmit such "modern" knowledge as seems to be indispensable to create a basis for healthy living (1979:7-8 emphasis mine).

### 1.1.5 The Research Question

The poor economic and health realities of the Dagaaba in the UWR, as illustrated by their health and development profiles, suggest the need for a health intervention such as the

PHC programme. In addition, it was anticipated (perhaps, logically too) that the region would demonstrate a high rate of free health services utilization given the poor health conditions of the population and the region's weak economic profile. In spite of these realities, health resources generated by the programme in the region are rarely used by the people. Bainge (1985) and Appiah-Denkyira (1989) suggest that the UWR has the lowest rate of health services utilization in Ghana. Their view is statistically supported by daily regional health services utilization data of 1988 (the latest utilization data of its kind at the time of fieldwork) reproduced in Table 1.3.

Table 1.3: Average Daily PHC (Level B) Attendances by Regions

| Greater Accra | Ash-anti | Brong Ahafo | Cen-tral | Eas-tern | Nor-thern | Upper East | Upper West | Volta | Wes-tern |
|---|---|---|---|---|---|---|---|---|---|
| 23 | 32 | 21 | 19 | 24 | 10 | 22 | 4 | 25 | 27 |

Source: Ghana Health Statistics (1989:5).

Considering these statistics, it seems a very interesting paradox that the people of the UWR who have the most to benefit from the health services provided by the programme given the nature of their health and economic statuses, are the ones most reluctant to embrace it and use its facilities and resources. Within the framework of this paradox, I formulated a research question: "Why would people suffering from the worst health conditions in the country and demonstrating evidence of pecuniary deficiency remain unattracted to services provided to promote health and improve quality of life at `affordable' costs?"[6]

In the summer of 1992 while I was in Ghana to participate in the final funeral rites of my mother, the importance of funeral rites as a factor in health behaviour dawned on me. At

one of our family conferences, it came to light that my mother's life could have been saved if she had been taken to the hospital earlier. However, as she was a widow, she received professional medical attention late. As a widow, a series of consultation and divination had to be done before deciding on what therapeutic regime to pursue. I felt this experience in my family, which was aware of modern professional healthcare services in nearby Kaleo (5 km away), Wa (10 km away), and Jirapa (50 km away), was likely to be a general problem in the community; and if so, could constitute a starting point for investigating the factors generating low propensity for modern healthcare services in the region.

Immediately, I started preliminary investigations and began to realize, albeit inconclusively, that, (1) customary kinship and institutional norms associated with funeral rites may inhibit utilization of available modern healthcare services; and that, (2) variations in utilization of these services may be influenced by individual status vis-`a-vis these rites. If these preliminary observations about determinants of Dagaaba healthcare services utilization were proved to be valid, then, it would become clear that such sociocultural processes could be factors in the explanation of low utilization of modern healthcare services by many traditional people. As such, attempts to understand why they seek help, when they seek help, how they seek help, and where they seek help should begin from these unique sociocultural processes. In other words, instead of seeking to understand utilization propensities of traditional people within the frameworks of macro-level structural factors and/or micro-level psychological or individual characteristics, attention should be paid to the importance of meso-level social and cultural processes. Macro- and micro-level factors may only be secondary among these people and have "indirect" rather than "direct" causal relationships with utilization propensities.

*A priori*, therefore, it is not implausible to hypothesize that both the character and the explanation for variation in utilization propensities should be sought within the sociocultural contexts and processes of particular societies. This study is designed principally to determine the importance of meso-level processes (such as funeral rites) as a factor in utilization of health care services among the Dagaaba in the UWR of Ghana. In simple terms, the study examines how participation in rites of death influence health seeking behaviour among people suffering from some of the worst health realities in the world. It also explores how these rites and individual status in them generate variations in propensity to use health care services.

## 1.2 Methods and Division of Study

As the study aims at providing a systematic framework for understanding the relationship(s) between ritual participation and propensity to use health care services in an essentially non-literate society, our methods have to be specific. For instance, our sampling procedure has to be "purposive" (Warwick & Lininger, 1975), "strategic" (Hunt, 1970), or "judgemental" (Bernard, 1988) . In other words, to maximize the validity of data, the selection of informants or respondents must be based on certain salient characteristics of the population.

Probability sampling often assumes equal probability of observation of all units in the population universe studied. A random sample of the universe is, therefore, expected to yield a representative picture of that population (Johnson, 1990). In reality, however, a true "representative" random sample is not always possible, particularly in field research. It is so, as Johnson (1990) suggests, because of the difficulty in knowing the universe *a priori* or to have what Bernard (1988) calls a "sampling frame". In addition, a difficulty arises in the ability of small random samples of large populations to capture sufficient numbers of cases that are

certainly of theoretical interest.

Given these limitations of probability sampling, a non-probability sampling of specific sub-groups (Folch-Lyon & Trost, 1981) was designed to select respondents from the sample community. The sub-groups included ritual participants, ritual specialists, local/localized health professionals and community civic leaders. In other words, our method of sampling was similar to Cook & Cambell's (1979) "model of deliberate sampling for heterogeneity". A combination of informant-oriented and observation-oriented methods (Willms et al., 1991) or a qualitative-ethnographic design was used to collect data.

### 1.2.1 Why a Qualitative-Ethnographic Design?

As the study is an attempt to understand the social construction of cultural meanings in health services utilization, qualitative-ethnographic techniques are considered more useful for both theoretical and practical reasons. Theoretically, descriptive analysis of people's perceptions, attitudes, beliefs, views and feelings, as well as behaviour (internal reality of cultural events) can easily be offered by qualitative-ethnographic techniques. According to Hakim (1987) and Patton (1987), access to the internal reality of cultural events is easier through personal relationships between the interviewer and the interviewed.

In addition to its theoretical appropriateness, qualitative-ethnographic design is also practically useful. Given the essentially non-literate character of the population under consideration and, therefore, the respondents, the application of quantitative methods, particularly questionnaires, would have been less useful. Besides the inappropriateness of questionnaires for non-literate respondents, it is often argued that the ability of questionnaire methods to represent sociocultural attitudes is limited. For example, Bernard (1988) suggests that qualitative-ethnographic design ensures the formulation of relevant and sensitive

questions in the native language of respondents which a questionnaire is unable to do.

However, qualitative-ethnographic design is not without weaknesses. A major weakness often emphasized by its critics is that the small numbers of respondents, characteristic of qualitative design, hardly represent the population universe even if great care is taken to include all relevant dimensions in the sample. Also, Borman et al. (1986) criticize qualitative methods, particularly ethnography, as too subjective, too value laden, neither replicable nor generalizable, trivial in conclusions and lacks internal validity, neither empirical, rigorous nor systematic.

In spite of these demerits, qualitative-ethnographic design is credited with several advantages. One great strength of this design is its flexibility and ability to obtain valid data as individuals are interviewed in their own world. Through mutual sharing and interaction in the natural setting of the interviewed, the investigator is afforded the opportunity to understand fully the former's point of view, their relation to life, and their vision of the world (Geertz, 1976). Besides, as Krenz and Sax (1986) point out, if little correspondence exists between measures and "reality" in quantitative research, then it is plausible to say that quantitative research produces little "truth" (in certain settings) that is useful in the context of educational practice. For this reason, qualitative research appears to be more appropriate in such settings.

Despite the charges and countercharges, which appear to mirror an ongoing debate in the social sciences between positivists and subjectivists (Pinxten, 1981), qualitative-ethnographic design appears to be more appropriate in this study where our interest is in sociocultural determinants of behaviour in an essentially non-literate environment. Consistent with our study interest and quality of research site, qualitative-ethnographic design will not

only provide "holistic-inductive approach based on naturalistic inquiry" (Patton, 1980:39), but it will also be appropriate for the analytical approach adopted in the study.

### 1.2.2 Division of Study

The study is in eight chapters. Chapter 1 provides an overview of the problems of health and health services utilization in Ghana in general and the JWR in particular. Attempts at promoting equal accessibility to healthcare through a PHC programme, problems encountered in implementing the programme and explanations offered for the problems have been outlined in this chapter. The chapter analysizes the socioeconomic environment and hypothesizes that low propensity of the Dagaaba in the UWR to use modern healthcare services may be influenced by death rites. It thus contends that the problem of low utilization is largely sociocultural.

The importance of the social context in understanding "Why?", "When?", and "How?" people seek medical care and "What?" type of care they seek can never be denied. Chapter 2, therefore, takes the reader on a tour of the Dagaaba cultural life as related to healthcare. It sketches their cultural distinctiveness and maps out their institutional structures and patterns of social organization, interactions and interrelationships. Social institutions like marriage, family and kinship as well as their economic and political structures, and their various health implications provide thematic structure for the chapter. The objective of this chapter is to provide the context within which the key concepts - funeral rites, health, illness and propensity for healthcare services - are situated. The chapter emphasizes, though very briefly, the place of tradition and custom in influencing behaviour among the Dagaaba. However, it concludes with a notification that, although these symbols may set conditions and

consequences for behaviour, individually, Dagaaba behave according to the meanings their tradition and custom hold for them.

"Buildings" that are able to withstand the vagaries of environmental pressures are constructed on appropriate architectural designs. Chapter 3 informs the reader about the nature of the architectural design upon which this study is constructed. It provides limits to the search for sites by inviting readers to the Manlarla (a sub-group of the Dagaaba), and provides "constractors" for the construction by relying on qualitative-ethnographic techniques (in-depth interviews, participant observations and focus group discussions). The importance and limitations of the study are outlined within the context of Dagaaba socio-ethnography sketched in Chapter 2. In short, Chapter 3 presents the theoretical and methodological frames utilized in the collection and analysis of data.

With these theoretical and methodological frames as anaytical lenses, we now take a "trip" into the religious universe of the Manlarla. In view of the centrality of religion in their conception of life and death, health and illness, and, indeed, utilization of available healthcare services, Chapter 4 "dissects" Manlarla religious life. It indicates the place of the human being in the complex network of relationships (spiritual, natural and social). The relative influence of each set of relationships on health is determined by the extent to which an individual or a group, of which the individual is a member, deviates from harmony (or equilibrium) and gravitates into disharmony (or disequilibrium) and vice versa. In short, the chapter captures Manlarla conception and definition of human being, spells out the agents they believe transmit and/or cause illness and analyzes the practitioners and processes involved in the restoration of health.

Chapter 5 is devoted to an analysis of Manlarla rites of death. In other words, the

chapter reconstructs Manlarla eschatology and attitudes towards death and explains the location of this *mysterium tremendum* by focussing on the symbolic transformations of the deceased, the bereaved and the community. The objective here is to establish that, even though every individual in Manlarla society is subject to the virtues and vices of tradition and custom, ritual participants (widows, widowers, orphans, heirs and family heads) occupy a special place. They are conceptualized as Kpiin noba death people, a conception that not only justifies their location in the network of relationships, but also influences their health seeking behaviour as different from what happened previously. The chapter, therefore, takes the reader on a ritual ride beginning with rites that challenge meanings to life (primary rites of death), through those that restore meaning (secondary rites of death). It analyzes the secondary rites in terms of those rites that inoculate participants against threats of illness (ritual protection) and yet, at the same time, incubate factors (ritual control) that make them more vulnerable to illness and less inclined towards orthodox medicine. In other words, it argues that ritual control inhibits not only the frequency, but also the choice of therapeutic intervention in time of illness.

The inhibiting "sword" of ritual control remains an assertion without empirical and/or statistical data. Chapter 6, therefore, attempts to move the analysis away from assertions to empirical validation by inviting readers to some of the interesting and dynamic patterns of healthcare services utilization. It examines patterns of healthcare services utilization of 60 participants of funeral rites. Starting with pre-rites patterns of utilization, the chapter ends with utilization patterns emerging after participating in these rites (post-rites utilization patterns). The chapter also looks at inter- and intra-gender variations in propensity of utilization. Socio-demographic characteristics such as age, sex, education, religion, and

marital status, identified in Chapter 3, are brought to bear on the analysis. The idea is to determine their influence, if any, on individual utilization propensity. It concludes that Manlarla low utilization propensity for health care services should be analyzed in terms of the incompatibility between PHC implementation principle and strategy, and the local traditional beliefs, values, and customs. Health care resources are not physically unavailable in the society; they are culturally "inaccessible" to majority of potential users.

The researcher believes that sociological investigations like this should bring the social limitations of the health service programme into illumination that will, hopefully, lead to reform in its implementation. If this should occur, then this study will have contributed to the development of a utilization model that integrates local beliefs of disease etiology and healing paths with modern professional medical practice. As such, Chapter 7 is devoted to an interpretation of the data. These interpretations are made against the background of areas of congruence and conflict between the two health care systems. The centrality of sociocultural order in the use of health care services is established. While doing that, it also provides answers to questions arising from the data analysis, especially Chapter 6.

Chapter 8 summarizes the findings of the study and makes some suggestions considered pertinent for the future of PHC in Manlarla society. It examines the implications of the interpretations in Chapter 7 for the PHC programme. For instance, with the outlining of a more comprehensive utilization model (which suggests the importance of tradition and the essential dimensions but often neglected death-related rites), health policy-makers and researchers on intervention studies are drawn to "new" areas in utilization mechanics that have always "called" but not loud enough to capture political and/or professional attention.

## 1.3 Conclusion

In this chapter, we have tried to introduce the subject matter and illustrate the nature of the study. Generally, the magnitude of the problem in Ghana and particularly its dimensions in the UWR were examined. We have tried to provide a framework for answering such questions as: Why does disease remain endemic in the region? What is the effect of this among the Dagaaba? Why are the Dagaaba reluctant to avail themselves to modern healthcare services? Why is the situation more serious with participants of funeral rites than non-participants? In short, we have tried to instil a sociological perspective of the propensity of ritual participants to use healthcare services. A sociological perspective, according to Eitzen and Timmer (1985:6), "focuses on the way in which individual behaviour is influenced, conditioned, shaped, constrained, or determined by their social relationships to other human beings and to a variety of social institutions".

We have also briefly described the methodological orientations of the study. The approach is essentially interpretive and socio-psychological with elements of structural-functionalist and conflict perspectives slipping in at irregular intervals, thus giving it a "grounded theoretical" colouring. In this kind of approach, as Tepperman and Richardson (1991:18) suggest, "people are able to interact socially, while intuiting the meanings that lie behind the other's actions or take the role of the other". The contentions of the study are crystalized around two issues. First, that PHC programme is culturally inaccessible to the Dagaaba (or Manlarla for that matter) in the UWR, and especially inaccessible to the participants of death rites (who constitute a major segment in the region). Second, it is proposed that utilization would improve if local traditions and customs are recognized and accounted for by the programme. Only in this way can we expect the "utilization magic bullet"

to be an effective shot, and the "cycle of socioeconomic impoverishment" of the region to be tracked down.

The existential form of illness and its management among the Dagaaba is dynamic. In other words, life (with all its dimensions) is a process. As a process, dimensions of it are better understood if studied or approached from a dynamic, holistic perspective. Every whole is processed not just anyhow, but according to some leading socially "vital" and culturally "valid" principles (Matthews, 1976, 1983), principles that ensure process "viability", system cohesion and programme sustainability. Processes are thus meaningful only from the general pattern of a functional system and can be correctly understood and scientifically interpreted only in the context of this system. As Berger and Luckmann note:

> Reality is socially defined. But the definitions are always *embodied*, that is, concrete individuals and groups of individuals serve as definers of reality. To understand the state of the socially constructed universe at any given time, or its change over time, one must understand the social organization that permits the definers to do their defining. Put a little crudely, it is essential to keep pushing questions about the historically available conceptualizations of reality from the abstract "What?" to the sociologically concrete "Says who?" (1966:134).

For this reason, it is insightful to begin by defining the leading principles in the dynamic processing of the Dagaaba social system. This is the content of the chapter that follows.

## Endnotes

1. Some of these Committees include the Brachott Committee (1961), the Easmon Committee (1969), the Konotey-Ahulu Committee (1970), the Health Sector Committee (1971), and the PHC Committees of the 1980s. A health planning unit was also created within the Ministry of Health to collaborate with the National Economic Planning Unit for a rational planning of the health care system.

2. In 1970 the Danfa Comprehensive Rural Health and Family Planning Project took off as a joint-project between the Ghana Medical School and the School of Public Health, University of California, Los Angeles with financial aid from USAID. In 1976, the Ministry of Health, with assistance from WHO and UNICEF, established the Brong Ahafo Rural Integrated Development Project at Kintampo.

3. In the Upper West Region, Danish Development Assistance (DANIDA) health projects are under way. On May 30, 1995, for instance, the Danish Minister for Development Cooperation stated in the region that, "I am satisfied with the way and manner DANIDA projects are being executed in the Upper West Region". We only hope that this impression does not turn into a nine-day wonder (a great probability without account of local realities).

4. Sir Gordon Guggisberg was Governor of Ghana (then Gold Coast) between 1923 and 1927. He is upheld in the country's colonial history as the greatest "modernizer", for it was during his term as governor that the country was put on the map of "development" in terms of educational and health infrastructures.

5. The "Northern Territories" (NTs), an umbrella name for what is today known as the Northern, Upper East, and Upper West Regions, was a British Protectorate (1885-1957). The "Colony" referred to areas along the coast of the country where European Forts and Castles were built. However, by the time Guggisberg became Governor of the Gold Coast (1923-1927), the Colony had included Ashanti.

6. Primary health care services are cheaper in terms of fee-for-service; in terms of time as they are available at reasonable travelling distances; and in terms of psychological barriers since the staff of the programme share the same culture, speak the local language and sleep with the people in the communities they work.

# CHAPTER 2

## DAGAABA SOCIAL STRUCTURE AND INSTITUTIONS

*The darkest thing about Africa has always been our ignorance about it.* (G. H.T. Kimble in Tuurey, 1982:16)

### 2.1 Introduction

This chapter presents an overview of the Dagaaba among whom I grew up. It indicates their geographical location, historical background, and provides a preliminary sketch of their social organization. This quick ethnographic survey, far from being comprehensive, is aimed at helping the reader locate and understand the cultural identity of the Dagaaba whose funeral rites and propensity to use health services are the main ingredients of this study. Attention is focused on those aspects of their cultural organization that "manage social crises" and afford opportunity for the promotion of social harmony and the establishment of healthy relations at the interpersonal and group levels. As Kroeger (1983) observes, health should not only be viewed as an individual's search for care, but also a community's concern for and effort to maintain healthy relations.

### 2.2 The Dagaaba: Location, Identity and Language

The Dagaaba on whom this study is focused may be relatively unknown to the outside world but they are numerically the dominant ethnic group in the UWR of Ghana. Yelpaala (1992) estimates them to be slightly over one-half of a million. However, this appears to be a gross underestimation of their actual numerical strength. Constituting 70% (306,606) of the region's population (Ghana, 1987a; McCoy, 1988), the Dagaaba also have between one-

quarter and one-third of this numerical representation located elsewhere in Ghana (Kuwabong, 1990). Census statistics of this category of Dagaaba are normally added to figures of their host regions.

In addition, Dagaaba spread across the border into Burkina Faso, divided only by the Black Volta River. It is estimated that they constitute about 5% (300,000) of the country's population (Benoit et al., 1976). Due to Europeans' arbitrarily imposed demarcations during the Scramble for Africa, these Dagaaba, like most Africans, now have their fate permanently sealed by and destined to different national and political affiliations. The Anglo-French Convention of 14th June, 1898, using the river which runs in a north-south direction, gave off the Dagaaba living west of the river to the French, while those Dagaaba living east of the river became a British Protectorate in January 1902 (McFarland, 1987; Metcalfe, 1965).

Sprinklings of Dagaaba are also found in Cote d'Ivoire (Tuurey, 1982). Whether these pockets of Dagaaba in Cote d'Ivoire migrated from Ghana and/or Burkina Faso or they are indigenous to their present habitat is not established. Equally unclear at the time of data collection, is their numerical strength relative to Cote d'Ivoire's population. However, statistical estimation by an elder of this category of Dagaaba puts them around 100,000. Wherever the Dagaaba may be located in the West African sub-region and in what numbers, there is no doubt that they are particularly concentrated around the intersection of longitude 3 West and latitude 10 North (see Figure 2.1; Goody, 1967) and constitute about a million people.

The territory inhabited by the Dagaaba is typical of the savannah woodland of West Africa, a vegetation belt dominated by tall grasses and short trees interspersed with scattered shrubs which are nowhere more dense than an average "orchard bush" (ibid.:1). This savannah

woodland is well defined by two seasons, the dry season and the wet season. The former, which runs from November to April, is distinguished by a "dust-laden wind", the harmattan, while the latter, characterized by a "thick green blanket of vegetation", runs from May to October. In general, temperatures in the savannah woodland range between 20 and 35 degrees Celsius. Human activities (except crisis times) are tailored to fit into the dictates of the seasonal changes.

Culturally and linguistically, the Dagaaba share in the Mossi-Dagomba (or Mole-Dagomba) cultural traditions (Tuurey, 1982). Their language, Dagaare, is one of the many Mossi-Dagbane languages spoken in the savannah woodland territory of Ghana and beyond. The compound word Mossi-Dagomba is used by ethnologists to denote a large group of Voltaic people (Westermann & Bryan, 1952). They include the Dagomba, Mamprussi, Kusasi, Mossi, Busanse, Bulsa, Nanumba, Gurunni and Dagaaba. The languages spoken by these people belong to the Gur group of the Niger-Congo family of African languages (Greenberg, 1949).

A variety of terms are often used to describe the Dagaaba ethnically. These terms not only sometimes baffle the indigenes, but they also almost always confuse strangers. Terms such as Dagara, Dagarti, LoDagaa, Degabe, Wiile and Dagaba are sometimes used interchangeably with the term Dagaaba. As Bekye (1991) and many others maintain, two factors probably account for this terminological confusion. First is the dialect differences in the common language spoken by the people. Second is the misrepresentations made by early European colonial ethnologists in their efforts to identify and describe the people for their sponsors.

The Dagaaba have three major dialect groups, the Lor dialect group, the Lobr dialect

group, and the Dagaar dialect group (see Figure 2.2). The Lor dialect speakers are located in the twin-towns of Babile and Birifor in Ghana and the towns of Gaoua and Diebougou in Burkina Faso. They call both themselves and their territory Lo and their dialect Lor. The Lobr dialect speakers are concentrated in the north-western corner of Ghana, especially the Hamile and Nandom areas and, like the Lor, across into Burkina Faso, where they are concentrated around Pina. This group of Dagaaba call both themselves and the dialect spoken by them Dagara. The Dagaar dialect speakers, on the other hand, live exclusively in Ghana and are bounded to the north by the Lobr dialect speakers and to the west by the Lor dialect group. They are particularly concentrated in towns like Jirapa, Kaleo, Nadowli and Wa. This group of Dagaaba call themselves Dagaba and their dialect Dagari or Dagatiri (probably a corrupted term from the Akan language of southern Ghana).

Between the Lor and Lobr dialect speakers, on the one hand, and the Dagaar dialect speakers, on the other, terms are coined and used for internal references only. The Dagaar dialect speakers, for instance, call both their Lor and Lobr dialect brothers Loori (a Dagaar dialect approximation of the terms Lor and Lobr) which when pronounced incidentally sounds like Lori (or Lobi) an ethnic group in Burkina Faso. Similarly, the Lor and Lobr dialect speakers call their Dagaar dialect counterparts Degabe (Lor and Lobr dialects approximation of the term Dagaba). In spite of these internal reference terminologies, the three dialect groups recognize they are one people, Dagaaba, with a common language, Dagaare. Given the complexity of this internal relationship, Archbishop Kpiebaya was right when he said that, "one of the main reasons why groups in Dagao (territory of Dagaaba) refer to others as Loori and Degabe is that they hear these groups speaking their language with a completely different accent. They know that they are all Dagaaba, but their dialects differ" (1973:11).

However, European colonial administrators and ethnologists wrongly equated these dialect variations and internal reference terminologies with different ethnic groups. For instance, the British colonial administration (more disposed to the Dagaar dialect group than the other two) understood the Dagaaba society to be inhabited by two distinct ethnic groups, the Lobi and the Dagarti. The term Loori, used by the Dagaar dialect speakers to refer to their counterparts, the Lor and Lobr dialects speakers, was misconstrued by the British colonial administration for a distinct ethnic group. This group was thus identified and, consequently, described as the Lobi, an Anglicized version of the term "Loori" (Labouret, 1931:50).

Similarly, the term Dagatiri, used by the Dagaar dialect speakers in reference to their own dialect, was wrongly conceptualized by the British colonial administration to mean a different language and, therefore, an ethnic group. Accordingly, the Dagaar dialect speakers of Jirapa, Kaleo, Nadowli and Wa areas were identified and described as the Dagarti (Rattray, 1932). Here, the British ignored the internal reference terms Degabe or Dagaba (the people) and rather Anglicized the term Dagatiri (the dialect) which appeared to bear resemblance with such terms as Ashanti and Fanti, ethnic groups with which the British had long established relations. From the analysis, it is most probable G. Tuurey was incorrect in suggesting that the term Dagarti is an Anglicized version of the term Dagaba (Tuurey, 1982:13).

The French, in identifying and describing the Dagaaba, made similar wrong assumptions. Unlike the British, the French were more disposed to the Lor and Lobr dialect groups but, like the British, they divided the Dagaaba into two, Dagara and Degabe. The Dagara (the Lor and Lobr dialect groups) were correctly identified and described by the French but misconstrued for a distinct ethnic group. Similarly, the term Degabe, used by both the Lor and Lobr dialect groups in reference to their Dagaar dialect counterparts, was also

appropriately adopted by the French but wrongly applied to the group as a distinct ethnic group.

In an attempt to disentangle the uses to which the appellatios Lobi and Dagarti have been put, J. Goody added a new dimension to the terminological confusion. Goody conceptualized the Dagaaba as comprising three major linguistic variants, the Wiile, LoDagaa and the Dagaba (1967:3). The Wiile, he explains, is composed of the LoWiil (located in Gaoua) and LoBirifor (located in Babile and Birifor) sub-variants, while the LoDagaa comprises the LoPiel (Nandom and Hamile areas) and the LoSaal (Lawra area). The Dagaba were identified with towns like Jirapa, Kaleo, Nadowli and Wa. Without discussing the details of Goody's error, as it would complicate matters, it suffices to point out that Goody's effort was directed at distinguishing linguistic variants and not disentangling the erroneous ethnic appellations imposed on the people by European colonialists and early ethnologists.

This analysis is not in any way aimed at belittling the value of all that the colonial administrators and early ethnologists and anthropologists have recorded about the Dagaaba. Rather, the analysis is aimed at pointing out that given the internal reference complexities of the Dagaaba, it is not surprising colonial administrators, ethnologists and anthropologists largely ignored, muddled, confused and compromised ethnographic standards. Their identifications and descriptions of the Dagaaba are, therefore, linguistically reasonable but ethnically unrealistic.

In Ghana today, the term Dagarti is wrongly used for both the people and their language, while in Burkina Faso, the expression Dagara is used for both (Der, 1989; Some', 1993; Yabang, 1990). The people in both countries use Dagaaba and Dagaare in reference to themselves and their language respectively. I do not know what the sprinklings of Dagaaba

in Cote d'Ivoire call themselves and their dialect. Nor is it clear what they call the dialects spoken by their "blood" brothers in Ghana and Burkina Faso. What is clear to me, however, is that Tuurey (1982) suggests the Dagaaba in Ghana call their counterparts in Cote d'Ivoire LoNyangala and their dialect Nyangaale (see Figure 2.2).

The importance of this analysis is twofold. First, readers are informed that whether it is Dagaaba, Dagara, Dagarti or even Wiile they come across in the literature, the reference is always to the same people. Second, the analysis helps in the identification of the study site and definition of the population universe. That is, even though the reference term is Dagaaba, implying a totality of the Lor, the Lobr, the Dagaar and possibly the LoNyangala dialect groups, the study is based on the funeral rites and health services utilization of only one of them, the Dagaar dialect group.

## 2.3 The Dagaaba: A Brief History

The difficulty in identification and description of the Dagaaba arising out of the complex internal reference terminologies could be a result of the character of their migration and settlement history. Oral tradition has it that the Dagaaba have not always been at their present territory nor have they always been known as Dagaaba. Different dialect and sub-dialect groups as well as different clans (and interestingly sub-clans) trace their origins to different places.

The history of the Dagaaba is intrinsically linked with the history of those Gur-speaking people, who for centuries, have occupied the vast expanse of land lying between the forest belt and the Upper Niger bend in West Africa (Westermann, 1927). This territory of Gur languages is generally referred to as the Voltaic Region, an appellation derived from the

river Volta, whose three tributaries (the Black, Red and White Voltas) drain its basin (Goody, 1967:2). This basin is occupied by a vast congeries of West African peoples. These include the Birifor, Senufo, Konkomba, Gurma, Gurunsi, Sissala, Vagla, Bobo, Bimoba, Tampulma, Dogon, Gonja, Fulani, Ninisi and the Mossi-Dagomba peoples (Anquandah, 1982:17).

Tracing the history of the Dagaaba, like the history of most African peoples, is fraught with innumerable difficulties. The absence of documentary evidence and late application of archaeological methods to discover Africa's past generally account for these difficulties (Bekye, 1991). In Ghana, however, recent archaeological excavations have produced several paleolithic, neolothic and Iron Age cultural artifacts (Shinnie, 1990). Particularly in northern Ghana, where the Dagaaba are located, a number of sites excavated (see Figure 2.3) by the Volta Basin Research Project suggest that the area must have been settled by the first half of the second millenium B.C. These revealing excavations significantly led to the identification of a sedentary culture code-named the Kintampo culture (after the town of excavations). Bones and teeth of cattle, dwarf goats and sheep were found in excavated places. Carbonized remains of food plants such as cowpeas, hackberry and oil palm were also found in rock shelters (Kense, 1992).

The excavations at Ntereso in particular, produced remains of elephants, hippes and other animals together with implements for hunting such as arrowheads, bone harpoons and bone fish hooks. Evidence of these artifacts thus suggests that these early sedentary agriculturalists and pastorialists also carried out hunting and fishing activities. By radiocarbon techniques, the existence of this Kintampo-culture of farming and pastorialism in Ghana is dated to around the middle part of the second millenium B.C (Anquandah, 1982; Stahl, 1992). This sedentary habitation and pastorialism constitutes a landmark in Ghanaian cultural history.

It pioneered an imagination into life and art in village communities of the past. For instance, the tool-kit of the Kintampo-culture included bifacial ground stone, arrowheads, and microliths, wood working and bush clearing implements such as stone axes and stone hoes (ibid.).

The pottery craft, though pre-dating farming, is found to have been a relatively organized industry in the Kintampo-culture. The products of the industry were simple and comprised wide-mouthed bowls, jars, cooking and waterpots, usually ornamented with combs (Davies, 1969; Flight, 1976). There is sufficient evidence of the diffusion of the Kintampo-culture among the Dagaaba. For instance, while hunting and pottery are still widely practised by the people, farming remains the life-blood of their economy. The farming methods and implements used are still very simple - the hoe, cutlass and axe (hoe-cultivation). As Bekye (1991) observes, a lot of gaps still exist in the history not only of the Dagaaba, but almost all African peoples. These gaps are, however, being bridged by collaborative studies in ethnology, linguistics, anthropology, sociology, archaeology, history and oral traditions. Excavations of the Volta Basin Research Project, for instance, are pushing the frontiers of our historical knowledge backwards, though with difficulties.

But if the reconstruction of the Dagaaba pre-history is difficult, the comprehension of their immediate history is even worse. Four hypotheses of Dagaaba origin are proposed by ethnologists. The ethnologist Rattray suggests that the Dagaaba have their origins in Mali. This Mali-origin hypothesis is often pushed aside as a non-starter in the light of what is processed as recent studies (Bekye, 1991). However, certain material features, speech and terms of the Dagaaba and the Bambara of Mali seem to suggest otherwise. For instance, the most obvious material link of the two people is in the flat-roofed house architecture and the

Xylophone. In terms of speech, the Bambara Ina sogma good morning, and Era sira did you get up? appear to have some resemblance with the Dagaare Ang soma and Eda ira? for good morning and did you get up respectively. Similarly, the Bambara term for witch Souba sounds like the Dagaare term Suoba for same, while shea butter is known as Kaana and Kaang in Bambara and Dagaare respectively. There are probably many more hidden terminological similarities that could come to light if time was taken to examine the two languages with a linguistic bias. Rattray may, therefore, be spared the ethnographic embarassment associated with his supposedly incorrect location of Dagaaba's immediate origin in Mali because these terminological similarities suggest a somewhat ultimate connection of either the two peoples or segments of them.

The ethnologist Tauxier traces the origins of the Dagaaba to Zanga , a Mossi territory in present day Burkina Faso. The basis of this hypothesis is located within the expansionist drive of the Mossi. He suggests that during the Mossi expansion of the 14th century some Mossi, fleeing from Tengkodogo due to famine, settled at Zanga (Tauxier, 1924). For the period these famine driven Mossi stayed at Zanga, they intermarried with the indigenes and produced the Dagaaba. Tauxier argues his point by examining similarities between Dagaare and Mossi. Some Dagaaba, especially the Emuola clan, trace their immediate history to Mossi territory in Burkina Faso. But using the historical origins of one clan to argue for all clans is faulty. Besides, the Emuola are believed to have migrated from Mogho (Tuurey, 1982:42) and not Zanga as Tauxier suggests. Similarly, locating Dagaaba immediate history in Mossi territory on the basis of language similarity is equally faulty. The proximity of the two languages, for instance, is explained by the fact of the common proto-language, Mossi-Dagbane, that they share (Bekye, 1991).

A third hypothesis, and by far the most popular, is the Dagomba-origin hypothesis proposed by ethnologists Hebert and Delafosse among others. This group of ethnologists traces Dagaaba origin to Dagbon (the territory of Dagomba) in present day Northern Region of Ghana (see Figure 2.3). Hebert's conclusions, for instance, are the result of an extensive ethnographic survey of the Dagaaba in Ghana and Burkina Faso. Conducting in-depth interviews among Dagaaba elders, Hebert reports that "leur reponse est mette; ils tirent leur origine des Dagomba, dont ils seraient une branche dissidente..." (1979:26). Gabriel Tuurey, a Dagao, educationist and historian, gives an elaborate analysis of the Dagomba-origin hypothesis.

According to him, the Mole-speaking Dagomba were a loosely organized group of people without a centralized political structure. However, towards the beginning of the 15th century, a "conquering band of strangers" imposed themselves upon these loosely organized people and founded the Dagomba Kingdom. These conquering bands of strangers reportedly descended from Tohajie, the Red Hunter, who left his Zamfara home state in present day northern Nigeria for a location in Gruma in today's Burkina Faso. Tohajie's grandson, Gbewa, apparently left Gruma for Pusiga (near Bawku) in the UER of Ghana (see Figure 2.3). While in Pusiga, Gbewa produced eight sons one of whom, Sitobo, imposed himself on the Mole-speaking people and founded the Dagomba Kingdom (Tuurey, 1982:26-29).

Tuurey's account of Sitobo's imposition seems to have collaborated an earlier report by J. Anquandah who accordingly reported that:

> The Mossi state-forming dynasties met older indigenous people north of the Volta Confluence - the Fulse, Ninisi, Kipirsi, Kassena, Nanumba, Konkomba, and the Mole-Dagomba who, lacking centralised political institutions, had evolved non-feudal and highly democratic forms of political organisations, led by shrine priests. In some cases, the immigrants absorbed the indigenes as

> lower classes of their political systems, but in other cases, they persecuted them thus compelling some of them to emigrate eastward and northward (1982:80).

Tuurey's account did mention persecutions under one of the Dagomba Kings, Na Nyagse, (1476-1492). Under Na Nyagse a problem arose in connection with ownership of land. The indigenous Mole-speaking Dagomba insisted the land belonged to them by virtue of first occupation, while the self-imposed overlords claimed ownership of the land by virtue of conquest. This controversy led to an armed conflict which ended in a brutal massacre of the local Dagomba; a massacre described by most historians as the "bloodiest and most phenomenal ever witnessed in the area" (Tuurey, 1982:30). Undoubtedly, the repercussions of such a carnage would have been great. Consequently, a sizeable number of local Dagomba, who could neither support an unjust foreign usurpation of their land nor withstand the tyrannical and obnoxious rule of Na Nyagse, decided to break away and to look for new lands where they could enjoy their political liberty.

Departing from Dagbon, this heterogeneous blend of several clans moved westward towards Daboya. From Daboya the group of defeated rebels split into two. One group continued westward in the direction of Bole (see Figure 2.3), while the second group turned northward towards the Fumbusi-Kundugu areas. Each group further divided up as they moved from one temporary settlement to the other. Finally, survivors of the groups converged at an open space of land that laid stretching from the Kulpawn valley to the east of the Sissala people to the Lobi settlements along the Black Volta in the west (Goody, 1954).

These break-away Dagomba elements, referred to as Dagban-Sabli (Black Dagomba as translated by Tuurey) by their more docile kinsmen left behind in Dagbon, had finally found a permanent settlement. The word Sabli, however, has multiple meanings including black and

hide. Under the circumstances, it appears to me, Sabli aptly describes a situation of hiding rather than a distinction of colour. Therefore, Dagban-Sabli should translate "Hidden-Dagomba" (those Dagomba who went into hiding) and not Black-Dagomba as translated by Tuurey. Tuurey reports that this new group, which settled closer to the Lobi than the Sissala, covered an expanse of land "from Nandaw-Wala and Han in the east to Charikpong in the west, and from Yipaala in the south to beyond Hamile in the north" (Tuurey, 1982:36). If the rebellious movement of the break-away Dagomba elements coincided with the rule of Na Nyagse (1476-1492), as we are inclined to believe, then the first settlement was effectively occupied some time before 1500.

The more acquiescent kinsmen call their break away brothers Dagban-sabli probably as an expression of anger, but the "break-aways" refer to themselves as Dagaaba. The appellation Dagaaba (singular, Dagao) etymologically is believed by some people to describe the rebellious nature of the break away from Dagbon. As such, explanations have been offered in an attempt to link its origin to the break away. Der (1989), for instance, gives the etymology of Dagara as coming from the words Da and Gar which together mean "gone wild"; and that this was used by the Dagomba to refer to the break-away group as "a people who had gone wild". Indeed, Da gar means gone wild in Dagaare. But my study of Dagbane and consultations with linguistic experts of Dagbane suggest the non-existence of any combined terminology like Da gar. Da does exist in the language of the Dagomba but no word like Gar exists. And if Der insists that this term was coined by the Dagomba to refer to their break-away brothers, then he must be refering to a different group of Dagomba.

Similarly, Bekye (1991) associates the etymology of Dagaaba with rebellion. He explains that if Dao or Deb stands for man, and Gara means rebel, then, Dao-gara or Deb-

gara would mean "man rebel". Derivatively, the name Dagaaba could reasonably be rendered "rebellious man". By this, Bekye implies the break-away group coined the term in reference to themselves. The language of the people at the time of the break-away from Dagbon was Dagbane and not Dagaare. But Deb and Dao are Dagaare and not Dagbane terms. Bekye's conclusion is, therefore, untenable unless otherwise proven that the people developed a la..guage (Dagaare) immediately after the break-away.

On the contrary, others present a non-rebellious etymology of the term Dagaaba. For Baeka (1980), the term Dagara comes from the terms Da and Gara which he translates to mean "to buy a horse saddle". He then suggests that the name Dagaaba was given by the Dagomba to a Mossi prince (and his descendants) who had come to Da buy Gara a horse saddle (Baeka, 1980:21). But as Saanchi (1992) suggests, if Baeka's translation of Gara is wrong, then the basis of his arguments must be unacceptable. Da does mean to buy; however, Gara refers to the gadget used to hobble a horse, and not "horse saddle" as Baeka translates.

Tuurey (1982) thinks that the name Dagaaba is simply a corruption from the terms Dagbane the language and Dagomba the people from whom the Dagaaba broke away. Taking Tuurey's argument further, Saanchi (1992) suggests that if the Dagomba-origin hypothesis is acceptable (though it is by no means conclusive), then the word Dagaaba could even be a simplification of Dagbamba the original name for Dagomba. That both Dagaaba and Dagbamba have the plural person marker ba; and various languages of the Oti-Volta (Mossi-Dagbane) group use gb in some words where others of the same language group use g. He therefore argued that Dagaare could have developed through a combination of the g/gb alternation and the process of rhotacism whereby the n in Dagbane was converted to r and the n from Dagbana (person from Dagbon) was also converted to r thus giving us Dagaare

and Dagara. Saanchi's conclusion appears to lend support to an early Islamic/Hausa record of the people. But the question that remains unanswered is who engaged in these processes of alternation and rhotacism (the Dagomba, the Lobi, the Dagaaba, or the academics?). Saanchi's beautiful analysis is, however, silent on this.

According to some Etuolo elders from Nyimbale (one of the first Mole-Dagbane speaking settlements in Dagao), the appellation Dagaaba must have originated from the Lobi terms Da and Gaar. Da in Lobi language means either "roam" or "push", and Gaar means either "wild" or "ahead". Thus, the compound term Da gaar could either be translated as "push ahead" or "roam wildly". Assuming we are right about the Dagaaba break-away and their subsequent movement into the Lobi territory, then it is possible that the former must have met the latter in a manner characteristic of wanderers. Be that as it may, the Lobi felt compelled not only to maintain their distance, as they did, but also to describe this bunch of wanderers as Da-gaar (wild roamers).

After the wandering search for land had progressed into permanent settlements with a unique language, the Dagomba word Ba meaning "We" (Greenberg, 1966) was introduced to convert the purely Lobi appellation, Da gaar, into a Lobi-Dagomba term Da gaar ba, thereby, sealing it as an ethnic group. The compound term Da-gaa-ba, therefore, implies either "we who roamed" (with a sense of wandering search) or "we who pushed ahead" (as evidenced in the involuntary departure of the Lobi from their original settlements in present day Ghana). This probably may explain why those Dagaaba, who later migrated across the Black Volta river into Burkina Faso, call themselves Dagara. Living in the midst of the Lobi, these "migrant" Dagaaba lost their Dagbane term Ba completely to the Lobi descriptive term Da gaar.

This etymological path appears to fit into some of the dimensions characterizing the Dagaaba break-away from Dagbon. First, they broke away in protest of an unjust system. Leaving one's known and loved environment for reasons that have nothing to do with one's personality deficiencies is sufficient justification for one to appear "wild". Second, the Dagaaba search for "new lands" where they could enjoy their political liberty without fear of domination from another political tyrant was probably long and tiring and possibly, for the most part, without food. It is quite natural that in the seemingly unending search for these new lands, some of the break-away Dagomba appeared lost and haggard and, therefore, appeared in the imagination of their hosts, the Lobi, as a bunch of "wild roamers". Third, records indicate that the break-away Dagomba elements met two indigenous groups of people, the Lobi and the Sissala. It is also on record that they settled closer to the Lobi than the Sissala. Given this background analysis, it appears reasonable to conclude that the Lobi were more likely than the Sissala to interact with these new settlers on daily basis. Under the circumstances, the Lobi were reasonably disposed to coin a reference appellation, as they did, for the break-away Dagomba.

The Accra-Dagomba-origin hypothesis is yet another dimension. Hebert reports that his interviews with Dagaaba elders also suggest some clan groups might have come from around Accra and along the coast of Ghana. Linking this hypothesis to the Dagomba-origin hypothesis, it appeared these clan groups turned southward in their first movement, sojourned in and around Accra and along the coast to Cape Coast (Oguaa or Goi) for several decades before turning northward again apparently fleeing from "the men with guns", possibly slave raiders (Bekye, 1991). Leaving in organized clans at dark and in a deceitful manner, these Dagaaba eventually re-joined their brothers who had preceded them to Dagao.

As Bekye (1991) rightly pointed out, a lot of questions about each of these hypotheses remain unanswered. For instance, evidence concerning the sojourn in and around Accra and along the coast is provided by Dagaaba oral tradition. And a close examination of the old architecture of Elmina also suggests a possible affinity with the Lobi/Dagaaba architecture. This notwithstanding, independent evidence is still required about the history of the coastal peoples before the hypothesis can be tested. Such an endeavour is beyond the scope of the present study. In the face of all these uncertainties about Dagaaba origins, however, we are certain about one thing. Oral tradition appears unanimous on the Dagomba-origin hypothesis.

The discussion of Dagaaba history and origin cannot be concluded without a mention of other groups of people who, though Dagaaba, do not trace their origin to Dagbon. The Muslem communities of Wa are reportedly descendants of Mandingo and Hausa traders. Their ancestors left their homelands in Mali and Hausaland in northern Nigeria in search of booming markets where they could do trade. These people may have preceded the Dagomba elements for they had settled by the first decade of the 14th century (Dougah, 1962). However, they were not many enough to effect any change in the ethnic composition of the area.

Another group of non-Dagomba Dagaaba are the Guombo, Esuolo, Monyarla and Emuola. The Guombo trace their origins to Komkomba territory in north-eastern Ghana, the Monyarla to Kong in Gonja territory in northern Ghana, while the Esuolo trace their origin to Zini in the Sisaala district of Tumu in the UWR of Ghana. The last group is the Emuola who trace their origin to Mogho in Mossi territory in Burkina Faso. For various reasons, these groups of people migrated to what is known today as the UWR and quickly integrated themselves among the Mossi-Dagomba elements who were already there. They have since

fully "nationalized" among the Mole-speaking Dagomba, and together they are the Dagaaba of today. Gabriel Tuurey illustrates this point in the following observation:

> All those people who are native speakers of N ye ya meaning "I say", belong to the Mole-speaking community no matter whether they are Wala, Manlarla, Sonuona, Mantare, Namane, Guombo, Monyarla, Dorimbo, Wechage, Bulenge, Mankure, Samune, Lissala, Gbare, Jirabala, Tizzala, Dongmine, Tuopare, Zimuopare, etc and their being Mole-speaking necessarily makes them also Dagaaba ethnically (1982:14).

## 2.4 The Dagaaba Social Organization

Phenomenal social and cultural changes have occurred in traditional Ghanaian societies as a result of contact with the West since 1472. They have become melting pots of unprecedented processes of cultural interaction and social evolution. This notwithstanding, many of these societies still maintain their forms of social organization and cultural identities. They have conserved, sometimes relatively intact, their social and economic systems, political and religious institutions and a lot more of their ritual beliefs and customary practices than is often imagined (Bekye, 1991:110). The Dagaaba, as one such group of people, have maintained much of their traditional social structures, beliefs and customary practices.

According to Durkheim (1951), social structures and practices or "social facts" are those orderly, patterned and enduring relationships that hold between elements of a society. They are orderly formations that exist in their own right, *sui generis*. That is, they are objective, external and unavailable for change at the will or caprice of particular individuals in society. Consequently, these structures occupy a supreme position in their constraining or coercive impact on social behaviour as well as on individual conduct. Social structures and all that they entail are, therefore, those peculiar realms of phenomena that are utterly intangible and yet real in their regulatory influence of social and individual actions.

The maintenance of these structures, institutions and practices, Dagaaba elders say, "is for the welfare of the community as well as for the well-being of the individual". For this reason, a logical starting point of viewing the Dagaaba social organization would be an examination of the concept of the individual in Dagaaba society. The individual shall be examined in the processes of statuses - jural, political and social - at various levels and contexts and we will show how these spin out the complex social threads that provide the texture of kinship relations in Dagaaba society.

### 2.4.1 The Individual in Dagaaba Society

A person's genealogical ties are fixed by his or her parentage. The nature and character of the set of rights and duties which define an individual's statuses and roles in society arise from the fact of birth as a social rather than as a biological event. S/he can neither divest herself or himself from, nor be divested of, the social bonds created by her or his birth and yet remain a member of society. Nor can the individual fully and unconditionally acquire these bonds except by birth and through a socially recognized marriage. No ties exist among the Dagaaba that wholly supercede them in structuring the character of interpersonal relations and in defining the pattern of affiliations of individuals to defined social groups (Boman-I: In Press).

A person acquires significant social ties through both parents. However, agnatic relationship, especially for a man, has tremendous structural import. Patrilineal descent is not only the "vertebral principle" of Dagaaba social organization, but also the institutional mechanism that ensures the continuity and stability of the social system. For this reason, men in Dagao tend to hold the reins of authority, direct economic life, control political

organization and feature prominently in ceremonial engagements. Respondents were unanimous that, "from the father, a Dagadao (male Dagao) acquires clan membership and the set of rights and obligations arising therefrom". For instance, he acquires a quantum of rights to inherit certain categories of property, to succeed to certain offices and to assume certain statuses that are all ritual and social in character. At the same time, he assumes responsibility for obligations associated with such status metamorphosis. No structural or institutional provision exists among the Dagaaba which permits the woman to inherit or transmit property or succeed to and transmit offices of a ritual or political sort. However, clan membership and the concomitant totemic observances, together with her ritual allegiance to her ancestors, create a pattern of relationship of considerable significance for the woman and her offspring (Boman-I: In Press)

From the discussion, it is clear that in Dagao the individual does not and cannot exist alone except corporately. His or her existence is dependent on other people (contemporaries and past generations). As Mbiti (1969:106) notes, "the individual is simply part of the whole"; and as such, the "community must make, create and produce the individual" for the corporate group. Dagaaba society is, therefore, characterized by personal progress rather than abstract progress of society. That is to say, society is perceived as a constant entity within and through which the individual grows progressively as s/he reaches successive stages of life. A similar view was expressed by one informant when he said, "...just as God created us (human beings) physically, so must we create the individual socially for corporate living". To do this implies taking the individual through "rites of incorporation" (van Gennep, 1960) so that the individual becomes fully integrated into the entire society. These rites continue throughout an individual's life time and may even continue after death depending upon his or her achieved

status at the time of death.

Progressive aging, social achievement, ritual participation and increased responsibility towards society are all signals of stages in an individual's progress and status enhancement. Old age, for instance, is associated with high ranking social status, respect and prestige. Dagaaba believe that an individual's wisdom, participation in (or authority) and responsibility towards society (or decision-making power) grow progressively with aging and increasing life experience. These norms constitute a common knowledge available to, and known by every member of the society. Through socialization, the individual in Dagao has clear idea of what would be considered an offense, a breach of norms and taboos. Each of these "deviations" is considered anti-custom, an abomination that endangers the well-being of the corporate group as a whole.

The simple, unpretentious clarity of these "conventions" is a fundamental nurturing principle and a cardinal point in understanding how the Dagaaba view human life. The institution within which nurturance is provided for the individual and which serves as the growing point for the development of kinship and lineage systems of the Dagaaba is the family. But the family emerges out of the institution of marriage. Through marriage the individual is born and through marriage s/he becomes a responsible adult. This view is by no means unique to the Dagaaba. As Maquet echoed, "in the African continent, to be an adult is above all to be married, to be a mother or father; if bachelors exist in African societies, their situation is not a normal, expected social role" (1972:67). What, then, constitutes marriage and where is its place among the Dagaaba?

### 2.4.2 Marriage Among the Dagaaba

Marriage is understood as a union geared towards the procreation and rearing of children, and for the provision of associated reciprocal domestic services. Thus, families are established only through heterosexual marriage. "The elementary family is established through marriage; polygyny creates a number of elementary families centred on one man. Marriage being virilocal, a woman has to leave her own father's house and join the compound of her father-in-law; henceforth she lives apart from the main body of her agnatic kin" (Goody, 1967:48).

The importance of marriage in Dagaaba society cannot be overemphasized. It assures both continuity of life and cohesion of the social group (Dery, 1987; Kpiebaya, 1986). To marry is to enter into the service of life to which each normal person is called. Marriage is a social obligation, a factor of individual and collective survival and a sign of moral and social equilibrium (Kuukure, 1985:29). A female respondent emphasized that, "a healthy male or female adult who remains unmarried in Dagao becomes an object of shame, pity and derision". For instance, "to die without a child", another informant added, "is almost a curse". And worse still, an unmarried individual deserves no elaborate funeral, the "ticket of passage to the ancestors" or the symbolic thread of conquest over death (Anleumwine, 1981; Bekye, 1991; Kuukure, 1985; Mbiti, 1969). From this, it appears reasonable to contend that the community-life, which is generated and sustained through marriage, is stretched into the "life" of hereafter. As such, marriage among the Dagaaba is not just an obligation but also a sacred undertaking which must neither be abused nor despised.

In addition to guaranteeing better life chances, continuity, prestige and power (arising from having many children) for family groups, marriage also establishes streams of reciprocal

relationships between two families, two lineages and two clans. The rule of clan exogamy sets in motion a series of kinship ties between members of two patriclans. As one respondent, Ningkpeng-Nuori of Bayaoyiri stressed, "marriage is always a family and lineage affair; but it is also sometimes a Baloo clan matter". Presumably, this is because marriage brings not only families and lineages, but also clans in close systems of interests and solidarity. In Dagaaba society, therefore, the social dimension of marriage and not the individual dimension is often emphasized. "Marriage in Dagao is a social affair and not a private enterprise" (Kpiebaya, 1986:3).

Contracting a valid or a socially recognized marriage is, therefore, a corporate concern involving not only the bride and the groom, but their kinsfolk as well. Elders of the boy, after consultations with a diviner and sometimes after required sacrifices, give their "placet" to the courtship, make necessary negotiations, and arrange for the marriage "payments", bride-price (Kuukure, 1985). Similarly, elders of the girl consult a diviner, make sacrifices, entertain the courtship, engage in renegotiations and accept the bride-price. The bride-price is the sign, guarantee and witness of the marriage. This "marriage gift", as Mbiti (1969) insists it should be visualized and called, is an important and complex institution among the Dagaaba.

On the one hand, "the marriage gift is a token of gratitude to the bride's family group for the gesture of allowing one of them to be married by the groom's family group", one female respondent explains. On the other hand, another suggests, "it is a symbolic compensation or indemnity for the 'loss' sustained by the bride's family group by her marriage to the groom's family group". However, for the bride and the groom, the gift legalizes their marriage contract and defines their rights to the reciprocal domestic services. The gift extends clan rights to the bride and elevates her both as a person and as a wife, while the

groom is reminded of his responsibilities to both his wife and agnatic kinship group.

As a rule, part of this gift must be used to acquire sacrificial materials for the ancestors and gods. The objective here, the people maintain, is to invoke spiritual blessings for the marriage and continuous protection for the woman, the rights over whom are being vested in another lineage as a whole (in its dead and living members). An abrogation of these rights either wilfully (adultery and divorce) or unwilfully (death) has to be expatiated by rites such as sacrifice at the ancestor altars and sometimes lineage gods.

It is the duty of the head of the family to provide the marriage gift for a man's first marriage (Kpiebaya, 1986). One respondent, for instance, revealed that, "marriage gifts arising from his two subsequent marriages became his sole responsibility". In one of those instances, he was assisted by his maternal uncles as he could not provide the gift from his own reserves. Monogamous marriage thus appears to be the general rule and common right of the Dagaaba, while polygynous marriage is accepted and widely practised as a mark of "wealth", but also out of necessity as in levirate (or widow inheritance).

Most respondents expressed that levirate is one of the reasons for polygyny in Dagao. Consistent with the social nature of marriage, a dead man's widow(s) must be inherited by either his brother(s) or nearest of kin in the patrilineage, unless the widow(s) decide(s) otherwise. With this kind of marriage, no gifts are required since rights over the woman would have been transferred to the man's lineage as a whole with the first marriage gifts. Nevertheless, some rites have to be performed to ensure the first husband (now dead) does not interfere unnecessarily with the new marital relationship. In this regard, levirate does not only appear to reinforce agnatic ties, but it also serves as an insurance mechanism for the integration of the woman following the psychic tensions and social rupture sustainable upon

the death of her husband.

Marriage is not only a responsibility for everyone in Dagao, it is also a religious duty. As described earlier, the choosing of a partner, preparations for marriage, marriage itself and the presentation of marriage gifts are all masked with religious expressions. Similarly, procreation, divorce, death and widow inheritance are all regarded and experienced as religious dimensions of social life. Marriage is, therefore, a sacred drama that results in the establishment of a family, and "no normal person may keep away from this dynamic scene of (social) action" (Mbiti, 1969:148). The predominance of the social-spiritual dimension of marriage in Dagao, Kuukure (1985) observes, puts brakes on any headlong rush to define the family. What is the family and how do the Dagaaba conceptualize it? In what ways does its conception relate to issues of health and health seeking?

### 2.4.3 The Family and Kinship System

Like most African peoples, the family among the Dagaaba has a much wider circle of members than implied in the West. The family in Dagao has three Kpankpama"wings". The first wing is composed of living members and may include such categories of people as parents and grandparents, uncles and aunts, brothers and sisters and their children, as well as other close relatives. The second wing refers to those recently departed relatives designated by Mbiti (1969) as the "living-dead". This wing of the family is physically remote and yet spiritually near not only because it remains alive in the memories of surviving family members, but also because of the belief that it has tremendous interest and influence in family affairs. Thus, the living-dead "solidify and mystically bind together the whole family" (Mbiti, 1969:104). The third wing of the family in Dagao comprises the unborn members who "are

still in the loins of the living" and constitute the "buds of hope and expectation for family continuity" (ibid.:105).

The family in Dagao is generally virilocal with built-in polygynous tendencies. It is the matrix of all the structural ties of the individual. As Kaleo-Naa explained to me during data collection, the family "is the institutional mechanism for furnishing new threads of kinship among Dagaaba". In other words, it is the focal field of social relations based on the principle of consanguinity. The workings of the patterns of kinship and the formation of the ideas and values which shape attitudes and mould behaviour of individuals in all their kin-based relationships, occur in the context of the family. The family, under the "authority" of its "heads", therefore, provides the context for interaction between ramifying cognitic kinship and the more narrowly focused agnatic ties.

These ties, at the minimal and elementary levels, include those cognatic kinship ties which link parent to child and sibling to sibling, and those ties, agnatic in character, which set apart the males as instruments for continuing the lineage system (Boman-I: In Press). Through his or her primary relations of consanguinity in the domestic family, the individual acquires and sustains links with agnates of his or her clan in other families. Within this setting, the structure of relationship is double sided, each relationship containing within it both agnatic and cognatic components (Kuukure, 1985) with varying implications for health and health seeking.

In a joint or extended family of three generational structure, for example, the relationship among members of adjacent, alternate and identical generations differ according to stipulated rules and norms. These rules and norms which define the process and pattern of interaction are rooted in the principles of social structure and are crucial for the maintenance

of social cohesion and well-being. Grandfather, father and son are agnatic kinsmen and belong together in the same lineage. They are united by a common interest to ensure the continuity of the lineage by the performance of those rites which not only guarantee survival and social well-being, but also promote harmony. Thus, rules of behaviour, patterns of relationship, structure of rights and duties deriving from agnatic and cognatic relationships form part of a complex whole of common interests. These common interests, this writer observed, serve to mobilize corporate action and maintain corporate identity and solidarity in the event of disruptive threats (illness and/or death).

Although the principle of Babiilong patriliny is overwhelmingly dominant in structuring the jural, social, economic, political and ritual constitution of the Dagaaba, one respondent noted that, Mabiilong maternal origin or matriliny and the tie acquired therefrom are also crucial in social organization. The nature and quality of the bonds between mother's brothers and sister's son are of special sociological significance. He explained that, "an individual's maternal uncle and maternal grandfather as well as other members of their immediate lineage play roles which impinge directly and frequently on his/her life". For instance, a wide range of resources, both material and affectional, are provided from which s/he can draw in time of need. Her/his maternal uncle's home is the second home into which s/he can withdraw during crisis periods in her or his life, including illness episodes. S/he has no property, succession or inheritance rights in the matriclan. Nevertheless, these special maternal privileges s/he enjoys there at once equates her/him with a daughter/son in sentiment but differentiates her/him from one in jural terms. Social recognition of the matrilinial line thus gives rise to a set of uterine ties between mother and child as well as Mabiiri mother's children complementary to the agnatic bond between father and child and Babiiri father's children.

The analysis of marriage and the structure of the family and kinship system of the Dagaaba makes clear the operation of a number of structural principles which give meaning and pattern to social behaviour. For instance, as indicated above centrifugal forces associated with matriliny and related uterine ties counter-balance the otherwise overwhelming centripetal ties associated with patrliny. But Dagaaba marriage and family structures alone do not exhaust all the social and institutional arrangements that have relevance for this study. Other aspects of their society that have demonstrated relevance for the study include the economic structure, the political organization and, above all, the religious experience. As one family head and catechist said, "we (Dagaaba) believe in the existence of a self-sufficient 'Being' who is responsible for the creation and/or sustenance of heaven and earth, man and woman, the natural and social life". This religious orientation of the society obliterates any division between the sacred and the profane. Every vital social, economic and political activity of the people has a sacred aspect. Undoubtedly, therefore, the Dagaaba world view, which provides basis for their cultural configuration, is not only essentially religious but also very central to this study. In view of its centrality to this study, the Dagaaba religious experience (cosmology) is tackled in a separate chapter. However, their economic structure and political organization are addressed in the pages that follow.

## 2.5 The Society: Its Economic Structure

The features of Dagaaba society are an expression of the general characteristics of a peasant economy - a complex articulation of both subsistence and commodity modes of production. Peasant societies are "part societies"; reciprocally developing and sustaining economic, political, social and cultural links with wider and more complex social systems. The

current Dagaaba economic life evolved out of an interplay between the forces of tradition, more concerned with insuring the social security and survival of the group, and the forces of innovation and change, arising from the more differentiated and complex wider social mileaux.

The trends and patterns of economic development with implications for health in the society are observable in the following response processes:

> A response to the need for adequate food security, especially in an ecological zone "where seasonal hunger is quite wide spread and regular in occurrence, a function of the conjunction of hunger-producing circumstances: low and unreliable rainfall, pockets of high population density and a heavy dependence on cereal cultivation without irrigation" (Hunter, 1967:167-168); and
>
> A response for cash to enhance purchasing power in a situation where the cash nexus is assuming an increasing role in the processes of social and economic transactions (Boman-I: In Press).

The dominant method of cultivation, adopted in part response to the new demands of the society and in part adjustment to factor availability in the peasant economy of the Dagaaba, is rotational bush-fallow. This cropping arrangement is used for growing cereals (maize, rice, sorghum and millet), legumes (beans, bambara-beans and groundnuts), tubers (yams and sweet potato) and vegetables (pumpkins, okra and peppers) for home consumption. The tenancy periods, according to personal experience, are long, varying between 4 - 6 years and entail careful farm husbandary in crop rotations, elaborate crop mixtures and a careful system of crop succession to ensure adequate yields. These food crops are supplemented with meat from chicken, guinea fowls, goats, sheep, pigs and cattle. Fishing in rivers, ponds and streams, and hunting down of game add more to the protein content of the people's diet (Tuurey, 1982:20).

In an economy where labour power is abundant relative to other factors especially land; where soils are relatively infertile and fragile and where moisture, supplied mainly through rainfall, is inadequate, the scheme of crop rotations ensure that demands on the soils are varied from one year to another with the types of crops sown. Similarly, crop mixtures, growing several crops on the same plot and in the same season, ensures a high density of plants and an economy of weed control. Successions or the planting of crops one after another during the same season - beans and maize, followed later by either a crop of guinea corn or millet - spread labour requirements and help to ensure a more regular and varied flow of foodstuffs by staggering the harvest (Boman-I: In Press). Under such cropping arrangements, usufructuary rights as against land tenure rights tend to be more crucial and are, therefore, more clearly defined. Thus, the individual, Kaleo-Naa explained, "while retaining some loose property relationship in communally owned land as a spatial dimension of the corporate group of which he is a member, tends to define and assert with more vigour, rights to crops raised on such corporate land".

The researcher was also told that in communities where land occupancy ratios are higher, fallow periods tend to be shorter, yields are lower and claims on individual plots more sharply pursued. This situation provides three kinds of effects in the society. At the level of domestic family, whose structure and size find expression in the character and pattern of residence, a tendency to early and perhaps premature fissioning is occurring, making lax, those jural, economic and affective bonds (springing from factors of kinship and marriage) that impose specific obligations on members. This development is in response to the need for adequate food supplies for the sustenance of the group (minimally defined) and also the need for a surplus, over and above subsistence needs, for exchange transactions.

Another effect observed by the researcher is a short-term cyclical migration whereby middle-aged men and women leave at the onset of the agricultural season to establish farms in relatively wetter, sparser and more fertile parts of the country, and to return home during the dry season after the harvest. The third effect observed is somewhat long-term. Here, young able-bodied men with high aspirations migrate to the southern part of the country which is relatively more developed than the northern part. But due to low educational attainments by these migrants, as indicated in Chapter 1, they often lack the skills and expertise required for good jobs. Thus, most of them work in the mines as underground labourers, the health consequences of which are devastating not only to the miners themselves but also to their dependants.

The structural effects of these short-term cyclical and long-term migratory phenomena and the precipitant fissioning process are manifest in the material, cultural and ritual life of the people. These manifestations, in some respects, tend to enhance and promote health, while, in other respects, they undermine health among the people. For example, the migration, especially of the more elderly siblings, means that the adjacent older generation assumes the primary responsibility of provisioning for the rest of the dependent members within the domestic family at the time when that generation (if alive) is incapacitated by age and senility. Work, which is irregular and unsystematic within this group, is confined to the .ired soils in the close vicinity of the village. Consequently, it is unrewarding as harvest lasts for shorter periods and consists of the least nutritious cereals.

To compound matters, family members working as underground miners and supplementing poor harvests with "hot cash" die in epidemic proportions, sometimes as a result of noncontractual mining activities, but mostly due to the undeveloped nature of the

mines, and the toxic chemicals produced and inhaled by the miners. Smith (1981:129) observed that respiratory hazards were highly grave in non-gassy mines where ventilation was poorest. Similarly, the physical quality of the mines leaves an indelible impression on the lives of many miners. For instance, while I was home gathering data for this study, a shaft in Obuasi collapsed and killed 31 people, 25 of whom were Dagaaba. Besides, countless numbers become incapacitated in their economic and social productive life as a result of other occupational hazards. As Krahn and Lowe observe:

> ...the breathing of polluted air, the contact with cancer producing materials, dangerous machinery and equipment, unsafe work sites and extremely hot, cold, damp or noisy work environments, have historically taken their toll on workers in terms of decreased life expectancies and increasing rates of illness and injuries (1993:277).

As Marx lamented, "such modes of production ...not only produce the deterioration of human labour power by robbing... its normal moral and physical conditions of development and function, but they also produce the premature exhaustion and death of this labour power itself" (1967:265).

The net effect of these multiple factors is the production of a veritable spectre of hunger in affected families where both malnutrition and undernutrition are rife. This situation is further exacerbated when part of these smaller harvests is sold to generate and sustain purchasing power, or channelled into the celebration of funerals of premature deaths. The incidence and severity of disease tend to be higher among people from such families and therefore the need for health services are greater for such people. But as the conceptual framework (see Figure 3.1) seeks to project, the processes of early fissioning, short-term cyclical and increasing long-term migration, and funeral observances are all adaptive responses to structural forces, especially economic. These structural forces impinge on and

threaten to play havoc with those institutions of the Dagaaba that serve as social insurance mechanisms for the maintenance of harmony and the promotion of social integration and health at the individual and societal levels.

## 2.6 The Society: Its Political Organization

Many African societies have been ruled by monarchs, chiefs or kings. Their authority was neither absolute nor despotic. Totalitarian rule is not an African traditional phenomenon. The Kings, though monarchs by right of descent, could be deposed or could abdicate. They ruled with councils of elders who counter-balanced the possibility of emerging despotic tendencies (Ladouceur, 1979). If found to be abusive of their powers, the Kings were forced into performing rites that cut them off from ancestral forces and protection. For instance, in Ashanti a King was destooled by either whipping off his shoes or making him sit on the ground (so that he came into forbidden contact with the sacred power of the earth), or his body was mutilated (Busia, 1951). This style of government takes one of six forms. These are described by Murdock as Gentile, Aristocracy, Berber Republic, Gada Republic, Oriental Despotism, and African Despotism (Murdock, 1959:33).

But many other African societies are more loosely oganized. They either have no tribal ruler at all or may have one only as a figure of convenience. Examples from the latter include such figure-heads as Yidaamba clan elders and Tendaamba earth-priests who perform ritual functions on behalf of the community. This form of government is described by Murdock as Primitive Democracy, "the first and simplest, as well as the most widespread type of political system found in Africa" (Kuukure, 1985:36). However, sometimes chiefs were imposed on such groups for the convenience of imperial rule. Under colonial regime, these "acephalous"

people were erroneously assumed by arrogant and uninformed Europeans with a colonializing agenda to be living in "ordered anarchy" without chiefs. "So a direct centralized administration was imposed, as 'warrant chiefs', picked by district commissioners, were appointed to represent village groups (Parrinder, 1969:90).

Lowie singled out the Dagaaba (whom he called 'Lobi', a generic name wrongly used by some British researchers for the Dagaaba) as an extreme example of acephalous systems in Africa (Lowie, 1948:11-12). Both British and French colonial administrations described them as anarchic, as being without a law. Goody obviously shares the same conviction and underscores it in, "The Dagaaba have no centralized political system, and settlements do not automatically group themselves into larger territorially defined units that one can call a society or a tribe (Goody, 1967:3). "They had no chiefs in pre-colonial times and some were appointed for each settlement" (Goody, 1967:87-89) when the "British arrived in 1913" (McCoy, 1988:19). Nevertheless, "I tried to discover how social control was maintained, to show the order existing within the apparently orderless social system" (Goody, 1967:75-104).

Far from being anarchic, Dagaaba society has always been well oganized. They were organized as "polycephalous" communities or mini theocratic republics with the Tendaamba as Judges almost similar to the time of the rule of Judges in ancient Israel. The basis of their social organization, as already explained, is kinship and the lineage emerges as the focal point of all relationships. Among them, seniority is the general rule in the exercise of authority. At the level of the family, for instance, the family head Deodao (or Zagadao) is the oldest sane male of the oldest generation. Thus, in a family of three generational categories authority proceeds from grandfather to father and to son. Whoever becomes the Zagadao (or Yidaandao, where Yiri or Yir refers to an extended family) commands particular respect and

all others in the family submit to his authority in the carrying out of their respective routine daily chores, in health and in illness.

The next level of authority is the Boore lineage. As in many West African agricultural communities, the lineage emerges as a localized land-owning group. Dispersed descent groups are linked by clanship. Authority, then, is delegated to the senior sane living member of the patrlineage, seniority being defined by age within generation categories. Within each lineage, it is the oldest man of the oldest generation who has charge of maintaining the rules and customs established by their founding ancestors. The power of the Yidaana is especially spiritual, and he is assisted in the exercise of his sacred duty by the elders of the same generation. Decisions are reached through discussions and informal concensus. However, nothing of import such as decisions pertaining to marriage, illness and death is taken without consultation with the diviner.

The authority of the Yidaana is not rigid; behaving more like a sage than a chief in the exercise of his authority. Considered as a living representative of the ancestors of the lineage, the Yidaana does not compel compliance, but persuades and menaces with spiritual sanctions. Events of insubordination are appealed to ancestral authority for necessary action. This action, I was told, is always a kind of punishment meted out either directly to the recalcitrant member or indirectly to the insubordinate's wife, child or close relative. The punishment sometimes comes in the form of sudden death, but mostly it is believed to be meted out in the form of incurable disease, snake bite, mortal fall, and so on.

The next level of authority noted among the Dagaaba is Baloo the patriclan. The patriclan, the widest agnatic descent group, consists of a chain of groups separated by allegiance to different Tengbama earth-gods and/or Duma totems, and displaying considerable

cultural and even linguistic diversity. The inhabitants of a village, with a few exceptions, belong to a number of different patriclans. In this situation, each clan sector has a Yidaana clan elder to whom they accord respect, and acknowledge his authority in matters pertaining to that clan sector. But the authority of the Yidaana in this situation is not limited to the supervision of inherited customs, marriage arrangements, distribution of farmlands, settlements of disputes, and illness within his clan sector. He equally has the obligation of forging relationships with the exterior of the clan in relation to the same life situations.

Above the level of the descent group is the Tendaana earth-priest. He is the priest of Tenge the Earth Divinity and custodian of the Tengbane earth-god. The Tendaana is usually the elder of the lineage that traditionally first settled or occupied the land. On his death, the Tendaana is succeeded by the oldest surviving male of that lineage. Each local community has a Tendaana who is charged with the responsibility of maintaining good relations with mother earth and thus assuring the welfare of the community and well-being of individuals within his territory of jurisdiction. In fact, most respondents generally agreed with the informant who stated that, "the Tendaana of Nyimbale (being earth-priest of the first settlement) propitiates the Tenge with sacrifices at planting and harvesting. He ritually validates any conversion of untilled lands into social use, and deals with illnesses and neutralizes curses pertaining to mother earth". The basic sanctions behind the cohesion of strictly localized groups more inclusive than the clan sector, derives from common allegiance to the Tengbane. In the event of spilling of blood, Tenge is defiled and must be expiated by extraordinary sacrifices. As one respondent said, "to prevent contamination and possible awful circumstances, the Tendaana has ritual authority to stop feuding and to mediate in disputes which threaten to provoke their occurrence".

Both descent groups and ritual congregations are important determinants of social order and well-being among the Dagaaba. But the authority of the Tendaana is by far the most important. As an agricultural people, the Tenge is considered sacred and worthy of reverence and must neither be arbitrarily manipulated nor indiscriminately defiled. As a Divinity, it must be propitiated by customarily "ordained" priests, the Tendaamba. Since the exercise of its authority extends beyond the nuclear kinship situations, peaceful co-existence is maintained partly by the system of merging descent groups, but mainly by supernatural sanctions of the Tengbane. This is how the importance of the office of the Tendaana, as a political and ritual unit of the community, is visualized in relation to health and illness.

But the Tendaana is never a despot, nor can he ever be one. The use of his power is defined and controlled by traditions and customs, and supervised by the ancestors and gods. The ancestors and gods in Dagao thus constitute another level of authority, the invisible power. For instance, the Tendaana must exercise his authority according to traditions and only in those circumstances prescribed by custom. Going against or beyond that which has been so prescribed can easily lead to either the demise of the Tendaana himself or his close relations. The powers that perform this unpleasant duty, the writer was told, are the ancestors and gods acting as "messengers" of Naa-Ngmen the Supreme Being.

Needless to say, in the evolving Dagaaba society of today, the authority and functions of the Tendaana have greatly altered. His role has assumed a low profile in confrontation with the new social, political and religious structures. These have tremendously diminished his status and deflated his role. Much of his administrative and juridical functions have been taken over by the various organs of modern local government such as the local councils and/or assemblies, development committees, the police, the courts, and so on.

At the informal community level, his authority and functions have been superseded by the emergence of such authorities as the Naa king/chief, the Makadjia queen-mother and the Samaare youth leader. In religious matters, Christian leaders and Muslem teachers now vie with him for spiritual authority and allegiance. In spite of all these erosions of his authority, the Tendaana is still the recognized custodian of the land. So, in matters pertaining to its use and defilement, and associated illnesses, he still exerts considerable influence on all who live within his jurisdiction.

## 2.7 Conclusion

As illustrated by the analyses above, various structures, institutions and personalities (visible and invisible) within Dagaaba society tend to provide frameworks for social organization and patterns for healthy inter-personal relationships. Ultimately, however, it is neither the institutional structures nor their symbolic personalities per se that exert influence on individual and/or group behaviour in Dagao. Rather, it is the complex of Dagaaba beliefs and practices, as internalized by individuals, that exert a powerful influence towards peace, social order and well-being, and determine appropriate behaviour in emerging situations. "Good health", they say, "requires good living habits and harmonious social relations". Anything that "weakens the body or disturbs the mind" signals ill-health. For instance, thoughts and words, especially of people in authority, are believed to have power capable of generating the state [blessing (health) or curse (illness)] they symbolize.Thus,

> while people may act within the framework of an organization, culture, or group, it is their interpretations and definitions of the situation that determine their action. Social roles, norms, values, and goals may set conditions and consequences for action, but do not determine what a person will do (Bogdan and Taylor, 1984:15).

The "monarchy" in this case, therefore, is people's inner sense of identity, the unwavering "perch" from which they survey the landscape of their daily lives. As J. Douglas notes, the "forces that move human beings as human beings rather than simply human bodies...are meaningful stuff. They are internal ideas, feelings and motives" (1970:ix). In this chapter, I have tried to capture the forces that move the Dagaaba as a people.

The objecti[illegible] for this study is to offer a sociological explanation for a set of Dagaaba beliefs and practices (rites of death) and demonstrate how participation in them influence their propensity to use available health services. Certainly, this will become clear and comprehensible if it is effectively pursued. But to pursue it effectively, the population and the variables at stak[illegible] the "social facts" (Durkheim, 1951) or social phenomena must be brought to terms with sociological principles and scientific investigative methods. This is the subject matter of the chapter that follows.

# CHAPTER 3

# THEORETICAL AND METHODOLOGICAL ISSUES

> *If we describe what people do without inquiring into their subjective reasons for doing it, we are talking about behaviour. If we study the subjective aspects of what they do, the reasons and ideas underlying and guiding it, then we are concerned with the world of meaning. If we concern ourselves both with what people are overtly and objectively seen to do (or not to do) and their reasons for doing so (or not doing so) which relate to the world of meaning and understanding, we then describe (analyze) action.* (Reynolds, 1976:xv)

## 3.1 Introduction

In Chapter 2, the institutional structures and authority patterns of the Dagaaba were examined. How these structures and authority relations play out complex procedures and processes with implications for health were indicated. This chapter will, therefore, examine some of the theoretical journeys made in search for improved health for residents of rural communities in Ghana. By doing so, it is hoped that some of the areas of incongruence between availability ("accessibility") and effective utilization of health services will be revealed. The chapter will also define the sample site and spell out some of its unique features that suggest the importance of the study. Finally, the specific methods used to collect data will be analyzed and their limitations broached. In short, the chapter will supply the theoretical and methodological boundaries within which the study is located.

## 3.2 Theoretical Perspectives

Deplorable health conditions in rural Ghana have not been a neglected issue. Efforts to alleviate rural health problems have been made since the mid-1960s. However, these efforts

failed because they were based on Western theoretical models with little or no relevance to local health beliefs, customs and practices. Sociologists and anthropologists have long demonstrated the limits of health programmes planned exclusively around models based on cosmopolitan medical and social sciences (Foster, 1977; Paul, 1955; Polgar, 1962). "The principle that health programmes should start with people as they are and the community as it is" (Paul, 1955:476) emphasizes the need to discover where particular groups of people stand (Bloom and Reid, 1984), and our "willingness to meet them must be matched by a knowledge of the meeting place" (Paul, 1955:477). In other words, to design programmes for people as if they mattered, we should not only consider the economic viability of the programmes, but also the networks of social vitality and cultural validity within the community must be emphasized (Matthews, 1976, 1983).

In his review of approaches to the study of health services utilization, McKinlay (1972) identifies six analytically distinct orientations. These are the economic, socio-demographic, geographic, social-psychological, sociocultural and organizational or "delivery systems". However, given the complexity of the field, "seldom do researchers in the area of utilization behaviour adopt only one approach to the exclusion of all others, although one may be given greater emphasis" (McKinlay, 1972:140).

For this reason, many studies in medical sociology tend to identify the effects of specific variables (Cockerham, 1978; Mechanic, 1979; Tuckett, 1976), while some tend to provide useful basis for classifying the determinants of health care (Kohn and White, 1976). Those that tend to classify the determinants group them into macro-sociological and micro-psychological perspectives (Phillips, 1990), with each generating different models to explain health services utilization dynamics.

Micro-psychological or "individualistic" persperctives (Dingwall, 1977) generate models such as the health belief model (HBM). The HBM was developed to explain factors determining health-related behaviours, especially to answer the questions, "When and Why people seek care" (Becker, 1974). This model emphasizes that an individual's propensity or "readiness" to use or not to use health services is motivated by some "perceived benefit" (Rosenstock, 1966). That is, an individual who believes himself/herself susceptible to a disease that could generate serious consequences but that can somehow be prevented or ameliorated by action on his/her part will take action to use health services. Conversely, an individual who is not motivated by any "perceived benefit" or who does not feel "seriously threatened" when sick will not take action to restore health (Phillips, 1990).

The model is useful insofar as it emphasizes environmental and cognitive elements of behaviour. For instance, it recommends the reduction of barriers such as high service costs, long distances to health care centres and inconvenient service hours. However, it remains less useful insofar as it fails to attach weight to "variables" that may be influential in these considerations. Commenting on Rosenstocks's concept of psychological readiness, for example, Dingwall (1977) asks: "How do we recognize a state of readiness to act apart from deducing it post hoc from some observed conduct?" And, if recognition is only by this post hoc linking of consequent and supposed antecedent, "how can it have any predictive status?" (1977:3).

Also implicit in this approach is an optimization process through which action is taken, given the individual's tastes and preferences. Individual action (or inaction) is, therefore, to be seen as an outcome of simple exercise in calculus. This is where the problem arises. Little or no recognition is given to the role of sociocultural agents (structures and processes) that

structure and shape options available for choice. For example, if the deciding factor of action is how we perceive and value our objectives, why do we have different choices under similar conditions? In other words, tastes and preferences are not given, yet this theory leaves them unexplained. Given this high level of abstraction and tendency of psychological reductionism, the HBM appears to be more a conceptual framework of illness behaviour than a "model".

While we must recognize the limitations inherent in micro-psychological reductionism, there is an equal limitation in macro-sociological perspectives. These perspectives emphasize the politics and economics of health resources (materials, personnel, and finance) distribution. This approach emphasizes that patterns of utilization are "forced or imposed" on people through inequitable distribution of resources. Significant contributions have been made, especially by scholars emphasizing availability and/or accessibility of health resources (Aday & Andersen, 1974; Joseph & Phillips, 1984; McKinlay, 1972, Walters, 1980) as factors in health seeking in rural communities and among urban lower social classes. These scholars have either introduced additional variables or emphasized different factors in modelling the use of health services (Phillips, 1990:180). For instance, while Aday and Andersen (1974) envisage utilization as a product of combined characteristics of patient, provider and the system of health care, great emphasis is put on the provider and the system. In broad terms, they argue that health policy is based on "inputs" to health services (characteristics of the delivery system and population at risk), while the "outputs", dependent on the "inputs", are utilization and consumer satisfaction. This macro-structural, reductionist framework, though places less emphasis on the patient's characteristics, is useful insofar as health policies (in terms of nature, organization, finance, and personnel) are seen as influences on utilization.

In Ghana, for example, Appiah-Kubi (1981:3) observed that about 15% of the population enjoys 85% of the national health resources; and that majority of those who are underserved are the poor living in the rural areas. Similarly, Fosu (1986:252) noted that expenditure on tertiary hospital care (specialized services), benefitting only 1% of the population, amounted to 40% of the health budget; and expenditure on secondary hospital care, serving only 9% of the population, amounted to 45% of the budget. By contrast, expenditure on primary care, serving 90% of the population, was a mere 15% of total health spending. The distribution of funds and other health resources in inverse proportion to the number of people requiring them was considered an important factor in the use of health services by rural communities. The situation attracted the following comment from the "architects" of Ghana's social transformation:

> ...health care services in the country have been concentrated in urban-centres and health resources mainly directed at serving a small, high income sector of the population...Rural health programmes, like the people they are designed to serve, remain at the mercy of urban facilities (Ghana, 1982:1).

Following from the failures of these efforts, the country's health care policy was reformulated in 1982 committing it to redress inequities in health care through a "comprehensive and integrated" health delivery. This impetus, as Senah (1989) observes, probably stemmed from the WHO-UNICEF Alma Ata Conference declaration of "health for all" (HFA) by the year 2000. Since the reformulation of the health policy what has been achieved for the rural masses, the common traditional people?

At PHC review conferences held at the University of Ghana, Accra, regional directors of health services (RDHS) revealed with concern the low utilization rates of PHC resources in rural communities across the country (Ghana, 1984, 1989). While most observers have

since attributed this development to macro-structural factors (transportation, lack of resources, etc), others have associated it with individual psychological readiness or micro-processes (basic human motives, individual decision-making, etc). Such macro- and micro-level explanations are valid under certain circumstances and in certain cultural settings. It is, however, difficult to pin the low use of health services in the UWR on either of these two levels of explanation. For instance, the macro-level perspective, which assumes behaviour is shaped and regulated by ponderous structures largely impervious to explicit choice, is unable to explain variations in individual use of health services under similar structural conditions. Similarly, individual psychological readiness is unable to account for social-structural and/or institutional influences on individual health seeking behaviour.

In other words, these approaches fail to recognize, at least in any systematic way, that preferences or behaviour alternatives and outcomes are structured and restructured as part of the historical developments of particular societies. As Stinchcombe noted:

> ...the core process conceived as central to social structure is the choice between socially structured alternatives. This differs from the choice process of economic theory, in which the alternatives are conceived to have inherent utilities. It differs from the choice process of learning theory, in which the alternatives are conceived to emit reinforcing or extinguishing stimuli. It differs from both of these in that...the utility or reinforcement of a particular alternative choice is thought of as socially established, as part of the institutional order (in Burns et al., 1985:9).

From this viewpoint, the explanatory power of both theoretical perspectives is weakened by their inability to account for what Mechanic (1989) calls "processual influences" of health perceptions and response and what Kleinman calls the "cultural context of patient's experience". According to Mechanic, an awareness of symptoms generates one of two response processes: a truncated and brief response process for minor and self-limited

symptoms and an extended appraisal response process for symptoms of uncertain and life-threatening nature. These appraisal response processes are usually mediated by many intervening factors including sociocultural variables (Kleinman, 1980). Arguing that a patient's behaviour is greatly influenced by the cultural context experienced by the patient, Kleinman concludes, "the decision to seek help, where to seek help (popular, folk or professional), and when to do so all depend on how the illness is understood and interpreted by the patient and/or his or her family or community" (ibid.:50). These appraisals go through culturally valid negotiations between illness beliefs (including their causes) and perceptions of treatment benefits (including their efficacies) at the end of which the community's "lay referral systems" (Freidson, 1970) are processed.

Modelling the use of health services for such sociocultural environments, Suchman (1964, 1966) emphasizes, should rely more on social group influences and less on psychological state of readiness or macro-structural factors. He contends that since very different levels of knowledge and attitudes to disease and illness exist among different groups of people, use of health services will be better explained by such differences. In other words, individual decision to use or not to use particular health services is dependent on larger sociocultural processes. For instance, he explains that a cosmopolitan social structure is more likely to be associated with a modern health orientation than is a traditional social structure, in which lay health beliefs tend to prevail.

This model is of significance insofar as it helps to explain some differences in utilization behaviour between urban and rural residents and between various ethnic and/or minority groups (Phillips, 1990). It is also important in explaining why migrant rural natives found in cities might favour traditional medicine (ibid.). However, the model remains less

useful in explaining intra-ethnic or even intra-family differences in utilization behaviour. Nor does it explain why an individual's propensity for health services, ceteris paribus, changes through time. In other words, people's propensity for health services is determined more by the processes of negotiation between their own conceptions of health and illness and appropriate methods of redress than by availability of resources at the individual and societal levels. It is within this framework that the examination of the relationship between Dagaaba funeral rites and their subsequent health seeking behaviour has meaning.

### 3.2.1 The Framework: Dagaaba Funeral Rites and Health

> In the systematic study of a society, or any of its sectors, ...the establishment of a framework against which the real situation can be viewed is not only helpful but adds meaning to the facts acquired and the understanding achieved (Jones, 1973:9).

Of all the social and cultural "rites of passage" (van Gennep, 1960) of the Dagaaba, funeral celebration is the most impressive and lavish (Goody, 1962: 11; Saanchi, 1992). It is one area of their culture that has withstood the influences of colonialism, Islam and Christianity (Kuukure, 1985). As Nyame observed, in Ghana, the value placed on education is lower than that bestowed on festivals and funerals (West Africa, 1993:1985). Dagaaba funeral celebrations affect the health of participants in various ways. But two of these tend to have serious health implications for the people. First, there are great nutritional consequences of lavish death celebrations for people with limited supply of food. Second, funeral rites are part of a complex network of symbols and actions associated with Dagaaba conception of life, health and illness. This is reflected in the structural and functional readjustments made to reach a new equilibrium. Kinship and customary norms associated with these readjustments, as examined in Chapter 2, generate additional network of social

relations, sanctions and taboos for survivors that tend to influence their health seeking behaviour.

This clearly demonstrates the importance of funeral rites as a factor in health seeking and, for that matter, the use of health services among the people. While such unofficial but publicly popular determinants of care may be important among the people, it tends to be moreso for participants of funeral rites. For instance, a woman is "inherited" by the deceased husband's kinsman in order to create a new equilibrium and ensure continuity of life. However, their participation in rites of death that enables them to function as normal human beings also makes both the widow and the "heir" unable to freely seek health care anytime anywhere. Participants in these rites, they say, are Kpiin noba death people, and under normal circumstances do not easily become victims of earthly Bonime "things" without "spiritual influence". These processes, as will be demonstrated in the study, are graphically illustrated in Figure 3.1.

The framework implies that the economic and cultural realities (systems) of the Dagaaba make them more vulnerable to "premature death". As relatively young people die, younger ones pick up the mantle of life through the performance of appropriate rites. These rites explain death, define new identities (statuses), and reallocate resources, roles and responsibilities. The rites, as shall be seen, are, undoubtedly, "health" enhancing as they are believed to redeem individuals and the community as a whole from the crisis of death. However, with the operation of certain norms and rules (ritual control) associated with participation in death rites, a participant's health appears invariably compromised as s/he becomes a subject of prolonged divination and consultation in times of illness.

As broached in Chapter 1, for instance, norms associated with widow inheritance

inhibit the health-seeking behaviour of both the widow and the heir. Not only do these norms determine their propensity for service utilization, but they also influence their "choice" of health service. Even though these norms of ritual behaviour limit individual choice of health service and thus thwart satisfaction, they are, nevertheless, maintained, controlled and continuously reinforced. Their maintenance, control and reinforcement, like participants' behaviour, are all oriented towards the cohesion and continuity of the existing system.

While this framework suggests an influential relationship between death rites and health, previous studies on death celebrations among the Dagaaba have mainly dealt with religious, ritualistic, linguistic and anthropological aspects. For instance, Goody (1962) examines Dagaaba mortuary customs and inheritance practices. Strumph (1976) analyzes Dagaaba funeral performance as traditional drama, the main function of which is to provide cathartic release for the mourners. Godsey (1980) discusses the use of the xylophones in the Birifor (sub-group of Dagaaba) funeral ceremony. Baeka (1980) provides the cohesive ingredient of Dagaaba funeral ceremonies, while Anleumwine (1981) considers the performance of funeral rites as a factor for social control. In a synoptic piece, Kuukure (1985) examines the interaction between Dagaaba celebration of the dead and Christian eschatology. Among the literary contributions are Yabang (1981) and Yemeh (1986) who examine the Dagaaba Dirge, while Kuwabong (1990) analyzes the language of Xylophones at Dagaaba funerals. Finally, Saanchi (1992) presents the linguistic and literary significance of sung dirges at Dagaaba funerals.

As will be demonstrated in Chapter 4, Dagaaba blame most deaths, like illness, on supernatural forces, divine retribution, and the malevolence of a witch or a sorcerer. Rites associated with death reflect this world view. Therefore, to understand funeral rites as a factor

in health services utilization among the Dagaaba, we need to examine their symbolic representations in health and in illness. As Turner (1969) and Some' (1993) suggest, to understand the inner structure of ideas and meanings in rituals, it is necessary to appreciate how the symbols in them are interpreted.

However, the absence of research among the Dagaaba that carefully constructs their funeral rites as symbols and actions of life, health and illness makes their culturally mediated negotiations, health perceptions and responses appear remote in health seeking. Accordingly, health programmes are designed based on assumptions and principles that ignore these culturally valid concerns of the people. As a result, such health programmes in the community are less likely to be accepted by the population irrespective of their perceived necessity and relative accessibility. This study is an attempt to fill in the knowledge gap within the frameworks of Mechanic's (1989) processual influence, Kleinman's (1980) cultural context, and Freidson's (1970) referral system.

## 3.3 Statement of Objectives

We indicated in Chapter 1 that research is generated by the existence of a problem. A research problem is either peculiar to a given community or object, or it may be a problem in which local interest is only part of a general concern. Whether a research problem is unique to a particular community or is part of a general concern, it must raise a number of questions, questions that must be answered in order to address or solve the problem. The objectives of study are designed and oriented towards answering the questions raised by the problem. In this study, a wide range of sociocultural issues are relevant to and will be brought to bear on our problem. However, to understand how social processes and cultural ideas influence health

seeking behaviour especially the use of health care services among the Dagaaba, these issues must be within manageable proportions. Consequently, this study will be limited in scope to the following specific objectives:

1. providing an understanding of the social, psychological, economic, political and religious experiences of the Dagaaba;
2. reflecting on the meaning of funeral rites among the Dagaaba;
3. examining how the social, psychological, economic, political and religious experiences of the Dagaaba interact with their rites of death to influence the use of health services available in the community;
4. explaining inter- and intra-gender variations in the use of health services; and,
5. designing a model that integrates local perspectives into health programmes, enhances effective utilization of health resources and thus, improves the community's social and economic productive life.

## 3.4 The Research Setting

In order to carry out a study that seeks to explore how rites of death influence health seeking behaviour, an appropriate site must be chosen. A research problem, its objectives and the nature of cooperation and/or participation of the prospective universe of people or objects influence the choice of research site. In other words, both theoretical and practical considerations influence the process of site selection. Bogdam and Taylor (1984:27) suggest that, "any setting that meets the substantive and theoretical interests of the researcher and that is open for study might be chosen as a research site".

Most study sites are chosen for their accessibility, "typicality" and supposedly

representative nature. Sometimes, however, it may be necessary to select "atypical" and inaccessible sites especially when they are thought to represent some "unique" form of culture or experience (Pelto, 1970). Thus, the process of selecting research sites, Pituckmahaket et al. (1989) suggest, is a progressive process of elimination based on the following principles: (1) the degree of involvement in the activities specified in the research objectives; (2) a clearly defined and numerically limited population; (3) the level of site accessibility desired; (4) an initial site survey assessment of the potential research environment.

These factors appear to suggest that the researcher should have some level of familiarity with the prospective study site. Without attempting to deflate the importance of these points in site selection, it is important to emphasize that there is sometimes the danger of biases arising especially as a result of choosing a familiar site. Familiarity, especially with issues bordering on humanly designed behaviour, can sometimes generate emotional attachments and introduce biases. This springs from the fact that purposeful human behaviour by its very nature involves ultimate values which make it almost impossible to view with a disinterested attitude. For this reason, it is the recommendation of Bogdan and Taylor that "a researcher chooses settings in which the subjects are strangers to them and in which they have no particular professional knowledge or expertise" (op.cit.: 27).

Some of the questions that arise out of this recommendation are: Should "insiders" just resign themselves to fate and make no attempts at understanding the necessity or otherwise of issues that impinge on their daily lives? Should they wait and become subjects of study only when "outsiders" are awakened to their intellectual call and are successful in their financial lobbies for research funds? I think not. An "insider", agitated by problems within his/her own socio-cultural milieu, also has a moral right as well as an intellectual

justification to seek explanations. Besides, the difficulty in holding their own beliefs and feelings in abeyance (Bogdan and Taylor, 1984) does not make an "insider" an all-round impediment on scientific research. As a matter of fact, an "insider" has certain unique advantages when pursuing scientific study in familiar territories.

For instance, being familiar to the site enables the researcher to view problems more sympathetically without appearing to be patronising and dismissive. It gives him/her a better socio-cosmic and linguistic, cultural grounding, mutual trust and communication lines unavailable to the "outsider" with only a tourist knowledge of site. In short, a researcher who is only fleetingly familiar with the site may go there with a different, sometimes, conflicting cultural baggage and expectations, a vice in research endeavour that obstructs the collection of empirically valid and reliable data. In addition, being a native and/or familiar with site minimizes disruptive take-overs of interviews with women by men. For example, the desire of husbands to act as mediators between their wives and "strange" interviewers will be minimal. An "inside" perspective is, therefore, essential if data is to be collected and interpreted accurately.

With these considerations and caveats in mind, the following factors influenced the choice of the Dagaaba of the UWR in general and the Manlarla community in particular for this study:

1. medico-cultural factors: That is, the overall health status or conditions of the area as reflected in the national health statistics and the community's own belief and response systems;
2. eco-geographical factors: That is, factors related to accessibility, population size, spatial distribution of the people and the distances from healthcare centres;

3. socio-economic and political factors: That is, sources of livelihood in the area, potentials for the establishment of cooperation and rapport with community members as well as officials from the MOH;

4. Personality factors: That is, my own research interest in the area, previous work on some aspect of their culture, work experience in the community as a primary healthcare coordinator, and my ability to appreciate the traditions and customs and to speak the local dialect of the people as one of them.

## 3.5 Sampling Procedures and Techniques

Surveys differ markedly in the way they cover a given population. The population is the aggregate of persons or objects under investigation. In terms of my sample population, I am concerned with the Manlarle variant of the Dagaar dialect group. Numbering about 50,000 people in the Nadowli district, Manlarla live in about 50 village communities (Ghana, 1987b) with Nyimbale as their first place of settlement (Tourey, 1982) and Kaleo as the traditional administrative centre.

The Manlarla are a sedentary, agricultural people highly dependent on good rains for successful harvest. Generally, they are poor and live on subsistence economy levels. Women supplement the yields from farming activities by engaging in pottery, weaving and basketing. The people are essentially illiterate. While very few have gone beyond primary education, fewer are in professions such as nursing, teaching and administration. Most Manlarla able-bodied men, therefore, migrate in large numbers to the southern part of the country in search of jobs in construction firms and plantations, but mostly in mining companies. The separation of secular and religious authority in the offices of the Naa chief, Tendaana earth-priest and/or

Yidaana lineage/clan elder, as the case may be, is a fundamental basis of Manlarla village organization.

The ambit of their environs is circumscribed by other Dagaar dialect speakers like the Wala to the south and the Monyarla to the north and east, and the Dolimbo to the south-west. The Manlarla also share a common boundary with the Lor dialect speakers to the west in Burkina Faso along the Black Volta River. The Manlarla, like all Dagaaba, are outwardly friendly and hospitable but secretive about some of their beliefs and ritual life (Some', 1993). Even though this ethnographic delimination is inevitable for purposes of this study, it is imperative to state, however, that rites of death and their health implications are basically and fundamentally the same in their major representations throughout Dagao.

In spite of this fundamental principle of uniformity of institutional networks and ritual customs of the Dagaaba in general and the Manlarla in particular, it is impracticable, in terms of time, financial resources and available energy, to conduct a study that will take the entire Manlarla area as a sample population. Thus, three communities, representing the three major clans of the Manlarla, were chosen for detailed investigation. The communities and clans they represent in brackets are as follows: Loho (Emo), Nanville (Eko) and Nyimbale (Eto).

The clans were chosen to ensure fair distribution of respondents across the population universe as each of these major clans has different migration and settlement history, as well as different totemic objects. The three villages were chosen for the sample because they are the original settlements and/or traditional centres of their respective clans. As custodians of clan totemic and ancestral pride, therefore, these village communities strive to preserve tradition and custom in their "purest" form in the wake of "modernizing influences".

### 3.5.1 Demographic Characteristics of Sample Villages

According to figures from the most recent (though somewhat out of date) population census (Ghana, 1987), the sample villages for the study had a total population of 2,581 inhabitants. The individual village population data for 1984 as well as the population census figures for 1960 and 1970 are contained in Table 3.1.

Table 3.1: Demographic Characteristics of Sample Villages

| Village Community | Population | | | | |
|---|---|---|---|---|---|
| | 1960 | 1970 | 1984 | | |
| | Total | Total | Male | Female | Total |
| Loho (Emo) | 563 | 600 | 376 | 444 | 820 |
| Nanville (Eko) | 898 | 764 | 552 | 606 | 1158 |
| Nyimbale (Eto) | 491 | 558 | 277 | 326 | 603 |
| Totals | 1952 | 1922 | 1205 | 1376 | 2581 |

Source: 1984 Population Census of Ghana, Volume 10, UWR, Ghana (1987a).

### 3.5.2 Sampling Techniques

The objective of the study is to analyze the relationship between participation in funeral rites and utilization of health services. The question that remains is, "Who should be interviewed? Guided by the study objective, the population universe was necessarily selective. Even within this population, respondents had to be carefully selected. But to carefully select respondents implies knowledge of the population universe, its traditions and customs, as well as current redressals of the study problem. How was this to be accomplished?

Before going to Ghana in 1994 to collect data, several people, including S. Boman-I

(epidemiologist & minister of state, Ghana) and E. Zumakpeh (member of parliament, Ghana), were contacted. Through them, arrangements were made for me to discuss the study with Dr. Appiah-Denkyira (DOH for the UWR) as soon as I arrived. D. Kuwabong (lecturer, University of Ghana), who had given me some literature about Dagaare customs, also advised me to meet with the Most Rev. G.E Kpiebaya (Archbishop of Tamale, Ghana), Rev. Msgr. Lawrence Kyemaalo and Rev. Fr. Francis Bagbr who have all done extensive work among the Dagaaba about their traditions and customs.

Having acquainted myself with the main dimensions of the study, the next issue was to determine criteria for inclusion in the study. The criteria included all sane living participants of funeral rites in the selected communities who were at least 15 years old at the time of data collection. This implies all sane adults related to those departed kinsmen (including women) either by marriage, parentage, or by right of inheritance whose funeral rites had been performed or were being performed at the time of investigation. "Children" were excluded from the universe because I considered them too young to be critical. In specific terms, these people include widows, widowers, orphans, heirs and family heads. The death of children, unmarried adults or people accused of witchcraft calls for no elaborate funeral celebrations among the Manlarla and, so, their surviving relatives were excluded.

After determining criteria for inclusion in the sample population, the next question was, "How do I identify potential respondents?" Potential respondents were identified from each community through the "network" system. Informed natives of the communities were asked whom they thought I should speak to about my study. For instance, Paul Kant (administrator, UER, Ghana) and native of the sample area advised me to see Ali Tengeleoye of Nyogluu, Ninkpeng-Nuori of Bayawyiri, Johnson Jebuni of Nayipaala, Bornah of Goriyiri

and Konbangsuma of Boo (renowned traditionalists of villages and/or sections in the Kaleo traditional area). While in the UWR capital, Wa, I discussed the study with a cousin, Rev. Fr. Paul Langnidomah. He also expanded my list to include Ninnang (educationist) and Peter Dong-gilee (cathechist). Finally, Mathias Puozaa (director, Institute of Adult Education, Wa) led me to the Daffiama-Tuore area where preliminary interviews were arranged with a number of ritual specialists.

There was a high level of agreement about the choice of some informants. From this list of potential informants, compiled through networking, I selected respondents on the basis of ritual status (widow, heir, etc), ritual experience (illness, etc) and background (literate, married, etc). Data were collected from these ritual participants about their services utilization before and after participating in rites of death. The reason for this was to establish a relationship, if any, between participation in these rites and utilization of health services.

Data were also collected from three other "supporting" categories of respondents in the communities. Such categories included people associated with rites of death (ritual specialists), people associated with the provision of health services in the communities (local and localized health professionals), and people responsible for community administration and general welfare (community civic leaders). Ritual specialists found and interviewed within the villages included Bogsuuriba undertakers, Bogsuuri-namene ritual specialists and Tendaamba earth-priests. Those local and localized health professionals interviewed were active providers of some kind of health services to their communities. These included such practitioners as Tiin eriba aning konvogriba herbalists and bonesetters, Karimugre mallams and faith-healers, Bugbugriba diviners and spirit mediums, as well as Nasaal tiin eriba PHC workers such as nurses. The community civic leaders identified in each village community at the time of data

collection and interviewed included Namene chiefs, Makadjimene women leaders and Samarimene youth leaders. For all these categories of people, data were collected in order to ascertain their role as custodians of some aspects of community life that have implications for health, and to obtain their views on the use of health services by ritual participants. Hence, the designation "supporting" respondents for them.

Thus, within each community, respondents from these special sub-groups (Higginbotham et al., 1979) were selected on the basis of what Johnson (1990:37) calls criteria concerning "theoretical qualifications" and criteria concerning "innate abilities". The term theoretical qualification emphasizes the importance of theory (or theories) in guiding the selection of respondents in terms of such things as status, role, position, expertise, category or sub-group membership, dimension, and knowledge. Whereas these criteria are consciously specified, carefully reached, theoretically representative and meaningful, the criteria concerning innate abilities become more a matter of personal chemistry, interpersonal capability, and the ability to establish a trusting relationship (ibid.:38). While the range of theoretically significant and representative respondents was identified by the first set of criteria, the final choice of respondents was determined by the second set of criteria.

Two analytical frameworks usually determine what is theoretically representative in the sampling of respondents. Johnson (1990:24) identifies these as, (1) theory driven cases or a priori analytical framework base on previously determined "theoretical categories, classifications, dimensions, typologies, and so on"; and (2) data driven exploratory cases or emergent analytical framework based on the "discovery of emergent categories or dimensions". What is implied here is that two approaches were open to me in this study. One approach was to start with a priori conceptual and theoretical frameworks or definitions

of the subject, or by outlining the elements that would be considered pertinent to these definitions, and to go from there to verify these notions in the light of what is expressed in reality. The idea would be to discover how much the reality tallies with the formulated definitions. In this case, this would mean approaching Manlarla ritual and health realities with a mind already made up. Expressed differently, it would imply approaching the field with a set pattern of already formulated presuppositions and notions which need to be verified.

The danger of such an approach, as Bekye observes, consists in the fact that, not only does it restrict the scope of the investigation to within the narrow confines of the pre-set notions, but it is reductionist in as much as the tendency would be to twist, and to force research findings to fit into a prefabricated mental mould (1991:132). Many early "foreign" anthropologists and ethnologists as well as cultural historians of African peoples and their religious and ritual practices were victims of their own theories. Their prefabricated theories blinded them to an objective valuation of the deeper and inner significance of the religious and ritual practices of the people they studied. So inclined were they in the justification of preconceived theories that no matter how carefully they camouflaged their opinions under scientific trappings, the fact of their biases still showed through. The evolutionary theories of Tylor's "animism", Frazer's "totemism", and Schmidt's "primitive monotheism" are but a few of such preconceived theories and concepts.

As a social-religious phenomena, Manlarla funeral rites are dynamic and not static. Thus, they defy any watertight conceptualization and/or formulation. In other words, while theoretical and reflective dimensions are not to be denied in studying them, they are nevertheless secondary. In the context of the Manlarla where religion is life and their daily living and ritual fuse into an inseparable entity, our approach has to be equally dynamic and

life oriented. Under the circumstance, the second approach appears to be more useful in this study. This approach would let observable facts speak for themselves. As Bekye (1991) suggests, it allows them to unfold to legitimate conclusions of their own.

### 3.5.3 The Sample Population

In the sampled village communities, a total of ninety (90) people were interviewed, thirty (30) from each village community. The table below illustrates the composition of the sampled respondents within each of the carefully selected special sub-groups.

Table 3.2: Sample Size Composition

| Sub-group | Villages | | | |
|---|---|---|---|---|
| | Loho | Nanville | Nyimbale | Total |
| Ritual Participant | 20 | 20 | 20 | 60 |
| Ritual Specialist | 3 | 3 | 3 | 9 |
| Local/Localized Health Professional | 4 | 4 | 4 | 12 |
| Community Civic Leader | 3 | 3 | 3 | 9 |
| Totals | 30 | 30 | 30 | 90 |

The underlying assumption that variability exists, in terms of the propensity of health services utilization, between and within genders requires that the sampling strategies be designed so as to be capable of collecting data representative of that heterogeneity. Thus, age, sex, marital status, education and religion were accounted for in the selection of informants. The objective here was to determine if variations in individuals' propensities for health services utilization were influenced by such variables.

## 3.6 Methods of Data Collection

The main purpose of this preliminary study is the understanding of the meanings of behaviour. In the social sciences, the term methodology applies to how research is conducted. However, "as in everything we do, our assumptions, interests, and goals greatly influence which methodological procedures we choose. When stripped to their essentials, most debates over methods are debates over assumptions and goals, and over theory and perspective" (Bogdan and Taylor, 1984:1). The appropriateness of a qualitative-ethnographic study design such as utilized here to explore the social construction of meanings in health services utilization among the Manlarla has already been underscored in Chapter 1. Therefore, the three sections that follow simply enumerate the specific methods of data collection used, analyze their importance, and discuss their merits and limitations.

Qualitative-ethnographic techniques of data collection are many and varied. They include participant observation, interviewing, life histories, case studies, review of records, and focus group discussions (Ramakrishna and Brieger, 1987; WHO, 1983). These techniques are either used individually or in combination with others to generate data. In this particular study, a combination of informant-oriented and observation-oriented methods (Willms et al., 1991) were employed, a principle of multi-instrument research or "triangulation" (Morgan, 1988:25).

The specific methods used to collect data from the sample population were indepth interviews, participant observations, and focus group discussions. These methods were chosen to build and strengthen reliability and validity. As Hammersley and Atkinson (1983) argue, reliability and validity increase in qualitative research with the use of multiple data sources. We shall now discuss how each of these methods was utilized and/or applied in the

study. In addition,we shall briefly indicate some of their advantages and limitations.

### 3.6.1 In-depth Interviews (IDIs)

Indepth interviewing is one of the most widely used methods of data collection in the social sciences. Here researchers interview informants in their homes, in the fields, at work or wherever they can be located to elicit their construction of reality. An indepth interview is an informal, unstructured or semi-structured conversation used especially for a more intensive study of perceptions, beliefs, motivations, attitudes and experiences (Singha, 1989:75). Burgess (1982) summarizes that indepth interviews provide opportunity for researchers to probe deeply, uncover new clues, open up new dimensions of a problem and secure vivid, accurate, inclusive accounts based on personal experience. That is to say, the flexibility of indepth interviewing allows for the free expression of ideas by the interviewed within the broad confines of the topical questions. My experience with and knowledge about the social life of the subjects were an asset for a successful indepth interviewing.

Indepth interviews were conducted in order to generate data about how rites of death influence behaviour in general and health seeking in particular, from individuals (specialists and ordinary people) who either have knowledge of the issues at stake or have experienced them in the course of their lives. For instance, data from ritual participants about their health seeking patterns before and after participating in funeral rites and from ritual specialists and health professionals about their practices were generated through indepth interviews. Using an ethnographic field guide (see Appendix A), community and household organization (including authority structure in this and the other world), place of funeral rites, conceptions of health and illness and procedures of health seeking were explored.

Most interviews were conducted in private homes and/or under the shades of convenient trees. Women, for reasons of a social and personal nature preferred to be interviewed in the house. Socially, it is unacceptable for them to be seen in lengthy conversations with "strangers". Personally, most female respondents wanted to continue with their domestic and/or commercial chores (child caring, home guarding, pito brewing, or basket weaving), while we engaged in study discussions. There were a number of advantages for house-interviewing. For example, responses from people interviewed indoors were free from the influence of droves of curious, sometimes, disruptive onlookers who often got attracted to outdoor interview sites. Interviews varied in length and formality according to the situation and the respondent. However, most interviews lasted between 1.5 and 2 hours each. Where appropriate, I took along gifts of Kola nuts and tobacco, while in other cases, I either bought drinks or gave cash to female respondents for salt and/or Keta school boys herrings as a token of appreciation for time spent.

It is sometimes argued that research interests such as opinions, attitudes, values, beliefs and interpretations can be inferred from actions. Much as this is true, unstructured interviews, however, can help identify, clarify, and amplify these feelings and impressions. A better way of getting what people have in their heads is by listening to what they say. This is not to deny the importance of behaviour. But when actors are facilitated to speak for themselves, they not only describe their significant behaviours but also their feelings, thoughts and evaluations of these behaviours. In addition, case studies or life histories can be obtained only with unstructured interviews. Open-ended questions, for instance, were asked of participants of funeral rites to ascertain the factors that influence their definitions of symptoms, treatment decisions and choice of practitioner/therapeutic regime.

For the ritual specialists and health professionals, the idea was to ascertain their views on rituals, and why and how funeral rites influence health seeking in the community in general and propensity for health services utilization of their "clientele" in particular. Specifically, the questions probed their views about disease causation, illness classification, and constraints of health seeking. Few notes were taken during conversations, while the whole conversation was tape recorded. This allowed me to pay full attention to what was being said by respondents which, in turn, facilitated the social "rapport" needed for a successful conversation.

Mention was made in Chapter 1 about reported estimates of deaths within the sample community that could be associated with mining occupation. To do this, the writer had to rely on the cooperation and memory of the village chiefs, queen-mothers and youth leaders. This category of respondents was considered useful for this type of investigation because of two reasons. First, as community civic leaders, they must be given official notification of deaths and causes of deaths that occur either locally or "abroad". Second, once notified, they are obliged to either be present or be represented at such funerals. To elicit information about deaths and their causes, each informant was asked how many adults had died in the village in the past three years and the causes of death (if they knew). The number of deaths and their reported causes were recorded. The modal response in each case (that is, the number and cause with highest frequency) was taken as a reflection of the truth.

Indepth interviews, as a method of data collection, has its limitations. Pelto (1970), for instance, writes that aside from interviewer-effect on the quality of key informants' responses, several other problems associated with interpretation and analysis of verbal data from selected individuals loom large. Individuals, he maintains, are embodiments of particular images, images that influence the way they see and present themselves and their positions in

the world of persons and things to people; and that their verbal statements to researchers are therefore affected by this tendency. However, as Lofland (1976) advises, if a non-threatening, self-controlled, supportive, polite, and cordial interaction in everyday life is carried on, then, interviewing will come easy as respondents will feel more open and comfortable responding to questions. To minimize weaknesses and maximize strengths, however, indepth interviewing was combined with other methods, especially observation methods. "Interviews and participant observation are complementary methods of testing the completeness and accuracy of data obtained from one or other methods" (Buzzard, 1984:276).

### 3.6.2 Participant Observations (POs)

As a collaboration for my interviews, I attended many public funeral celebrations as a participant observer. Participant observation is that systematic, or carefully planned, watching of the social activities of a group or aggregate of individuals. It is a discovery procedure used for uncovering tacit knowledge in a small local context such as health services utilization patterns of ritual participants among the Manlarla. The purpose here was to observe and describe the social actions (rites of death) of the people and use the description as foundation for the formulation of a grounded theory. A grounded theory approach stresses "the development of theory, without any particular commitment to specific kinds of data, lines of research, or theoretical interests" (Strauss, 1987:5). In other words, these propositions are not deduced from existing theory. Rather, the new data gathered provide grounds for producing one. Participant observation is particularly useful in stages of research when the problem is not well defined, for community level studies where wide generalization is not critical, and for the study of problems with important cultural components (Ole Sena, 1991).

Observations were conducted at 15 funeral celebrations, 5 in each of the three sampled communities. The funerals ranged from those for young, promising individuals to those for old, decaying people; from "social significants" to "social insignificants". Unstructured observations (Burgess, 1982) of both "primary" and "secondary" rites were conducted at each village community. By primary rites I am referring to those rites performed immediately at the instance of death. These are otherwise known as Kuore grieving rites. Literally, Kuore means grieving arising from death. On the other hand, secondary rite imply those rites of death performed with a view to restoring harmony and ensuring continuity in individual, in family and in community life. Such rites are described in Manlarla nomenclature as Komaale restore rites. Literally, Maale means repair or restore. Thus, Komaale literally translated means funeral repair or restore. This suggests that rites associated with such level of funeral celebration must be rites aimed at "restoring" a previous balance lost or "repairing" that which has been dismantled.

These unstructured observations allowed me to record almost "everything" that occurred. Here, two types of data (what people said and what they did) were observed and recorded. For those rites of death performed by women and for women only, a woman had to be recruited to observe and record, as systematically as possible, what was happening. The woman was middle-aged, of uncommon intelligence and passion, and with demonstrated interest in community and women's welfare, as well as research interest in traditional health care system. She has been working with various women's groups (especially the 31st December Women's Movement and the National Council on Women and Development) in the region with the aim of making them more socially and economically productive. She is loved and respected by women in the region and she is well known among the men-folk. Like

me, she also tape recorded all that was said and was sometimes allowed to ask questions for clarification while a ritual activity was in progress. Each week-end, following recordings, we met as a team and tried to interpret what was recorded in the course of the week. We carried out follow-up exercises by visiting individual participants we suspected to be the "know-all" for clarifications and further discussions of issues that appeared ambiguous to us.

This method was particularly useful as it ensured the formulation of sensitive questions in the local dialect and within participants' frames of mind (Berger and Luckmann, 1966). Coupled with in-depth interviewing, participant observation gives the researcher the "cultural knowledge necessary for building a theoretical understanding of human existence" (Singha, 1989:77). As a matter of fact, most of the informants were selected based upon their contributions during these initial unstructured participant observations. In addition, the method provided me with an opportunity to intuitively understand the place of funeral rites within the Dagaaba cosmology and the health implications of participating in them.

Participant observation, like in-depth interviews, also has its limitations. Hoben (1982) sees qualitative methods in general and participant observation in particular as soft, not scientific, lacking rigour, and not repeatable. Weaver (1985) also notes that participant observation requires many years of fieldwork and ethnographic data accumulation that is sometimes confusing and often not useful for policy and planning purposes. Participant observation is also criticized for its use of small-scale, in-depth research results which cannot be generalized to a larger population (McCall and Simmons, 1969).

The importance of participant observation lies in its ability to increase confidence about the meaning of data. In this study, the objects of observation were participants' attitudes, beliefs, feelings, opinions, behaviour, responses, motivations, statements, questions,

ritual songs and dirges, as well as procedures and the manner of presentation. The objective was to understand how they relate to health seeking (especially, how they influence utilization of health services). The only way through which the meanings and implications of such processes of reality could be grasped by me was by participating in them and observing them as they progressed. Singha (1989) states that all social science knowledge is grounded in our everyday lives and observations of community life and its empirical reality only become socially intelligible and meaningful through participation.

### 3.6.3 Focus Group Discussions (FGDs)

To further increase the reliability and validity of data gathered through indepth interviews and participant observation methods, a third method, focus group discussions, was introduced towards the end of data collection. By this time, all respondents within the selected sub-groups had been interviewed, rites of death had been observed, and areas of concern clearly mapped out. The questions that guided these group discussions were formulated taking into account both the issues at stake and the character of the particular group in question. For example, sessions were sex divided. That is, men and women were put in different sessions. Some people may argue that the presence of men give women reassurance and encouragement. However, in the Manlarla society "mixed-group" discussions are not likely to yield maximum results as women are "unable" to express themselves about certain issues before the menfolk.

Before each session began, I introduced the concerns as mapped out from earlier interviews and observations. I also indicated to participants that my interest in group discussions was their own perceptions, opinions and feelings about the issues and not the

widely acknowledged cultural precepts. Notes from earlier interviews with these groups of respondents helped in the determination of changes in their expressed views due to the interaction characteristic of focus group discussions. Such changes, if noticed in the course of the group discussions, were immediately brought out for further clarifications. If the changes were noticed after the group discussions, follow-ups were made to the sources of such changes for further discussions.

Focus group discussions are sessions in which small numbers of informants, usually 6 to 12 (Stewart & Shamdasani, 1990:57), talk about issues relevant to the project of research. Participants of focus group discussions are selected from specific target groups with germane opinions and ideas about what is to be investigated (Dawson et al., 1991; Krueger, 1988). The "hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in the group" (Morgan, 1988:12).

In this study, as Vong-Ek (1989) suggests, focus group discussions were used to determine those opinions, ideas, attitudes and knowledge held by target groups which regulate group and individual behaviour. Conducted as open discussions, participants commented on issues, asked questions and responded to comments by others. Deference often shown in the one-to-one interview situations was less guarded during these group discussions and interviews. This method of eliciting data thus permitted the confirmation of what was truly local knowledge (Geertz, 1983) and the dismissal of what was purely idiosyncratic (Ole Sena, 1991). Indeed, inputs from these group discussions were particularly helpful in comparing and measuring the correctness and completeness of earlier statements by informants during interviews and observations.

At the beginning of each session, a chairperson was selected (and sometimes elected if more than one person was nominated) to ensure smooth and open discussions. An "elder" from among participants was normally invited by the chairperson-elect to commit proceedings into the able hands of the ancestors and the earth-god. An identification was also required each time a participant made a contribution in the form of a comment, suggestion, observation or even a question. This was thought necessary in order to be able to trace sources of statements and/or changes for clarifications if unnoticed until after the session. At the end of each session, local beer (provided by the researcher) was served to participants after a little was poured for the gods and ancestors (our invisible guests throughout the sessions).

The benefits and weaknesses of focus group discussions have been identified by a number of writers including Higginbotham and Cox (1979) and Dawson et al. (1991). Higginbotham and Cox, for instance, list seven advantages of focus group discussions as flexibility, contingencies handling, participants' stimulation, speed, relatively modest cost, ready production of hypotheses and ideas, and direct connection between researcher and informants. On the other hand, Dawson et al. (1991) explain that the researcher/facilitator has less control over the discussion which may cause a difficulty in the analysis of the results. For instance, they emphasize that difference between groups can pose a problem as each group has unique characteristics and results could reflect the idiosyncrasies of individual sessions. While that is possible, as Morgan (1988:10) states, "from the social sciences' point of view, focus groups are useful either as a self-contained means of collecting data or as a supplement to both quantitative and other qualitative methods". In this study, focus group discussions were conducted as a supplementary method to both interviewing and participant observation. As such, any weaknesses were minimized.

## 3.7 Importance of the Study

The study is important as a result of concern for the underdevelopment crisis of the UWR of Ghana, a crisis Falola (1992:3) suggests is partly the result of the state of health care delivery in the African continent as a whole. The bulk of African productive population lives in rural co. mmunities where tradition and custom determine social life. For instance, about 65 percent of Ghanaians and 89% Upper Westerners live in rural communities (Ghana, 1987b). Development infrastructures in these communities are not only always inadequate, but they are also sometimes inappropriate (Oberender and Diesfeld, 1983). Inappropriate infrastructural delivery in these communities is likely to result in ineffective utilization as important local perspectives are often ignored in their conception and execution.

Low utilization rate of health infrastructures in the UWR of Ghana in general and among the Manlarla in particular, means the persistence of their preventable and controllable health problems. The persistence of their health problems means loss of vital social and economic productive life which, in turn, reinforces the underdevelopment syndrome among the people. Consequently, increase in socioeconomic productive life is essential for all people but critical for the people of the UWR who must accomplish a lot with very limited resources.

In addition, while policies for improving the use of health services in rural communities are presently being initiated in Ghana, the cultural complexity of communities as factors that determine propensity to use health services are poorly understood. For this reason, there is a greater need than ever for research that seeks to understand local people's conceptions of the world in which they live. At least in this cultural context, health and its determinants derive largely from the world view which is manifested in sociocultural practices and processes. Thus, the importance of sociocultural practices and processes as a factor in

health determination in all its dimensions should be given greater priority in health research in such communities. Yet, among the Dagaaba in general and Manlarla in particular, such a study has not previously been conducted.

The conception and execution of programmes of intervention require financial and organizational resources. But an understanding of the people in question and their indigenous strategies is required in order to empower the financial and organizational resources to achieve results. As Mechanic (1989) stresses, such an approach not only contributes to a more accurate understanding of the importance of processual influences on community and/or individual behaviour but also offers an opportunity for the revelation of possibilities for constructive interventions.

## 3.8 Limitations of the Study

In the quest for material for this study, a variety of difficulties were encountered which inhibited the collection of empirically reliable and valid data from certain individuals. There were a few instances when initially targeted respondents refused to entertain any discussions of their practices and experience with me. The reason was that they were afraid they might violate the sacred code of "professional confidentiality" in the course of our discussions, the consequences of which, they maintained, would be disastrous and could only be controlled by the performance of expensive rituals.

In other cases, it was the emotional involvement of participants that prevented the collection of such empirical data. Two of the 15 funeral rites I attended were so emotionally charged that I did not even venture any discussions of issues that did not appear clear to me. In the first instance, the deceased was a young, promising and successful miner. In the second

case, the deceased had occupied important social statuses (mines captain, chief of Dagaaba miners, chairman of development committees, a husband and a father) and played vital social roles in each of these capacities. My experience with such funerals has been that participants remain completely lost to uncontrolled emotions set in motion by the verbal replay of the deeds and virtues of the people who were no more. In these two instances, I found myself in an emotionally worse situation than my more experienced respondents. Consequently, I relied heavily on what was recorded on cassette recorder for discussions at a later date. Even though these personal, emotional "travels" had revealed to me what it means to be in the position of respondents, the importance of what might have been gained from detached participation and observation needs to be noted.

Two of the "supporting" respondents were not available for the follow-up visits designed to clarify outstanding issues. One respondent died shortly after the funeral at which he was in attendance, while the other travelled beyond reach. For purposes of consistency the analysis is, therefore, limited to 88 respondents (60 ritual participants and 28 supporting respondents) from whom all relevant information was extracted.

Neither I nor my assistant was allowed to participate in those rites of death considered to be reserved for ritual chiefs. For this level of ritual performance, even inexperienced and unreliable (okra-mouthed) initiates are disallowed participation. At this point, it is believed, ritual chiefs communicate with the spirit world. When the ritual chief of Nyimbale-Paala was asked what they normally discuss with the spirits he simply said, "my son, when you become a ritual chief you will understand all this without being told". However, a respondent from Nyimbale-Kore indicated ritual chiefs always call for the spiritual protection of their respective sections. Sometimes, he added, "wicked ritual chiefs use elements of funeral

decorations to invoke vengeance on the part of the deceased". This vengeance, they maintain, comes in the form of Popaale swollen belly (males) and Muora a sickness that resembles AIDS (females).

Other problems included failing memories of respondents, contradictory responses, a pronounced tendency of most elderly respondents to romanticize the past and denigrate the present, and the willingness of most young respondents to glorify the present and "play the game" (saying what they believed I wanted to hear). This is by no means unique to Manlarla society. Many rural people have been made to feel that their beliefs and traditional practices are backward. They also observe their "distant" brothers and sisters, who come on sporadic visits, trying to promote the supposed virtues of their new lives. For these reasons, many young men and women, literate and non-literate are sometimes reluctant to "say it all" for fear that they may be labelled ignorant and out of touch with the "modern" world. While it is unrealistic to hope for complete accuracy, the cooperation from chiefs, village elders, ritual specialists, health professionals and, above all, many ritual participants, contributed a large measure of validity and reliability to the data I collected.

## 3.9 Conclusion

This chapter has provided an outline of the research architecture, its theoretical and methodological frames as well as the importance and limitations of the study. Theoretically, the study does not remain confined to any particular theoretical persuasion like structural-functionalism, conflict theory, or symbolic interactionism. This stems from the conviction that qualitative researchers should neither seek "truth nor morality" but rather they should capture the process of interpretation, a process that requires what Weber (1968) calls *Verstehen*, the

empathic understanding or ability to reproduce in one's own mind the feelings, motives, and thoughts behind the actions of others.

The methods used to collect data were interviews, observations and group discussions. Various problems were encountered in the field. But reliability and validity of data remain high as the researcher enjoyed an unprecedented level of cooperation, a virtue in research that could be a mirage but for the researcher's familiarity with the site and people. What needs to be done now is to make the theoretical and methodological frames enter into dialogue with Manlarla daily struggles and experiences. This way, it will be possible to explore their concepts of pain, suffering, frustration, faith and hope (that is, Manlarla history of death, health and illness). As E.W. Burgess suggests, "in the life history is revealed as in no other way the inner life of the person, his moral struggles, his successes and failures in securing his destiny in a world too often at variance with his hopes and ideals" (see Shaw, 1966:4).

# CHAPTER 4

## MANLARLA COSMOLOGY AND HEALTH

*For the African, the spiritual universe is a unit with the physical, the two intermingle and dovetail into each other so much that it is not easy, or even necessary, at times, to draw a distinction or separate them. The Dagaaba, to be sure, do not make any distinction between natural and supernatural, they have no concepts at all equivalent to the vaguer, and not unrelated dichotomy between the sacred and the profane.* (E. Kuukure, 1985:60)

### 4.1 Introduction

The profound mystery of the creation of the universe has influenced the beliefs and moulded the philosophies of peoples of the world since the beginning of time. In short, it has directed their religious life. Wallace (1966) defines religion as a kind of behaviour which can be classified as belief and ritual in supernatural beings, powers, and forces. This implies humans' confession of impotence in certain matters. The Manlarla, who are the focus of this study, are no exception to this universal confession. Within the framework of their traditional life, a Manlarlo native of Manlarla society is immersed in a religious participation beginning before birth and continuing after death. For them, to live is to be caught up in a web of religious drama. This is fundamental as it implies that they live in a spiritual universe.

In this chapter, we shall be dealing with Manlarla's conception of life, its place within their religious universe, particularly what they do and say with respect to those areas of experience which they feel are beyond the control of human beings and the understanding of ordinary human knowledge. As Birnmaum et al. suggest, religion is also "a propitiation or conciliation of powers superior to man which are believed to direct and control the course of

nature and of human life" (1966:33). We do not intend to make a study of Manlarla religion as such, but to focus on those issues or beliefs that relate to their life and death. We shall explore the relevance of these beliefs to their conception of health and management of illness, and demonstrate how these linkages influence health seeking behaviour.

In sketching the broad outlines of Manlarla cosmology (religious experience), we intend not only to locate the definitions of health and illness, but also to identify and place the various practitioners and their clients within the context of Manlarla social thought. In other words, the reciprocal relationships between patients and practitioners, and between the latter and the "worlds" of their "profession" are critical features of Manlarla social thought that are essential in understanding differential access to and variation in propensity for and/or utilization of available healthcare services.

## 4.2 N'taan be: The Manlarla Philosophy of Life

The social heritage of every people does more than supply a set of skills for making a living and a set of blue-prints for human relations. The Manlarla have passed on a certain conception of life from one generation to the other, a philosophy that determines the boundaries between empirical knowledge and their religious consciousness. For them, organic life is a philosophical category denoting a visible, active experience of a material component, Enga body, and an invisible, spiritual existence of an immaterial counterpart, Sie spirit (see Figure 4.1). The destiny of the visible material component is to provide livelihood, suffer pain, die, be disposed off or discarded and left to rot. As one literate male respondent aptly described it, "it is a storehouse for all kinds of foreign invaders such as food, misfortunes, diseases and injuries, and death".

On the contrary, the destiny of the invisible, immaterial element is to nourish the death-body, exit it in sleep and at death and continue life in a different domain. By its ability to nourish the material component, this spiritual element exerts control over it and dictates its behaviour. At night, while the material body is relaxing in sleep, the spiritual entity exits and to avoid awareness of its exit, its activities are recast in the sleeping body as dreams. One respondent, a herbalist and teacher said, "it is Sie that brings diseases and troubles to Enga; Sie exits Enga at night, engages in all kinds of activities and whatever trouble is encountered during its exit is quickly deposited in Enga upon return". Another respondent, a herbalist, teacher and chief added, "failure on the part of Sie to return to Enga means death of the latter". These body and soul relationships are not unique to Manlarla society. For instance, Barasch (1993:262) quotes 16th century Agrippa as observing that, "so great a power is there of the soul upon the body, that whichever way the soul imagines and dreams that it goes, thither doth it lead the body".

Manlarla notion of perpetuality of life is evidenced in the immortality of the spirit and consolidated in their belief in the existence of a hierarchy of spirits that govern the universe. The spirit world, as we shall see later in the chapter, is conceptualized as comprising protective spirits and destructive spirits. Above these spirits is Naa-Ngmen who created all things. He manifests His power through a pantheon of subordinate Ngmeme gods animating natural phenomena and Kpiine ancestor-spirits whose constant contact with life on earth brings the spirit world closer to the human world. Having created the universe in "His own image", Naa-Ngmen provided it with health and illness, and life and death, as evidenced in animal, plant, insect and human transitions.

The natural world with all its endowments is believed to be created for the good use

of human beings. One respondent, a retired educationist and practising catechist said,

> Just as Naa-Ngmen provided man with woman so that he may multiple and fill the earth, so did He provide our world with air to breathe, sun to heat us, moon to brighten our nights and water to nourish plants and animals, all of which facilitate health and sustain human life.

And since these resources offered by nature are part of the divine plan, he added, "they must not be abused or used inappropriately". That is, the anthropocentric ontology or order of things, as ordained by Naa-Ngmen, should neither be altered nor be destroyed.

Locked in this triple web of complex relationships with themselves, with nature and with the spirits, balance is considered by the Manlarla as essential to ensure human life. The essence of life, then, is in "being", not in "becoming". An abused order or network must be reconciled with the abuser(s) as quickly as possible. This is normally done through reconciliations, prayers, sacrifice, and offerings. Failure to do this, as appropriately determined, compels the invitation of some kind of supernatural wrath. Certain illnesses are, therefore, believed to be the result of failure to reconcile abused order with abuser(s). Under such situations, a respondent said, "a forced 'pill' is released maliciously to restore the essential balance that has been upset". It is within the framework of this belief Manlarla usually attribute illness (and death) to supernatural forces, divine retribution and the malevolence of a witch/wizard or a sorcerer.

Health is one canon of the spiritual part of life and is understood as a state of being; that is, harmony in all one's relationships: relationships within the human world, and with the natural and supernatural worlds. The other canon of the spiritual part of life is illness. Illness is a state of disharmony with one's universe of worlds. As discussed later in the chapter, Manlarla believe that health or illness is symptomatic of "correct" or "wrong" relationship

with constituents of the universe. So conceptualized," health and illness are far more social than biological; there is a more unitary psychosomatic relation, or reciprocity between mind and matter" (Appiah-Kubi, 1981:10). Health is associated with good, with blessings, with beauty, with love, with respect; all that is positively valued in life. On the contrary, illness in Manlarla thought is a negative reflection and/or expression of an individual's status vis-a-vis the cosmic order. Put differently, illness shows an expression of disarticulation in an individual's relationship with his/her worldly contemporaries or, as Appiah-Kubi puts it, "illness shows that which has fallen out of a delicate balance" (ibid.).

To this extent, the Manlarla understanding of health and illness, therefore, is spiritual and/or relational (Ole Sena, 1991). As a result, much of their lifetime is spent maintaining healthy relations and reconciling broken relationships. An old man from Nyimbale said, "how can you talk of health when you can't even talk to your neighbour or when you're out of favour with the gods and ancestors". Another from Loho explained, "among us, there exist a Kyebaa web of life. The birds and the animals, the earth and the sky, the totems and the clans, our personal souls and the Great Spirit, all exist within this web. To be in health is to remain in good balance". Health is, therefore, the result of harmonious relationships, whereas illness is a consequence of broken/disharmonious relationships. This is graphically illustrated in Figure 4.1. However, the basis of N'taan be and its dimensions is the Manlarla conception of the universe.

## 4.3 Manlarla Conception of the Universe

The universe is conceptualized as comprising three different and yet interdependent worlds: the supernatural (spirit) world, the natural (physical) world and the social (human)

world (see Figure 4.2).The supernatural world is believed to "control" activities and behaviour in the other two. One respondent acknowledged that the supernatural world manifests its control over the human and natural worlds by generating and sustaining harmony and disharmony in the form of "health or illness" and "rain or drought". In this sense, Manlarla universe is not only a religious one, but also it stands in complete unity and solidarity with its constituent parts as one mode of existence presupposes all the others. It is under these circumstances that a balance is necessary and must be maintained at all times to ensure the survival of the whole order. With this conception of the universe, they are able to provide themselves with relevant and adequate responses both to the mystery of creation and to the mystery of life in all its dimensions.

Lacking any form of written alphabet, Manlarla express their knowledge of creation and the purpose of the universe through folklore such as myths, legends and fables. Their predilection for myths of both religious and popular character is very remarkable (Kuwabong, 1990). Most Manlarla stories are not different from those told by other Dagaare speakers, but their style, the phrasing, and the embroidery of incidents have their own local colour and unique Manlarle quality. In their presentation, for instance, one always feels a great sense of humour, a delight in puns, and a tremendous emphasis on structures and authority as ordained. Manlarla folklores are means of expressing, teaching and transmitting knowledge of realities with deep sociocultural meanings and implications for individual health and community survival, cohesion and solidarity.

The term myth as used here has a different meaning from its common usage. In everyday language, myth seems to imply falsehood. That is, to say it is a myth is another way of saying it is false or it is not real. Thus, to speak of mythology is to run the risk of being

misunderstood to mean irrealities, mere fantasies, or things with neither a historical nor a real signification. Ethnologists, historians of religion and sociologists use the term in reference to "sacred tradition, primordial revelation, or exemplary model" (Eliade, 1963:1). Myth is, therefore, a "story" that is a most precious possession. As Ninian Smart observes:

> To use the term myth in relation to religious phenomenon is quite neutral as to the truth or falsity of the story enshrined in the myth. In origin, the term "myth" means "story", and in calling something a story, we are not thereby saying that it is true or false. We are just reporting on what has been said. Similarly, here we are concerned with reporting on what is believed (1970:18).

Within the framework of these stories, Manlarla have come to institutionalize their beliefs about the existence of certain abnormal and extra-ordinary forces and powers in the universe. These beliefs, as the researcher observed from a variety of statements and expressions made by respondents, include: (1) the belief in the existence of ancestor spirits and non-ancestor or nature spirits; (2) the belief in the presence of anti-social and destructive power of witches/wizards, sorcerers and other evil agents whose activities are sometimes incapable of escaping the "vigilant eye" of the "visionaries"; (3) the belief in the intrinsic efficacy of certain natural substances which are used as "medicines" to save or to harm, depending upon their preparation methodology by qualified practitioners (see Figure 4.2).

Against such belief structure, Manlarla are able to generate and sustain a moral order or code that colours their activities, interactions and interrelationships. Forde, in analysing African mode of thinking, for instance, writes;

> One is impressed not only by the great diversity of actual expressions of belief, but also by substantial underlying similarities in religious outlook and moral injunction...Where the natural processes involved in good fortune and in bad remain largely unknown and uncontrolled by physical means, men have at all times rationalized their fate by postulating mysterious forces and beings in

nature, and mysterious powers among their fellows (1965:58-62).

Mythology is, therefore, the response of Manlarla imagination to the unchartered spheres of their experience. However, since this mythology is neither developed nor rationalized into theology, inconsistencies may exist here and there. Whatever discrepancies are there, these myths still give definite form to many Manlarla notions of phenomena and serve as a warrant for the carrying out of the many ritual acts (such as funeral rites) and secular acts (such as health seeking) in prescribed ways. Evans-Pritchard (1976) demonstrates a similar intellectual logic behind Zande beliefs by showing that these beliefs are not a miscellaneous scattering of disparate notions but rather a systematic set of ideas and social causality of misfortune, including illness.

As depicted in Figure 4.2, the basis of Manlarla religious attitude and activities originates from the belief in a power transcendental to the universe of extra-ordinary and abnormal forces. This power is real and supreme. As such, its influence is experienced in all three worlds: the supernatural, natural and social. This power is called Naa-Ngmen or Naa-Mwine, as sometimes rendered (Almighty God or King God). The influence of Naa-Ngmen on Manlarla activities, including health seeking, is presented in the sections below.

## 4.4 The Supernatural (Spirit) World and Health

The world is now mainly a secular one in most Western societies. As Bibby (1993) suggests, most people in these societies may go to Church on Sundays and birth, marriage and death may be solemnized, but they do not feel that religion has anything to do with the large sectors of life. Influenced by the watertight categories into which Aristotle and other scholastic philosophers believed they could separate all reality, religious, social, economic,

political life and healthcare in Western societies are viewed as clear-cut spheres.

With the Manlarla, it is quite different. For instance, a 34 year old headmaster of a Junior Secondary School remarked, "how can you think of any human endeavour outside the realm of Almighty God who makes and unmakes at His pleasure?". The Manlarla world is thus a whole with daily activities coloured by their conceptions of supernatural forces, some protecting and others threatening. This is not to deny the presence of abstractions in Manlarla social thought. However, such abstractions may just be for the sake of convenience as realities in human life blend into the supernatural.

Manlarla conception of the supernatural is to be understood from their conception of Naa-Ngmen. According to Archbishop (Rtd) P. Dery, Dagaaba (Manlarla included) conception of Naa-Ngmen can be understood from the way they live and interact with one another, in the frequent sacrifices made to the deities, in the Bagre myth, in the beliefs in the life hereafter, in the names, in daily greetings and wishes and in the various rites such as divination, birth rites and funeral rites (in Kpiebaya, 1973:35). Where do the Dagaaba locate this "Supreme Spirit"?

### 4.4.1 Naa-Ngmen: The Supreme Spirit

The location of Naa-Ngmen is in the sky above. As indicated by Manlarla stories and sacrificial statements, His power transcends the boundaries of the sky thus making Him both far and near. If you ask a Manlarlo whether s/he believes in the existence of Naa-Ngmen, the response is always given in a metaphorically proverbial question: Ang wulo bibile woo? who shows a child an elephant? The implication in this proverb is clear: Naa-Ngmen's existence is so obvious a reality that even a child need not be shown. His existence and power are

demonstrated in Manlarla daily life experiences through their names, greetings, wishes, thoughts, proverbs and statements. Some of these names, wishes and expressions of gratitude and what they intend to convey are listed below.

Some names with bearing on Naa-Ngmen

| | | |
|---|---|---|
| Venko-Ngmen | leave it to God | appeal to God's will |
| Anleu-Ngmen | who has become God | appeal to God's omnipotence |
| Ngmen-Bataazie | God has no location | appeal to God's omnipresence |
| Ngmen-Labagna | God is the knower | appeal to God's immanence |

Wishes for the traveller

| | |
|---|---|
| Naa-Ngmen na biele fo | God will accompany you |
| Naa-Ngmen na de fo gbee | God will lift or take your feet |
| Naa-Ngmen na eri fo zubeo | God will protect you from misfortune |
| Naa-Ngmen na pogi fo puori | God will be behind you or cover your back |

Expressions of gratitude to a benefactor/ess

| | |
|---|---|
| Naa-Ngmen na maale fo | God will bless you |
| Naa-Ngmen na pogi a vuori | God will replace what is given out |
| Naa-Ngmen na yuote pansong | God will open good door for us |
| Naa-Ngmen na kote laanfie | Good will give us good health |

From these names, wishes and statements of gratitude, Manlarla demonstrate their belief in and admit the existence of Naa-Ngmen who is spiritual, immaterial and non-physical and yet personal and supreme. He is living and all life emanates from Him. As the creator and sustainer of all things including life and death, health and illness, Manlarla attribute the

occurrence of everything to His will as in the expressions Ka Naa-Ngmen sagi if God allows or permits it, Naa-Ngmen na kote nyovori may God give us life. Naa-Ngmen na kote laanfie bii enmaare may God give us health or peace, Naa-Ngmen na kote kpiengo may God give us strength, Naa-Ngmen na ire te yeli faareng may God prevent us from evil-doing or in names such as Ngmendieye or Ngmensagee God has accepted it or God has permitted it.

He is believed to be the ultimate controller of creation with His power permeating the entire universe of human experience. It is against this background that Manlarla sometimes attribute illnesses to Naa-Ngmen, for anything that happens must receive His divine approval. As a respondent said, "a 'building' demolished by God can't be reconstituted without His assistance". Another respondent reawakened my memories to the lamentations of the Bibilical Job when he said, "if He (God) breaks a house down, there is no rebuilding; if He imprisons a man, there is no release". Such metaphors speak an inclusive language. To seek health, one has to live and perform according to the wishes of Naa-Ngmen. But instructions about the wishes of Naa-Ngmen, Manlarla believe, are mostly carried out by subordinate spirits playing an intermediary role between Him and human beings.

### 4.4.2 Intermediary Spirits

According to stories that are heard from childhood, Naa-Ngmen had lived closer to human beings on earth. However, as one story portrays, the wickedness of an old woman forced Him to withdraw from earth into the sky. The story goes that,

> ...an old woman, who was always moving from one misfortune to the other, decided to avenge for God's failure to protect her from her stream of misfortunes. Through similar stories, the woman knew Naa-Ngmen to be a handsome, completely grey Oldman with distaste for impurities and disfiguring substances.

> This quality of Naa-Ngmen provided the woman with a suitable revenge weapon as she decided to make an evening fire with damp wood using her misfortunes as an alibi for her inability to fetch dry ones. The smoke produced from this contrived vengeance was so thick that it started discolouring His long acknowledged grey beauty. To prevent the disfiguring of His beauty, Naa-Ngmen moved up into the sky and since then the sky has been His official habitation.

However, though located in the sky, Manlarla names, wishes and expressions of gratitude, as indicated earlier, show that Naa-Ngmen also occupies Himself with their daily life. This conviction indicates the power of Naa-Ngmen who could be transcendent and yet immanent, remote and yet nearby, so that humans can, and in fact do, establish contact with Him.The agents through which Naa-Ngmen manifests these powers on Manlarla daily life are the spirits (nature and ancestor). These links with the spiritual world are maintained through the acts of observances, worship and offerings.

Generally speaking, these spirits belong to the ontological mode of existence between Him and humans. While some of these spirits are believed to be Gyin sonne good or protective in their interaction with humans, others are believed to be Gyin faare evil or malevolent. The good spirits are perceived as Naa-Ngmen's true representatives. As His acccredited ambassadors to the social and natural worlds, they have delegated powers and authority with which they provide, deprive, or deny the necessities of life such as rain, fertility, blessings, protection, and health to their designated "provinces" which may be individuals, families, lineages, clans or even communities. The main function of this category of spirits, one earth-priest emphasized, "is the promotion and preservation of the spiritual and material well-being of the individual and/or the community as a whole". For this reason, he added, "we are always careful not to offend them; when we unintentionally do it, we pacify them before they exhaust their patience".

The malevolent spirits and a few human beings also have access to this "spiritual" power. They have knowledge and ability to tap and manipulate it. But as the earth-priest lamented, "malevolent spirits and evil human agents use it to inflict pain and suffering such as drought, infertility, sickness and death on their victims". However, this researcher observed that some human agents use their knowledge of this power for the good of all. While colle :ting data for the study, I was privileged to observe one renowned herbalist using his powers in divination to diagnose and treat a Muora patient. I cannot comment on the scientific efficacy of his treatment. But I was certainly moved by his powers of revelation and the satisfaction written on the face of his female client. In another case, a Catholic charismatic leader recounted the "revival bullet of prayer" on a stroke patient from Nyimbale. In both examples, "practitioners" used their knowledge to restore the essential balance required for harmonious living and continuity of life.

In terms of communication, both the protective and the malevolent spirits are believed to be ontologically closer to Naa-Ngmen than human beings (though some humans have an edge over others). In other words, whereas humans require intermediaries (as demonstrated by Manlarla acts of offering, sacrifice and divination) to communicate with Him, these spirits do not. One popular offering and/or sacrifice citation among them which demonstrates the intermediary role of the earthly gods was recorded during fieldwork and is reproduced below.

| | |
|---|---|
| Naa-Ngmen, die buntong;<br>Naa-Ngmen, die buntong.<br>Bunde mara ang de maang<br>mang deng nuu tong kye kofo.<br>Kaa nang dabe toloo, N kong<br>sage deng nuu tong kye kofo.<br>Kye foo baraa a yeli ka fo<br>zu bela toore, ka nie muong<br>taa yeli, ka O buoli fo<br>Naa-Ngmen yuori, kye de a<br>buntong nga loo.<br>Ka fo na sigiwang,<br>wa de a yela maale.<br>Bie fo Naang neng Kpambie<br>tezing, kye ka N de buntong<br>nga loo (Kpiine, Naamane<br>bii Kala). | Almighty, receive our ash offering;<br>Almighty, receive our ash offering.<br>Hot flames have cooled, and I have<br>put my hand in before giving it to you.<br>If it were hot, I could never have put<br>my hand in before you.<br>But you created them and said that<br>your location is far; but that in<br>times of need or calamity, we should<br>call your name and throw<br>these ashes.<br>That you would come down and<br>provide us the needed aid.<br>Remain seated in your Kingly throne,<br>while I deliver this offering of<br>ashes through (ancestors, river god<br>or medicine god). |

From this citation, it can be concluded that Manlarla generally appeal to Naa-Ngmen in times of crisis, including illness. However, believing that they are deficient in His language and as a demonstration of reverence for Him, they make these appeals through intermediary spirits. According to most informants, the spirits that play this intermediary role between Naa-Ngmen and humans are of two categories: Gyinne nature spirits and Kpiine ancestor spirits (see Figure 4.2).

## I Gyinne: Nature Spirits

One category of intermediary spirits observable in Figure 4.2 is that of the Gyinne nature spirits. In the natural world of the Manlarla are domestic and wild animals, plants and trees, birds and insects as well as the many creatures and phenomena of nature like the sky, lighning, rain, earth, mountains, rocks, streams and so on. Each of these animate and

inanimate phenomena is believed to be a living entity with a Gyinna spiritual force. In other words, as one respondent explained, "anything created by Naa-Ngmen has Enga body and Sie spirit, and the spirit also has Nyovori life and Vogrong breath in it".

Gyinne are believed to be immortal and cannot be destroyed. They exit the Enga physical entities they animate once the entities are dead or destroyed. Human beings are, therefore, believed to be surrounded by many Gyinne, some of which can do considerable harm. A 37 year old family head explained, "in the course of our farming activities, we destroy many plants and trees and we kill many animals and insects". In the process "we release their Gyinne from their material habitations upon ourselves". His wife, an inherited widow, added, "when we burn the bushes that they clear, the air around us and the other objects (visible and invisible) are polluted"...By destroying life and offending malevolent powers, "we also release upon ourselves their Gyinne". These released Gyinne, they believe, may avenge the destruction and disturbance by sending misfortune or illness, especially Dao sagine irritations.

But, as we noted earlier, not all Gyinne are malevolent. In fact, some of them act to counteract the malevolent acts of those that seek to harm human beings. They may act as personal or collective tutelaries such as totems. For this reason, they are also believed to be Naa-Ngmen's ambassadors to certain provinces. Manlarla have a pantheon of such Gyinne through whom Naa-Ngmen manifests Himself. These protective Gyinne are represented by icons and are generally known as Ngmeme gods.

Within the study area, informants listed some of these Ngmeme to include Nyimbalee Datong, Chariba Sengo, Lori Kojo, Sankanee Kalibi, Nanvilee Kyiele and Lohee Kala. A ritual specialist told me "regular sacrificial rites are performed and petitions made to these protective Gyinne principally to atone for the transgressions of their counterparts, but also

to appease the spirits in general". The objective here is to maintain healthy relationships or to ensure the essential "balance" despite the inevitable destructions of natural substances.

Gyinne, therefore, represent the personifications of Naa-Ngmen's activities and the manifestations of His power in natural phenomena and objects. Believed to come from Him and act as servants and intermediaries between Him and the physical manifestations of the natural world, Manlarla hold them ontologically closer to Naa-Ngmen than the physical objects themselves. Specific examples of these iconic representations and their health implications are discussed later in this chapter under natural (physical) world.

## II Kpiine: Ancestor Spirits

The second category of intermediary spirits is Kpiine ancestors. These are the spirits of dead members of the human world believed to inhabit the spirit world and provide basis for the belief in the continuation of the clan and/or community. Confirmation for this belief is expressed as, Ka mang kpi N na gaala Nnabaale mene zie if I die I will go to my ancestors in the spirit world. As spirits, they are invisible, but sometimes make themselves visible to surviving descendants either in dreams or imaginations. In reality, they have sunk beyond the physical and mental horizons of surviving descendants. Since they have sunk beyond the physical and mental horizons of the visible world (Mbiti, 1969), they are within the state of Saakumene collective immortality. In this study, the terms Kpiine and Saakumene are used interchangeably.

Becoming an ancestor spirit is a kind of social elevation. Thus, Manlarla show respect and high regard for them. They are believed to appear in dreams, especially of Kpiin noba death people and medicine men and women, the only recognized "human links" between them

and their surviving descendants. The appearance of Kpiine, or their accredited delegates, Tenkpiine (see section below), in the dreams of Kpiin noba is taken seriously. Through their dreams, the Kpiine give out information or warn surviving descendants of ill-health or disharmonious relationships. In this regard, a respondent from Nyimbale shared his dream experience with me. His said:

> One of my sons, Danyagorba, was putting up a house in the village. His effort aroused jealousy and envy. Some evil people in our village, considering my son's effort as an unnecessary display of wealth, planned to end his life.
>
> Our Saakumene ancestors sent my senior brother, Yekouba, to "disturb" my sleep. In the sleep, I saw we were in a mourning procession with my senior brother leading. Other members of our lineage were there. We were moving between our house and the Yengkpeng compound for public funeral rites.
>
> I didn't understand this dream. The following morning I consulted a Bugbugra diviner. He told me the meaning of my dream. He also told me what to do to neutralize the power of the evil people.
>
> According to him (Bugbugra), our Saakumene did not want my son to be killed. So they sent my senior brother (then a living-dead), to "warn me" as Yidaana family head.
>
> To "spoil" the plans and wishes of the evil people, the Bugbugra advised me to make a ritual declaration (which I did) at the Kpiintige altar of the ancestors. This way, both my son and the project were spiritually protected.
>
> I will give them (Saakumene) my offering of thanks after the third year (as a male) and only when the project is completed and my son is alive.

Incidentally, his consulting diviner was included in the sample of selected specialists for the study; and so I contacted him in his village, Nyimbale-Charile, to find out how he determines the meanings of dreams. After the generally acknowledged hospitality of the people of Charile had been demonstrated, I stated the purpose of my call in very vague terms. In our culture, interactions between "unequals" are supposed to begin like that for two

reasons. First, it is a way of inviting the consent of the superordinate. Second, depending upon the superordinate's response, the subordinate is better able to design and organize the rest of the interaction. With his consent granted and my confidence boosted, I asked how meanings of dreams are ascertained by him. He answered, "I don't ascertain meanings to dreams. I appeal to the spirits to do that for me. So what I do is to tell them (clients) what they (spirits) say". How do you get the spirits to do this for you? He siad, "N'yaanga my grandson, the way I do this depends on the nature of the dream; I can only tell you how I draw the attention of the spirits". What he told me is produced below.

> Saakumene, N'nabaalemene, Kpiine, and Tengsare, we pray about and for peace, food and health. But the family has changed; the house has changed. We sleep with our eyes open; our mind is scattered, animals are dying, children are vomitting, and women can't bear children anymore. What is happening? We eat with the dead, we drink with them and we mourn with them. What is happening? What did we do wrong?How did we do it? We need your intervention. If Naamane the river god allows the streams to dry up, it is his shame. For whose home is this? It was yours before it became ours.

Just as Kpiine use Kpiin noba and other personalities as links for resolving relationships of ill-health, so do these personalities consult them, through divination, as part of their ritually ordained role to restore health. Their position vis-`a-vis human health is summarized in the words of one ritual specialist. He said, "their authority must be acknowledged by all, and their instructions and admonitions followed with accuracy because they protect us and provide us with our needs".These statements reveal several significant things about the moral implications of disease and death. First, children are ill and women are barren because people have failed in some obligations. Second, it is the job of the ancestor spirits to reveal these human failings and provide guidelines for overcoming them. By informing descendants the underlying relation between an illness episode and socially

disruptive behaviour, Kpiine play a very important role in Manlarla social system.

Ancestor spirits, like nature spirits, are believed to sleep in the day time and roam at night in folktales and stories. They visit human dwellings during the day only when they want to engage in daylight demonstration of their anger. At Tuori village, for instance, a man, whose funeral was one of the many funerals the researcher attended, was believed to have been clubed down by ancestor spirits. He met his fate at about 12.00 noon while passing under an apple tree. His offence, as told by lineage elders, was "persistent disregard for the authority of ancestors".

Rites of various kinds are performed to keep contact with ancestor spirits and to enlist their protective powers. From personal experience as native of the culture, food, drinks, animals and fowls are offered to them either periodically or on demand. Words often accompany such offerings, in the form of prayers, invocations, instructions or thanksgiving to the departed. These words serve as the bridge of communion and Manlarla witness that they recognize the departed to be alive in a more powerful domain. The case from Tuori village cited above clearly indicates that disregard for these observances is extremely dangerous and disturbing to the social network of relationships and individual health.

Human relationships with the spirits vary from community to community and from one religious persuasion to another. For instance, among the Ekuola, especially those in Nanville, it was observed that a strong Catholic influence is gradually changing the belief systems of the people, while among the Etuolo of Nyimbale, where there is a weak Catholic influence, the opposite was more at grips with the people. Nevertheless, in both cases, the researcher found elements of a real, active and powerful relationship with the ancestors. This was especially the case with the spirits of the recently departed, Tenkpiine living-dead.

## III Tenkpiine: The Living Dead

Tenkpiine the living-dead constitute a different segment of the world of spirits (see Fig.4.2). These are spirits believed to be in a state of transition. They are still within the state of Saamene personal immortality. Their process of dying is not complete and they are referred to by their names. So, they are the living-dead. According to one respondent, "the living-dead are the closest links that we have with the spirit world; they listen to us, hear our call and run to our rescue", hence the term Tenkpiine earthly spirits. Another respondent (a retired miner) said, Tenkpiine are of importance to us because "they are multilingual, speaking our human language and the languages of the Kpiine and Naa-Ngmen", whom they are drawing nearer ontologically. Tenkpiine are the spirits with which the Kpiin noba are most connected. Indeed, it is through them that the spirit world becomes personal to the human world.

Tenkpiine are believed to return to their human families as frequently as necessary to share meals with them, especially during ritual observances and festivals such as Zumbenti. Zumbenti festival was celebrated while the researcher was collecting data for this study. During this festival, I observed ritual meals were served in special calabashes and placed in-between large pots of water in kitchens over night. Tenkpiine were expected by their respective family members to visit the kitchens at mid-night for their share of the sacrificial beast and food. I was told participation of Tenkpiine in these ritual meals, determined by the identification of perforations on the meat and at the bottom of the Saab or Tuozaafe special meal, is indicative of good health. On the other hand, failure to identify these perforations in meals served them is indicative of ill-health, a development that calls for divination to determine possible causes.

The Tenkpiine are also believed to know a lot about the needs of their respective

families because they have just left them physically. And having just left the human world, they appear to be more interested in what goes on in it, especially matters relating to their "possessions" and "property" left behind. Most respondents believed that Tenkpiine's frequent visits are to ensure their Bonime "things" are put to proper use. One respondent, a 45 year old family head said, "their feelings and instructions about these things are mostly reflected in our dreams and any misappropriation of them is punishable by Kpiin kyiir death whip". Kpiin kyiir is an umbrella term used by the Manlarla to refer to illness or death resulting from ancestor involvement.

In conclusion, Tenkpiine are believed to generally appear in the dreams of family heads, but sometimes in those of widows, orphans and heirs who together constitute the segment Kpiin noba. When they appear, they are recognized by names. And during this dream encounter, they enquire about family affairs, give warning of impending "danger", or rebuke those who fail to follow spiritual instructions. Indeed, Tenkpiine are the invisible guardians of traditions, customs, ethics and family activities. Abuse of tradition, custum, ethics and morals is ultimately considered an offence against the forebearers who, in that capacity, act as the invisible police of the families and communities. Indeed, as one respondent stated, "their recent departure places them in a capacity that enables them not only to better appreciate our needs, but also to effectively monitor our aspirations". At the same time, they have full access to the channels of communication with Naa-Ngmen. So like the Kpiine, Tenkpiine have a general interest in and responsibility for families, lineages, clans and even communities. But the spirits that, however, link individuals to the spirit world are the Sigre tutelaries or Dung-ngmeme guardian spirits.

## IV Sigre bii Dung-Ngmeme: Tutelary or Guardian Spirits

A Sigra tutelary refers to either a clan spirit, a lineage spirit, and a family spirit, which is theoretically the same for all members, or to a specific ancestor or ancestress indicated by a diviner as being an individual's personal Dung-ngmen guardian spirit. In Nyimbale, for instance, an example was given in the case of a child who had come to the human world with three personal guardian spirits.

> An ancestor, Danyagre, had volunteered to be the boy's guardian but on his way from the spirit world to the human world, he came upon a fight between a tortoise and a snake. After several hours of persuasion, they gave up the fight and decided to become his guardian creatures. This child was born at his mother's paternal hometown, Duori. As custom demanded, he was given the name Duori-Naa chief of Duori.
>
> Unsatisfied with the name, the child was always crying late at night for no observable reason. A consultation with a diviner revealed that he preferred to use the name of his guardian ancestor, Danyagre. Accordingly, the child was ritually named after his guardian ancestor, a ceremony which reportedly ended the boy's night crying.
>
> Three weeks later, a snake was found lying with the child in his baby cot in a rather nurturing posture. Again when a diviner was consulted, it came to light that he came upon it in an encounter with another creature which was slower than the snake.
>
> And exactly a week later, the tortoise also arrived thus sealing the boy's baggage of tutelary accumulation.

Tutelaries and the other protective spirits have the functional duty of preventing those they protect from unnecessary misfortune and ill-health. It is believed that it is only when they withdraw their protective shield that dependents can become easy prey to malevolent spirits and evil human agents. One respondent and ritual specialist remarked, "Ma dang kpine mang wegi ka nanne nye zo kpe sogle only after one's protective walls have cracked that scorpions

can find a place to hide in his house". Jack Goody made a similar observation among the LoDagaa when he quoted an oldman as saying, "how can you harm an obedient cow unless you have the Nakyiine's herdsman's consent?" (1962:210).

## V Kogre: The Ghosts

Ghosts are the souls of human beings that have failed to gain admission into the spirit world. According to respondents, three types of ghosts exist among the Manlarla: Tenkogre the spiritual elements of those members of society who are "thrown away" at death , Kpikyeyire the images of those individuals believed to ressurrect body and soul but live by hiding, and Kpiinkogre the souls of the dead whose funerals have not been properly handled to make their spiritual presence acceptable in the spirit world. Tenkogre are "destined" to the human world by virtue of their own destructive role in life, the Kpikyeyire because of their desire to exert influence on the living, while Kpiinkogre temporarily "wander" in the human world by virtue of either inappropriate or incomplete rites performed by surviving relatives.

A Tenkoge (singular of Tenkogre) assumes a physico-spiritual form and displays these visible and invisible qualities whenever it chooses. It is vengeful because it has been "abandoned" and mostly uses farm huts and tree holes as its involuntary habitation. Whilst a child living among my people, this belief used to frighten me anytime I had to go to farm alone. An undertaker revealed during investigations that, "a Tenkoge moves far away from its immediate human neighbourhood for permanent settlement only after delivering a series of devastating blows (illnesses) considered commensurate with the 'dishonour' done it".

A Kpikyeyi (singular of Kpikyeyire), after resurrecting, assumes a "human" form, moves far away from its immediate neighbourhood and engages in normal life activities

(sometimes the exact activity of its previous life) wherever it relocates. Awareness of their resurrection is brought to neighbours either by unusual prints over their graves, by people who personally witness the resurrection, or by travellers and/or traders who may come across them during their commercial expeditions in their new "homes". Sometimes most of these Kpikyevire evolve to become reputed medicine men or women capable of inflicting illness and restoring health.

The third category of ghosts, Kpiinkogre, remain in their invisible form and stay within their immediate human neighbourhood awaiting the necessary ritual amendments. They qualify for entry considerations once these amendments are made on their "visas" for the spirit world. While they remain calm, relatives refer to them as Kpiime. However, vengeance by inflicting illness sometimes becomes part of their formular of operation. At this transformation, they are called Kpiinkogre ancestor ghost. This, I was told, usually happens when relatives are thought to be delaying unnecessarily in making the ritual amendments for their transition. But unlike Tenkogre who attack indiscriminately, respondents maintained that Kpiinkogre direct their anger against family members and relatives.

While the protective spirits (nature and ancestor spirits and the living-dead and tutelaries) are believed to be ambassadors of Naa-Ngmen, ghosts, in whatever form, are not considered to be His ambassadors or true representatives. As such, they are not accorded the respect and honour that characterize the interaction between the spirits and human beings. "Because they inflict us with ghost sickness", one respondent explained, "we do not revere them; we fear them".

## 4.5 The Natural (Physical) World and Health

The Manlarla natural world is full of unexplained physical phenomena. The mountains

and the hills, the rivers and the streams, the earth and the sky, rain and wind, thunder and lightning, bushes and trees are all physical entities that present a world of unexplained dilemmas to the Manlarla. These natural entities are believed to be mystical objects not simply for the fright generated in human beings by their physical conditions but, more importantly, because of the belief that they possess some powers.

With these powers, they are believed to be able to influence the course of life on earth by either sustaining it through the provisioning of necessities like soil fertility, rains, prosperity and health or denying it through soil infertility, inadequate rains, privation and illness. The power of each natural phenomenon to either do this or that is believed to derive from the Naa-Ngmen Supreme Entity. To keep the spiritual powers of the natural world in line with the aims and aspirations of the human world, Manlarla have, therefore, elevated a few of them to the status of minor Ngmeme deities or divinities upon whom constant petitions and offerings are made.

### 4.5.1 Ngmeme: Deities or Divinities

A Ngmene deity or divinity is normally represented by an icon or an altar and is considered as a receptacle through which contacts are developed and maintained with the powers that control nature (Kuukure, 1985:61). Contacts with a given deity are generated and sustained especially through the petitions and through the various sacrifices and offerings made to it according to the demands of a given time and the wishes of its adherents. These sacred entities do not only symbolize Naa-Ngmen, but they are also regarded, in the same manner that most Christians and Moslems regard churches and mosques, as the "House of God". Below is a sketch of some of these deities that are held in high regard within the

framework of Manlarla sociocultural milieu with health implications.

## I Tengbane: The Earth God

In our analysis of Manlarla socio-political and religious organization, mention was made of the significance of an entity, Tenga. We realized the importance of Tenga in their religious activities and that it is through its god, Tengbane, that Manlarla villages emerge as religious units. It is Tengbane that provides sanctions against interpersonal aggression (bloodshed and jealousy), against self-destruction (suicide and witchcraft), against acts of deprivation (theft and disrespect) and control over sexuality (sex outside the house and outside marriage). These are, in general, the "thou shall not dos" in terms of mother-earth in Manlarla society.

But also attributed to it are accidents in pregnancy, snake bites, diseases such as headache, dysentery, dropsy and all ailments of the stomach (see Appendix D). Fifty-four respondents (60%) believed that violations of the Tengbane's taboos, as mentioned above, could generate any of these ailments in a person. Consequently, a PHC nurse declared, "a diviner is always consulted to determine the involvement or otherwise of Tengbane in such illnesses before a therapeutic intervention can be devised or recommended". A divination/consultation in this respect implies an examination of the patient's network of social, natural and spiritual relationships. If this first line of consultation proves negative, the act of divination is extended to the patient's immediate relatives. "It is only after these lines of divination are exhausted without any clues of Tengbane's involvement that the patient will be brought to us", another nurse remarked. One respondent, whose mother had become a victim of these series of consultations, lamented, "at this point when things would have been too late, the illness is regarded natural and treatable at PHC centres".

However, if Tengbane's involvement is revealed, then the Tendaana necessarily becomes an important link in the healing process as appropriate sacrifices have to be made to neutralize the potence of Tengbane's retribution. Thus, Tengbane is more than a place of prayer. It is also a nourishing power and medical authority in its unification of the two opposite aspects of human existence: health and illness, and life and death.

## II Sangmen: The Rain God

Manlarla contrast Tenga earth with Sazu sky. Sazu, conceptualized as the habitation of Naa-Ngmen, nourishes Tenga just as Tenga nourishes all the living things on it, including human beings. Any phenomena associated with Sazu derives its name from this major term. For instance, rain is Saa, thunder is Satanno, lightning is Sanyigre, rainbow is Satammo, while Sapii refers to the arrow of rain. In fact, the term Saa embodies all that is of and all that is produced by Sagbane the skin of the sky, particularly rain, thunder and lightning from which Sangmen the rain god derives its name.

In Manlarla conception of these natural entities, Sazu appears to be more powerful than Tenga. The former is not only the habitation of the Supreme Entity, Naa-Ngmen, but also it nourishes the latter. For the same reason, Sangmen seems to be much more feared than Tengbane (though the latter is more popular) among the Manlarla. Parrinder's observation of African religions aptly captures the conception of Tenga and Sazu in Manlarla society.

> The over-arching sky (Sazu) appears to be wider than the earth (Tenga) and powerful forces operate within it. The firmament itself may be personalized, but often it is vaguely associated with the supreme being, and it has been seen that in myths of the divine withdrawal the two are virtually identified (Parrinder, 1969:49).

Like Tengbane, certain diseases are attributed to Sangmen. For instance, water accidents, accidents of lightning, boils and rashes, guinea worms, river blindness and other

eye diseases (see Appendix D) are believed to be caused by factors directly or indirectly associated with Sangmen. Relatives of patients who have any of these sicknesses will normally consult a diviner to determine the involvement or otherwise of Sangmen before knowing what to do in terms of therapeutic decision. In cases where Sangmen is involved, the Sadaana rain fetish or owner of Sangmen becomes an important link in the healing process. However, a non-involvement of Sangmen implies the sickness is natural and can be treated by local or localized health professionals.

## III Tiibu: The Medicine God

Tiibu or medicine shrine, as Goody (1972) prefers to translate it, is a multi-purpose god. According to Goody, the LoDagaa term Tiib possibly connotes Tii medicine and Tie tree; for most medicine the roots, leaves, bark and twigs of trees are essential constituents (1972:18). Like the LoDagaa, Manlarla acquire most of their Tiin medicine from roots, leaves, bark, seeds, fruits, and twigs of trees and plants. But the term Tiibu as used by them to refer to a medicine god cannot be said to derive in part from tree as Goody postulates among the LoDagaa.

A tree is popularly called Dao among the Manlarla and if it had any derivative connotation for their medicine god, then the term would have been something other than Tiibu, perhaps Daabu. Once it is not Daabu, I am inclined to support only that part of Goody's derivative analysis that associates the term Tii (or Tiin) with Tiib (or Tiibu). Tiin in the context of Manlarla sociocultural milieu (perhaps, all Dagaaba) means more than the material substance from a tree. It also embraces the spiritual power behind it, the spirit active "behind the scenes".

There is a proliferation of these Tiibe (plural of Tiibu) in Manlarla society but only

three of them, Kala (located in Loho), Kyiele (located in Nanville) and Maalkunde (located in Nyimbale), are mentioned here to illustrate the importance of Tiibu in Manlarla health practices. Kala, Kyiele and Maalkunde were procured for the protection of their adherents, for success in farming and hunting, for casting spells and, above all, for the restoration of health. Kala, for instance, ensures fertility (of land, animals and humans) and good harvest, and provides protection against and cure for arrow poisoning and snake bites. At its annual sacrifices (usually just before farming begins), crowds of pilgrims flock there with their votive or thanksgiving offerings (Kuukure, 1985:69). Petitions for the new year are also made at this annual sacrificial convention at the end of which its medicine is distributed to pilgrims.

Of extreme significance here is the fact that Tiibu owners and dispensers of its Tiin do not divorce the potency of the latter from the spiritual power of the former. It is in this context that Naa-Ngmen and His associates (the spirits behind the scenes) are believed to be indispensable for the prevention and cure of diseases. Thus, Kalmaalba adherents of Kala god see and present themselves and their Tiin under the aegis of some mystical power, especially Kontonne. This psycho-religious aspect of Tiin in Manlarla society appears to be more effective in healing patients than the material substance itself. If this is true, it is so because of the belief that positive spiritual forces are behind the potion and the prophet of this therapeutic "doctrine" is the Kontoma spirit being of the wild.

## IV Kontonne: Spirit Beings of the Wild

Beings of the wild is Goody's coinage for those dwarf-like creatures or fairies of human appearance perceived by people of West Africa to be the masters of the natural world. Because of the unique role these creatures play between the spirit world and the human

world, I prefer to refer to them as "spirit beings of the wild". Inhabiting the hills, rivers and trees, their flocks are the wild animals and their crops the wild fruits and roots (Goody, 1972:19).

They are believed to have profound knowledge of the medicinal value of different trees and other natural substances. Indeed, Manlarla believe they acquainted humans with the qualities of divination and of the material substances required for preventive and curative medicine. Diviners often appeal to them to reveal the cause(s) of happenings and what to do when approached by clients. Throughout the West African region, they are conceived as "the speedy messengers of God" (Rattray, 1927:26, 38), an Anglophone West African description that was echoed in French West Africa as, "des esprits errants, des ge'nies a' la force redoutable dont il convient de se consilier les bonnes graces" (Girault, 1959:343).

Kontonne are central figures in most Manlarla myths, especially the myths of creation and death. Like the spirits, Kontonne are believed to roam in the night and stand in an intermediary position between Naa-Ngmen and humans. But unlike them, they are portrayed concretely, in speech, as in Kontonbuola spirit mediumship, and in sculpture (Goody, 19972:19). Their influence on Manlarla sociocultural activities is evidenced in the myths that Kontonne taught humans all their major accomplishments of life. "While they are 'the beings of the wild' they are also the transmitters of man's culture, for, as the myth relates, it is they who first showed him how to cultivate the land, to cook food, to make iron, and to shoot with bow and arrow" (Goody, 1972:19) and to brew Pito local beer. Even today the manifestation of Kontonne's influence on Manlarla illnesses is evident in the presence of the Bag-ngmen god of the initiates.

## V Bagngmen: God of the Initiates

Bagre in a narrow sense is an icon upon which regular Bagmaale sacrifices and offerings, and/or Bagkaabe petitions are made by its Bagmaalba adherents . In this narrow sense, Bagre is not very different from a personal, family, lineage or clan god. However, in a much broader sense, Bagre is a kind of religious organization or movement whose membership cuts across families, lineages, and clans and sometimes ethnic groups. Among the Manlarla two kinds of Bagre associations exist: Bagkaang and Bagdegre. For detailed analysis of the Bagre association see Goody (1972). What is important to note here is that members of each of the two Bagre associations jealously guard against possible infiltration by non-members just as both guard against the inquisitiveness of non-initiates. Annual conferences for each Bagre association are held shortly after harvest during which Bagseoriba neophytes are initiated and its Bag-ngmen god built for them. It is from this broader conceptualization that our discussions will derive.

Membership of the Bagre association is both open and closed to the general Manlarla public. It is closed because one does not just wish to become a member by going through its ritual ceremonies. But it is also open because it has no pre-ordained membership. The Bagre association is a "calling" to which only the chosen must be admitted. It works on the basis of "many are called, but few are chosen" as pertains in the Catholic Priesthood. The criteria for selection are not known as prospective converts are revealed in either dreams of the would-be converts themselves or in those of close relatives who are already members. In either of these instances, a Bugbugra diviner is consulted to confirm or negate the implication of the dream. Sometimes, would-be converts are taken into the bush by Kontonne and during this involuntary excursion they are taught several things including perhaps the possibility of

constructing a Bag-ngmen. Not all alleged Kontonne captured people get initiated into the Bagre association for different people are captured for different reasons.

The specific reasons for which people are called into Bagre association may vary, but they are largely 'medical': to ward off misfortune. Bag-ngmen is believed to provide intiates with prosperity, well-being, peace and above all immunity against sicknesses. At the same time, it is capable of causing such havoc as infant mortality, insanity and barrenness among others. To this end, Bag-ngmen initiates converts into the mysteries of the supernatural world, life and death, health and illness and brings them into communion with the Kontonne, who are indispensable in the process of illness determination in the social world.

## 4.6 The Social (Human) World and Health

The social world of the Manlarla is the one as lived in and reproduced by human beings in their daily interactions and interrelationships on earth. A respondent, 45 year old educationist, said, "life is given to humans by God... But in order to sustain it, humans must consciously engage in healthy transactions with the giver of life and the natural resources provided to support it". Of immense importance, however, is the recognition that the nature of interactions and interrelationships between and among humans and human groups, to a great extent, determines the quality of life and the relationship between humans and the natural resources provided by God. For intance, a respondent asked, "What will be the use of the fertile soils of the land if people can't cultivate them because of ethnic conflicts as happening to our neighbours"? Here, the respondent was referring to the Dagomba, Gonja and Konkomba people who have been engaged in ethnic battles. Or, as another respondent (a literate widow) questioned, "What will be the essence of procreation if women and children

are constant objects of domestic and environmental violence?"

Harmonious interactions and interrelatioships are so vital that Manlarla spare no time ensuring that they are guaranteed in their socio-spiritual world. For them, health of the mind and body is so fundamental to good living that if humans have any personal rights at all, then, it is the right to good health. And, any measure of good health, they believe, is given by God and God alone. The Manlarla social world, though not chaotic, is short of being a heaven. Two categories of people, ordinary and super humans, are the players of this social drama.

### 4.6.1 Ninsaale Butelhi: Ordinary Human Beings

Generally speaking, ordinary people are referred to as Zonne or Butelhi the "blind" among the Manlarla. Blind here does not imply an impairment of sight which makes them unable to see visible phenomena. Rather, it means these people are unable to penetrate the mysteries of creation, life and death with their ordinary eyes, imagination and knowledge. But since their daily life is influenced by these mysteries they must, therefore, rely on the goodwill and/or "professional" practice of other people (superhuman beings) in order to appreciate their universe and participate in its affairs with some amount of confidence.

### 4.6.2 Ninsaale Berema: Superhuman Beings

The superhuman beings are those people in the human world who have knowledge of tapping and manipulating the spirit world. These are people with "eyes", imagination and knowledge that enable them to penetrate, to some extent, the mysteries of creation, life and death. They manipulate the spirit world in order to either harm intended victims or to save lives and help clients who call on them for such services. Within the Manlarla society, this category of people include witches/wizards, sorcerers, visionaries and the specialists.

## I Suore aning Suolong: Witches/Wizards and Witchcraft

The Manlarla believe that by witchcraft evil men and women, acting separately or in a group, can cause the illness or death of those they hate. They either operate as Sosogla black witch or as Sopila white witch. Like the spirits, Sosogla is mainly active at night wearing the hides of dangerous animals, birds, bats, snakes, hedgehogs and so on. Generally, it is believed to attack its victims by capturing their souls. On the other hand, Sopila attacks its victims during the day by capturing their heads in what is known as Zu de or Zu kpage.

The captured souls or heads are mystically replaced with temporary ones. This is done to keep the victims alive while the reactions of the tutelaries, lineage/clan gods, ancestors and the visionaries are weighed against the power of their malicious "enterprise". Manlarla believe it is after this that witches attempt to devour the vital organs (usually the lungs, liver, heart and brains) of their victims. To substantiate the act of soul capture by the witches/wizards, one respondent recounted a story of antiquity. According to him, "a witch was once asked to demonstrate how they captured souls in witchcraft while the victims remained active in society. The witch reportedly asked for a live lizard and when it was brought she flayed it, removed all vital organs, stuffed it with sand, beat it with her witchcraft cane and it became alive again".

Another respondent (a ritual specialist and chief) was contacted with a view to understanding how witchcraft cases were handled. He told me such cases are treated by people with anti-witchcraft gods. Coincidentally, the ritual chief of Nyimbale village had an anti-witchcraft god. He told me,"to deal with witchcraft effectively, you must first understand their techniques of operation". Accordingly, he listed some of the techniques used in witchcraft to capture souls and heads as follows: (1) they may "feed" their victims with

"poison", a preparation made of powdered human flesh or bones and the bile of specific animals which is blown into the faces of victims; (2) they may cast spells over something closely associated with the victims such as nail parings, hair, a shadow or a fragment of clothing likely to present the unique scent of the victims; (3) they may magically shoot into their victims small objects instructed to perform particular functions once the target is hit. Principal symptoms of this technique manifest in victims in the form of emaciation, sudden and sharp pain in an unusually localized area with a lump or other evidence of a foreign body (this is referred to as local missiles throwing); (4) they may use narcortic plants and through magical devices overdose their victims (sicknesses such as fainting and "epileptic" seizures are evidence of this technique).

"Witchcraft belief is extraordinarily persistent among the Manlarla", one respondent remarked, and another added, "even educated people and some converts of the Islamic and Christian faith who have considerably relinquished other aspects of our Manlarla traditional religion, such as sacrifices, still show tremendous fear of witches/wizards". This shows the magnitude of witches' influence on Manlarla daily life and conception of illness causation. Witches and wizards, as Imperato (1970) observes, are individuals with an innate malicious power which works to cause harm to the health of their victims.

The mystical power that is possessed by them is known as Suolong witchcraft. Usually old women without children or with "irresponsible" children and widows with multiple "robes" in funeral rites (widows who have had the ordeal of burying more than one husband) are often accused of witchcraft. One undertaker said, "their power and strength accrue with age and ritual robes". However, with the spread of Christianity and Islam and with the numerical reduction of the "doubting Thomases", beliefs in witchcraft are beginning to wane.

## II Ninberema aning Berebo: Sorcerers and Sorcery

The sorcerer is an individual who consciously engages in bad magic for the purpose of inflicting illness or some other harm on intended victims. They operate day and night. Unlike in witchcraft, any interested person can engage in sorcery. For this reason of easy entry, Ninberema sorcerers , are now many in Manlarla society. At one of our focus group sessions, a group member lamented that "many young people return home from Jonga a farming community with 'self-styled' personal protective charms. But these charms do more harm to us than good to them". In another session, it was revealed that, "with a few exceptions, the majority of them operate in secrecy thereby making it all the more difficult for us to protect ourselves against their operations". In a third session, an attempt was made to compare witchcraft and sorcery in Manlarla society. It was a near consensus that, "the belief in witchcraft may be diminishing among the Manlarla but not the belief in sorcery, not even among the educated, the Moslems and Christians who have emancipated themselves from some aspects of our traditional religion".

The techniques used by them to get intended victims are many and varied. In most cases, they are not very different from those applied by witches/wizards to capture souls and heads. Essentially, these techniques are two: the use of material substances, and the use of spirit agents. One 55 year old respondent and ritual chief said, "sorcery involves the use of materials such as herbs, hair and nail parrings over which a secret formula is pronounced imparting a magical maleficient power to the substances and spirit agents".

Two broad methods are used to achieve their imagined end by material substances. First, the respondent continued, "a sorcerer will either deposit these materials near the door way of the intended victim's house, hide them in his/her ceiling, bury them on the path known

to be used by intended victim (especially the path leading to his/her farm), or dispatch the substance through the air (Lorba or local missile throwing)". The second method, he said, "involves depositing the substance directly into the intended victim's food or drink as in food poisoning Beraa". In these operations, there must be physical contact between the intended victim and the substance of execution. Individuals not earmarked for destruction but who come into contact with these substances, he concluded, "may suffer minor effects".

The Manlarla expression, Ka deo ba ire fo wala ka yenge na nye fo? if the "house" doesn't deliver you how can the "outside" get you?, links the operation of sorcerers to the protective walls of the family. Two protective loop holes are implied here. First, it implies the active involvement of Deo noba house people, for it is only family members, close relatives and trusted friends who can have easy access to most of the materials required for sorcery operations. Second, it implies the consent of personal and collective protective spirits. For, as we discussed earlier, it is only when their protective shield is withdrawn that malevolent spirits and evil human agents can demonstrate their supernatural prowess.

Sorcery is also believed to be practised frequently through the use of spirit agents. A common technique among other Dagaaba is the use of a Karimuga or Mallam a Muslem who also practises "medicine". Because of the rather insignificant numerical representation of Muslems among the Manlarla, this technique is not popular. It was, however, mentioned by most respondents that a dangerous trend of "farming" spirits, Agba male and Agbe female, had emerged among Jonga returnees. This trend, we had occasion to understand, is more dangerous to society than good to their owners. Among the Manlarla, the roots of accusation and victimization of witchcraft and sorcery generally lie in disputes and jealousies arising out of individuals sharing important social relationships. Both witchcraft and sorcery are

extremely complex practices among the Manlarla and, sometimes, lines of difference between them seem rather blurred.

## III Ninbinveriba aning Ninbinve: Visionaries and Vision

In Manlarla cosmology, Ninbinveriba visionaries are an important category of people who have "four eyes". They, like witches/wizards and sorcerers, are people with knowledge of some aspects of the divine power. The first pair of eyes is visible and designed for seeing ordinary phenomena, while the second additional pair, which is invisible, gives them a piercing supernatural vision. Generally, there are two categories of visionaries: those that see the departed and/or lost souls of kinsfolk, and those that see the activities inherent in witchcraft and to some extent in sorcery. Only on very rare occasions can an individual possess the power to see both departed and/or lost souls and activities of witchcraft and sorcery.

Most visionaries are born with Ninbinve powers of vision though it is also commonly believed that individuals wishing to be initiated into the "practice" are sometimes successful. Their power to see and reveal the activities of witchcraft and sorcery makes the visionaries constant targets of supernatural elimination. For example, infants born with this power are targets of elimination by witches and sorcerers before they mature. For as they maintain, mature visionaries are more difficult to eliminate than immature ones. With the revelations of visionaries, Manlarla are sometimes able to restore lost souls, and regain the souls and heads captured in either witchcraft or sorcery.

What is primarily distinctive in Manlarla conception of the universe is not the personality, impersonality or superpersonality of the supernatural and extra-ordinary powers, but the fact that they play an unprecedented role in health and illness. For example, illness

appears when relationships with these powers "have become subverted". Thus, in contrast with Western conception of illness that focuses on the question, "How?", Manlarla conception is an understanding that focuses on the question, "Why?". It is against this background that the specialists and their practices are going to be examined.

## 4.7 Suosuoniba aning ba Toma: Specialists and their Practices

It must be mentioned at the onset that it is extremely difficult terminologically to describe individually or collectively the category of people designated Suonsuoniba specialist here. Different terms for them exist but some overlap, just as Ba toma the nature and role of their practices also overlap. Functional overlapping between them presents a selection difficulty. So, they are designated specialists here only because everything of theirs (language, symbolism, knowledge, and skill) is "special" and not easily accessible to the ordinary person.

Among the Manlarla, like most African peoples, religion is almost inseparably linked with the practice of health care. The idioms of health and healing have so dominated religious forms that it is often hard to distinguish them as separate systems of action (Dareer, 1983; Feierman and Janzen, 1992; Hannay, 1980; Pedersen and Baruffati, 1989). For instance, Dareer observes that the practice of female circumcision in Sudan and the performance of uvulectomies on new-borns in Northern Nigeria are practices considered to be controlled exclusively by God. The power of healing and curing as exercised by specialists in such societies is thus believed to derive from Him. So, while practising as medicine people and diviners, these specialists must also be seen as religious experts.

Specialists of different practices (traditional-religious and modern-scientific) play an important role in the life of Manlarla society, which ultimately affects their health seeking

behaviour. These include local health professionals such as herbalists, bonesetters, diviners, spirit mediums, soothsayers, mallams, faith healers,local missile extractors, TBAs, priests and prophets, and formal (or localized) health professionals such as physicians, laboratory technicians, nurses and other health care workers (see Fig. 4.2). However, discussions shall be limited to those specialists found to exist and practise actively within the sample area at the time of data collection. These include herbalists/bonesetters, diviners/soothsayers, mallams/faith-healers and different categories of PHC workers.

### 4.7.1 Tiin Ira aning Kornyogra: The Herbalist and the Bonesetter

Tiin ireba herbalists and Kornyogreba bonesetters specialize in different herbs and go by different names such as medicine men or women, traditional doctors or witch doctors. According to Sayibu, President of the Ghana National Association of Traditional Healers, UWR and a native of Nyimbale-Charile community, herbalists acquire knowledge about the medical value, quality and use of different herbs, trees, leaves, roots, barks, grasses and from objects like bones, feathers, eggs, shells, charcoal, animals and insects waste products. While most herbalists prepare and provide medicine for common or natural diseases, uncommon or supernatural diseases require divination in order to determine their real causes, cures and prevention for individual cases. Thus, most professional herbalists are also diviners.

As diviners, herbalists do not only deal with diseases, they also have antidotes for other forms of human suffering such as barrenness and misfortunes. For this reason, most herbalists and bone-setters also have knowledge of purging, combating witchcraft, detecting sorcery, and neutralizing curses, as well as penetrating the mysteries of death and the invisible world of spirits. Chief G.B Woli, Secretary of the Traditional Medical Practitioners, UWR,

and a native of the Nanville village area and teacher C. Kpienta, a herbalist and native of Loho village, provided illuminating examples of their encounters with patients with supernatural sicknesses. At Duong village, where a clinic for dealing with compound fractures is constructed, I was told "supernaturally caused accidents that result in compound fractures are never treated until the 'Why' is established, and permission is sought and given". This was confirmed by Isaac Luginaah, a graduate student of York University, who was once a patient of the clinic as a victim of a supernaturally motivated fracture.

The functions of herbalists and bonesetters in Manlarla society are varied and sometimes overlap with those of other specialists, especially the diviners. To deal with patients effectively, a respondent said, "herbalists and bonesetters first have to discover the cause of sickness, reveal the agent of transmission, determine the reason, diagnose the nature of the disease, assess the extent of damage, recommend the appropriate treatment and supply means for preventing its reoccurrence". Similarly, as Sayibu demonstrated to the researcher, treatment application also ranges from the use of massages, blades, knives and drenching, to the sacrifice of fowls, goats, sheep or even dogs, the observation of taboos and the avoidance of certain foods and people. For instance, a widow does not use anything black (including medicine). Nor does a family head greet a blind or semi-blind person before taking breakfast. This process of treatment is dualistic: partly physical (material) and partly psychological (spiritual), a view that is consistent with Manlarla conception of the human being. Manlarla conceive of the human being in material and spiritual terms and, indeed, any form of misfortune or human suffering is also seen this way (see Fig. 4.1). For this reason, the effectiveness of any regime of treatment/intervention will depend on how it appeals to both the material and spiritual qualities of the therapy group and/or the patient.

### 4.7.2 Bugbugra aning Kontonbuola: The Diviner and the Spirit-Medium

Diviners are primarily concerned with the acts of divination. They are the agents through whom the mysteries of human life are unveiled. They use a variety of divination techniques to accomplish this. As Naazuing (a famous diviner) once said while visiting my village, "We can do all sorts of things by using mediums, oracles, common sense, die-casting, intuitive knowledge and insights and hypnotism". Their ability to restrict entry into the knowledge of operation adds to their respect, stature and dignity in the communities within which they practise.

There are three categories of diviners who perform divination as a responsibility in Manlarla society. According to respondents these are the diviners, diviner-healers and diviner-spirit mediums. A Bugbugra diviner tries to foretell the future, discover hidden knowledge and uncover the causes of illness with the use of a Bugidao divination stick and some Libi pila cowrie shells. In addition, he advises his clients on what to do in case of illness but does not provide medicine. For instance, he may advise them to offer sacrifices to particular gods using fowls and animals of particular colours. A Bugbug-tiin-ira diviner-healer discovers the cause of illness and provides appropriate medicine by using several divination objects. Some of these objects include divination stones, gourds, numbers, palm reading, cowrie shells, image formation in pots of water or mirrors, listening to and interpreting sounds, using s[illegible]nces by means of which the diviner gets in touch with the spirit world (see Mbiti, 1969). A spirit-medium is an individual who serves as an intermediary between spirits and humans. Thus, a Kontonbuola diviner-spirit medium is the practitioner who, through the use of spirits, especially Kontonne, uncovers the cause of illness and indicates appropriate therapeutic and/or social measures to be implemented.

Among the Manlarla, die-casting is the most popular divination technique which is carried out with the use of divination sticks and/or cowrie shells. With the aid of particular spirit-beings of the wild to whom the diviner's shrine is dedicated, cause(s) of illness is (are) revealed and possible course(s) of action is (are) devised. We indicated earlier in the chapter that certain mortal accidents and sickness such as snake bite, aches and difficult childbirth are often associated with Tengbane, while those of lightning, and eye diseases and boils are associated with Sangmen. Accidents associated with drowning are associated with Naamane river god ("son" of Sangmen). "When these gods are suspected at the occurrence of any of these illnesses", a respondent said, "intervention is normally withheld until after we've verified or ascertained the reason(s) for (or the why? of) the illness". To do this, a diviner is contacted who begins his die-casting.

In a die-casting consultation, the gods or spirits suspected are appealed to for confirmation or negation of the suspicion. This procedure of die-casting involves the throwing of four cowries on the floor or ground. A cowry when thrown can either fall with its front facing upwards (light) indicating Yelminga true or fall with its front facing downwards (darkness) indicating Ziri false. Within this understanding, a four-cowry die-casting can produce five possible combinations. Some of these combinations are odd and others even. An even combination indicates confirmation of the suspicion, whereas an odd combination indicates its negation.

To illustrate this I shall use the character Y to indicate Yelminga and the character Z to indicate Ziri. The five possible combinations and conclusions will therefore be as below:

| | | |
|---|---|---|
| YZZZ | Odd combination | Negation |
| YYZZ | Even combination | Confirmation (but for another's offence) |
| YYYZ | Odd combination | Negation (but breaking relationship elsewhere) |
| YYYY | Even combination | Confirmation (for victim's own offence) |
| ZZZZ | Even combination | Confirmation (for a god not suspected) |

Every case of suspicion thus has three out of five chances of being confirmed, though with different explanations. The YYZZ confirmation, for instance, implies the involvement of the suspected god in the illness but for the offence of somebody other than the victim, while YYYY implies punishment for patient's own offence. In the case of ZZZZ, consultants are informed of the involvement of a god other than the one suspected. To determine which god, cowrie shells are thrown again as mention is made, one after the other, of all possible gods - personal and collective. The combination YZZZ negates the suspicion completely, while YYYZ negates it with an explanation that, even though the illness in question is not caused by any god, individual or family relationships may be breaking down somewhere. Failure to determine the "appropriate" cause of an illness, they maintain, often leads to a chain of deaths in the family.

All negated suspicions suggest no further enquiries before treatment or intervention as sickness is seen as having a solely natural cause. Here, the patient is sent to either a herbalist for herbal medicine or to a clinic for orthodox medicine. Confirmed suspicions, however, call for further enquiries to determine the appropriate agent or counter measure as the case may be. As one respondent said, "the sickness, even though naturally born (caused)

is nevertheless perceived to be impregnated (motivated) by a supernatural agent". Such supernaturally caused or motivated illnesses require, in addition to physical treatment, spiritual treatment in the form of sacrifices for the atonement of the transgressions and for the appeasement of the offended spirits.

### 4.7.3 Karimugre: The Mallam and the Faith-Healer

Mallams and faith healers are comparatively a very recent development and the least consulted in Manlarla society. A small proportion (less than 5%) of Manlarla are Muslems and about 30% are Christians. It is estimated that 60% of Dagaaba are traditional religious followers, 30% Christian (of which 25% are Catholics) and a little over 5% are Muslems (Baker, 1986:70). Manlarla religious composition appears to be a reflection of what pertains among the Dagaaba as a whole. Within this 33-35% of Muslems and Christians are the Karimugre Islamic and Christian faith healers.

They are religious experts as well as medicine people. For instance, a Karimuga in addition to interpreting the Qu'ran (Koran) also diagnoses the causes of illness, neutralizes it and prevents its further occurrence. Because of the belief in malevolent spirits among the people, amulets and talismen are sometimes prepared by Karimugre. As a respondent emphasized, "we wear them to protect ourselves from the vengeful acts of spirits (especially ritually abandoned ghosts), as well as neutralizing the intriques of evil human agents".

Like the diviners, mallams begin investigating a problem by evaluating a patient's network of social relationships. The idea is to determine if information given contains indications of conflicts. In addition, one respondent said, "the patient's religious conduct is examined in search of disharmony of sufficient proportions to which the illness can be

attributed". If after this round of mallam-patient interaction, nothing of sufficient proportion is discovered, she continued, investigation is extended to close (and sometimes distant) relatives. It must, however, be mentioned that mallams receive and treat more patients from among non-Muslems than from Muslems. Indeed, this is one of the most effective means through which new converts are brought to grips with the Islamic faith in Manlarla society.

If after interrogating a patient, the mallam has sufficient cause to believe that the sickness is caused naturally, herbs may be provided. Thus, mallams, like the other specialists, treat simple problems without imputations of human or supernatural cause with herbal medicine. However, in the event of a supernatural involvement or social intriques, one respondent said, "the mallam determines the specific reason for the occurrence of the illness by reading relevant passages from the Koran and Arabic medical texts or by interpreting Tawidh Koranic verses written on slates". The written formulas on these slates are washed off and the Miina water given to the sick person to drink or rub into his/her body as the case may be. "For those mallams without access to Arabic medical texts or poor understanding of Arabic", he continued, "cowrie shells are thrown on the floor and their positions interpreted in addition to the Koranic scriptures".

In other instances, especially where the patient is believed to suffer from "unholiness", s/he is asked to observe Al-siyam fasting and/or performs Al-zakat almsgiving. As one Muslem widower said, "Islam calls for the purity of the body and the soul, and so Zakat is regarded primarily as an act of purification and worship". However, the chief medical occupation of Mallams is the manufacture of Islamic amulets and talismans worn by clients and/or patients to ward off evil forces and to prevent illness.

### 4.7.4 Nasaal Tiin Ireba: Localized Health Professionals

The concept and principles of Nasaal-tiin-ireba localized health professionals are located within the implementation of the PHC programme. The programme, as noted in Chapter 1, was discussed and adopted in a WHO/UNICEF Declaration of 1978. The Declaration was made against the background of the experience of limitations in the conventional health delivery system - over-centralized and top-heavy, cure-biased, and hospital-based - and therefore, tending to yield less than maximum positive impact on the health status of many people (WHO, 1978).

Thus the PHC, in which the health delivery apparatus focuses on a mixture of curative, disease prevention and health promotion, organized on the basis and principles of equity, inter-sectoral collaboration and community participation within the framework of decentralized structures, was adopted in Ghana as an alternative to the conventional healthcare system and as the most appropriate means of guaranteeing "health for all" (HFA) by the year 2000. Within these guiding principles, the Ghana MOH developed the three-tier structure (see Table 1.1) - for its implementation and management (Ghana, 1985).

At each of these levels of health delivery there are corresponding professional workers (doctors, nurses, technicians and health care aides). At the level of the community, for instance, the most visible elements are the clinics and community health workers. There are three types of health workers at this level. The first group of health workers comprises volunteers with or without any formal education. They receive a couple of months' training in hygiene and are then sent out to practice as advisors of environmental hygiene. These hygiene "specialists" are usually very active on local market days, especially around slaughter and Pito houses.They are called Samasama, a Manlarle derivative of the term summons (the

source of their legitimacy and power). Their power lies in their ability to summon offenders before higher health authorities.

The second group of health workers comprises the community health nurses (CHNs) who are normally government employees with a minimum of ten years of formal education and two to three years of professional training. They are selected on the basis of performance in a competitive examination, trained and posted out. Their tasks, according to the regional director of health services, include regular village to village and house to house visits during which the principles of PHC are addressed. Their practise of "social medicine", intimately linked with people's living conditions and the values of local populations, is sometimes resented. As one respondent remarked,

> ...they (CHNs), like the "samasama" who call themselves "inspectors", poke around our homes and compounds looking for "pools of water", "old" structures, and "dirty" Tampuore refuse dump; issuing steady streams of summons and fines for those of us who relieve ourselves in places other than the "filthy" public latrines, or dump garbage in handy places within our compounds rather than designated areas in the bush. They really worry us in many ways, without any obvious benefits to anyone except those who collect the fines or get jobs as "inspectors" and "doctors".

The third category of localized health professionals in Manlarla society are the state registered nurses (SRNs), registered nurses (RNs) and dispensers who run health centres and clinics available in the communities. As a basic requirement for training, most of these professionals normally receive certifications in secondary education before they are allowed to participate in the qualifying examination for nursing training. Successful candidates undergo a three to four-year theoretical and clinical training in human biology and illness episodes within the framework of modern scientific medicine.

Their functions include preventive services such as family planning, curative services

(diagnosis and treatment of illnesses brought to clinics or health centres) and outreach clinic services to selected villages at regular intervals. Complicated problems are, however, referred to the district hospitals for examination and further action. By village standards, professionals of this category are often equated with doctors and are, indeed, called "doctors". It is the services provided by these three categories of PHC workers that will concern us in our analysis of localized professional health services utilization at the level of the communtiy.

## 4.8 Laafilong aning Baalong: Manlarla Conception of Health and Illness

Health is generally perceived in functional and relational terms. For some respondents, a healthy person is the one who "eats well", "thinks well", "is able to work in the farm or play in the field" and "feels good". For others, a healthy person is the one who"sleeps well", "feels at peace with neighbours, gods and ancestors", "has no dangerous thought" and "no physical impairment". This conception of health is not different from that given by the WHO in 1948 as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In short, health is, therefore, a reflection of our ability to carry out the daily tasks of living.

Conversely, for most respondents, a person who is ill is the one who is unable to enjoy these virtues of life. While some respondents said, "a person is regarded ill when s/he is not feeling well", others associated illness with "withdrawal from organized and productive work". Still others declare a person ill when there is a "change in his/her manner of carrying out vital life functions". People experiencing illness, they maintained, do not only seek rest and comfort, but they also require help from their immediate co-members. One respondent, for instance, illustrated this when he said:

> supposing my father was alive and I was working to help him and one day he heard I had died in an accident, my father would never be himself again. He may not be physically sick but he certainly will be ill spiritually. He will be unable to carry out his normal functions without assistance from others.

Such conceptions of health and illness, as expressed by respondents, tend to resemble what psychologist Williams James once called "the religion of healthy-mindedness". According to this doctrine, healthy thoughts are, a priori happy thoughts.

### 4.8.1 Baalong aning O Longbee: Illness and its Dimensions

To appreciate illness dimensions among the Manlarla, we need to first understand the dimensions of health. From section 4.8, three main dimensions can be distinguished from Manlarla conception of health. First, health is seen in terms of an ordained order including the absence of disease and/or problem (clinical health). Disease here refers to the malfunctioning of biological and/or psychological processes (Kleinman, 1980:72) in a single individual. For instance, a snake bites an individual just as lightning strikes or malaria attacks an individual but these events generate problems that vibrate in all networks of relationships. Secondly, health is described in terms of a resource (role-performance). Manlarla conceive of a healthy individual when s/he has adequate body strength (that is, physical and mental capacity) which enables the individual to work or play or to resist illness or temptations as the case may be. The final dimension describes health in terms of equilibrium (adaptive health). Equilibrium is a notion that highlights on general well-being by emphasizing harmony and balance within oneself and with one's physical and social environment.

Illness, for the Manlarla, refers to a disturbance in the order of things. That is, the psychosocial experience and/or meaning of perceived disease or problem. This includes all secondary personal and social responses to a primary malfunctioning in an individual's

physiological or psychological status or both (Kleinman, 1980:72). Illness is, therefore, a social category involving processes of attention, perception, affective response, cognition, and valuation directed at the disease and its manifestations such as symptoms and role impairment. For this reason, illness is also understood among the Manlarla in terms of three dimensional metaphors: illness as destroyer, illness as occupation and illness as liberator.

Baalong la yeli saana illness as destroyer denotes a deranged bodily (physical and psychological) state or an impairment of the normal state of the body or of one or more of its parts and is usually traceable to a specific cause such as a parasite, a dietary deficiency, a snake bite, lightning or a human or non-human agent. Manlarla say Baalong la bonzaa ang saana yela illness is anything that destroys. As such, illness destroys an individual's physical, mental and social personality (his or her order) if not permanently then at least for a period of time. This dimension of illness emphasizes the natural aspect of human experience of disease, suffering and pain (the clinical-natural reality).

Illness as occupation captures the social component of illness. Most respondents were of the opinion that Baalong ela bongbee toma illness is the occupation of evil agents (human and non-human). One respondent said, "illness is inflicted on victims in order to prevent the performance of certain roles". In addition to interfering with people's lives in its limiting effect on their capacities (resources), another said, "illness fulfils the occupational agenda of these malevolent agents". That is, hostility, jealousy, envy and senseless acts of vengeance, that pervade and structure interpersonal relations, are believed to be motivations that lead others to promote illness and injury either directly (through poisoning) or indirectly (through the services of a sorcerer or a witch). Whichever method is applied, agents preoccupy themselves with making people unable to fulfil certain vital social roles (the functional-social reality).

Illness, like health, reflects the relationship of people to their environment within the framework of an ordained order. But unlike health which reflects equilibrium and harmony with the ordained order, illness reflects a disharmonious relationship, a relationship that indicates a "falling apart" of constituents of the order (a disequilibrium). To restore ourselves to the "goodness" of the order (Durkheim, 1951), the disequilibrium or its predisposing and/or enabling factors must be removed. But how do we know that we are out of tune with the "social beat?" Manlarla maintain that Baalong mang kpe te teng bang nyovori tona it is when we are ill that we know the importance of life. In this regard, illness librates us from the "syndrome" of taking the "goodness" of health for granted. A respondent said, "illness warns us of catastrophes or impending catastrophes in our social and spiritual relationships".

Such mystical relationships may seem opaque to many people in Western societies. But for populations of traditional cultures, these "myths" are guideposts to healing. One Christian respondent, for instance, related the Biblical story of Job as a veritable map of illness that liberates. He said, "Job's illness manifested in a series of devastating personal reversals (loss of his children, destruction of his fortune, tragic wreckage of a good life and boils) but finally all these ended in his salvation (liberation)". In other words, transgressions of the spiritual and/or social code are believed to be resolved by divine intervention in the form of illness or Biripuore withdrawal of protection. Within the framework of this dimension, emphasis is on the psychological measure necessary for the restoration of the essential equilibrium (the psycho-spiritual reality).

### 4.8.2 Baalong Muno: Illness Classifications

We have already demonstrated that possible sources of fear are very numerous among

the Manlarla. But what do all these dreaded things mean to them? Although Manlarla worry about property loss, unsuccessful harvest or damage of some sort or even death, their fears are primarily focused upon illness. This is clear from the expression, Baalong beou mang zora kuu meng bo it is illnesses (especially 'bad' ones) that I fear otherwise, what is death? For this reason, they appear to have a variety of classifications for illness. For purposes of this study, we shall limit ourselves to three major categories: general, specific, and causal agents.

## A General Classification

The general category of illness classification has no age, sex or season boundary. Illnesses of this category affect anybody at any time of the year and include the following minor categories:

### I Dakye Baalong: Illness of Carelessness

Respondents believe these illnesses result from one's own careless behaviour or the carelessness of another person. Examples were given as illnesses arising from dirty food and water, lack of personal hygiene (like dirt in the home and irregular bathing practice), dust, soil eating (especially babies), exposure to cold harmattan winds and inability to provide Dungkaraa mosquito repellants which are everywhere in Manlarla society. Such careless illnesses result in natural imbalances in the human organism and modern professional medicine is considered to be more efficacious in treating them even though certain herbs are also commendable.

### II Baalong Lognaa: Communicable Illness

These diseases, respondents believe, are easily transferred to other people (especially relatives) who are said to have the same Gyinn zing blood spirit with the sufferer. Contagious or communicable illnesses like tuberculosis (TB) and infectious diseases like Baabasu syphilis,

otherwise known as "Kumasi sickness" were mentioned. "Kumasi" is synonymous with the gold mining towns of Obuasi, Konongo, Bibiani and Prestea where TB and syphilis are common. Illnesses of this category are believed to have natural basis and can be treated using natural means (herbal or orthodox).

III Tulo Baalong: Illness of Misappropriation

As we noted earlier in the chapter, certain illnesses arise from misappropriation of family property especially animals (such as cows) and money, including cowries (especially those meant for brideswealth or marriage gifts). Illnesses of this nature, often characterized by sudden outbreak of severe symptons, are believed to have supernatural causation or motivation and therefore are better treated by following a supernatural medical regime.

IV Tukpe Baalong: Follow-In Illness

"A quarrel is an involuntary evil", a Manlarlo will say. It comes as a spontaneous reaction to serious disagreements in human interactions. But a quarrel especially between spouses, between parents and siblings or between any close relatives is not a sign of family unity and solidarity. Such quarrels easily generate a hurling of Pore curses from the superordinate and Zunne kunbambare painfully lasting insults from the subordinate to the hearing of all (good/evil spirits and good/evil human beings). Although these modes of exchange are only outgrowths of excessive anger, they are nevertheless believed to cause illness. "Using such occasions of betrayal of unity and solidarity as an alibi", one respondent said, "the good spirits withdraw their protection thereby creating an opportunity for the evil spirits and evil human agents to inflict the family with illness". Such illnesses, they believe, are characterized by unusually quick developments in unusual places of the body and are believed to have a supernatural origin, and only supernaturally curable.

## V Boore Baalong: Genetic Illness

Susceptibility to certain types of disease is believed to run in certain families. Sicknesses like Konkonne leprosy and Kunkunne epilepsy are genetic illnesses, the cause of which is believed to be within the family history. Usually included here are other chronic illnesses such as Haahe asthma, Zol baalong imbecility, and Yanyare strains of madness. These are believed to have either a natural cause as in the case of leprosy or a supernatural foundation as with epilepsy. The understanding is that no treatment can totally heal them except Naa-Ngmen. Patients with such illnesses are better contained in domestic hospices either awaiting a miraculous healing crusade or the next logical thing (death) to perform its unholy duty.

## VI Baalong Egnaa: Brought-On Illness

Oath-taking, taboos, and their breaking are part of Manlarla social life. An earth-priest explained that, "oaths, taboos and important moral ethics broken deliberately are restored by either a god or a spirit (mostly nature spirits)". "To do this", he continued, "the god or spirit sends an illness to the offender (mostly) or to a close relative of the offender (sometimes) as punishment for the conscious disregard for spirits, oaths and taboos". This viewpoint of the earth-priest was supported by an illustrative example from a 47 year old family head. According to him:

> Furivuore (his neighbour) got leprosy only three weeks after his wife had refused to give a needy person (a spirit in disguise) some of the food she had cooked. The spirit person pleaded with God that she shouldn't be given food any more. So the husband (sole provider of the family's food) became sick of leprosy.

This category of illnesses is synonymous with Suuri baalong illnesses of anger. They have a supernatural causation and, as Sayibu said, "cure is possible only after the god angered has

received a supernatural pacification either in real offerings or promise of offerings". However, if its "physical manifestation is extensive", Chief Woli added, "some natural treatment is recommended after these offerings".

VII Baalong Doraa: Warning Illness

Manlarla understand that sometimes oaths and taboos are broken unknowingly. They also know that certain matters are taken for granted that neverthess cause imbalances between the constituents of the universe. Still other times, "evil eyes" are directed at people without reasonable justification. Under these circumstances, they believe, a warning illness is sent by the gods and spirits to alert the family. In most situations, these premonitions come in the form of minor ailments to the Kpiin noba. But in other occasions, they may come in the form of dreams to family heads, as we noted in the case of Nyimbale. This becomes necessary, as one respondent observed, "when we become imbalanced beyond a point that the flesh becomes mute and only dreams can speak". The causation of both the dreams and ailments is supernatural. As soon as the warning is received and appropriate measures taken, healing is also over.

VIII Baalong Kpienga: Sudden Illness

Included in this category are acute illnesses such as heart attack and accidents like falls from trees, motor/car accidents and accidents in the mines. What is common to all these illnesses is that even though some may be supernaturally motivated, immediate action is required to restore broken ribs, skulls, arms, and legs. Recovery is considered to be difficult (if not impossible) if the source of conflict is not identified and appropriately appeased.

X Mang-Boa Baalong: Self-Invited Illness

This category refers to those illnesses that arise from uncontrolled temptations and

bad habits. Respondents mentioned sicknesses emanating from drinking, smoking, drugs, sexual activity and stealing. Illnesses of this nature can have a natural and/or supernatural origin. For instance, a brain damage of a "marihuana" smoker or a drug addict could be considered the natural reaction of his or her smoking or drug taking behaviour. But an individual suffering from Muora (a sickness related to sexual behaviour) or any sexually transmitted diseases could have two possible causes: natural causation, arising in response to his or her uncontrolled sexual drive, and a supernatural causation, arising from either a supernatural disapproval of the behaviour or a curse from a spouse if the victim is in a recognized marriage. In addition, certain illnesses arise from an individual's dabbling with bad medicines and evil spirits. Respondents associated this last group of illnesses with young people returning from their farm settlements in Jonga.

B Specific Classification

The second major category of illness classification is specific. Sicknesses here are classified according to natural divisions such as age, sex and season. These sicknesses probably stand for Manlarla conception of illness as a biological factor. They are those illnesses that just occur and are neither the result of any personal malice nor the fault of the patient. They are normally not supposed to cross-attack. That is, to attack people outside of these specific natural boundaries (age, sex and season). Manlarla say that human transition is like "urine from a circumcised male copulatory organ, beginning from under one's shadow spreading out and ending under the shadow once more". In other words, what is natural and alive has an inherent tendency or quality of breaking down of its own accord against the tide of events. These break- downs are not held to result from any personal malice or retribution for some wrong doing. The illustrations below will probably make this classification clearer.

## I Age-Specific Illness

In terms of age, the researcher observed that Manlarla classify illnesses into two categories: Bilbil baalong sicknesses associated with children and Nimbere baalong sicknesses associated with adults. For instance, certain diseases including Tagikyuure measles, Gyima convulsions, Binkuong "teething" diarrhoea, and Nyuo baalong navel pains are associated with the growth of infants and children, while the aging process in general may generate the break down of certain bodily organs, thereby, causing sicknesses as Kpugra hernia, Si orr waist pains, Puo nateri ulcers, and Nyin orr tooth ache (see Appendix B).

## II Sex-Specific Illness

Manlarla also understand that the physical and biological compositions of males and females are different and so they classify illnesses into Poge baalong sicknesses associated with females and Dao baalong sicknesses associated with males. In the natural growth of females and males, Manlarla maintain, certain unique illnesses manifest. For instance, the case of menstrual cramps, the pains of adultery, the traumas of menopause and the strains of widowhood are all unique female illnesses, while hernia is considered a uniquely male malady.

## III Season-Specific Illness

In Manlarla society, like in most societies of the savannah grassland of Western Sudan, two main seasons exist. Manlarla call them Uonne the dry season and Siengo the wet season. According to respondents, an illness is classified under a given season depending upon when it is more common. Thus, Manlarla have Uonne baalong sicknesses of the dry season and Siengo baalong sicknesses of the wet season. For instance, diseases of Siengo as revealed by respondents include diarrhoea, malaria, bodily pains, snake bite, guinea worm, anus sores, hernia and whooping cough, while diseases associated with Uonne include sore throat,

measles, sore eyes, convulsions, anaemia, mumps and meningitis (see Appendix D).

## C Causal Agent

The final major category of illness classification is the perceived causal agent. Manlarla believe in a dual system of illness or sickness causation: natural and supernatural.

### I Natural Agents

A sicknesses that is perceived to have natural causation is known as Baalong pila plain sickness, while any sickness believed to be supernaturally motivated or caused is referred to as Baalong sogla secret or hidden sickness. Pila in Manlarle dialect means white, plain or open. For instance, Yeli pila means an open or a plain matter or issue, while Po pila and Sukyiri pila imply open or plain stomach and open or plain heart respectively. Logically, by Baalong pila Manlarla are referring to those illnesses that are believed to be caused purely by natural factors, without any hidden agenda or motive. Respondents suggested such illnesses (see Chapter 6) are open to treatment within the "popular" sector of Manlarla traditional healthcare system (herbal medicine) and/or by the modern scientific healthcare system (orthodox medicine).

### II Supernatural Agents

On the other hand, a sickness perceived to have supernatural causation is known as Baalong sogla. Sogle means secret, hidden or darkness. For instance, Te sogle means let's hide. And Sogla, which derives from this root term Sogle, implies lack of the illumination necessary to enable the identification of what is before us. For instance, Zi sogla means dark place, while Sukyiri sogla and Yeli sogla mean dark heart and hidden matter or issue respectively. From this, it appears logical that Baalong sogla in Manlarla medical nomenclature refers to those illnesses whose natural (physical) manifestation in the death-

body may not be in doubt, while their causal factors sometimes remain concealed in mystical phenomena. Treatment for such illnesses is sought within the realms of the folk sector of Manlarla traditional health care system (supernatural or spiritual medicine). Herbal or modern scientific medicine may sometimes be used only as a complement to supernatural techniques of treatment, especially when the natural-clinical manifestations are great.

### 4.8.3 The Healing Process

All human groups have available to them, as part of their "inherited and learned cultural traditions", a set of explanations about the causes of illness, and the ways of eliminating them or minimizing their effects. Thus, a healing process is developed and followed in accordance with meanings assigned to each illness episode. In the process of inputing and assigning meanings, the socio-cultural context of the sufferer and sometimes the illness episode itself are taken into consideration. This is what Mechanic (1989) implied when he suggested that "processual influences" are factors par excellence in health perceptions and responses and what Kleinman (1978) calls the "cultural context of the patient's experience".

Manlarla healing system is personalistic (Foster and Anderson, 1978) because it explains illness, first and foremost, in terms of unhealthy relationships. To understand the etiology of illness is to discover where one's relationships are breaking down. Are they breaking down as a result of a natural response or a supernatural reaction to human behaviour in the web of interlocking relatioships? Whatever is presumed to be the cause for the break down in relationships, health or a healthy relation is restored through the processes of identification and reconciliation, the equivalents of biomedical diagnosis and treatment. In the case of improper nutritional regime, an appropriate regime is recommended sometimes in

addition to prescribed herbs. In the case of a supernatural involvement, the particular spirit, god or agent is identified, "the why" ascertained, and reconciliation procedures followed.

To do this, a culturally ordained order of presentation must be followed. Parents, especially the mother, are important links between their children and specialists or practitioners (local or localized) in times of illness. It is they who label the illness, and based upon ..at, decide where to seek help. Acute illnesses and accidents call for immediate attention and so relatives or people on the spot take responsibility while the rightful family members are contacted. Chronic illnesses already have a processed pattern of intervention and so the ordained order would have been exhausted.

In most cases, however, a patient labels the illness himself/herself and may begin administering self medication. Only when a reasonable time period has elapsed without any improvement will the patient discuss his/her feeling with a family member (the father if the patient is an adult male or the mother if an adult female). Depending upon the explanation, the parents may discuss, label it and recommend an appropriate therapeutic intervention. If this level of intervention proves equally unsatisfactory, it becomes the duty of the father or family head to inform lineage elders who may convene a meeting, constitute a therapy management group and determine the next line of action. At the formation of a therapy group, the illness is no longer considered to be ordinary in nature. Rather, it is viewed as life-threatening and probably due to some supernatural cause.

Manlarla practice various forms of healing remedies. But of particular importance is that they all aim at the restoration of essential balance of individuals, families and communities. Within the philosophical framework of N'taanbe, Manlarla healing process can best be understood within three dimensions of life. First, life is holistic, that is, the spiritual,

natural and social worlds are viewed as integral parts of one cosmic whole and thus balance is essential within each and between them for proper functioning of all constituents at all levels. Second, life is a web of interconnecting relationships that may change in form but not in content at different points of human transition and, therefore, deviations by individuals or family groups are regarded extraordinarily unhealthy for proper functioning of the system. Third, life is "self" identification within community, that is, to answer the question "who am I?", a Manlarlo will say "we are, therefore, I am" and not "I think, therefore I am", so common with self identification in the West.

From this understanding, it could be concluded that healing, among the Manlarla, is idiosyncratic at best, a power-sharing "deal" among individuals' physiological pathology, psyche, emotional history, social context, elders, healers, medicines and gods. This probably underscores Manlarla's emphasis on the question "Why?" in times of illness. That is, why did this and not that person get sick?. Why this particular disease? Why this season and not another season? Why this part of the body and not a different part? Manlarla do not seem to demonstrate serious interest in the question "How?", which is the foundation of Western biomedical practice. A 39 year old herbalist summarized this when he said: "there are greater things in healing than physical repair. If you don't look beyond getting rid of the physical disorder (disease), you may never deal with what's brought your life to a halt". The point of getting well, then, a 51 year old bonesetter insisted, "isn't necessarily going back to physical (pathological) normalcy, but to restore broken vital relationships". Under these circumstances, Manlarla models of healing or wellness call not just for eliminating symptoms, but for a thorough going regeneration of body and mind. This brings us to the various causes of illness in Manlarla society.

### 4.8.4 Causes of Illness

The cause of illness is seen as a function of an individual's network of natural, social and spiritual relationships. For instance, as a social phenomenon, illness is attributed to some conflict in the social system either with past members of the community (ancestors and living-dead), or with non-human agencies (gods) or with living members of the community (witches and sorcerers). In practice, a sickness comes upon an individual physically and/or mystically. For example, an apparently natural encounter like snake bite does not provide sufficient explanation or cause for sickness from snake poison. The snake, they believe, is only a transmiting object acting on behalf or for a mystical agent. As such, the snake is not the real cause of the problem.

Like most African societies, Manlarla have a dualist conception of disease causation, a departure from the western scientific canons of pathogenesis and also from the notion that Africans believe all diseases, including even minor illnesses, have ultimate supernatural causes. Through a careful field investigation and systematic description of the complex system of words used by the Bono of Ghana, Warren (1975) not only exposes the theoretical shallowness of the notion that Africans believe all diseases have supernatural causation, but also demonstrates its analytical incompatibility with the African conception of disease. His conclusion clearly conveys that African diseases are either naturally or spiritually caused.

Building upon this dualist system of disease causation within the context of Manlarla socio-cultural milieu, it is observable that any specific illness has three levels of causation: immediate, efficient and ultimate. The immediate causal level of a concrete sickness is the manifestation or technique of entry such as poison, cold, snake bite and lightning (clinical-natural processes which address the question, How?). But poison does not just affect

anybody, nor does lightning strike at will and a snake bite at random. These are believed to be efficiently directed events. For instance, a 33 year old widow said, "we know that if you eat dirty food you can get diarrhoea, but something must have pushed you to eat that dirty food". To find out what that "something" is, her husband and head of the family said, "we consult the diviner". A diviner consulted later in the study revealed that, "there can be no efficient execution of an illness episode by a causal (natural) agent without some guidance from within".

The efficient causal level of an illness is, therefore, to be located in the agent directing or transmitting the sickness (see Figure 4.1) through the techniques as in the first level. In other words, "the How?" of a sickness does not provide an exhaustive answer for Manlarla, since they also believe that once a sickness can come to me and not to you, then that sickness must have been directed to me by something else. The notion of chance in this situation is held constant for all. The efficient dimension of cause is sought through the activities of a witch (or wizard), a sorcerer, some kind of evil agent or one's own behaviour or those of other functional-social processes answering the question, What?).

The ultimate causal level is conceptualized within the understanding that if a transmitting and/or efficient agent can penetrate the protective walls of ancestor spirits, gods, living-dead and tutelaries, then these protective powers must have withdrawn their protection. For example, among Manlarla Christians, Job's illness clearly demonstrates a perfect example of the withdrawal of God's protection, allowing Satan to lay his hand upon Job's body. Manlarla believe that before these powers withdraw or relax their protection, something grievous must have compelled it. This is demonstrated by their expression Dang kpinc mang wegi ka nanne nye kpe it is a cracked wall that invites scorpions.

Under these circumstances, the question to address is neither how the sickness is caused nor what caused the sickness? These questions are considered secondary and answers to them may be known. For instance, "How did I, s/he become sick?" From a snake bite for sure. "What is behind the snake?" An evil human agent or spirit. For them, the primary questions to ask, then, are: "Why did the snake and the agent or spirit succeed?" "Why me and not another person?" "Why did my protective powers withdraw their protection?" "Why did they withdraw it this season and not another season?" These questions define what went wrong and, only after they have been appropriately addressed, will it be possible to determine what must be done (psychological-spiritual processes addressing the question, Why?).

Sometimes, the ultimate and efficient causal levels coincide. This is the case in most supernaturally- caused illnesses. That is, a god or spirit that is supposed to protect may sometimes withdraw protection and inflict illness directly. In the case of illness arising from a breach of a taboo, or of a false oath against a god or engaging in behaviour contrary to custom (for example, adultery of a widow), the ultimate cause may very well be also the efficient cause. Similarly, in warning illnesses, as mentioned above, the efficient causal agent (spirit or god) inflicting the illness may also be the ultimate causal factor (the protective power). For example, while I was collecting data a chain of illesses, suspected to be caused by the ancestors, occurred in Nyimbale; a development that called for a spiritual petition to the ancestors. The petition was recorded and is reproduced below.

> Abaree, Danyagre, Mwaabu, Yirinoba, Sampuo, Zoore, Yekouba (names of immediate ancestors), why are you doing this to us? Where did we go wrong? Why are you spoiling the house? Why can't our tears dry up?You too were here (earth) and you used to make similar (perhaps worse) errors. Why can't you tell us but resort to inflicting us with pains of illness?

This triple separation of levels of causation is not necessarily explicitly made by the

Manlarla. However, I do not think this way of analysing things distorts their view of illness causation. This is because when a person is sick, the family will first try to label the sickness by the technique employed or symptoms displayed, find out which agency may be involved, and then determine the reason and measures for averting future troubles. It is only after these three processes of determination have all been accounted for or satisfactorily settled that the individual can fully recover or be fully treated. If Manlarla associate sickness with a multifarious possibility of transgressions in natural forces, social manipulations and supernatural ordination, how do they discover precisely which symptoms require what attention? That is, how do they relate symptoms to causes in order to be able to determine the appropriate specialist to go for help?

### 4.8.5 Symptoms and Diagnosis

It is the manifestation (physical or mystical) of symptoms or signs that generate awareness of an illness episode. The awareness so generated, according to Mechanic (1989), in turn, generates one of two response processes: a truncated and brief response process for minor and self-limited symptoms and an extented appraisal response process for symptoms of uncertain and life-threatening nature. Minor and self-limited symptoms among the Manlarla are of two types: minor-natural illnesses like fever, malaria, burns and aches, and natural-social illness like "teething" diarrhoea, menstrual pains and old-age illnesses considered as necessary for human transition. Such illness episodes are conceived to have a natural course and a standard duration. These illnesses are labelled and diagnosed by either experienced family members (if the person afflicted has never experienced the illness or is too young to understand) or by the victim him/herself (if experienced before or old enough).

On the other hand, uncertain and life-threatening illnesses are generally believed to be due to "transgressions" in the social realm (such as "evil-eye" or envy illnesses) and the supernatural realm (such as spirit illnesses or illnesses due to withdrawal of protection) and are usually diagnosed by a professional diviner. According to respondents, there are two ways through which such illnesses are labelled and diagnosed. First, an illness may not manifest its life-threatening dimension from the onset. Under such circumstances, one respondent explained, "labelling and diagnosis may begin from the framework of minor illnesses until proven otherwise". When the natural course and standard duration expected of it are defied, a reappraisal of the episode by a much broader family or lineage labelling-team becomes necessary. The composition of the team, I was told, is dependent upon the status of the patient. For instance, while the labelling-team members for a non-ritual participant come from elders and "experts" within the family, that of a ritual participant is derived from elders and "experts" of the entire lineage.

Secondly, an illness may reveal its life-threatening dimension from the onset by either revealing unusual symptoms, manifesting itself in either an unusual sex or age or during an unusual season, or appearing on unusual spots of the victim's body. In the event of any of these manifestations, another respondent emphasized, "human or supernatural involvements are immediately suspected and a diviner is consulted". During such consultations, the therapy-group (labelling-team plus diviner) does not ask how the patient became ill. Instead, they ask why they are sick, what is involved and what should be done. My association with herbalist Sayibu revealed that, recognized or experienced syndromes of humanly- or supernaturally-caused illnesses are not consistently attributed to the same human or supernatural cause. Each case, he said, "is considered individually and the specific human or supernatural cause,

treatment and prevention determined". Below is what he illustrated for me as the method used in his diagnostic activities.

> Naazung kontonne, help us with this diagnosis; Kyina puore baalong, we are unable to determine our problem. Tenbiing yuoraa, something appears to be wrong with us. We stay together, we eat together, we sleep together, and we talk together; yet the house is falling. May we understand why the house can't stand anymore. If there is a "night-roamer" among us, find him/her out.

From this brief presentation, diagnosis appears to be the focal point of thought in the treatment of a patient. From diagnosis, Feinstein (1967:73) suggests, "the thinking goes chronologically backward to decide about 'pathogenesis' and etiology of the ailment. From diagnosis also, the thinking goes chronologically forward to predict prognosis and to choose therapy...The taxonomy used for diagnosis will thus inevitably establish the patterns in which 'clinicians' observe, think, remember and act". Therefore, diagnosis is not only a clinical reality but also a social process through which illness is constructed and certain persons are cast into the role of patients (Parsons, 1951). If illness is a social category and diagnosis is a social process, then we should expect to find variation in treatment and prevention of diseases across cultures, sub-cultures and over time. That is, treatment decisions or choices will depend on the complex interplay of many factors, including general cultural norms and values as well as the norms and values that are specific to a particular sub-group of the main culture at a particular time.

### 4.8.6 Treatment and Prevention of Disease

Mechanic informs us that responses to illness are usually mediated by many intervening factors including sociocultural variables (1989). Similarly, Kleinman (1980) notes that the decision to seek help and where to seek help (popular, folk or professional health

sector), depends on how the illness is understood and interpreted by the patient and/or his or family or community. These considerations or appraisals go through negotiations between illness beliefs and perceptions of treatment benefits or efficacies at the end of which the community's "lay referal systems" (Freidson, 1970) are processed.

Manlarla maintain that Baalong beree mang wuli baalong sangbo the perceived cause of an illness determines where to go for help or treatment. Their concepts of disease causation and disease management are intimately bound to their religion and conception of the universe. With a triple theory of disease causation (recognizing natural, social and supernatural causes), they employ natural techniques and empirical knowledge for treating those diseases thought or believed to have natural cause, social reconciliatory mechanisms for those with social basis, and resort to supernatural procedures when they are believed to be either supernaturally induced or caused.

With this conception of disease causation, Manlarla treatment procedure for naturally caused illnesses is not different from the Western procedure. Emphasis in both healthcare systems is normally on how one is ill and how the illness can be removed and health restored. However, treatment procedure for humanly or supernaturally caused illnesses (which do not exist under Western biomedicine) is significantly different. Here, the question emphasized is why an individual is sick and not how he or she is sick.

In Western societies, the specialist (or physician) in whatever illness episode tells patients how they became ill. That is, what the problem is and how it is caused. For instance, one hears statements like; "mom, you've influenza; you got it by breathing in the virus"'. The traditional Manlarla specialist, in a supernaturally motivated or caused illness, tells the patient and/or his or her illness management group things like, "you've this illness because your

ancestor spirits or some gods are angry that you've denied them their entitlement in sacrifice". Within such framework of medical intervention, a sacrifice to the peeved ancestor or god may constitute treatment, a means to treatment or serve as a preventive measure for its future occurrence (see Appendix D).

In modern scientific medicine (as represented by localized health professionals), there are elaborate clinical procedures for determining symptoms and treatment (Ghana, 1994b). However, the social and spiritual aspects of the human being and of the illness in question are less important. On the other hand, in Manlarla traditional medicine, as our data from local specialists appear to indicate, there are elaborate procedures for determining the social and spiritual aspects of an individual's illness. Even an individual's sin or moral failing, they believe, can either lead to self-induced sickness or other-imposed sickness (sickness due to another's sin or moral failing). Some 55% of respondents expressed that, "most sicknesses and accidents resulting from 'sin' often manifest in the children or other close relatives of the sinner". Whether self-induced or other-imposed, Manlarla believe that illness influences interpersonal relationships of members of the wider community and a whole range of external phenomena are brought to bear on decisions about it.

### 4.8.7 Criteria for Decision-Making

Illness and illness behaviour have meaning only when they are placed and analysed within the context of the social thought of the people from which the notions of causation, therapy and agents of therapy are derived. Thus, while disease and the "case" in Western culture and thought system is a biological, individual non-moral problem, the sick, among the Manlarla, is invariably the centre of social strains and collective concern. The social and

collective basis of this lies in their expression, Ninyena ba biera baalong illness is not an individual affair. A sick person attracts attention not only because incapacitation impairs the performance of social roles, but also because illness, when severe and protracted, tends to constitute a threat to the texture of kin relations. Given the implications of illness for the maintenance and reproduction of social structure, some degree of consistency must be maintained between categories of disease causation on the one hand, and the search for therapy (the adoption of various therapeutic strategies and the key agents of therapy) on the other. In other words, decisions about illness episodes and the choice of therapeutic intervention will vary according to cultural standards.

The decision to seek treatment may be an easy assignment for illnesses that are considered to fall within the framework of Baalong pila natural (plain) illness. Here a decision is based on manifested symptoms, resources and sometimes on the patient's own desire (if patient is an elder of a family or lineage). However, for illnesses that are suspected to fall within the domain of Baalong sogla spiritual (hidden) illness, the decision to seek help and where to do so are influenced by the roles of elders (family or lineage depending upon the status of the patient) and local specialists. Elders and specialists, therefore, function to complement each other in their roles as guardians of social and spiritual health. For, as one elder said, "with all my social authority in my family, I can't act on illness without the specialist's diagnosis". But one specialist also said, "my powers of diagnosis and perhaps of treatment lack the social authority to compel attendance and compliance".

The criteria for illness decision making is even more complex with the category of ritual participants in Manlarla society. For, as we shall see in Chapter 5, funeral rites involve (directly or indirectly) the reformulation of social norms that serve as sanctions on behaviour

(the ritual control). Group discussions with ritual participants and ritual specialists in sample villages suggest four (rather contradictory) reasons for this. First, ritual participants are Kpiin noba death-people or dead-living. As such, they are the true representatives of the spirit world on earth, a status that entitles them to enjoy a more formidable spiritual protection than non-participants. Second, as Kpiin noba, they are part humans and part spirits. Spirits, as we explained earlier, do not fall sick. So, by virtue of the spirit quality in them, they are believed to be too strong to fall easily to natural disasters. Third, ritual participants are the direct descendants of the ancestor spirits. As such, it is through them ancestor anger (including illness) becomes manifest. Finally, ritual participants have many more serious contractual relationships with the spirit world than non-participants, the breach of any of which is a potential source for illness.

For these reasons, 62% of respondents suggested that any illness of a ritual participant is considered a serious matter". For them, "there is no difference between Baalong pila and Baalong sogla. Every illness experience for them belongs to the latter and thus requires elaborate divination". The logic for this is simple. Such persons are ritual participants; and as funeral ritual participants, are part human and part spirit. Spirits do not fall sick, yet this person is sick. In addition, such a person is a dead-living; and as a dead-living, is the direct representative of the ancestors. Representatives of the ancestors not only receive more spiritual protection from them, but their bodies are also used more as objects for expressing ancestor anger than the bodies of non-representatives. With these caveats in mind, Manlarla are always suspicious that "something" may be acting behind every illness experience of a ritual participant.

Sometimes, the individual concerned may refuse to inform elders about his or her

illness experience and seek help within the popular sector of the traditional health care system. This is especially possible when the illness is yet to have any visible (clinical-natural) manifestations. However, 52% of respondents indicated that, "they seldom do it for fear of the ritual consequences". Several proverbs were given to demonstrate this point but, for lack of space, only three are presented. Bibile ba benla O ba a child does not deceive the father, Baba sogla nyiera bini you never hide to shit, and Yuore ba gagna gbekpeng penis is never bigger than thigh.

The implications of these proverbs are complementary. In the first case, if one wishes to prosper one does not deceive the one who is responsible for one (usually one's protector). In other words, if you wish to be in perfect health you do not deceive the one who is responsible for your life. Here, father is synonymous with protector. In the second example, whatever one thinks one is doing in secrecy will come to light sooner or later, the consequences of which are more devastating than could ever be imagined. In the third, you never pretend to be wiser than your creator/protector. What is clearly established by these examples is that, all cases of ill-health should and must always be reported to appropriate authorities (in this case, the elders).

When the ill-health of a ritual participant is made known to the elders, a series of divination processes are often generated to determine the "real" cause(s). Depending upon the quality of diviners around, 57% of informants said, "an illness verification may take several days and, sometimes, weeks to complete". Under such circumstances, even minor illnesses can develop into dangerous and life-threatening experiences, especially for ritual participants as treatment process is unduly delayed for them. For this category of people, utilization of healthcare services is likely to be influenced more by such meso-level

sociocultural processes (recognition of their spiritual identity/status) than by macro-level structural factors.

## 4.9 Conclusion

One major point to note about this chapter is the fact that traditional Manlarla are convinced of the existence of three worlds - the supernatural, the natural and the social. While God created the first two worlds, the third world is the creation of humans with the guidance of and blessing from God. This understanding of creation makes the Manlarla world view essentially religious. Their religion is, among other things, a way of representing and interpreting the external world as well as human experience. In general, Manlarla religion is a mode of experience or a response to life as lived by them. In particular, it is a system of responses to those aspects of experience (especially, episodes of illness and death) which threaten to overturn the sense of an intelligible order they have known through socialization and have lived in the past.

While individual respondents may have expressed themselves differently on these issues, a consensus emerged around a few main themes. For instance, the acceptance of a planned and ordered universe, the idea of a balanced relationship among the worlds and their constituents, between matter and spirit or being and consciousness, and the necessity for humans' cooperation for the continuity of the universe as created and ordained came through in clear conception. Within this framework of order, certain arguments were made.

We argued that health and illness are inextricably associated with socially approved behaviour and moral conduct.We also noted that the victim of an illness may not necessarily be the offender but just an illness-agent for either a broken relationship in the family or for the

offence of a kinsman (or woman). The importance of symptoms and course of illness as well as the ritual status of the patient in illness deliberations and labelling was equally noted. These cultural-specific deliberations and labels provide substantiation for the choice of healthcare services in Manlarla society. In Chapter 1 we argued that Kpiin noba are many among the Manlarla due to epidemic deaths arising from mining occupations; and that in order to pick up the thread of living, the people perform funeral rites and reallocate roles. But the participation in these rites and acceptance of new social identities come with "strong" spiritual sanctions (ritual control). All these factors tend to influence the utilization of available healthcare services by ritual participants.

From these, we can hypothesize that low utilization rate of PHC resources in the region, therefore, is more likely to be located in these sociocultural processes than in macro-sociological factors. Furthermore, we can also hypothesize that inter- and intra-gender variations in the propensity to use healthcare services are more likely to find explanation in individuals' status vis-`a-vis these rites and their control mechanisms than in micro-psychological characteristics. This is because the theory and processes of care (or healing) are part of the coherent system that constitutes the basis for Manlarla conception of the universe. But, what is this ritual control? How does it become institutionalized among the people? What is its place in relation to social action and behaviour in Manlarla society? The chapter that follows provides answers to these questions by analyzing the ritual transformations of Kpiin noba. It is intended to illustrate the genesis of the ritual control and erect a foundation for constructing meanings for their low propensity to use healthcare services, an issue that is tackled in Chapter 6.

# CHAPTER 5

# MANLARLA FUNERAL RITES AND HEALTH

*No one can hope to appreciate the thoughts and feelings (actions and behaviour) of the African who does not realize that to him the dead are not really dead but living, in full command of all their faculties including memory, endowed with greater abilities and power than when they were on earth...No doubt ever enters their mind as to the continuance of life after death* (A. Talbot, 1962:298)

## 5.1 Introduction

Generally speaking, all human societies are characterized by mortality. This inevitable universal destiny raises an eternal question in the minds of those who care to be agitated about the meaning of human existence: What is behind this human-death bound existence? For some people, human death-bound existence appears absurd, and the actual syndrome, death, seen as the dreadful end of life's absurdity. For other people, it is an ordained phenomenon saturated with meaning extending beyond the horror of the corpse. In any case, there is hardly any human society where death is not reluctantly accepted. Nor are there any human groups which do not dispose of their dead. Some people dispose of the corpse hurriedly, while others do it slowly with painstaking attention. Whatever form this disposal takes, some kind of ritual follows it.

A ritual, according to Max Gluckman, is "the highly conventionalized performances, of which people believe that they can help, by mystical means outside of sensory observations and control, to protect, purify, or enrich the participants and their group" (1966:224). Among the Manlarla, ritual surrounds all aspects of life. It is even especially all important in their

funeral ceremonies. In this chapter, we shall examine the ways in which Manlarla organize rites of death, how people attain ritual status, and how this status controls behaviour with implications for the use of health services.

The reality and inevitability of death is a complex phenomenon among the Manlarla. But it would be futile to imagine that I could deal adequately with all its dimensions here. Consequently, only those issues considered important in individual health and community well being will be analyzed. As respondents maintained, rites of death are performed to "maximize individual health and community wellness by minimizing disruptive and disintegrating factors caused by death". In doing so, I hope to bring out clearly areas of disharmony (ill-health, if you like) generated in individuals and in the community by death. I shall also describe and analyze how the people interact and interrelate in order to re-establish harmony and restore health, a "restoration" which, nevertheless, reveals an interesting paradox (ritual control) which, in turn, defines subsequent health seeking behaviour for ritual participants.

Manlarla ideas about and concepts, fears, and attitudes towards this *mysterium tremendum* are expressed in funeral rites as well as in the proliferation of necrophobic names like Kuubakyire death is inevitable, Kuubatatobo death has no ears, and Kuubatazie death has no place. For them, death must be confronted with ceremonies and rites, in concrete and "efficacious" acts, capable of enabling the bereaved to accept and assimilate it as an ontological reality, as a transition from the social realm to the domain of the spirit world. Nevertheless, Manlarla still dread death, especially Kuu faa evil or bad death and Kuu kpienga premature death. As a consequence of this dread, they preoccupy themselves with possible measures of delaying death, by improving health. And when it occurs, they spare no time in dealing with it the best they can in order to rekindle the flame of life. They are

attempts by the people to negotiate goals (such as health) with powerful beings. While general health and well-being are guaranteed by these rites, the health or well-being of individual ritual participants is sometimes compromised by them. This chapter also analyzes the foundation of this "contradiction".

## 5.2 Origin and Causes of Death

Manlarla have mythological explanations about the origin of death. While accepting it as part of human natural heritage from Kontoma spirit-being of the wild, every human death is thought to have external causes, making it both natural and unnatural. For instance, 81 or 92% of respondents underscored death as a natural human inheritance. Yet throughout my fieldwork, I could feel a general reluctance among them to accept the natural necessity of it. This reluctance is also reflected in their myths, stories and legends. These stories, coming from different backgrounds and told in various forms, link the origin of death to an error of somebody or some creature, to the "message manque" (Kuukure, 1985:109). One story that attributes the origin of death to an error by the "father" of the human world, the Hunter, was narrated to me by an old male Christian respondent and is summarized below. It goes that:

> ...the Hunter, who was also the King of all creatures of the natural world, was living in perfect harmony with his family and the families of all other creatures in the forest. Death was unknown in the Hunter's family but not in the animals and birds' families; for anytime the Hunters wanted a palatable meal they relied on the reluctant generosity of the other families...
>
> One day, disaster struck the buffalo family. His favorite son had been killed unintentionally in the course of an evening "hide and seek". All families gathered around the corpse in total dismay. It was the first time a thing like that had happened.
>
> A creature, Kontoma, came by and seeing their plight promised to teach the King of the forest, the Hunter, and his "trusted one" the secret of "waking the

dead". They must, however, agree to keep the secret to themselves...

Could you invite your trusted one over, my friend the Hunter, Kontoma demanded. The Hunter invited his wife. Kontoma, in total disbelief, asked him if a woman was his trusted one? And the Hunter confirmed his choice.

This secret can wake up only a person or an animal at a time, and it is a "gift" with great cost, Kontoma warned. We are prepared to pay the cost no matter how great, the Hunter and his wife replied.

Kontoma said, death would be part of your package if this secret is ever known by anybody unless absolutely necessary. In addition, the power of the secret tail would be "emptied". At this point, the Hunter hesitated but his wife urged him on declaring,"but who on earth do you think would divulge this rare knowledge if not you (the Hunter)?"

Trusting that he would never do it, the Hunter sanctioned the deal. So, Kontoma gave them the secret tail and revealed its method of application. They immediately used it to wake up the young buffalo. Happiness was restored in the forest...

One day, the brother-in-law of the Hunter came demanding to know something about the secret tail. "But who told you I have a secret tail?", the Hunter asked. "Don't be such a fool; don't you know these trees around us all have ears?", the brother-in-law quarried.

"I don't have any secret tail; go back home and never come to me again with such nonsense", the Hunter warned.

This was a warning the brother-in-law couldn't take easily, so a quarrel broke up between them which eventually resulted in the death of both. All the other creatures ran away in fear and have since remained terrified anytime humans are in sight.

The wife of the Hunter, the only person at the time with knowledge of how to use the secret tail, now had to make a difficult choice. She had to choose between waking her husband or waking her brother. She chose to wake the latter while the Hunter was left dead and later buried in the facade of his house.

Kontoma came by the night after burial, woke up the Hunter and asked, "did

> you say a woman was your trusted one?" The Hunter nodded his head in disappointment. "It's over my dear friend; go back and "sleep"; you've become the first victim of your own misplacement of trust", said Kontoma.
>
> Since then death has become a permanent feature among the Hunter's descendants and a woman is yet to be restored as a trusted one in Manlarla folktales.

Because of the multiplicity of stories explaining the origin of death, Manlarla are never specific about its origin. But if they are hesitant about its origin, they are, nevertheless, elaborate about the causes of a concrete death. In the first place, Manlarla believe that the destiny of old people with Yaane grandchildren is to die. As a 34 year old, male orphan said,"Ka nie wa de porgiba ko fo biiri kaba dogira fo yaane, bong le kyeri ka kuu naang if you marry for your children who are now begetting you grandchildren, what is left if not death?". Such people, as Kuukure (1985:110) rightly observes, are considered to have won an honourable place in the community as they have "established their houses", humans' ultimate purpose on earth.

At the funerals of these people, therefore, it is not uncommon to hear statements like, O ba saang kuu s/he has not spoiled or wasted death, O kuu meng ta it is time for him/her to die. Deaths of this nature are considered to be matured, striking at the right-age and arising from the completion of one's life-cycle on earth. The pains normally associated with death are less hurting, and adjustment to the loss much easier. There is usually a lot of joking, dancing and feasting at such funerals. J. Goody aptly captured this among the LoDagaba, LoSaala and the LoWiile when he observed that:

> ...it can therefore be understood that in all these communities the older the deceased, the more joking at his funeral; for the loss is less acutely felt than in the case of a younger man (or woman). A fundamental difference exists between the attitude to death of a person who has lived the full span and

> produced male heirs, and to that of a younger man dead before his time. The first allows for a gradual alienation from the network of jural and individual ties; the community anticipates the readjustments required. On the other hand, an unexpected death causes a sudden rent in the fabric of relationships and makes greater demands upon the system (1962:125).

In practice, however, death sometimes strikes by violence, physical or mystical (Goody, 1962). Thus, the natural causes, by themselves, do not provide sufficient explanations for the death of human beings. In addition to the natural cause, therefore, Manlarla also see death as a function of an individual's network of spiritual and human relationships. For instance, 63 respondents (72%) of the 88 respondents contacted for data attributed death to human machinations and/or supernatural involvement.

In our analysis of illness causation among the Manlarla, we identified three levels: immediate, efficient and ultimate. Similarly, three levels of causation (immediate, efficient and ultimate) are present in each concrete death. The immediate cause refers to the technique of execution or method used to kill the deceased such as disease, snake bite, poison, lightning, and so on (elements within the natural world). The efficient cause refers to the person or act behind the killing of the deceased such as witches, sorcerers, and curses (agents within the human world). For instance, a 37 year old heir, who lost a brother through snake bite, remarked, "Yening ka waabo pagi nyina duna noba koora? where does a snake get teeth to bite people to death?" This implies the snake was directed by an agent with "teeth". The ultimate cause is either an ancestor, a ghost, a god, a Kontoma or a collective or personal tutelary (the deities and spirits of the supernatural world). In each concrete case of death, God remains the silent commander.

Be that as it may, one would have thought that the people would see God as intrinsically "evil". On the contrary, He is seen as the supreme balancer of good and evil as

revealed in an expression by an old female respondent, "Naa-Ngmen duora yoore kuong God provides water for termites". The termites are physically weak and if left alone to provide water for construction may never be able to do so in centuries. Her statement was complemented by a young male orphan who said, "Naa-Ngmen la sogna God is the balancer/helper". He intervenes regularly on behalf of the weak and needy. For, as Evans-Pritchard (1976:12, 19) observed among the Zande, Manlarla also believe "God evens things out, rewarding good to those who follow good conduct, and evil to those who follow evil conduct, and overlooking breaches done accidentally or in error".

## 5.3 Approaches to Death Celebrations

Celebrations of death are a type of collective behaviour which defies organization under a single set of sociological concepts or a single theory. Rather, they constitute a kind of behaviour which does not fall into a pattern of social routines. Much like the concept of culture, social science interpretations of death celebrations have undergone a process of parochialism, a parochialism which has had the effect of eliminating a transcendental and universal conception of the phenomena. Nevertheless, it is neither my intention nor the purpose of this study to trace step by step the parochialism of approaches to death celebrations. The intention here is to discuss the meaning and interpretations of these celebrations, examine the contextual evidence upon which Manlarla celebrate them, and xplore how participation in them influences subsequent health behaviour (especially utilization of health services) of the community in general and ritual participants in particular.

Lubbock (1902:226-27) contended that dreams constitute the basis for beliefs in the other life, beliefs upon which mortuary activities are to be located. Tylor (1920) in his animist

elaboration emphasized the logic of these beliefs within the body-soul dichotomy. This dichotomy, he maintained, gives rise to the associated beliefs in invisible ancestral powers and the metamorphosis of the soul into ghost. Tylor's animist religious undertones found expression in Spencer's (1896) evolutionary theory in which he proposed a single historical sequence for beliefs in superbeings beginning with the family cult. However, Spencer has not been spared on this conclusion. As Jevons wrote, "like all other private cults, the worship of ancestors was modelled on the public worship of the community, and as the family is an institution of later growth than the tribe or clan, the worship of family ancestors is a later practice than the worship of the tribal god" (1902:13). It is probably this development that convinced Durkheim, Frazer, and other contemporaries to single out as the most primitive form of religious practice, totemism or "the cult of the clan". What is, however, important in all these contributions is the fact that religion remains as the core of funeral rites.

Manlarla universe, although divided into three (spiritual, physical and human), is also divided into sacred and profane. Religion permeates every aspect of the sacred world and has tremendous influence on the affairs of the profane world. Sacred activities like funerals owe their qualities of sacredness to no intrinsic value but rather to group attitudes and sentiments (Goody, 1967). This world of sacredness requires reverence and special non-utilitarian treatment. Social solidarity and integration depend largely upon general consensus or "conscience collective". Conscience collective or "collective representations" are shared ways of thinking and feeling (beliefs, values and norms) which bind the members of the society together to form a tightly knit community (Durkheim, 1951). Even though they exist outside of individuals of any given society, they exercise a sanctioning power over their behaviour.

Among the Manlarla, the conditions necessary for the development of personal

consciousness are absent or rudimentary at best. Consequently, far from being an incorrigible individualist, a Manlarlo lacks any self-conscious identity and s/he is, therefore, completely absorbed by the group. For instance, when respondents were asked "Who they were" during fieldwork, almost all of them found the question ridiculous. After some effort to get them to understand the essence of the question, 63 respondents volunteered some kind of responses. A close examination of these responses revealed that 47 or 75% identified "self" within community, thus, emphasizing the philosophy of N'taan be. In this society, therefore, the goal, purpose or motivating force behind individual and/or group actions is the maximization of the social or collective good.

It is this collective identity that compelled Durkheim to conclude that, "...in such societies where culture is coterminous with the conscience collective, the mind of the individual is a mirror of the beliefs and feelings of the collectivity, and the solidarity produced in this manner is called mechanical precisely because individuals are capable of no thought and action independent of the group" (1964:156-160), at least, not without being labelled "deviants". One positive implication of this conclusion is that human practices are to be analyzed in terms of both their inherent purposes and associated beliefs of other institutions within the social system. From this, it stands to reason that in such societies, of which the Manlarla society is no exception, ideas of death rites will not be found as opinions and attitudes but always closely linked to the institutional fields in which the rites are symbolized. Thus, images of death rites among the people should not be identified as independent intellectualizations but as collective consciouness manifested in the religious institution.

Sociologically, therefore, Manlarla perform funeral rites within the framework of an institution, the religious institution. The dictionary definition of an institution is "long-

established law, custom or practice of a club or society". If an institution is an established phenomenon, then it must have some purposes to accomplish which are very much desired or valued by the people concerned. Hertzler's analysis of social institutions remains examplary in this regard. He said:

> ...social institutions are purposive, regulatory and consequently primary configurations, unconsciously and/or deliberately, to satisfy individual wants and social needs bound up with the efficient operation of any plurality of persons. They consist of codes, rules and ideologies, unwritten and essentially symbolic organizational and material implementations. They evidence themselves, socially in standardized and uniform practices and observances, and individually in attitudes and habitual behaviour of persons.They are sustained and enforced by public opinion, acting both informally and formally through specifically devised agencies (Hertzler, 1964:1-5).

In concert with the above analytical exposition of institutional theory, it could be said that Manlarla celebrate funerals the way they do as a result of a deep emotional revelation standardized by their conception of creation and the essence of human existence. For instance, responses from 60 respondents or 68% of the sample suggest that the horror of the corpse alone cannot explain associated emotions and ritual but that the social implications for the group concerned must also be taken into account. They express this as: "Kuore ba puona a funeral does not rot". That is, while a corpse may fail to stand a few days of physical "exposure", a funeral can stand years of social "torture". This is by no means unique to the Manlarla. Radcliffe-Brown observed that traditional societies celebrate funerals because of the need to fulfil the "social sequence" (1940:188-204). He argues that every major stage a person reaches in social life: birth, puberty, adolescence, marriage, is marked by some formalization. As such, one who has been heralded as a member of a society cannot be allowed to pass out of it entirely without valediction.

Consequently, Gluckmann (1966) objects to mortuary analysis as "a response of the individual to death". To analyze them entirely by the emotional comfort given to the dead person and his survivors, for him, is to avoid many of the important issues involved (1966:117). For example, why is an unloved parent or relative buried with the same full ceremony given to a loved parent or relative? Or why is a loved one sometimes "thrown away" while an unloved one is treated with full ceremonial decorum? Malinowski's (1954) inquiry remains examplary in answering these questions by locating the significance of funeral celebrations in religion. He views religious ceremonies which address the experience of death as self-contained acts, the aim of which is achieved in their very performance.

> The ceremonial of death which ties the survivors to the body and rivets them to the place of death, the beliefs in the existence of the spirits, in its beneficient and malevolent intentions, in the duties of a series of commemorative and sacrificial ceremonies - in all this religion counteracts the centrifugal forces of dismay, fear, demoralization, and provides the most powerful means of reintegration of the group's shaken solidarity and of the establishment of its morale (Malinowski, 1954:52-53).

Similarly, Sarpong (1974) observes that Akans in Ghana believe the spirit (the invisible living image of a dead person) continues to live much the same kind of life that the integrated men and women lived on earth and may die and be born again. This mystical presence of the dead, he argues, accounts for not only death ceremonies, but also the reason why existing or surviving relatives of the deceased endeavour to perform fitting ceremonies and rites as dictated to them by custom. Sarpong's observation about the Akans of Ghana is applicable to the Manlarla of the UWR of Ghana.

Linking this analysis to the Manlarla expression "Kuore ba puona", it could be said that their funeral celebrations are of import more because of their social implications than for the horror of the corpse. Their society, like any other society, is an on-going system. As such,

the death of any member constitutes a threat, an illness if you like, to their very existence and solidarity. These social threats are soothed or counteracted by the performance of appropriate funeral rites. Links between such threats and rites generated by death were summarized by one family head when he said to me, "M'bi dao, te saakumene toma ang la ka tenang ba ele te kon la my son, since it is our ancestral work and pride, if we don't follow it we won't laugh". Metaphorically speaking, to "laugh" means to be healthy and to be at peace in and harmony with one's environment. For, as they maintain, "it is only from a healthy body and a peaceful mind that 'laughter' can be expected". How do the Manlarla organize and celebrate their funerals to ensure healthy bodies and peaceful minds?

## 5.4 Manlarla Funeral Organization

Death does not merely mean the loss of one individual from a given community. It is also a challenge and a threat to the meaning of human existence in and for that community. In most societies of the West, the physician's determination of death as a non-reversible cessation of life tends to meet the need for verification. That is, the physician's ritual satisfies their conception of death. The Manlarla have a much more complex view of death that is not addressed by this biomedical approach. For them death implies, in addition to the cessation of life, major philosophical, religious and social discontinuities. But they are not merely passive objects to whom these discontinuities occur. Their confidence in an existing order which enabled them to function with a sense of security may for a while remain altered, but the Manlarla are able to graft new experiences onto the old and through that process are able to maintain a thread of continuity of perception and meaning to life. These new experiences are grafted onto the old order through the way Manlarla conduct funeral rites and the

symbolic role these rites play in their cosmology. The sections that follow deal with some of these Manlarla conceptions of death.

### 5.4.1 Manlarla Social Structure and Death Rites

Manlarla practise a subsistence mixed economy of hoe-cultivation and animal rearing. They cultivate a fair variety of crops most important of which are millet, sorghum, maize, yams, beans and groundnuts. The animals that are reared are significant, not merely for subsistence or as wealth, but more for creating and maintaining the all-important network of social and spiritual relationships and alignments in the social structure that arise especially from marriage, illness and death. The society is patrilineal and marriage is patrilocal. But more important in the society is religion which permeates all other institutions of their social structure viz: political, economic, education, and family and marriage. Gender roles are designed by custom and distributed accordingly with males playing a dominant role in all institutions. The forces of nature, as we noted in Chapter 4, may be manipulated by specialists through properties intrinsic in various objects, animate and inanimate.

The society is, therefore, largely traditional in terms of Weber's terminology and the main concerns are centred on three orientational variables (Apter, 1966). According to Apter, the first, termed behavioral alternatives, is the systems of authority as legitimized by the various levels of traditional political system (the family, lineage, clan, priest, chieftaincy hierarchy and its subordinate wings - Porsarihe and Bipola associations). The second variable, termed goal orientation, simply refers to the type of expectations built into the traditional system by which individuals view the future and alter their activities where necessary. The third refers to the sanctioned aspects of social actions which manifest in the social norms

of the society. The conception of norm implies that the individual in a given situation should, ought, or must follow certain behaviour in his/her attempt to perform his/her defined roles.

The belief that ancestors give supernatural support to lineage members and descendants through ritual representatives is supreme. They also believe in the threat of mystical retribution in life or in death. As such, moral and jural roles are believed to be given to humans by supernatural beings. These social precepts are unequivocally placed beyond the vagaries of human action and the validity of morals essential for the continuity of the society established by mores which no human agent can challenge. It is this dependence upon super-sensible powers that compelled Radcliffe-Brown to conclude that "...in these societies the performance of such magico-religious acts and observances must have as their goal the desire to increase their hold on life" (1964:531-534). They provide some kind of insurance against threats to life or disruption of the social unit and ensure health of and peace within the group.

In the context of Manlarla cosmology, we learnt death is never within the natural cause of events. Answers given by them to the problems of meaning generated by death often incorporate supernatural forces and transcendental values. Nor do they see death as the end of mortal life. These are manifested in the unique way in which they perform their rites of death and talk of the dead. The dead person is sometimes said, O kuli ye s/he has gone home, O gaa ye s/he has gone, or for the child, O zo ye s/he has run away because s/he has not fulfilled her/his earthly mission. For them, funeral rites constitute the final rites of passage (van Gennep, 1960) in a human's life cycle. Responses from the ritual specialists interviewed suggest that funeral rites are expressions signalling separation of the dead from the social world, the bereaved from the dead, while integrating the soul of the deceased to the spirit world and facilitating the adjustment process of the bereaved to the new situation created by

death. As one of them summarized, "ritual processes are aimed at providing mechanisms for harmonious living in the worlds of humans and spirits".

## 5.5 Primary Rites: The New Identities

In Manlaria society, like other societies, new identities are assumed at the instance of death. Two forms of identities may be created by death: psychological and social. Psychologically, the shock of the death of someone dear to us may generate in us a loss of perceptual reinforcements. Our old identities may give way to new cues that have no meaning, little meaning or a meaning different from the old (Marris, 1974). As an old widow recounted, "every human being, before death, would have occupied certain positions (statuses) and performed associated duties (roles) in society". "Death" does not only tear these accustomed statuses and roles asunder, but it also "engenders new ones for which adjustment is required". The magnitude of these new problems of social and spiritual identity will depend on the social position of the victim of death. Ray (1976:141), for example, notes that "when a family loses one of its members, especially a senior member, a significant moral and social gap occurs. The family together with other kinsmen must close this gap and reconstitute itself through a series of ritual and social adjustments".

Death thus removes people physically and socially from society and from the statuses they once occupied and roles they once performed. That is, old relationships, especially with fellow members of society, will change, thereby creating new identity realities. As observed during fieldwork, the type and number of new identity realities created in a situation like this normally depend upon the type and variety of statuses of the deceased in his/her family or community. For instance, the death of a child generates no new identities beyond the physical

presence of the corpse, while the death of a married man generates, at least, three levels of new identity realities for which reorganization is required for a new equilibrium. The object of the rites (the deceased), the subjects of the rites (the bereaved), and the perpetuator of the rites (the community) all assume new identities. In concrete terms, the man who is now dead becomes a living-dead and his wife and children become a widow and orphans respectively, while the community becomes disorganized and disoriented. Radcliffe-Brown explains this succinctly when he observed that:

> For the society a death is the loss of one of its members, one of its constituent parts. A person occupies a definite position in society, has a certain share in the social life, is one of the supports of the network of social relations. His death constitutes a partial destruction of the social cohesion, the normal social life is disorganized, the social equilibrium is disturbed. After the death the society has to organize itself anew and reach a new condition of equilibrium (1964:258).

Having assumed these new identities, a liminal period is required within which time these "victims of fate" are ritually prepared to assimilate the new experiences and adjust in order to be able to play the roles associated with the new identities or statuses. This view was echoed by a 49 year old family head when he said, "Ka kuu meng ko kaa kuore ba maale, yeli gyamaa mang saang; a kuu kong bang ta dapari; a nyovori deme meng kong bang kpe noba puo a death whose rites are not completed is capable of generating numerous social problems or illnesses; the deceased can neither join the ancestors nor can the survivors play their roles as human beings". Spiritually, the deceased remains a part of the old community of survivors while belonging to the new community of the ancestors. This uneasy position, his inherited widow chipped in, "is maintained until all rites of adjustment to his/her departure are properly observed and completed".

Traditionally, custom has served as mitigating agent for the Manlarla by offering

guideposts to behaviour and feeling at a time of disorganization caused by death. As we shall see, through such prescribed rites as Kuore, Kodeo, and Komaale, a time table is offered for mourning, for the expression of grief and gradual cessation of sorrow, for the integration of the deceased into the spirit world, for the reintegration of the bereaved into the social world and reorganization of family and community life. It is these social functions that present Manlarla rites of death as a mechanism for the adjustment processes of the deceased, the bereaved and the community.

### 5.5.1 The Deceased and the Bereaved

Among the Manlarla, a sick person is cared for by close relatives, especially classificatory sisters in the case of an old man. When the sickness does not yield to the ordinary household remedies, then the services of a specialists (traditional and professional) are solicited. Whether a sick person is with a traditional practitioner or at a modern hospital, it is still obligatory that relatives give their maximum attention and support. If their combined efforts prove unavailing and the patient is about to die, then it is proper for him or her to pass away in the arms of somebody preferably an old lady. A 43 year old earth-priest told me, "Yiri pomyaane seng kaba nyogi noba ang kpiire it is the traditional role of the old ladies to hold a dying person; Kye a bikpeng meng biebo somang but the presence of the eldest son is also very essential".

Throughout Manlarla society, an old lady said, "it is our traditional responsibility to practise midwifery. Since almost every person would have been delivered to the human world by us, it remains our duty again to 'despatch' or wish them *bon voyage* to the spirit world at death". Seventy-five respondents or 85% demonstrated strong support for this view and

practice, while the remaining 13 or 15% thought it actually did not matter who assisted a dying person. In both instances, however, the importance of dying in somebody's arms was emphasized. Failure to render this service to a dying kinsfolk often requires some purification rites after death.

As a rule, the eldest sons of Manlarla stay with their parents to cater for their needs in health, in illness and in death. However, in this era of frequent migrations, it is not uncommon to have all of a man's children living far away in search of wealth and health. Thus, as a 30 year old orphan said, "the presence of a 'son' (and not one's direct son) is now considered enough". But here, a ritual specialist explained, "the classificatory son is only ritually representing the absentee eldest son of the deceased". Sixty-nine respondents or 78% indicated the importance of the presence of a son, while 19 respondents or 22% did not appear to associate any importance to it. The presence of a son, they believe, is an indication that the dying person is nevertheless alive in her/his children; s/he is assured before the last breathe that there is someone to "remember" her/him and keep her/him in "personal immortality".That is, the dead person is not conquered by death; and a Manlarlo lives in dread of "passing away" without someone to perform this last and beginning rite of life and death.

There are many different kinds of funerals. The circumstances of death, its perceived cause(s), the age and social status as well as religious affiliation of the deceased are all factors taken into consideration as a family and the lineage decide what type of funeral to perform. For instance, the death of an influential or a "socially significant" person, on whom many people depend for either livelihood or leadership, is a momentous event, and perhaps a "calamity". The departure of such a person leaves a large rent in the fabric of family and society. The same cannot be said of a "socially insignificant". Whatever qualifies a death, the

rites that revolve around funeral celebrations are the exclusive prerogative of the Nimbera elders who, by virtue of their age, accumulated experience, knowledge and power, comprise the segment of the community that is indeed closest to the ancestors.

As death is not often attributed to natural causes, the unnatural cause(s) of each concrete death is (are) traced. Depending upon the cause(s), Manlarla classify death either as Kuu faa abnormal or evil death or Kuu song normal or good death. Deaths so classified, respondents noted, "are accorded corresponding funeral ceremonies and rites". As stated earlier, the death of an unweaned child deserves no funeral beyond the immediate family as it is considered to have no human personality of its own. But the death of some people with human personalities of their own may not be celebrated at all. For instance, a person who commits suicide or is accused of witchcraft at death has no funeral at all. Such people, as an old Moslem from Nanville told me, are "thrown away".

When I probed further, he said to me, "to throw a corpse away is similar to and different from the way a dead chicken is thrown away". The difference is that while the latter is simply flung into a handy bush where it has purpose for "nearby dogs and hovering vultures", the former is 'buried' where it serves no such purpose. The similarity is that they are both disposed of without the normal "rites". As to the abnormality of these rites, he said:

> You see, everything has a purpose. The purpose of the chicken is to "grow into a mature, edible fowl". If it dies without fully serving this purpose, it is disposed of without the "rites of its essence" like "feathers removal, piece cutting and soup preparation". When it dies in maturity and these rites are followed, then the "soul of the fowl is happy" that it has served its purpose, and the owner is also happy and proud that his "investments" have yielded some benefits.
>
> "It is the same for the human being". To be considered a human being is to be of "service to oneself, one's family and one's community". To be of service to

> "oneself, one's family and one's community" is to do what is "morally right". And what is "morally right" is what has been "ordained by Naa-Ngmen God, practised and passed over to us by our ancestors, and sustained by tradition and custom".
>
> Thus, "in our Nanville, any death arising from the victim's disservice to himself or herself, to his or her family or community calls for no normal mourning, burial and post-burial rites". Only "normal deaths receive normal rites".

For this reason, suicides, parricides and witches are given forms of disposal rites radically different from people who have observed the social norms and served their communities. They are "thrown away", a practice in disposal rites that invariably generates a sense of collective purpose and religious commitment in most people within the society. As Nanville-Naa explained, "funeral rites not only give us structure at times of disorganization, but also they help to reinforce social and religious behaviour, reiterate our purpose on earth and strengthen our cohesiveness".

Funerals appear to be the most obliging and most distressing rites among the Manlarla and take absolute precedence over all other activities and experiences. This is not to imply that attendance at funerals in one's neighbourhood is compulsory and automatic. A person may fail or refuse to attend a particular funeral because of ill-health or a "wrong" respectively. "To attend the funeral of someone who has done you a wrong that has not been expiated", a respondent (ritual specialist) said, "is to invite mystical retribution to yourself and your family". It is usually said, O kpela tulo s/he has mistaken. But the Manlarla expressions, Kuore ba bala funeral is not by-passed and Ba ba zagra kuore one does not refuse to attend a funeral, summarize it all. A funeral, *ceteris paribus*, must be attended. This may be either because of the recognition that sooner or later everyone will personally face death, or because of the magnitude of loss and sorrows generated in families by death. However, of extreme

importance is the recognition that to restore harmony of "community magnitude" requires the participation of all.

Immediately an adult dies, lineage elders use divination to seek a funeral "permission" from the ancestors. Divination provides a vehicle for the active negotiation of meaning and categorization of phenomena beyond the understanding of ordinary people. The diviner, through oracular rituals, contacts the world of the dead and "negotiates" permission on behalf of the lineage concerned. The granting of permission, an informant said, "implies that the death is Kuu song normal one". When a funeral permission is given, a propitiation of the Kpangkpang nuo hot fowl (usually a red cock with an outstanding comb for a man and a red hen with a shrill voice for a woman) is made to the ancestors. Its purposes, as Kukuure (1985) observes, are twofold: to request for a fitting and peaceful funeral celebration, and to adequately prepare the deceased for the journey to the spirit world. From observations, the propitiation ritual is often accompanied by a citation by the Sumwaara executioner which is repeated by those present. Typically, it goes like:

> Name of deceased...;
> you are journeying to your Ngmen daa God's market;
> so we are providing this red cock (man);
> so we are providing this red hen (woman);
> that you may take along with you on your journey to our ancestors.
>
> If you meet people on the way trying to obstruct your journey;
> you put them to flight by invoking our war cry (man).
> you weaken their nerves with our victory songs (woman).

The sacrificial blood, together with some herbs in very hot water, is used to wash the corpse and a bat by the classificatory wives and sisters of the deceased who are advanced in age (women in their menopause) and have become like men, or asexual (Goody, 1962:56).

Once the corpse and the bat are bathed or washed, they are greased with shea butter described as ritually "hot". Rubbing the melted shea butter in their palms, the women would stretch out and withdraw their arms twice in quick succession and on the third occasion anoint the corpse (in the case of a man). In the case of a woman, the women do that thrice and on the fourth occasion anoint the corpse. In both situations, however, the corpse is laid on a traditional mat. This rite is believed to transfer the impurity (caused by death) from the survivors to the corpse, and also from the community to the bat. At the same time, certain obligations are put in place. For instance, those between the survivors and the deceased include continuous communion, while those between the community and the bat include the forbidding of the latter's meat by the former. Failure to observe these obligations constitutes a major social-spiritual failing, consequences of which, they believe, reveal in illness.

The eldest available son of the deceased or any classificatory son rubs ashes (the cool residue of hot fire) on the deceased palms. A 39 year old ritual specialist explained the meaning of this rite as, "the child who was once nurtured by the deceased is now nurturing the deceased parent in return". In other words, just as a parent brings a child into the human world, so must the child assist in the parent's passage or transition into the spirit world. A 25 year old male orphan of traditional faith said, "ritually assisting your parents to the spirit world implies you agree to be their link on earth". This link, as we shall see in Chapter 6, has serious health implications, especially in the use of health care services for such people.

It was also observed that lineage elders, led by the family head and with ashes clinched in between their left fingers, embarked upon an anti-clockwise procession around the corpse. This rite, I was told, is aimed at determining the involvement or implication of any lineage elder in the death. In other words, whosoever agrees to participate in a rite, metaphorically

aimed at "making hot things cold", must be innocent in the death. In this regard, a traditional elder said, "it is only those considered to be pure and clean in their hearts that are qualified to perform this rite". Another respondent, a "Christian" widower, said: "we perform this rite because we believe that healthy hearts breed healthy lives". The ashes, as I observed, were dropped at the end of each successful round. Processions of this nature, which are continued for three times for a man and four times for a woman, are normally accompanied by a song in "condemnation" of mankind. An example, recorded during field investigations, is reproduced below.

| | |
|---|---|
| Ning saali sogla,<br>kye maa loo.<br>Ka fo na maa loo,<br>de maale ko gbe puo. | A (black) human being,<br>is not worthy of help.<br>Rather than to help him,<br>render it to the sole. |

A rough translation of this song, means that a human being is not worthy of any benevolence or help. To do that for a human being, you better render it to the sole of the foot. However, the social implication is different from this rough translation. A ritual specialist suggests that, "the rite is an attestation of the 'nothingness' of human beings on earth". Thus, the earthly destiny of humans, the death-bound existence, is revealed in this rite as it reminds the living of the inevitability of the syndrome and reiterates the need for an honourable life while on earth. In short, it is a challenge to the meanings of both human existence and assigned patterns of human interaction with implications for health. The manner in which these rites are employed depends upon the roles the deceased has filled, personal achievements in life and cause of death. Manlarla funeral rites, thus, focus on the metaphysical journey between two realms (social and spiritual).

### 5.5.2 Mourning Rites: Death as a Challenge to Meaning and Health

Death represents not only an interruption in continuity of life but also a break in the sense of meaning in life. To die does not mean to decompose or be finished. Rather, as generally believed by the people, it implies transformation of oneself from "one status to another", a transformation which implies an opportunity for "a better life if one has lived according to social norms and expectations, or for a worse life if one has not". Death is believed primarily to be a departure from one station of life to another station. To die, therefore, is to say "goodbye" to earth (the human world) and to head for the spirit world of ancestors. A young, educated widow lamented her husband's death as, "a departure without goodbye".

Anybody not acquainted with the Manlarla society will immediately wonder if a contradiction does not exist between this positive interpretation of death and their reaction to a concrete death. However, no contradiction exists as there is no society in which separation from loved ones arising out of death is easily accepted without a public expression of grief. The expression of grief or mourning, the conventional behaviour determined by the mores and customs of a given society, defines the way people should conduct themselves at the death of one of them (Averill, 1975 :232). This prescribed behaviour may or may not coincide with the actual feelings of all or some of the bereaved, but they risk incurring censure and illness if these sociocultural dictates are disobeyed. For this, a respondent said, "Te ba taa a eebu baalong zung we have no choice because of its illness implications"

Before mourning begins in Manlarla society, the undertakers are invited and shown the corpse. They are also shown the attire to be used in decorating both the body and the catafalque. From experience, membership to the group of undertakers in Manlarla society is

based on propinquity rather than descent. And as Goody rightly observed, Dagaaba in general maintain that, "No wegu soba ba mogra O tuora a person with a long face cannot suck his own wound" (1962:67). That is, the deceased's family and lineage are so preoccupied with thoughts of the loss that they are not organized enough to conduct appropriate rites.This does not imply a denial of self-help. Rather, it emphasizes the fact that in situations of shock, distress, and acute grief certain members of the community, who stand in some relationships (reciprocal funeral groups), are obliged to assist. Thus, these rites are not carried out by the funeral group of the deceased's lineage but by the funeral group of more distant agnates and sometimes by groups of other patriclans.

From the primary funeral rites that I observed, I noticed that while the undertakers were busy dressing up the corpse for public mourning, the elders of the bereaved families officially announced the death by a few loud cries. This was immediately taken over by the wailing of women and children, the pealing of Tumpaane royal drums, the hooting of Eela horns, the blasting of Malifare guns and the echoing of Gyile xylophones spreading the news from village to village. The loud cries of the family elders and the wailing of women and children established the fact of death in the locality. I learnt that the rhythms, and music from the royal drums, horns, guns and xylophones revealed the sex and social standing of the deceased to neighbouring villages. For those villages that were somewhat more distant, Koyeliba funeral messengers were despatched who revealed the identity of the individuals concerned.

The period of mourning reflects the deceased own social standing, that of his or her family and the state of the corpse. A person of high status is given a correspondingly elaborate funeral commensurate with the magnitude of the loss. But the funeral of a famous individual

can be shortened if the body is unable to stand the full period of mourning. The attire of the deceased and the decoration of the funeral stand or catafalque immediately reveal his or her earthly attainments. A renowned hunter's catafalque, for instance, is decorated with skulls of beasts killed by him and contemporaries of his guild. Weapons like bows, quivers of arrows and dry animal skins are hung as part of the decorations.

In some cases, I observed masqueraders and members of the hunters guild bearing guns, bows and arrows, swords and axes lined up mimicking hunting expeditions and clearly depicting the deceased's role in actual hunting expeditions. Similarly, at the funeral of one prominent Pito local beer brewer, a large calabash was placed in her lap with her hands inside it. At some, a large clay pot with a wide mouth was placed at their feet; and while the funeral was on, fellow brewers and/or potters intentionally broke calabashes and pots of Pito to symbolize the departure of the deceased from the mortal world. These activities, as I later learnt from some respondents, were not only symbolic of the trade of the deceased in life, but also assisted in the integration of the deceased in his/her new world as they enhanced the solidarity of survivors. An elder explained the solidarity dimension with a proverb, "Saa tor yaarong ka kaang laara ngmenaa dang na wa rain has 'beaten' salt and oil is laughing forgetting the sun will come some day". Death disrupts the community and the reorganization of life should be the concern of all because a healthy community breeds healthy individuals.

Funeral clothing, especially smocks are not placed on the dead person in an ordinary manner. Instead, they are turned inside out Wirimba and the pockets cut off so that the dead person cannot hide anything (especially souls of living relatives) not offered him or her for the journey. Relatives close to the deceased are especially more vulnerable with young children in the greatest danger bracket. Manlarla believe that, A kuu mene mang nyogla porgiba aneng

bibiire pagi ba puore some dead people "capture" women and children in order to perpetuate their network of social relations in the next world. Consequently, young children and other close relatives of the deceased are protected from this temptation of ill-health by tying twines to their ankles, females on their right and males on their left.

Another vulnerable group are the widows. Manlarla widows are distinguished by their white dresses, scarfs, and sometimes by twines tied to their waists. Throughout my observations, the widows were usually followed by sisters and/or friends. The widowers had long ropes tied also to their waist and the other end handled by another person. The purpose, one ritual specialist suggests, "is to prevent them (the bereaved) as Kotuo deme owners of bitter funeral, from engaging in harmful activities such as suicide and self-torture". In short, the objective is to maximize their health in the face of vunerability factors.

Dirges are sung at all Manlarla funerals, partly in praise of the dead and for his or her ancestral achievements, and partly in order to arouse the emotions of survivors (Saanchi, 1992). Token payments are often made by the bereaved to the dirge singers, while "caution" is taken for the insults that are sometimes hurled at the former by the latter. I later learnt from group discussions that, "insulting" dirges are contrived by "dirge experts" to "publicly bring the social deficiencies of the bereaved to terms with the reality of death". As such, these dirges normally emphasize areas of apparent disharmonious relationships that have been ignored by the bereaved, and suggest the need for and possible ways of "restoring" harmony (or health). If mourning rites are performed only when a loss generates discrepancy between expectations or fantasies and reality, resulting in an upsetting of confidence in the predictability of our physical and emotional environment (Marris, 1974), burial rites commence a search for the meaning of the unpredictable.

### 5.5.3 Burial Rites: The Search for Meaning and Health

To recover from the impact of death, it is necessary that a sense of meaning be restored. Most Manlarla recommend early morning and late evening as most appropriate for burial rites. Seventy respondents (78%) appeared to demonstrate preference for early morning and late evening burial. As one ritual specialist explained, "while the sun is shining and hot, someone's soul may be relaxing in the grave and may be covered unnoticed". I observed that when it was necessary to bury outside this time frame, or when there was suspicion that a deceased had hidden souls of relatives in the grave in order to perpetuate his/her network of social relations in the spirit world [as observed by Goody (1962)], specialists performing the burial rites went down the grave with thorns which were ritually used to drive out basking or "captured" souls.

When a burial "permission" was given by elders of the bereaved lineage, the ritual chief or someone delegated by him went before the xylophonists and said, A baare ye ye all is finished or it is over. This is a ritual expression understood by most people. It invites sympathizers to the xylophonists, thereby "deserting" the corpse and allowing the undertakers to prepare the body for burial. At this point, a burial rhythm was played three or four times depending upon the sex of the deceased. At this signal, women surrounding the stand in lamentation moved away. The undertakers approached the stand, threw off all decorative materials and wrapped the body in Wogye pila white thick burial costume. Among the Manlarla, white colour signifies purity, blessing and holiness. So burying with white, I was told, implies acceptance of death by survivors, and blessings for the deceased while s/he is still journeying to the place inhabited by purified (holy) spirits. In most cases, the body was taken into a room, laid in state and relatives and sympathizers invited to pay their last respects. If

the deceased was a homicide, a ritual mimicking homicide was demonstrated before removing the body.

The burial costume provided by the deceased's family was put over the body in an appropriate manner and taken to the grave for burial. While the body was being conveyed by some of the undertakers for burial, others remained to dismantle the catafalque as quickly as possible, gathered the money, crops and animals, and disposed of the calabashes, pots, and the sticks now considered to be dangerous for the health of the uninitiated. For instance, it is believed a person becomes barren by walking over any remains of the catafalque. At the same time, the surviving spouse was held firmly by funeral companions and prevented from either following the body to the grave or getting near the fast disppearing catafalque. This is done to prevent any soul loss arising out of shock and disbelief.

Among the Christians and Muslems in Manlarla society, prayers are said over the corpse before burial. A typical Muslem prayer observed at Wa on 25th June, 1994 and translated by Osman Chuuni during my investigations is presented below.

| | |
|---|---|
| Inna lillahi wa inna ilaihi raj'un. Allahumma ajurni fi musi bati wakh luf ti khairan minha Allahum magh fir li (Name of the deceased person) War fa'a darajata hu fil mah diyyana wakh lif hu fi 'agibihi fil ghabirina wagh fir lana walahu ya rabbal 'alamin waftah lahu fi qabritu wa nawwir lahu fih. | We are all for Allah and to Him do we all return. O my Lord, bear me up in my bereavement and replace this loss with a better replacement. O my Lord, forgive (Name of the deceased person); and raise him/her up in the ranks of the guided. Make one of us to take his/her place. Forgive us, as well as him/her, O Lord of the worlds. Make his/her world wide for him/her in the grave, and provide him/her therewith, Thy light. |

A grave may be dug anywhere as indicated by the family elder, who sometimes even starts the grave by striking the ground three or four times. For those of high status, the grave is dug either inside the compound house or the facade of it. Like the Ndebele of Southern Africa, the shape of Manlarla grave captures the movement of the sun. A male is buried rightwards facing Samuni east, while a female is buried leftwards facing Manuori west. In addition, Rattray (1932) observes the corpse is laid on its side in a sleeping position, with one hand under the cheek and the other folded across the chest. Sometimes, a fair sample of the deceased's earthly achievements like weapons, food, pots, calabashes, animal skeletons, and money are placed beside the corpse in appropriate positions to sustain and protect the person in the journey between the two worlds and also to serve as initial capital for the deceased in the spirit world.

The asymmetric duality of the sexes Goody (1962), of Samuni and Manuori, odd and even, left and right, light and darkness, health and illness, life and death, are often connected with one another in Manlarla's picture of the world and are allocated different "moral values" and "functional purposes". J. Goody observed that a man must necessarily face Samuni so that the rising sun will tell him to prepare for a hunt or for the farm. Similarly, a woman must prepare food for her husband and children who are away in the farm and fields at sunset. Thus, the need for her to face Manuori to keep track of time (Goody, 1962). This explanation about Samuni and Manuori burial positions informs us of a well defined gender roles among the people but remains silent about the health implications of such burial positions.

During fieldwork, I noticed ritual officiating specialists assigned illness, death, and evil to Manuori then turned to Samuni to call for health, life and prosperity. For instance, female ritual specialists were observed singing a song entitled: "Ka bong beo be yiri O yi gara

manuori if there is evil in the village it should disappear to the west". So, I asked ritual specialists about the meaning of my observation. Answers provided mirrored exactly Manlarla conception of the sexes. The "official view" of females among the people is that they constitute the stable foundation of society, mostly warm and positive. But, as "outsiders", they are also thought to harbour a component of distrust and hate which occasionally bursts forth. "Porgiba mang dogi te kye bana mang le kote women give birth to us but they also kill us", was one statement frequently cited by male respondents to explain the "double-edged" nature of females. To qualify for entry into the source of life, prosperity and health, symbolized by Samuni, male respondents maintained, "females must go through a process of ritual 'purification' at death". Thus, they are buried facing Manuori not just because of their evening domestic services to their households, but also because they must proceed to Manuori, where their evil component will be ritually washed off.

On the other hand, males are thought to be protective and highly dependable. More than 50 respondents explained this with reference to the death-origin myth, where the Hunter played a protective role in the bush. Males, respondents maintained, may not be as stable as the females but their loyalties to their families and communities are never in doubt. Therefore, they are buried facing Samuni not only because of their farming and hunting responsibilities, but also to emphasize or symbolize their "dependability and purity of heart". They are considered qualified to enter the source of health, life and prosperity at death without fears of "contaminating" it.

As part of the cultural experience of the Manlarla, I have always known that Samuni rain-basin symbolizes the promise of good, health and life as well as harmony, right, light, male, known, production, front, certainty and truth, while Manuori river-edge symbolizes the

accumulation of evil, illness and death as well as disharmony, left, darkness, female, unknown, consumption, back, uncertainty and falsehood. However, what was unknown is how such symbols interlaced with human conditions. For instance, one young undertaker said: "if an undertaker holds the corpse of a Bigberi lame child loosely or fails to lay a corpse facing its 'appropriate' direction, it can 're-enter' him and may result in an enlarged scrotum".

The Samuni-Manuori dichotomy also reveals a religious character. Explicit reference is made to this in relation to sacrificial rites. The body of the sacrificial animal or fowl must be appropriately positioned. Field observations indicate that, before they are slaughtered, such animals or fowls are usually laid facing the direction of good, life and health (Samuni) with their backs toward where evil accumulates and darkness and illness prevail (Manuori). Also, I observed that it is inauspicious if the body of a fowl, killed while making a sacrifice or in any protective ritual, falls facing down (darkness); it must face up (light). These all point to the fact that religion and health are inseparable among the people, and that meaning must be searched for and assigned to issues that cannot be explained outright. As such, differences in the position and form of burial are the most precise summation of the social personality of the deceased and the meanings assigned to health and illness in the sequence of funeral rites.

Another rite that is worth noting is known as Yagu/Yaga whitewashing. Whitewash is a mixture of clay and ashes from a burnt garment of a dead man which is believed to ritually symbolize his body. This symbolic mixture is administered to the widow as a protective shield, while she remains in her liminal state. Among the Emo-Lobi, a widow after Yaga is given a walking stick symbolizing the husband. It is believed to be a ritually powerful symbol that withers anybody it touches. A symbol, according to the Oxford English dictionary, is a "thing regarded by general consent as naturally typifying or representing or recalling something by

possession of analogous qualities or by association in fact or thought". For this reason, it could also be said that the rite constitutes a kind of "spiritual bonding" of the wearer to the deceased. Whitewash is also a test of the fidelity or faithfulness of the woman to her husband. "Since whitewash is a mixture of clay and a burnt garment of the deceased", one educated widow said: "it is believed to have strong associations with the mystical aspects of both Tenge earth and the spirit world". Contextually therefore, its application appears to have the effect of calling upon the Tengbane and the spirits to bear witness, so that if 'things' go wrong, as Goody (1962:58) observes, "supernatural sanctions can come into play".

Before a married man is buried, his widow(s) must be taken through this rite of whitewashing. The widow is publicly asked if she is prepared for the rite. Her refusal, a ritual specialist suggested, can have two interpretations: either her religious affiliation does not permit it (as with Christians), or she is implicated in her husband's death. If it is the latter, she is purified after her confession before the rite is administered. Once the whitewash is administered, the widow is ushered into a state of uncleanliness, a state of impurity that remains until the final rites of separation. The period of impurity usually lasts a few months depending upon the time of death. For instance, a death that occurs after April will have to wait until March or April the following year when final funeral rites are performed. On the other hand, a death that occurs in January may have its final funeral rites in March or April the same year.

During her period of uncleanliness, a widow is not expected to visit the sick or make any contribution in that regard except for her children who are equally unclean or impure. It is not uncommon for women "implicated" in their husbands' death to accept to participate in whitewashing rites without confessing. Such women prefer to privately face the consequences

of disregard for ritual purity to the public disgrace that they will be subjected to after confession. It is believed that a woman who is implicated in the death of her husband but refuses or fails to confess it for appropriate rites before participating in the rite of whitewashing is bound to suffer a retribution of some kind (especially, a sickness called Muora) from the spirit of her "disgraced" husband. For instance, at Sankana village, two cases of Muora were attributed to failure by surviving spouses to confess their implication in their husbands' death. I was able to contact one such woman who admitted her guilt. She said:

> It is so. I was "raped" while attending a Bagre festival at Nator village. I didn't report this Saambu impurity to N'siriba my husbands so that they could "cleanse" me. I continued to sleep with N'sira my husband, Ba yor their younger brother, until his death two years ago. I received his Yaga without confession. I also denied hints of it after his Kontonbuolaa.
>
> Four weeks later (that is, after husband's Kontonbuolaa), I started seeing him in my dreams every night. I reported both the dreams and the impurity to O bieri his senior brother, A yidaandao the family elder. But since then, N'baso N'menga I haven't been myself.

After saying this, she broke down in tears and the "chapter" on infidelity was closed. However, the association of her malady and the receipt of her husband's Yaga in "dirt" is well established and clear in her conscience.

## 5.6 Secondary Rites: The Ritual Redemption and Health

Death among the Manlarla is not only a sad event or a great cause of pain but also a dreadful contaminating power which puts all objects and relatives (near and far) in the neighbourhood of the deceased into a state of uncleanliness or impurity. A state of uncleanliness is characterized by the inability of people caught up in another's death to function normally. It is considered to be very dangerous if not properly treated. Proper treatment of uncleanliness caused by death implies the performance of the rites of redemption.

As Lindemann (1944:141-148) observes, the preliminary phase of mourning and despair, characterized by "a painful lack of capacity to initiate and maintain organized patterns of activity", is followed by a phase of "recovery during which a reorganization of attitude is effected not only in respect of the image of the deceased but also in the context of new relationships".

After the initial stages of shock, alarm, denial and acute grieving, the Manlarla now prepare to integrate the loss and grief into routine life. The bereaved now accept the reality of the loss with a lingering sense of depression and physical aches and pains. With diminished sense of self-esteem and constricted personalities, they embark upon the performance of rites aimed at reorganizing their new identities and reducing their vulnerability to the separation and loss. The basis of these rites among the people is expressed as Kuu benla O menga death is deceiving itself. In other words, they believe death has only disrupted and not destroyed the rhythm of life because a dead man (or woman) remains alive in his wife (or her husband) and children. These rites, as already mentioned, indicate humans' conquest of death, and explain the reason why secondary rites are not observed in memory of a bachelor or a spinster. Dead bachelors and spinsters are regarded conquered by death. In this respect, secondary rites, in addition to serving as mechanisms for redeeming what has been lost in life, also indicate the importance of marriage and procreation in the society.

### 5.6.1 Kodeo: The Need for Continuity

The Kodeo is the first of these secondary rites and it is observed on the seventh day after burial. Kuore, as we noted earlier, means funeral, while Deo either means house or room. Thus, Kodeo is a compound term meaning house or room funeral. The distinguishing

feature of Kodeo is that, its rites are internally performed by the bereaved lineage seven days after burial. Two purposes are served by this kind of funeral ritual. It enables those relatives who for some reason could not attend the primary rites to personally share their condolences. But it is specifically performed to fulfil the need for continuity after death. To do this, Manlarla first try to ascertain the real cause(s) of death.

A famous diviner-spirit medium from Nator village narrated a common procedure of ascertaining "real" or "specific" causes of death through his spirit-mediumship.

> Normally, an elder of the deceased's family accompanied by the surviving spouse and some other close relatives proceed to me (spirit medium) three days after burial for a man and four days after burial for a woman.
>
> The leader of the "funeral-divining" delegation will normally discuss their mission with me. Using my Kontonne, I will "contact and persuade" the soul of the deceased to come and explain the circumstances surrounding his/her death
>
> While the consultors are waiting in my De legru dark room with me, my Kontonne will usher in the soul of the deceased. Upon seeing his/her surviving relatives, he continued, the invited soul will demand to know their mission.
>
> The leader of the delegation (often the head of the family or his delegated representative) normally opens the consultation by saying, "your (deceased) sudden departure to the world of our ancestors without clues of cause(s) of death is a disturbing issue for us and the family at home. So we, representing the rest, are here to ascertain from you (the deceased) the reason(s) for your departure.
>
> The soul of the deceased, talking to the hearing and understanding of all, then reveals the cause(s) of his/her death. Depending upon the cause(s) of death revealed, the narrator continued, the consultors may demand to know what is to be done.
>
> Information about what to do (what medicine to drink and/or bath, sacrifices to make, objects to retrieve and/or return) in order to restore harmony and ensure continuity of life without him/her is also given by the soul.

> Sometimes, the deceased's soul may reveal that other souls of surviving members of the family are voluntarily following him/her (the deceased). In that case, medicine for retrieving their travelling documents, preventing their illegal entry into the spirit world (that is, recapturing their souls) and reintegrating them into community life will also be revealed to the consultors by the deceased.

On the seventh day after burial, the family gathers to account to themselves the earthly stewardship of their departed relative. The delegation to the Kontonbuolaa officially informs other family and lineage elders (except "victims" and young children) details of their consultations. Things including money owed either to the deceased or by the deceased to others are reported and accounted for. Promises made by him or her to others or to him or her by others are noted and procedures of fulfilment devised. Propitiations, sacrifices, objects to be retrieved or souls to be restored are all discussed on the seventh day after burial.

The spirit medium and the deceased (before s/he assumes the status of an ancestor) can be seen in light of these roles as important factors of health and harmony in the family. An instance to clarify these roles and confirm the narration by the spirit-medium at Nator was given in Nyimbale by a 32 year old family head, Arigyima Emoru. According to Emoru:

> A young man, Songkuyeh (whose funeral this writer attended), had died from a snake bite (immediate cause). His death was considered unusual not because people do not die from snake bites but because no one dies from snake bite while the medicine, Kala eeli horn of Kala, is still hanging around their necks. Deaths of this nature necessarily have hidden or remote cause(s).
>
> Consequently, the third day after burial, the family elder, Yekouba, and others (including the narrator) left for Songkuyeh's Kontonbuolaa at Nator. Songkuyeh had allegedly stolen a trap with a rabbit from somebody's farm around Eggu village. He ate the rabbit alone in the bush and took the trap home.
>
> Knowing very well that our family traps had different identification marks and

> that he would be asked to return his stolen trap if seen, the late Songkuyeh decided to keep his stolen property out of sight.
>
> A curse (efficient cause) was pronounced on the Tengbane (ultimate cause) by the owner of the trap. After taking us through this "unbelievable reality", Songkuyeh finally concluded, "this is simply the cause of my death. It is Mang boa kuu self invited death.
>
> During his Kontonbuolaa, Emoru continued, the soul of Songkuyeh also told us "where he'd hidden the trap, where it was stolen from, and what was to be done in order to neutralize the curse and prevent it from further damage in the family". Songkuyeh also revealed that he was being followed by one Kakuna's soul.

I did not go to Nator (the village of the oracle) with the delegation but I did go to the farm to help locate the trap. The trap was spotted at exactly where Songkuyeh, communicating through the oracle, said he had hidden it. When the trap was taken to the farm from which he reportedly stole it, one Dabaga of Charile, apparently a distant relative of Songkuyeh's family, claimed ownership of the trap and confirmed he cursed the Tengbane to punish the culprit. Sacrifices to neutralize the power of the curse were thus made to the Tengbane by the Tendaana and medicine for the restoration of Kakuna's soul and its reintegration into the social world prepared.

### 5.6.2 Komaale: From Soul to Ancestor Spirit

The Komaale, the second of the secondary rites, is more elaborate than the Kodeo but less elaborate than the Kuore. If the other rites were regarded as the passport of the deceased to the spirit world, Komaale must be the entry visa or permit. Discontinuities in normal life caused by death must be restored and roles involuntarily abandoned must be redistributed to facilitate the continuity of life without the deceased. In short, the lingering soul must be integrated into the ontological world to which it belongs and the disarranged survivors must

be reorganized to facilitate their adjustment to the loss sustained. In this context, we hope to see the degree to which the Manlarla regard death as a contagion and how they deal with it, for the "impure cloud" of death is believed to pollute everything "touched". The ritual mechanism that fulfils these functions is Komaale final rites of death.

Komaale is celebrated soon after harvest between the months of January and May. Meat is plentiful and Pito and food are in abundant supply. It is more like a feast for assembled sympathizers than a funeral. The widows are bathed and/or cleansed. This bathing or cleansing of the widow implies testing her faithfulness to her late husband. The Yaga ritual stick is burnt, food and drinks are served, and the widow is expected to dine with her invisible husband, presumably her last social-spiritual contact with him. Her acceptance of food and drink asserts her innocence and so her whitewash, ritually applied on her during the primary funeral rites, is washed off. This is the rite of Porko konso widow bathing.

However, her refusal to eat and dine with the late husband may either mean an implication in his death or a misconduct (such as having sex) within the period of her inpurity (that is, after her husband's death but before the final rites). The widow is, therefore, requested to acknowledge her role or confess her sin publicly, "repent", and be ritually "cleansed" before the final rite of separation with her husband can be performed. This rite is known as Porko maale widow cleansing. Since the final rite is one of "final separation and everlasting protection", informants told me "the widow will not be ritually redeemed while she remains in a state of unfaithfulness with her husband".

During Komaale the old ladies sprinkle ashes in the Kpiin deo the room in which the death occurred or the room previously occupied by the deceased, and the whole house will then be swept. The intention is to remove the pollution of death from the family and their

possessions. An old widow said, "by sweeping the dust in the house, we clean the survivors and the deceased of disease", for dirt has the generalized significance of "mystical defilement". This rite is intended to purify the soul in its transition to the spirit world, while facilitating the reintegration of survivors in the human world. One ritual chief said, "Ka fo sie yi kuu meng O mang barila puore deme degri. A zung, fo mang piirna a degri yi ba zie the exit of the soul at death leaves all close relations in dirt. And so, you've got to sweep the dirt away from their bodies". It is believed that if this rite is not performed or performed improperly, the people closest to the deceased are left defenseless against the attack of witches and sorcerers

Widows' heads are shaved and white pieces of cloth tied around them. Similarly, the heads of the orphans are shaved and saltless food prepared, served and fed them. J. Goody refers to the food served to them as the orphan/widow meal (1962:197-198).To prepare a meal without some ingredients is terrible but to prepare it without salt is cruel, a kind of forced ritual malnourishment. That is the message this rite projects. These rites mystically unite the departed with surviving members of his family of procreation. As a participant of rites of death myself, I recall ritual specialists saying to us that: "the food is a symbolic representation of the deceased's body which, when eaten, spiritually constructs a pillar of personal immortality of the deceased in you". "Its tastelessness informs you (widows and orphans) of the need to take up the mantle of provisioning for yourselves". The tying of a white piece of cloth on a widow's head, a ritual specialist suggests: "is a sign of the evil that has befallen her, while feeding her and the orphans with food and drink illustrates their helplessness". Accordingly, death places the family in a liminal state and in order for them to take up the thread of life again they must be gradually reintroduced to the fundamentals of healthy living.

For the deceased, these rites constitute a stamp of acceptance at the final check-point of the spirit world. Once the stamp of acceptance is embossed on his or her passport, the soul transforms into a spirit (the mother of all transformations) and takes a place in the spirit world as an ancestress or ancestor. As an ancestress or ancestor spirit, the deceased remains linked to his or her family, their actvities and their possessions in the human world and can act for their well-being or for their harm. An understanding of the nature of these rites depends upon a knowledge of the Manlarla concepts of the human personality, even though certain aspects are common to a wide range of societies. In his analysis of the Trobriands, for instance, Malinowski (1954) showed how closely their beliefs about the make-up of a human being were linked to other aspects of the social system, especially the organization of unilateral descent groups.

A study such as this, concerned with practical expressions and theoretical reflections, is important, not only for a clearer understanding of problems of meaning, but also for a deeper understanding of a people's life from which the meaning is derived. The celebration of funerals is an important social event carrying with it certain expectations in the behaviour of individuals. I have so far demonstrated that one main theme or thread running through the ritual states described above is the resolution of emotions and "conflicts" so as to be able to maximize the health of individuals and the well-being of the community. But death does not only generate emotions and conflicts for which solutions are necessary. It also engenders the involuntary abandonment of certain roles, the harmonious reallocation of which is one of the main purposes of funeral rites. Such rites constitute the subject matter of the section that follows.

### 5.6.3 Rites of Inheritance

A married man with children leaves a lot behind to be inherited at death. Land acquired by him for residential and/or production purposes, personal property such as clothing, widows and orphans, and statuses involuntarily relinquished are all "objects" to be ritually inherited by close kinsmen. Pieces of land acquired for residential and/or production purposes pass over into the hands of the family head, not as his personal property, but as family property to be administered on behalf of the family. The personal property of the deceased, such as clothing, has a complex inheritance procedure known as Kyene diibo. Ritually, the next of kin (the man immediately following the deceased in age and within the same generational line in the lineage) has the right to inherit him. But, in practice, what happens is that the next of kin chooses one piece of clothing and returns the rest to the bereaved family for use as determined by the family elder.

Porko deebo widow inheritance is by far the most complex of all. We intimated that all restrictions imposed on the homestead following death are lifted after the Komaale. For instance, the widow is ritually bathed and/or cleansed, and all associated restrictions imposed on her sexual behaviour following the death of her husband are lifted and "normal" life for her resumes. That is, the widow's sexual and other domestic services are ritually severed from the husband. This rite affords her the freedom to either enter into a new marital relationship, or remain single. If a widow decides to remain single, she is taken through the rite of Tiin de medicine eating. In such a case, the widow pledges the exercise of her sexual right to her husband in the spirit world. The purpose of this rite, therefore, is to seal the marital relationship between the widow and her husband. Mostly, widows in their menopause undertake this kind of sexual ritual bonding.

If a widow decides not to jeopardize her sexual freedom, there are two options to choose from. First, and the less common, is for the widow to agree to participate in the rites of final separation and thereafter refuse to be remarried within the deceased's lineage. In that case, the widow may either ritually and legally divorce her deceased husband and his entire lineage and clan or remain unmarried and yet ritually and legally married to them. In the former, the widow and her kinsmen negotiate a new marital relationship with a clan that marries wives and not daughters from the divorced clan. Under such circumstances, the marriage gift paid on behalf of the woman by the divorced clan is returned to them by the new clan through their former in-laws. A ritual revoking the marriage is performed aimed at officially informing the ancestors about the divorce. After the performance of this rite, the ancestors accordingly withdraw recognition of all reciprocal domestic services and spiritual protection from the woman. In the latter, the marriage gift is not returned and so all reciprocal domestic services and ritual protection of the deceased husband's lineage remain enforced.

The second, and by far the more common, is for the widow to agree to be taken through appropriate ritual bathing and/or cleansing and agree to remarry into her husband's lineage. This kind of marriage is called Porko diibo levirate or widow inheritance. Among the Manlarla, a widow can be inherited by either the deceased husband's junior brother (direct or classificatory) or son (direct or classificatory). A direct son can inherit any of his father's widows, except for his own mother. A brother or classificatory son who inherits a widow goes through one process of status change and ritual control (as a heir), while a direct son who inherits his father's widow goes through two processes of status change and ritual bonding (as an orphan and a heir). Under the circumstances, the degree of ritual bonding is likely to vary from one heir to another and therefore, the health implications too may vary.

## 5.7 Hereafter: The Destiny of the Soul

The location of the Dapari spirit world is not universally agreed on among the Dagaaba. For some Dagaaba, the spirit world is a distant place requiring weeks, months or even years of dangerous travelling. For instance, the LoDagaa believe that the land of the departed lies to Manuori west, being separated from the world of the living by the "river of death" (Goody, 1962). For this reason food, drink and weapons are normally buried with their dead to sustain and protect them in the journey between the two worlds.

However, for the Manlarla, the spirit world is geographically "here", being separated from the social world only by virtue of its invisibility to ordinary human eyes. The market of the spirit world, Dapari daa or Mugli nye kono, is believed to be located in the thick forest of Duong village. An elder from Duong confirmed this, and added that, "the spirit world is much like the human world in activities and in physical appearance". Unlike the visible human world, he added, "the beauty and commercial activities of the invisible spirit world can be seen only by those super-humans with four eyes and those individuals intiated into the Mugli nye kono god of the village".

If the Kuore is the deceased's passport and the Komaale his or her entry visa or permit, the nature of life that the individual might have led is the vehicle of transition into the spirit world. Entry into it, therefore, may not be as quick and easy as its geographical nearness may suppose. Rather, entry duration is largely determined by the quality of the traveller and travelling documents, and by the road worthiness of the vehicle of transition.

As soon as the last rite of Komaale is performed, the soul begins its journey, passing through several check points. Indeed, it is believed to be an "ordeal whose hardness depends on the nature of life led by each person in the human world". For instance, 82 respondents or

93% maintained that good people are given red carpet treatment and entry is made easy for them, while for the bad ones, entry is delayed up to a maximum of three years for a man and four years for a woman. A family head told me, "Ninsonne ba kpaara pama; a mang yuo kyenle bang the good ones don't knock at doors, they're opened waiting for them". The entry delay for bad people, according to Chief Woli, "is caused by the need for them to either convince the committees sitting on their transition, or make exorbitant payments (in the form of suffering on the part of the deceased, and illness, sacrifice and almsgiving on the part of the bereaved) as entry fees at each of the check points".

In addition to the belief in the hereafter, Manlarla also believe that a person is composed of two parts: the Enga physical entity and the Sie spiritual entity. The Enga is destined to rot in the grave days after burial, while Sie, which exits Enga at death, hangs around the human world until the final funeral rites are performed before journeying to the spirit world. Sie may, therefore, have up to four applications among the Manlarla. In addition to the form that journeys to the spirit world, it also refers to the part that wanders at night while a person is asleep, the component that vacates the human being in times of acute shock (as in soul loss), and the element of the human being captured in witchcraft.

In order to diffuse the possibility of misunderstanding arising out of these applications, I made contacts with experts in the Dagaare language, especially in the Manlarle dialect. Different terms kept coming up as I moved from one linguistic expert to another. While some experts divided the human being into "shadow", "breath" and "personality", others divided it into Enga, Sie and Jinna, the last being an Arabic loan word. My experience in this regard among the Manlarla experts has been that, it is not easy to divide a person into more than two parts with clearly defined terms for each part. It is an area that requires further investigation.

Those souls that succeed in processing their entry documents, according to informants, also transform themselves from Sie soul to Ninsie spirit, and join the ancestors in their benevolent mission (the destiny of the soul). Collectively, these ancestor spirits are called Kpiine and the Kpiintige symbolic lineage altar, established in honour of them, is a testimony of their benevolence. Sacrifices at such altars are presided over by the Yidaana lineage elder. However, those souls that fail to process their entry documents within the stipulated period, transform themselves from Sie soul to Kogii ghost and return to the human world to avenge their failure by inflicting illnesses on people.

## 5.8 Consequences of Participation: The Ritual Control

Evans-Pritchard in an introduction to Hertz's (1960) book, "Death and the Right Hand", points out that burial and mortuary rites are part of a continuum which begins at death and culminates in the rites for the dead as an ancestor, and no part of this sequence can meaningfully be considered in isolation. The significant point for any theory to explain, then, is that, "an experience of succession is not a succession of experiences". That is, we cannot say that funeral rites are in sequence or part of a continuum, as Evans-Pritchard suggests, unless something endures from the beginning to the end of the sequence. What is it that abides through the succession of funeral rites that we may call the ritual sequence or continuum? This study contends that the thing that abides through the succession of funeral rites is the concept of ritual control. What, then, constitutes ritual control?

If order is to be established and maintained in society, then, the tendency to pursue self-interests must be limited. As indicated earlier in the chapter, Durkheim (1951) conceptualizes the conscience collective as constraining power on individual behaviour, a

power that influences the human units of society to behave in certain ways regardless of their own selfish interests. According to C. Bell, four influential theses underlie Durkheim's analysis of ritual as a means of social control. She listed them as the social solidarity thesis, the channelling of conflict thesis, the repression thesis, and the definition of reality thesis (Bell, 1992:171). In terms of the social solidarity thesis, ritual is believed to exercise control through the promotion of consensus and the psychological and cognitive ramifications deriving therefrom. In other words, a major function of ritual appears to be its ability to increase the constraining power of the conscience collective. As Kertzer (1988:2) suggests, social solidarity is viewed as "a requirement of society" and ritual "as an indispensable element in the creation of that solidarity".

In other scholarly works, such as Gluckman (1965) and Turner (1967), emphasis is on how ritual deals with conflict. For instance, in his study of "rites of rebellion", Gluckman writes, while "...ritual entails dramatization of the moral relations of the group, it is effective because it exhibits all the tensions and strife inherent in social life itself" (1965:265). Similarly, Turner (1967) views ritual in a dialectical perspective. For him, while ritual expresses the formal structuring that maintains the ordered value system of a group, it affords a cathartic experience of *communitas*, or antistructure (Bell, 1992:172). In other words, while "norms and values become saturated with emotion, the gross and basic emotions become ennobled through contact with social values. The irksomeness of moral constraint is transformed into the 'love of virtue'" (Turner, 1967:30). Both Gluckman and Turner appear to be drawing attention to the individual as an entity controlled by group processes.

The repression thesis is probably an outgrowth of the channelling of conflict thesis, the main advocates of which include Girard (1977) and Burkett (1983). They suggest that

ritual represses individuals in society so as to allow for ordered social life. In cultures dominated by primal violence, for instance, ritual sacrifice substitutes for the violence that threatens social solidarity (Girard, 1977). While the repression thesis focuses on how ritual controls individuals' affective states, the definition of reality thesis emphasizes how ritual models ideal relations and structures of value. Here, ritual is seen as a symbolic modelling of the social order. Consequent upon this, Geertz (1980:123-24) sees ritual as that mechanism through which sets of cultural assumptions about the way things are and should be are expressed. From another lens, Bloch (1975) and Bourdieu (1977) emphasize the imperceptible controls such as "be respectful to elders" inherent in conventional ritual admonishments.

All four theses, as examined above, underlie the significance of ritual control among Manlarla ritual participants. The concept of ritual control of ritual participants in Manlarla society stems from the fact that strict rules exist in the performance of rites directed to the dead and the ancestors. For instance, respondents mentioned that they are admonished to "be respectful to ritual authorities", to "honour instructions as and when given by the 'invisible powers'", to "accept decisions customarily made by ancestral representatives", and to sustain the family, lineage and clan honour by "internalizing the traditional code of conduct, especially in matters pertaining to the world of spirits". In other words, ritual participants are admonished to "assimilate" a set of ritual attitudes and controls, ritual conscience and solidarity. Accordingly, ritual statuses and roles in Manlarla society are given, qualitatively and quantitatively, different relationships to socially valued products (including their spin-offs and spill-overs) of social activity.

The writer also observed that sacrificial objects such as animals, fowls and materials

have to be of sacred colour, and priests or officiating elders and ritual participants must refrain from sexual intercourse and certain foods and activities before and after ritual performance. Therefore, Buxton's (1973) observation among the Mandari applies to the Manlarla too. He writes:

> Being a mourner also involves abstinence from sexual intercourse. Since the object of intercourse is seen to be to beget a child a woman must not conceive while wearing the "clothing of death" since violation of this rule offends against the Mandari dialectic of the separation of incompatibles. The action of procreation belongs to life and must not be introduced into situations associated with death. To mix the two is death-dealing (1973:149).

These ritual norms clearly show that Manlarla regard their dead and ancestors as sacred entities. "The essence of human beings", one elder emphasized, "is not only to procreate but also to perpetuate the existence of the procreator in the memory of his/her descendants through continuous honouring of his/her spirit". Therefore, a dead person is never really dead in the minds and practices of his/her survivors. As a living-dead, s/he is not only personally immortalized in her/his survivors, but the survivors are also held in spiritual "communion" with her/him. Indeed, one could say the survivors are the "dead-living", a social-spiritual status conferred on them at the ritual "convocation" of death.

But if the survivors are held in spiritual communion with the dead it is because the former see the latter as benevolent intermediaries between them and Naa-Ngmen and the gods in the provision of life, health and other necessities needed for sustaining creation. The health dimension of the ancestral benevolent mission is experienced as protective, sustaining, upholding, saving and healing. Survivors here refers to the widows and widowers, orphans and heirs, and family heads who for purposes of this study are also tagged ritual participants. They enjoy a great amount of privilcges in their communities and are believed to receive ritual

protection from the ancestors. For instance, 65% of respondents believed that ritual participants are systematically protected against supernatural dangers, threats of illness and of the physical environment, and anti-social tensions.

Be that as it may, it was also observed that participants of funeral rites are the ones who suffer the greatest restrictions of freedom (the ritual control) in their "personal" life activities. They are traditionally bound to keep the ancestors in memory through libations, sacrifices, offerings, prayers and observation of other appropriate rites. For instance, after participating in rites of death a widow becomes an embodiment of herself (as a human being) and the deceased husband, while the family head becomes the single human link between the living members of the family and those of the spirit world. These social-spiritual statuses carry with them corresponding social-spiritual roles, performance (or non-performance) of which are believed to go with spiritual rewards (or spiritual punshments). Above all, they are under ritual obligation to follow all instructions given them by the living-dead. These obligations and restrictions, imposed on them because Bana la kpiin noba they are death-people by virtue of their unique status (partly human and partly embodiments of spirits), tend to define health seeking behaviour associated with them. Ritual control is, therefore, the process through which society influences the behaviour of its members through conformity with ritual norms.

## 5.9 Conclusion

From this chapter, we now know to what degree the religious properties of death are regarded as "contagions" among the Manlarla. The "impure cloud" which surrounds death supernaturally pollutes everything it "touches". This pollution may occur even where there is no physical contact with either the corpse or with any of its properties. Thus pollution, for

them, is not fundamentally a matter of contact, but of relationship to, the source of the contagion (the deceased). For example, a Manlarlo in Canada is considered "polluted" or "infected" at the death of his/her father or mother in far away Ghana, while funeral sympathizers who may sit near the corpse and even touch it will not be considered "infected". This supernatural infection requires ritual cleansing or purification. Failure to do this, or improperly doing it, can cause illness.

It has also been noted that the living-dead are those ancestor spirits with immediate surviving descendants on earth. They are dead in the sense that they are no longer in their physical bodies, and yet they are living because they retain features which describe them in physical terms. For instance, their personal names are maintained and they are counted as family members and recognized as husband or wife, brother or sister, or father or mother among surviving relatives. Each of these social-spiritual relationships carries with it several restrictions (prohibitions and obligations). These restrictions or patterned behaviours are ritually imposed on and/or internalized by surviving individuals through the sequential ritual processes associated with death. A violation of any of these ritually imposed/internalized restrictions is believed to attract supernatural wrath which manifests in the form of illness. This belief is consistent with Garfinkle's (1967) observation that once a regularity of interactive behaviour becomes established, failure to follow the expected pattern makes participants feel uncomfortable for a failure is understood as a negative statement about the relationship.

The spirits of Manlarla ancestors are ever present with the living among whom they work. They are believed to be capable of punishing the "deviant" and rewarding the "conformist". Consequently, sacrifices, propitiatory and supplicatory, must be made either

directly to them or indirectly through them to Naa-Ngmen in a bid to restore estranged relations and/or prevent their occurrence. Failure to do this, as frequently as desirable, implies "ancestor neglect", a social-spiritual failing that calls for supernatural correction. Most supernatural corrections, they maintain, also come in the form of illness whose diagnosis and/or treatment are the secret lore of the diviner and/or religious expert. To this extent, Manlarla funeral rites, like their stories and myths, are not only mechanisms for the preservation and sustenance of ancient Manlarla tradition, but they also have a significant usefulness as brakes upon the speed of cultural change.

The content of Manlarla myths and stories appear to be their nearest analogue to the Christian Bible. Just as the Bible is traditionally the book of Christian version of creation (and all that it entails), so also are the myths and stories the Manlarla version of creation and its dimensions. However, unlike in Christianity or Islam, I did not observe among the people a separate class of "ordained" clergy. Rather, as G. Tuurey observes, "a fetish-priest, or a priest-chief of a maximal lineage, a segmented lineage or a minimal lineage, depending on the occasion, tends to combine sacredotal duties with political ones" (1982:17). As a codified law is absent, this politico-ritual system presents a unified front to disintegrating pressures, including those arising from illness. Thus, the all pervasive configurations of funeral rites, Loho-Naa said, "preserve the cohesion of society and sustain the individual, protecting him/her from intolerable conflict and stresses that may arise from the loss". Of relevance here is the existence of structural arrangements for draining off tensions that otherwise might trigger deviant behaviour.

Rituals are thus conceived by Manlarla as social activities aimed at dealing with some of the basic universal problems of ordered social life. In our particular case of funeral rites,

three basic aspects are emphasized. First, rites of death define what may be called the "death situation"; they place participants in "ritual positions", and appropriately regulate their behaviour in conformity with both the death situation and ritual positions. Second, the situational definition, ritual placement and regulation of behaviour are conceptualized within the framework of some definite, continuous and organized ritual institution(s). Finally, inherent in these ritual institutions are normative structures and corresponding sanctions. Thus, ritual institutions are legitimized and made viable by ritual norms which, in turn, are upheld by ritual sanctions. In behavioral terms, such is the nature of the ritual control web in which ritual participants find themselves.

This presentation is a mere sketch of a ritually complex and culturally meaningful performance diversified by the recounting of dramatic representations of humans' "excursion" on earth. The model belief system of the Manlarla which shapes attitudes, prescribes and defines norms and influences behaviour is, therefore, to a large extent, a reflection of their social-spiritual structure. This structure manifests their believe in and recognition of the existence of a Supreme God below whom exists a host of tutelary gods, spirits (nature and ancestor), ghosts and Kontonne. Above all, we noted that the special relationship between ancestor spirits and the living descendants (manifested in the veneration of the ancestor spirits and the ritual control of ritual participants), lies at the core of Manlarla religious beliefs and funeral ritual practices. How this relationship and associated beliefs influence the propensity of ritual participants to use health services is the subject matter of the chapter that follows.

# CHAPTER 6

# RITUAL CONTROL AND UTILIZATION OF HEALTHCARE SERVICES

> *Just as patterns of social organization must be conceptualized as in continual state of potential flux through the processes of interpretation, evaluation, definition, and mapping, so the human personality must also be viewed as a constantly unfolding process rather than a rigid structure from which behaviour is mechanically released.* (J. Turner, 1974:181)

## 6.1 Introduction

In the preceding chapter, we noted that Durkheim (1965) perceives ritual as dramatizing collective representations and endowing them with a mystical ethos that in the course of experience not only promote acceptance but also inculcates deep-seated affective responses to them. For him, ritual illuminates religion, society and culture and plays a dynamic and necessary role in social integration and institutional consolidation. As Hess et al. (1982:402) put it, while Durkheim was looking into the nature of social life itself, he noted that beliefs (and rituals) emerge from human interactions and that religion and society are coterminous. This will be discussed at length in Chapter 7. Suffice to mention, however, that in Durkheim's view, "the idea of society is the soul of religion". That is, religious beliefs arise from people's experiences with the society they live in. In mechanically solidary societies such as the Manlarla, Durkheim believes religion is the inner voice that unites the people in pursuit of their basic needs. Ritual as a religious idiom, therefore, is an outgrowth of a relatively fixed social structure beyond which the individual has minimum control at best. In short, ritual is depicted as a mechanistically discrete and paradigmatic means of socio-cultural integration, appropriation and/or transformation.

Implied in this quality of ritual is the concept of "control". This control mechanism inherent in ritual, powerfully shapes behaviour and directs interactions towards the "collective good" or the goal of the social unit. As Marx (1965) suggests, ritual constrains behaviour because it is an ideological idiom. As an ideological idiom, it is a symbolic gesture of faith and conformity. In concert with this, ritual has two important dimensions: experiential (the emotional and personal interpretations of ritual activities) and consequential (the expression of ritualistic commitments in the secular world). Such is the case with Manlarla funeral rites.

The Manlarla, as Chapter 5 indicates, organize and celebrate death by performing corresponding rites within the framework of their culture. Geertz defines culture as "an ordered system of meaning and of symbols, in terms of which social interaction (and behaviour) takes place" (1973:144-145). For this reason, it could be said that the control mechanism emanating from ritual participation is a conduit of cultural integration in Manlarla society. What makes it an issue here, however, is that this mechanism of community cohesion and cultural integration tends to be more inhibiting in the health seeking behaviour of ritual participants than non-participants. In this chapter, we intend to show how this ritual control influences the use of available healthcare services by participants of rites of death in Manlarla society. Before considering data on health seeking behaviour of these ritual participants, it is insightful to first establish a correlation between bereavement and ill-health.

## 6.2 Bereavement and Ill-health

A causal relationship between bereavement and subsequent ill-health has previously been established. Parkes (1986) catalogues numerous cross-sectional studies which report a strong association between morbidity and bereavement. Similarly, Brown and Harris (1989)

indicate that stressful life change such as bereavement, is related to the onset of illness. They argue that bereavement disrupts familiar pattern of relationships which, in turn, engender an internal conflict between denial and acceptance in survivors. This ambivalence, they conclude, generally inhibits straightforward adjustment. In another study, Marris interviewed widows two years after the event and asked them to report their general health during that period. These women reported a high proportion of headaches, digestive upsets, rheumatism and asthma (Marris, 1986). From these studies, Parkes concludes that bereavement does influence the pattern of physical illness, though the causal mechanisms are yet to be fully understood (Bond and Bond, 1994:71).

In the situation under study, one may ask: How much of human suffering has been documented as a consequence of mining-related bereavement? From the above selective literature on bereavement, it appears there is no way of answering this question satisfactorily. However, the consequences of individual mining-related bereavements massing together within the same family or the same community has the potential of exerting strong influences on the quality of life of survivors. For example, Fischer and Phillips (1982) suggest that widowed people are more likely to be socially isolated than non-widowed people, while Bennett (1980) observes that social isolation is associated with low morale and difficulties in coping. Within this frame of understanding, it could be argued that, although mines-related bereavement by itself is only a bare objective fact in Manlarla society, it is a fact that is also capable of generating increased vulnerability and stress. Data from informants and my brief personal experience as coordinator of a primary health care programme in the area suggest that the number of Manlarla widows and orphans arising from death in the mines has been increasing, while the average age of these victims of fate has been decreasing. This, Nyimbale-

Naa, emphasized, "makes it all the more difficult for individual adjustment to bereavement".

Whether or not illness causal mechanisms of bereavement are established, it is clear that survivors of death stand in a double-edged disadvantaged position. First, they have sustained an irreversible loss, the loss of a loved one and associated real or potential role contributions of the deceased. Second, as a result of this loss, survivors become more vulnerable to environmental pressures than others. Be that as it may, Rahman et al. (1992:89) suggest "it would not be implausible to hypothesize that both the magnitude of and the explanation for the relative disadvantage of the bereaved in terms of mortality (and morbidity) may be different in varying cultural contexts. The sections that follow examine the relationship between bereavement and utilization of health care services in the context of Manlarla culture. Before that, it is important to understand the location of illness among the bereaved (participants of death rites) within the Manlarla medical nomenclature.

## 6.3 Illness and Illness Behaviour among the Bereaved in Manlarla Society

Mechanic (1962) puts illness behaviour, a hitherto biomedical concept, into the parlance of sociological theory. According to him, illness behaviour constitutes:

> the ways in which given symptoms may be differently perceived, evaluated, and acted (or not acted) upon by different kinds of persons...In short the realm of illness behaviour falls logically and chronologically between two major traditional concerns of medical science: etiology and therapy. Variables affecting illness behaviour come into play prior to medical scrutiny and treatment, but after etiological processes have been initiated. In this sense, illness behaviour even determines whether diagnosis and treatment will begin at all (Mechanic, 1962:189).

From this definition, illness behaviour would seem to comprise an individual's coping actions or responses to illness. In that case, Mechanic is suggesting that an individual's illness

behaviour is determined primarily by his or her unique social networks. That is, the patients' backgrounds and experiences pattern their illness behaviour in predictable ways. However, Waitzkin and Waterman (1976:19) suggest that Mechanic's analysis is one-dimensional; that the basic question (why does patients' illness behaviour vary in the way he describes?) is largely ignored. Nevertheless, Mechanic is credited for suggesting that what happens to a patient is largely dependent on the kind of person s/he is. Furthermore, he is credited for suggesting that who and what a patient is define the processual influences on healthcare decisions (Mechanic, 1989). It is this aspect of Mechanic's contribution that we shall transpose to our study of services utilization patterns among Manlarla ritual participants.

The cognitive and perceptual apparatus of the Manlarla, as noted in Chapter 4, is a reflection of their philosophy and the "theories" of the relationship between life and death. Through these theories, they are able to explain and interpret experience as well as anticipate the future. Given the dominance of the mystical which permeates their philosophy and thought process, perceptions of illness in general and illness conditions of the bereaved in particular are greatly influenced by non-empirical factors. For example, "germ" theory has no place in their perceptual scheme of disease causation and illness situations. Forces beyond the reach of direct human control are considered responsible for provoking many types of illness. Similarly, the distribution of illness is not seen as a chance or random process but corresponds to definite social structural arrangements. This is particularly the case with illness among their ritual participants.

Ritual participants are believed to fall ill either because of the mischief of others or through their own (or other people's) incompetences and inadequacies made manifest in the non-fulfilment of ritual obligations, misappropriation of collective property and/or defilement

of important gods. As social perception is non-demonstrable, the modes of illness perception among Manlarla ritual participants are only examinable through patterns of behaviour during periods of ill-health. Illness behaviour provides, therefore, an opportunity for us to examine the various ways in which individuals and/or groups of individuals in Manlarla society organize and mobilize resources in the face of illness. It involves not only the study of the participants involved in health institutions, but also all those in the society who seek, in various direct or indirect ways, to cure the sick or facilitate a return to normalcy following the dislocations attendant upon illness. As we shall see, in different phases and aspects, illness behaviour entails establishing contact with various people and numerous sub-systems connected with healthcare.

Approaching the study of healthcare services utilization of Manlarla ritual participants from the point of illness behaviour affords some "insight" into not only how the society perceives and defines illness and how resources are mobilized to deal with the problem of illness (Twumasi, 1979:97), but also generates understanding of the meanings the people attach to their actions. In this chapter, the main task is to analyze and explain the patterns of healthcare services utilization of respondents before and after ritual participation.

In Africa, health seeking behaviour has always been associated with such variables as the nature of the illness (Colson, 1971), accessibility of health care facilities (Lasker, 1981), and individual experience with such institutions as schools and religious institutions, especially those of European origin (Spring, 1980). Thus, in addition to assembling and analyzing participants' utilization patterns as determined by their social position, we shall examine the relative importance of such socio-demographic variables as clan, age, sex, education, religion, and marital status in mediating utilization decisions. From Durkheim, Goody, and Radcliffe-

Brown, we have inherited the notion that expressive dimensions of mortuary ritual are orchestrated and determined by such socio-cultural factors as age, gender and status. These characteristics, they believe, determine the effect of bereavement on survivors and processes generated to influence adjustment.

## 6.4 Socio-Demographic Characteristics of Respondents

In commencing this analysis, it is helpful to restate the prime objectives of the study. The prime purpose of this study is to examine sociologically the importance of funeral rites among the Manlaria and to determine the extent to which participation in them influence the use of available healthcare services. Consequently, related questions were formulated for the interviews with ritual participants, ritual specialists, healthcare service providers and community civic leaders. As noted in Chapter 3, the data were collected by interview, observation and group discussions. Respondents were selected on the basis of ritual participation in the past three years with representation reflecting major characteristics of the sample area such as clan, age, sex, education, religion and marital status. These characteristics appear to have ritual significance in the society. As we noted in Chapter 5, funerals display the individual's social position according to age, sex, ritual status, religious affiliation, and social and economic relations within the village and even beyond. Table 6.1 graphically illustrates the socio-demographic characteristics of the 60 ritual participants interviewed.

Table 6.1: Socio-Demographic Characteristics of Respondents (60 FRPs)

| Charac-teristics | Widow N=24 | Widower N=9 | Orphan N=9 | Heir N=12 | F/Head N=6 | Total N=60 |
|---|---|---|---|---|---|---|
| Clan | | | | | | |
| Emo | 8 | 3 | 3 | 4 | 2 | 20 |
| Eko | 8 | 3 | 3 | 4 | 2 | 20 |
| Eto | 8 | 3 | 3 | 4 | 2 | 20 |
| Age | | | | | | |
| Young | 16 | 1 | 9 | 8 | 1 | 35 |
| Old | 8 | 8 | 0 | 4 | 5 | 25 |
| Sex | | | | | | |
| Male | 0 | 9 | 5 | 12 | 6 | 32 |
| Female | 24 | 0 | 4 | 0 | 0 | 28 |
| Educ. | | | | | | |
| Illiterate | 9 | 6 | 8 | 10 | 5 | 38 |
| Literate | 15 | 3 | 1 | 2 | 1 | 22 |
| Religion | | | | | | |
| Trad'nal | 10 | 3 | 3 | 5 | 2 | 23 |
| Christian | 8 | 3 | 3 | 4 | 2 | 20 |
| Muslem | 6 | 3 | 3 | 3 | 2 | 17 |
| M/Status | | | | | | |
| Married | 9 | 7 | 2 | 12 | 5 | 35 |
| Single | 6 | 0 | 7 | 0 | 0 | 13 |
| Widowed | 9 | 2 | 0 | 0 | 1 | 12 |

As can be seen from the table, 60 people were interviewed, 20 from each of the village communities representing the three clans. All these 60 people interviewed indicated they celebrated the funeral rites of either a husband or a wife, a father or a mother, or a son or a brother in the past three years (1991-93). In Chapter 5, the importance of funeral celebrations

among the Manlarla was noted. As a ritual specialist from Nanville said, "funeral rites are organized to reintegrate the bereaved, to facilitate transition of the deceased, and to re-organize the community". The social and moral implications of this statement have been advanced in Chapter 5. What needs to be done now is to see how this translates into the well-being of individual participants. More specifically, we shall examine how participation in rites of death influences an individual's illness behaviour. Thus, the questions to answer here are: Is illness behaviour related to ritual participation? If so, what is the nature of the relationship? How does this relationship determine health seeking decisions? In short, how does ritual participation influence the utilization of healthcare services available in Manlarla society?

With the exception of 2 (3%) respondents who said they had no clear conception of the place of funeral rites, 58 (97%) agreed that funeral rites are very important in Manlarla society. Out of the 58 respondents, 9 (16%) contended that funeral rites "provide an outlet for the public expression of their grief" and so are only useful for the living, while the remaining 49 (84%) maintained that rites of death are "significant for the integration of both the living and the dead". However, it is important to mention that expressions from these 49 respondents revealed marked differences in the means of achieving this integration. Also, there was no agreement on the best way of optimizing integration from funeral performance.

A close examination of these disagreements points to differences in cosmological ideas and indicates how social values are expressed in the rites by different strata of the same social unit. Fordes (1970) defines values to mean ideas of worthwhileness governing a class of actions and imparting to each the index "good" or "bad", or "desirable" or "undesirable" as the case may be. Such values are embodied in a set of normative rules which govern the complex actions of the individual in society. In the section that follows, we shall examine the

health services available to and utilized by ritual participants as well as non-participants in Manlarla society.

## 6.5 Health Service Provision in Manlarla Society

Two healthcare systems (traditional and modern) exist side by side in the Manlarla local health system. The modern healthcare system (through the provision of orthodox medical services) began to seriously affect the people of the UWR in the beginning of the 1930s. This was the period Christian missionaries began to import and dispense European drugs for Christian converts and later for the general population (McCoy, 1988:56). This situation continued until the plagues of late 1940s which compelled a direct intervention of British colonial administration in the health services of the region (then Northwestern Province). Following internal self-rule in 1951, the MOH in Ghana was created to improve the health delivery system. At independence in 1957, the government of the Convention People's Party, under the guidance of Osagyefo Dr. Kwame Nkrumah, launched a series of development plans which emphasized the expansion and improvement of health services throughout the country. Nkrumah declared:

> ...we shall measure our progress by the improvement in the health of our people...The welfare of our people is our chief pride and it is this that my Government will ask to be judged (Nkrumah, 1969:51).

Towards the realization of this objective, physical health facilities were increased, while costs for services were reduced. In some areas, health services were even provided free of charge to users (Senah, 1989:248). These attempts at improving the health of the people had little, if any, impact on the Manlarla because their society was not provided with any health facility. However, in the 1980s following the adoption of the PHC strategy to health,

healthcare centres were opened, medical paraprofessions were developed, and the professionalisation of modern medicine in Manlarla society thus began. This modern healthcare sector has since continued to grow, and now comprises 2 health centres, 6 public clinics, and several community initiated health projects with over 100 professional practitioners (Ghana, 1994a).

Because of their noticeable structures, a visitor to the society could easily be misled into thinking that these clinics are the only institutions that provide health services to the people In reality, this is not the case. Less noticeable to the visitor but more a part of the life of the people is the traditional healthcare system. While sociologist Dunn defines the traditional healthcare system as "the pattern of social institutions and cultural traditions that evolves from deliberate behaviour to enhance health" (1976:135), anthropologists Fabrega and Silver perceive it as "the sum total of a group's way of defining illness, of explaining its sources and occurrences, and of dealing with its burdens" (1973:1). According to Phillips (1990:73), this system provides healthcare in various guises for as many as 80 to 90% of the rural population of South Asia and Africa, while conservative estimates of WHO suggest that between 60 and 90% of populations of developing countries rely on traditional herbs.

In Ghana, it is estimated that while the traditional healthcare system has a ratio of 1 traditional doctor to 400 people, the orthodox healthcare system has 1 doctor per 12,000 people (Ghana, 1993a:5). These ratios demonstrate how pervasive the traditional healthcare system is in the country. Unfortunately, no study of statistical ratios of both traditional and modern healthcare systems is available to illustrate how things stand in Manlarla society. Nonetheless, as noted in Chapter 4, the society has been a prominent centre of folk (sacred) medical practitioners to whom people from near and far come for treatment. Sellers of drugs

and herbal medicine, specialists in bonesetting and treatment of dislocations, TBAs, local missile extractors, diviners, and faith-healers all practise in and around their villages. A variety of popular medical treatments are also carried out by family members, especially older women. In addition, dieting, treatment with dried and distilled herbal medicines, informal religious rites for curing illnesses caused by "evil-eye" and for the "recapturing" of souls lost due to "fright", small rites at local shrines, and other popular therapies are all undertaken without the assistance of modern medical specialists.

The"doctors" and "nurses" of this traditional healthcare system are the various healers and their respective apprentices, the "wards" are their darkrooms, and the diagnostic instruments are their divination tools, techniques and agents. The "medicines" include herbs, prayers, fastings, chants, sacrifices, almsgiving, and purifications. In addition to giving treatment, they also, through divination, ascertain reasons for illness, determine agents responsible, and provide amulets, charms and talismans for preventing its reappearance. Generally, traditional practitioners do not advertise their treatments. People who have diseases they can treat seek them out and request their assistance. As one famous herbalist we had occasion to refer to more than once, Sayibu, said, "I cure people but I sit at home. People come and tell me what their problem is. If I know the herb (or treatment), I prepare it for them".

Consistent with these healthcare systems are three traditions of medicine - folk, professional and popular (Kleinman, 1980). Kleinman describes the folk sector as that "non-professional, non-bureaucratic, specialist sector of the local health system" (ibid.:59). Among the Manlarla, folk medicine can be classified into sacred (shamanism and ritual curing) and secular (herbalism, traditional surgical and manipulative treatments) (see Figure 4.2). On the

other hand, the professional sector of the local health system comprises the organized healing professions. In most societies, this sector is synonymous with modern scientific medicine, otherwise termed cosmopolitan or orthodox. Linking these two medical traditions is what Kleinman calls the popular sector.

The popular sector is thought of as a "matrix containing several levels: individual, family, social network, and community beliefs and activities. It is the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated" (ibid.:50). Popular medical practices are referred to as self-treatment, and it is estimated that between 70 to 90% of all illness episodes are managed within this health sector (Zola, 1972, 1973). The Manlarla are no exception to this universal practice. Of unique importance, however, is the fact that while applying appropriate processes (Mechanic, 1989), Manlarla utilize beliefs and values about illness and death that are part of the "cognitive structure of the popular culture" (Kleinman, 1980:52). Thus, illnesses assessed by these "lay therapy groups" through "lay processes" to require care beyond home remedies and family knowledge (Freidson, 1970) are referred to either the professional sector or the folk sector where a "range of treatment alternatives exist" (McKinlay, 1973; Zola, 1972, 1973).

The professional medical tradition may not be as popular as the other traditions in Manlarla society, but it is certainly the most dominant of the three. The reason for this is political or what could be termed "modern medical imperialism". However, this medical development is not unique to Manlarla society. For instance, Freidson (1970) provides a compelling description of how allopathic medicine, using legal and political resources, gained professional dominance in the United States. Dominance of the professional tradition in the system of care in Manlarla society, like in most societies, is often "equated with the entire

system of healthcare" (Kleinman, 1980:56). This probably explains (at least in part) why some professional personnel of this tradition in Manlarla society regard their own notions about illness and therapeutic procedures as rational, while considering those of the lay community and folk practitioners as irrational, "unscientific" and dangerous.

Manlarla medical theories, therapeutic forms and utilization patterns, as broached in Chapter 4, are, therefore, propounded and understood within the context of these traditions. In other words, the three medical traditions provide the underlying structure or basic explanatory models and theories of disease causation, cure and prevention. For instance, folk (sacred) medicine is grounded in the cosmology of Manlarla traditional religion. From this cosmology, as discussed in Chapter 4, are drawn the images of Gyinne, Kpiine and the "evil-eye", of human beings as agents of disease, as well as the logic of healing through the power of sacred words in sacrifices, petitions and Sarika almsgiving, or the "manipulation" of "impurity" and so on. That is, the cosmology provides the basis for their notions of illness caused by spirits and deities, or interpersonal jealousies and harm, and for therapy.

On the surface, the two healthcare systems do not appear to be at war in Manlarla society as commonly reported in other societies (Joseph & Phillips, 1984; Phillips, 1990) nor are traditional approaches considered illegal. At least, my field observation indicates that some patients, who are unable to get a cure from the modern healthcare system, go to the traditional healthcare system and vice versa. While conducting fieldwork in a traditional bone "clinic" in Duong village, I came into contact with many patients with compound and/or multiple fractures. As if by design, two of these patients, Peter Kuunyagna and Kontiri Tima-Iri, were well known to me. The former had been my primary school teacher, while the latter was an elementary school-mate in the 1970s. Both of them had come to Duong from the

Mines Hospital in Obuasi as victims of a fatal accident that claimed many lives. It is, therefore, necessary to examine how Manlarla ritual participants use these services and what determines which healthcare service provider they go to.

## 6.6 Utilization of Health Service Providers

The proposed conceptual framework for analysing services utilization among the Manlarla unifies Freidson's (1970) lay referral system, Mechanic's (1989) processual influence and Kleinman's (1980) socio-cultural context into one explanatory model. Unlike the primarily individualistic nature of theoretical models of illness behaviour originating in the psychological school, those deriving from the sociological school tend to be collectively oriented. That is, they emphasize that patterns of behaviour appropriate to specific illness situations are "learned" through socialization into particular cultures and/or sub-cultures such as that of ritual participants of Manlarla society. Within this paradigmatic framework, E. Freidson developed his lay referral system to explain individual utilization behaviour. For him:

> ...the structure or organization of the lay community is a factor influencing utilization, in that it organizes the process of becoming ill by pressing the sufferer into or away from the professional consulting room. The organization of lay referrals can enforce a particular orientation toward illness, or it can be so loose as to leave the individual fairly free of others' influence, to make decisions contrary to that of his peers without having to suffer their ridicule or scorn (Freidson, 1970:292).

The implication of this passage is that the lay referral structure not only provides lay consultants to whom the individual can turn for help, but also influences or determines actions for him/her. Freidson's views in this regard are summarized in Table 6.2.

Table 6.2: Predicted rates of Service Utilization by Variations in Lay Referral Systems

| Lay Referral Structure | Congruent with Professional | Incongruent with Professional |
|---|---|---|
| loose, truncated | medium to high utilization | medium to low utilization |
| cohesive, extended | highest utilization | lowest utilization |

Source: Freidson (1970:294).

From the table, two concepts (congruence and cohesiveness) are of significance. Freidson uses the term"congruence" to define the content of the lay societal reaction to deviance (illness), while "cohesiveness" defines the degree to which that reaction is so organized as to be escapable or inescapable by the individual (ibid.). Thus, in the Manlarla society (especially within the social group of ritual participants) where cohesiveness is extensive, we would expect an individual's behaviour to be greatly influenced by associated group norms and values. Data from the field suggest that while 26% of respondents said they do things based on what they think is right and proper, 74% of them said they do things based on cultural appropriateness (or acceptability by the "group"). According to Freidson, congruence of such norms and values with professional medical practice results in highest utilization of "professional" health services, while an incongruous relationship between them results in least utilization of services.

Advancing Freidson's argument, Kleinman (1980) suggests the sociocultural context within which an individual lives affects his/her illness behaviour. The part of his contribution that is of interest lies in his classification of the healthcare system into three overlapping sectors: the popular, the professional, and the folk as discussed earlier. Within these

healthcare sectors are their respective "core clinical realities and functions". These functions include: (1) "the cultural construction of illness as a psychological experience; (2) the establishment of general criteria to guide the healthcare seeking process and evaluate treatment approaches that exist prior to and independent of individual episodes of illness; (3) the management of particular illness episodes through communicative process such as labelling and explaining; (4) healing activity per se, which includes all types of therapeutic interventions from drugs and surgery to psychotherapy, supportive care, and healing rituals; (5) the management of therapeutic outcomes, including cure, treatment failure, recurrence, chronic illness, impairment and death" (Kleinman, 1980:71-72).

These clinical realities and functions serve as the springboard for understanding the lay referral mechanisms of Manlarla healthcare system. For instance, in times of illness the therapy management group determines the "best" treatment option and the most appropriate practitioner to consult and use. While determining the best available options, various processual considerations (including those arising from the ritual status of patients) would appear to be very influential in structuring and shaping the final outcome. That is, decisions regarding which sector(s) to explore and which practitioners to utilize are influenced by the "explanatory models" these patients and their families associate with the experience of disease, illness and sickness. Explanatory models (EMs), according to Kleinman, are "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (ibid.:105). Accordingly, sick ritual participants in Manlarla society are more likely to be referred to the traditional healthcare system than non-participants. This is why I think the unified EM provides a useful "window" through which health behaviours of participants of funeral rites in Manlarla society can be examined and interpreted.

To get an idea of their perception of the value of health, of the various health providers, and of the reasons for using one or the other, respondents were asked whether they had been sick prior to my investigation and, if so, where they went for help and why. In addition, respondents with wives (or husbands) and children where asked where they send them in times of illness. In the first instance, the idea was to ascertain not only respondents' conception of illness and utilization dynamics in the past, but also to ascertain the reasons and/or meaning assigned to their illness decisions and behaviour. In the second instance, the intention was to ascertain if respondents acted differently for themselves than in illnesses of other family members, and, if so, why. As Parsons (1964) notes, it is one thing to put a general value on health as something desirable, and quite another to behave in accordance with this valuation, especially when health comes into conflict with other priorities.

In terms of illness of other family members who are not ritual participants, 58% indicated that non-participants (especialiy children) are sent to hospital immediately their illnesses show signs of seriousness. The reason for this, they maintain, is because there is no spiritual danger[3] in doing so. However, 28% said all illnesses are delayed to ascertain possible causes. In other words, in such families, no seriously ill person (no matter his/her ritual status) is sent to hospital (or clinic) without ascertaining the "behind the scene cause(s)". The remaining 14% offered no opinion either because they were far away from illness decision-making processes or because they had made none recently. For illness episodes personally experienced in the past, all respondents reported they had been sick at least twice or more since their participation in funeral rituals. But none reported being sick more than five times. The table below documents the frequency of illness among respondents after ritual participation.

Table 6.3: Patterns of Illness among Respondents

| Respondent | Number of Times Ill | | | |
|---|---|---|---|---|
| | 2 | 3 | 4 | 5 |
| Widow (N=24) | 5 | 9 | 6 | 4 |
| Widower (N=9) | 4 | 3 | 1 | 1 |
| Orphan (N=9) | 3 | 5 | 1 | 0 |
| Heir (N=12) | 7 | 2 | 0 | 3 |
| F/Head (N=6) | 0 | 4 | 1 | 1 |

While all respondents reported ill-health since their participation in rites of death, 28% of them had difficulty recalling clinically their illness experience. The remaining 72% mentioned clinical situations like malaria, pneumonia, hernia, jaundice, headache, abdominal pains, toothache, waist pains, poisoning, malnutrition, boils, and difficulty in childbirth, and non-clinical illnesses like bad dreams, bewitching, soul loss, and local missile launching. I did not verify the accuracy of illnesses reported by respondents as this was not one of the objectives of the study. It was enough to hear from them whether or not they had been sick prior to my investigation.

But if the clinical reality was difficult for some respondents to reconstruct, the institutions and practitioners they went for help were mentioned without hesitation. The institutions and practitioners mentioned were Bugbugra soothsayer, diviner or spirit-medium, Asibite hospital or clinic, Tiin-ira herbalist, Kornyogra bonesetter, and Karimuga faith-healer. In other words, and for analytical purposes, all 60 respondents reported they choose between traditional and modern healthcare systems. While 5% had earlier indicated (during interviews)

they utilized only the traditional health care system in time of ill-health, 12% said they used only the modern health care system. However, during group discussions it came to light that these respondents implied preference for these health care systems rather than use of them.

This "U-turn" of the 10 respondents, whether intentional or otherwise, however, revealed a need to question respondents about their preference for service providers. Thus, during the final round of interviews, they were asked where they would normally want to go for help in time of illness; why they prefer their choices to other sources; and whether any obstacles prevent them from realizing their preferred method of illness management. All 60 respondents reportedly used and will always use both traditional and modern health care systems. While these data are relevant for a general understanding of services utilization among respondents, they do not tell us the patterns (simultaneous or hierarchical) of use. Further examination reveals that while all respondents (100%) reportedly practise hierarchical or sequential use of services, only 18% indicate ever using them simultaneously. In respect of hierarchical or sequential use of services, data show that while 35% of respondents use the traditional (folk) health care system first when sick, 65% use the modern (professional) health care system first when sick.

Assessment of the basis of (or reasons for) these reported utilization patterns suggests that neither physical availability, geographic proximity, nor economic accessibility is a major factor determining their use of health care services. The data are rather emphatic about the underlying cause(s) of illness, a view metaphorically expressed by most respondents as, Fo ba bigne sengo ka fo ba nye porga you don't lay a mat without seeing the woman. In other words, you do not (or cannot) take action on illness (use of a particular health care service) without knowing the cause of it. The frequencies obtained in this regard are tabulated below.

**Table 6.4: Factors Determining Why Health care Systems are used First**

| Availability | | Proximity | | Affordability | | Cause | |
|---|---|---|---|---|---|---|---|
| N | (%) | N | (%) | N | (%) | N | (%) |
| 6 | (10) | 4 | (6.7) | 13 | (21.7) | 37 | (61.7) |

Further discussions on underlying cause(s) and, for that matter, on the choice of one source of treatment over the other, revealed two issues of sociological significance. First, the data show that 70% see their ritual status and the concomitant ritual control over them as a major determining factor. For example, an old Traditional widow said, "because of my misfortune of burying three husbands everybody thinks I killed them. Children even run away as soon as they see me". While this attitude towards the widow is enough to increase her vulnerability to illness, she lamented, "all my ailments and problems are explained in terms of this God given misfortune. Anytime I'm sick, consultation takes weeks to yield results. I believe I'll die one day before they return from their diviners". A young male orphan, when asked about choice of treatment source, said, "if you're a member of our group (the group of ritual participants), you've no choice. Even the slightest headache arising from Kamana daang maize beer is assigned a spiritual meaning", the diagnosis of which is the diviner's secret lore.

Second,, from these statements and expressions of lamentations, one may conclude that sometimes the intended illness behaviour of ritual participants differ significantly from the normative illness behaviour of the sub-group. Under such situations, actual illness behaviour will be located somewhere in-between intended illness behaviour and normative illness behaviour. This appears to be the case especially when pressures to conform are so strong

that they stifle individual opinion and/or preference. Here, people do not challenge "instituted" illness behaviour not because they agree with it, but because they merely hide their real opinions in order to be supportive of group cohesion and enhance cultural integration. For instance, my uncle told me my mother was delayed from using modern professional medical treatment "not because the family agreed with the therapeutic process initiated by the elders of the lineage, but because the family didn't want to be excluded from Dunnee nuong the 'collective good' of society". By implication, while ritual participants may have and, indeed wish to engage in, unique and distinctive forms of illness behaviour, their membership of this ritual-culture presents a constraining power.

When I asked why illnesses of Kpiin noba are treated differently, my uncle continued, "most illnesses of Kpiin noba are spiritually induced. If you rush a spiritually induced illness for treatment without ascertaining the force behind it, it won't only be a waste of time and resources, but also Fo na kpela tulo you'll be mistaken". This is because the individual will be reversing an ordained order closely monitored and supervised by the ancestors (the invisible "law" enforcement officers), consequences of which, he added, "are much more devastating for all of us than the consequences of delaying treatment for an individual patient". The validity and/or importance of this statement was verified by other respondents.

Data obtained from them indicate that 53% strongly support it, 20% indicate non-support though they conform to it, while 27% do not support and openly disregard it. Given this statistical outcome among respondents, it can be said that the power of control of these invisible ancestors is not only believed to be great in relation to Kpiin noba, but it is also believed to be "negatively" exercised once their authority (as ordained) is disregarded in such matters. Consequently, lineage or family elders in the exercise of their moral authority, must

weigh the consequences of delaying response to an individual's clinical call with the group consequences of violating the collective code of an ordained order.

In another situation, a family head from Loho emphasized, "we delay medical attention because, in most cases, A baalong the clinical manifestation in individuals (especially Kpiin noba) isn't the real illness but a Doraa sign of a more 'serious' sickness". To test its popularity, this statement was also verified among respondents. Data show that, while 72% support the statement, 28% do not. This statistical outcome indicates that most respondents do not find it enough, if at all proper, to concern themselves with signs of illnesses. As a traditional medical practitioner from Loho suggests, "there may be success in diminishing the pain of A baalong the clinical reality in the individual with rushed treatments in clinics and hospitals, but the problem remains unresolved in the patient's network of relationships if the spiritual cause(s) isn't (aren't) discovered". The real path for complete recovery (healing), the data appear to suggest, lies in the ability to discover and uproot all underlying spiritually hidden influences. This is consistent with the Manlarla notion that bodies of Kpiin noba are storehouses for the manifestation of spiritual anger and/or ancestor admonitions.

This conclusion appears to be consistent with the data that the perceived cause(s) of sickness constitute the single most important factor influencing illness behaviour. How is the cause of an illness determined? A ritual specialist from Daffiama-Tuore said:

> You (refering to me) know our discussions would have been difficult without my son, Asumah, introducing you (a stranger) to me. Similarly, it will be difficult dealing with an illness unfamiliar to me. Just as Asumah told me you are an Etuolo neighbour and that you want to understand our funeral ritual practices, so does the diviner tell me what my illness is (cause) and how I can deal with it (treatment).

In addition to the perceived cause of illness and the status of the patient, the quality of the

service provider also influences the choice of the treatment source. For instance, he commented on such dimensions of quality as the diagnostic procedure, treatment efficacy, availability of medicine, future prevention of sickness, and reliability of source. Again, this was tested among respondents. Using seeds (ranged from 1 to 5). respondents were asked to rank each criterion against each source of treatment. In other words, each respondent was asked to indicate the performance of treatment sources using the criteria as possible quality factors. One seed means that the treatment source is the weakest with the particular criterion, while 5 seeds indicate the strongest treatment source with the criterion. The seed representation with the highest frequency for each criterion was recorded as respondents' evaluation of its relative significance. The result is presented in Table 6.5.

**Table 6.5: Matrix Scoring of Treatment Quality by Respondents**

| Source | Diagnosis | Treatment | Medicine | Prevention | Reliability |
|---|---|---|---|---|---|
| Hospital/ Clinic | 4 | 4 | 3 | 3 | 4 |
| Herbalist/ B/setter | 5 | 4 | 4 | 2 | 3 |
| Mallam/ F/healer | 3 | 3 | 2 | 4 | 2 |
| Diviner/ S/medium | 5 | 4 | 4 | 5 | 4 |

Reasons for choosing one or another type of health care service are complex. Of course, availability of the health service (Joseph & Phillips, 1984) and economic restraints such as lack of money or time (Akin et al., 1985:55) are major determinants of utilization

decisions. However, as the table above depicts, there are other considerations upon which respondents may base their choice of health care facility. In addition to the family and/or cultural determination of perceived cause of illness, diagnostic procedures, reliability, and so on influence the particular health care practitioner to consult. To determine the frequency of use (where respondents go most for treatment when sick), a pair-wise ranking of services was provided. Respondents were then asked to indicate the pair of service they patronize most. This results are tabulated in Table 6.6.

**Table 6.6: Where Respondents go Most when they are Sick**

| **Hospital / Clinic** | | **Herbalist / Bonesetter** | | **Mallam / Faith-Healer** | | **Diviner / Spirit-Medium** | |
|---|---|---|---|---|---|---|---|
| **N** | **(%)** | **N** | **(%)** | **N** | **(%)** | **N** | **(%)** |
| 17 | (28) | 12 | (20) | 9 | (15) | 22 | (37) |

Respondents were also asked why they use the services of a particular facility more than the others. The results show that while 72% often use traditional services, only 28% use modern services. Several reasons were given why this is so. For instance, one female respondent from Nyimbale said, "Fo ba buoro bibiiri gara dakuori yiri you don't look for children around a bachelor's house". Accordingly, an illness considered "natural" is simply treated with natural stuff (that is, either home remedies or medicine from a modern health care centre), while those illnesses believed to be supernaturally "induced" (as is normally the case with Kpiin noba) are dealt with by practitioners considered appropriate for dealing with such "supernatural" issues.

We also noted in Chapter 4 that the decision whether a disease has natural or supernatural cause is not taken by the patient. Rather, such decisions are negotiated between the elders and the practitioners within the framework of specific sociocultural context. As a female Traditional from Loho observed, "the elders hold absolute authority in treatment decisions. They consult the diviners and they have the power to accept or reject their advice". In another instance, a young widow from Nanville, who had laboured three days without modern medical attention, was asked if she did not think she gambled with her life. She answered, "I don't make decisions about my illness. I don't make them regarding treatment. I have implicit trust in my `husbands' and I accept the decisions they make for me".

When her `husbands' were asked why they did not send the woman to hospital one elder said, "we don't send our women to Asibite hospital; we have enough qualified Bidogriba midwives in Nanville". But why couldn't these midwives deliver her? I asked them. "This woman committed adultery while her first husband was alive but failed to confess it during Yaga rites of whitewashing", the elder continued. So, "she wasn't completely purified nor was she spiritually separated from her deceased husband", a ritual specialist said authoritatively. How did you know all this if she failed to confess it herself?, I asked them. "The diviner at Sombo village revealed it when I consulted him about her labour", the family head explained. "When she was confronted with it she confessed and I had to provide a ram for purifications before she could deliver", the new husband chipped in.

The authority to make decisions, therefore, is particularly valued by the Manlarla. Women and youngsters depend on male elders to make important decisions such as those related to illness and treatment. While authority clearly resides with the male elders of the families (and lineages), not all of them exercise their responsibilities as they deem appropriate.

A family head from Nyimbale said, "custom tells me what to do, when to do it, and how to do it. It tells me to seek advice from others in complex cases but also tells me to act out my responsibilities in a culturally prescribed manner". His view was supported by all but one (a Christian from Nanville) of the six family heads contacted for data.

The implication of this overwhelming support is that the elders' beliefs and perceptions of procedures regarding illness and treatment sources may not always coincide with those constructed by culture, prescribed by tradition and enshrined in customary practices. However, for reasons of social solidarity, such individualistic tendencies (or deviations) are suppressed for the "collective good" of the family and/or society. In other words, things are done in conformity with the cultural world view of communally constructed beliefs or ideological systems despite what a particular person may or may not hold to be true. Be that as it may, it is plausible, then, to say that this traditional view in Manlarla society is likely to play an important or active part in their illness definitions and treatment decisions. If so, the utilization of healthcare services by ritual participants in the society may provide a reflection of this traditional view. To show this in a systematic way, we first need to examine the use of healthcare services by respondents prior to their participation in rites of death.

## 6.7 Respondents' Pre-Rites Health Services Utilization Patterns

Consistent with the objective of determining what role ritual participation plays on health seeking behaviour, respondents' utilization patterns prior to their participation in funeral rites were examined. This will later be compared with their post-rites data in order to determine the directions of relationship. The best way of collecting healthcare services utilization data is an examination of personal health journals, diaries of daily activities and

attendance records of health institutions. However, due to the essentially non-literate nature of the society, life activities (like health seeking) that are best preserved by diaries are stored in "heads". Similarly, most healthcare service providers (especially the local practitioners) in the society either have no systematic way of keeping records of clients or do not find it necessary to keep them at all. Under the circumstances, the next best method - recollections and/or memories of respondents - was accepted and used to gather data. The assumption here was that there is no relationship (hypothesis of independence) between non-participation in death rites and use of available healthcare services (traditional and modern) among respondents. If, indeed, this was the case, expected and observed frequencies of both the traditional and modern healthcare services utilization would not be significantly different.

Data from respondents are, therefore, analyzed within the framework of the two healthcare systems. The table that follows is created to provide graphic illustration of 60 respondents, all of whom said they use both the traditional healthcare services (THS) and the modern healthcare services (MHS). Since both systems are reportedly used by all respondents, the question of focus had to be shifted from "use" *per se* to service of first consultation in times of illness. Under the column THS are respondents who indicated they consulted local health professionals of the traditional healthcare system (diviners, herbalists, etc) prior to their participation in rites of death, while the column MHS indicates those that consulted localized health professionals of the modern healthcare system (nurses, doctors, etc) before participating in funeral rites. The column Proportion shows the relative strength of frequencies within each ritual status dimension. Against each record is a corresponding percentage relative to the number of respondents for that category.

**Table 6.7: Respondents' Pre-Rites Health Services Utilization Patterns**

| Respondent* | | THS | (%) | MHS | (%) | Proportion of Usage (%) |
|---|---|---|---|---|---|---|
| Widow | N=24 | 10 | (42) | 14 | (58) | 40 |
| Widower | N= 9 | 4 | (44) | 5 | (56) | 15 |
| Orphan | N= 9 | 1 | (11) | 8 | (89) | 15 |
| Heir | N=12 | 4 | (33) | 8 | (67) | 20 |
| Family head | N= 6 | 2 | (33) | 4 | (67) | 10 |
| **Total** | **N=60** | **21** | **(35)** | **39** | **(65)** | **100** |

* Respondents had not participated in rites of death. Hence, they could not be truly widows, widowers, orphans, heirs and family heads.

From the table, the pattern of association (direction of relationship) between non-participation in rites of death (pre-rites status) and services utilization (that is, type of health care service used) is clear. The data show that while 35% reportedly consulted (used) THS, 65% reportedly consulted (used) MHS in times of illness. These statistics have two implications. First, if respondents randomly used health care systems, we should expect that pre-rites patterns would be comparable to their post-rites utilization data. Second, if respondents' non-ritual status was of any importance in their use of health care services, post-rites data would tell a different statistical utilization story. Put differently, sizeable differences between pre-rites and post-rites utilization patterns, *ceteris paribus*, would suggest the significance of rites of death in service use. The section below tests the validity of this probability.

## 6.8 Respondents' Post-Rites Health Services Utilization Patterns

To determine if participation in funeral rites is related (or unrelated) to the use of available healthcare services, post-rites utilization data were examined. To determine the direction of relationship, pre-rites utilization and post-rites utilization patterns were compared. In other words, reported post-rites utilization data were contrasted with reported data for pre-rites. In this way, it was possible to see if there was any change in propensity for healthcare services after ritual participation and, where there was change, the direction of this change. To do this, the 60 respondents who provided pre-rites utilization data were again contacted for their post-rites use of healthcare services. That is, the data that follow are based on utilization patterns of the same respondents after they had participated in rites of death. The data are analyzed to answer the questions: Does ritual participation influence healthcare services utilization of ritual participants? If so, what is the direction of the influence?

Table 6.8: Respondents' Post-Rites Health Services Utilization Patterns

| Respondent | | THS | (%) | MHS | (%) | Increase | (%) |
|---|---|---|---|---|---|---|---|
| Widow | N=24 | 19 | (79) | 5 | (21) | 9 | (38) |
| Widower | N=9 | 5 | (56) | 4 | (44) | 1 | (11) |
| Orphan | N=9 | 5 | (56) | 4 | (44) | 4 | (44) |
| Heir | N=12 | 8 | (67) | 4 | (33) | 4 | (33) |
| Family head | N=6 | 4 | (67) | 2 | (33) | 2 | (33) |
| Total | N=60 | 41 | (68) | 19 | (32) | 20 | (33) |

Again, we are assuming that there is no relationship between ritual participation and use of available healthcare services. In other words, there is independence between the two

variables. If the assumption was realistic, we would expect to have similar patterns (or not significant difference) of health care service use as revealed by pre-rites data. However, a significant difference between pre-rites and post-rites utilization data will be indicative of a strong relationship. Consequently, we shall be making an informed scrutiny of the disparities between pre-rites data and post-rites data (or responses) we would expect if use of health care services and participation in rites of death were unrelated (or independent).

**Table 6.9: Pre-Rites and Post-Rites use of Health care Services**

| Type of Service | Pre-Rites | | Post-Rites | |
|---|---|---|---|---|
| | N | (%) | N | (%) |
| THS | 21 | (35) | 41 | (68) |
| MHS | 39 | (65) | 19 | (32) |
| **Total** | **60** | **(100)** | **60** | **(100)** |

$P < .001$ $V = 0.33$

A statistical comparison of respondents' pre-rites and post-rites utilization of health care services reveals some large deviations. Instead of 21 respondents using THS and 39 respondents using MHS, 41 and 19 respondents reportedly use THS and MHS respectively. Are these disparities statistically significant? What is the strength of this relationship or association? We can see that this is a moderately strong relationship ($V = 0.33$) which is highly significant ( $p<.001$). Consequently, it can be concluded that, in Manlarla society, the probability of using THS or MHS first is dependent on the ritual status of the patient. Specifically, based on these sample data, we can conclude that the probability of using THS is significantly increased by participation in rites of death.

Having established that the ritual status of respondents (patients) and the use of available health care services in Manlarla society are related, the rest of the analysis will be centred on the relative influence, if any, of respondents' socio-demographic characteristics on utilization. In other words, we shall try to determine the role socio-demographic characteristics of respondents played in their pre-rites use of THS and the role they are playing in post-rites use of THS.

## 6.9 Socio-Demographic Characteristics and Services Utilization

The purpose here is to determine if such intervening variables as clan, age, sex, education, religion and marital status are not more influential in determining use of health care services (dependent variable) by respondents than respondents' ritual status (independent variable). Age and sex are two important variables that have been shown to influence utilization of health care services (Mechanic, 1978:163; Navarro, 1977:187). For instance, as people grow older, they require more health care services for chronic and perhaps acute conditions (Joseph & Phillips, 1984:119). Similarly, Kohn & White (1976) observed that women have higher morbidity than men and so should have more need for health care services. Ethnicity, education, religion and marital status have all been suggested as causes of differential utiiization (Freidson, 1970; McBroom, 1970). In determining the strength of relationship of these factors in the use of health care services by Manlarla ritual participants, we shall compute Cramer's V statistics for each of the demographic variables based on the summary of utilization in Table 6.10.

Table 6.10: Pre- and Post-Rites Utilization Patterns of THS by Socio-Demographic Characteristic.

| Category of Respondent | % of Utilization | | |
|---|---|---|---|
| | Pre-Rites | Post-Rites | Increase |
| Clan | | | |
| Emo | 35 | 70 | 35 |
| Eko | 25 | 60 | 35 |
| Eto | 45 | 75 | 30 |
| Age | | | |
| 15-39 years | 34 | 69 | 35 |
| 40+ years | 36 | 68 | 32 |
| Sex | | | |
| Male | 31 | 56 | 25 |
| Female | 39 | 82 | 43 |
| Education | | | |
| Non-literate | 45 | 79 | 34 |
| Literate | 18 | 50 | 32 |
| Religion | | | |
| Traditional | 48 | 74 | 36 |
| Christian | 25 | 65 | 40 |
| Muslem | 29 | 65 | 36 |
| Marital Status | | | |
| Married | 40 | 63 | 23 |
| Single | 23 | 69 | 46 |
| Widowed | 33 | 83 | 50 |

6.9.1 Clan Membership and Utilization of Health Services

Table 6.11: Clan and Type of Service

| Type of Service | Pre-Rites | | | Post-Rites | | | Total |
|---|---|---|---|---|---|---|---|
| | Emo (%) | Eko (%) | Eto (%) | Emo (%) | Eko (%) | Eto (%) | (%) |
| THS | 7 (35) | 5 (25) | 9 (45) | 14 (70) | 12 (60) | 15 (75) | 41 (68) |
| MHS | 13 (65) | 15 (75) | 11 (55) | 6 (30) | 8 (40) | 5 (25) | 19 (32) |
| Total | 20 (33) | 20 (33) | 20 (33) | 20 (33) | 20 (33) | 20 (33) | 60 (100) |

V = 0.17 V = 0.15

From the table, there appears to be some variation in both pre-rites and post-rites use of healthcare services. For instance, pre-rites data suggest that respondents from Eto (Nyimbale) are least likely to use MHS (11), while those from Eko (Nanville) are most likely to use MHS (15). Conversely, respondents from Eto are most likely to use THS (9), while those from Eko are least likely to use THS (5). Respondents from Emo with reported pre-rites frequencies of 7 for THS and 13 for MHS remain in-between the Eko and Eto clans. However, these differences in clan membership are not as strong as the differences found earlier due to participation in funeral rites.

Based on these statistical data, it can be concluded that use of healthcare services among Manlarla ritual participants is not dependent on clan membership. In other words, clan membership plays no statistically significant role as a factor in health seeking among participants of death rites. This is not surprising since we noted that the belief structures of traditional Manlarla, who constitute 70% of the population, are essentially the same.

## 6.9.2 Age of Respondent and Utilization of Health Services

Table 6.12: Age and Type of Service

| Type of Service | Pre-Rites | | Post-Rites | | Total |
|---|---|---|---|---|---|
| | 15-39 yrs. (%) | 40+ yrs. (%) | 15-39 yrs. (%) | 40+ yrs. (%) | (%) |
| THS | 12 | 9 | 24 | 17 | 41 |
| | (34) | (36) | (69) | (68) | (68) |
| MHS | 23 | 16 | 11 | 8 | 19 |
| | (66) | (64) | (31) | (32) | (32) |
| Total | 35 | 25 | 35 | 25 | 60 |
| | (58) | (42) | (58) | (42) | (100) |

V = 0.04 V = 0.02

From the table, the data show that while 12 young respondents used THS before ritual participation, 24 of them indicate they use THS after ritual participation. On the other hand, while 9 old respondents used THS before participating in rites of death, 17 report use of THS after ritual participation. The rates of utilization for the young and the old in both instances are very similar and differences do not appear to be of great consequences. That is, the inter-age differences of 2% for pre-rites and 1% for post-rites do not appear significant. Also, the observed Cramer's V scores suggest the association is very weak. Thus, age does not prove to be a factor influencing use of available healthcare services among ritual participants.

### 6.9.3 Sex of Respondent and Utilization of Health Services

Table 6.13: Sex and Type of Service

| Type of Service | Pre-Rites | | Post-Rites | | Total |
|---|---|---|---|---|---|
| | Male (%) | Female (%) | Male (%) | Female (%) | (%) |
| THS | 10 (31) | 11 (39) | 18 (56) | 23 (82) | 41 (68) |
| MHS | 22 (69) | 17 (61) | 14 (44) | 5 (18) | 19 (32) |
| Total | 32 (53) | 28 (47) | 32 (53) | 28 (47) | 60 (100) |

V = 0.09 V = 0.24

It can be concluded on the basis of this statistical relationship that there is a weak association between sex of ritual participants and use of healthcare services in Manlarla society. An important trend to bear in mind, however, is that the post-rites Cramer's V score is stronger than the pre-rites score. This difference suggests that post-rites use of healthcare services is more likely to be gender-based than pre-rites use of healthcare services.

Further examination of this reveals that while the Cramer's V score for males is 0.13, that for females is 0.64. This insight confirms that females are more likely than males to use THS as a result of their participation in death rites. Consequently, it could be said that being a female is an important mediatory variable in the use of healthcare services as a ritual participant. What is accountable for this since both males and females operate within the same cultural and ritual frameworks? Although this will be discussed later in the chapter, suffice to say that it may be a reflection of females' subordinate position in Manlarla society.

### 6.9.4 Education and Utilization of Health Services

Table 6.14: Education and Type of Service

| Type of Service | Pre-Rites | | Post-Rites | | Total |
|---|---|---|---|---|---|
| | Non-literate (%) | Literate (%) | Non-literate (%) | Literate (%) | (%) |
| THS | 17 (45) | 4 (18) | 30 (79) | 11 (50) | 41 (68) |
| MHS | 21 (55) | 18 (82) | 8 (21) | 11 (50) | 19 (32) |
| Total | 38 (63) | 22 (37) | 38 (63) | 22 (37) | 60 (100) |

V = 0.23 V = 0.26

The Cramer's V statistics of 0.23 (pre-rites) and 0.26 (post-rites) suggest a moderate association between education of ritual participants and use of healthcare services. In both ritual instances, however, non-literate respondents appear to be more likely to use THS than literate respondents. The inclination of literates for THS after ritual participation is quite phenomenal. The question that remains to be explained is: What is responsible for the more inclination of literate respondents towards THS after ritual participation than non-literates?

Data arising from group discussions show that most literates live and work outside their own localities. As such, while literate non-participants, to a greater degree, are free from most traditional norms and customs, literate participants of death rites are exposed to the same ritual rules as their non-literate counterparts no matter place of location. Several respondents expressed their opinions about these concerns. However, only two are provided here for space constraint. First, one educated widower said, "since I participated in the death rites of my wife, it has become more difficult for me to ignore them (norms and customs) as

mores of folk people". When I asked why? He said, "I 've since learnt to respect the `power' of the dead as my wife has joined their ranks". Of course, any normal being would respect the power of a loved one (visible or invisible). Second, a literate widow remarked:

> My brother (referring to me), do you know one thing? Our people are the witches and the gods. You perform rites of a loved one and your life is surrendered to forces never imagined before. The dos and don'ts are just too many. When my husband was alive and we were working far away in Bolga, these 'things' were never heard".

Her opinion implies that, for "fear" for the living, one has to behave appropriately as designed by the "forces" that be.

### 6.9.5 Religious Affiliation of Respondent and Utilization of Health Services

**Table 6.15: Religion and Type of Service**

| Type of Service | Pre-Rites | | | Post-Rites | | | Total |
|---|---|---|---|---|---|---|---|
| | Trad'nal (%) | Christian (%) | Moslem (%) | Trad'nal (%) | Christian (%) | Moslem (%) | (%) |
| THS | 11 (48) | 5 (25) | 5 (29) | 17 (74) | 13 (65) | 11 (65) | **41 (68)** |
| MHS | 12 (52) | 15 (75) | 12 (71) | 6 (26) | 7 (35) | 6 (35) | **19 (32)** |
| **Total** | **23 (38)** | **20 (33)** | **17 (28)** | **23 (38)** | **20 (33)** | **17 (28)** | **60 (100)** |

V = 0.21 V = 0.12

Based on these statistics, it can be concluded that use of health care services by ritual participants is not strongly associated with their religious affiliation. A significant proportional increase in all religious backgrounds to use THS is noticed in the post-rites period. Perhaps, this is an indication that the strength of the local social-spiritual forces favouring THS out-

weighs religious orientations. However, in both pre-rites and post-rites data, Traditionals appear to be more likely to use THS than Christians and Moslems. What accounts for this?

The most probable explanation for this is that many more Traditionals tend to believe that all diseases, unless otherwise proven, are supernaturally motivated than their Christian and Moslem counterparts. As evidenced in a statement by one elder, Traditionals tend to have many more breakable spiritual relationships than non-Traditionals. He said, "we Dagakore Traditionals have many sources of ill-health. Our gods are too many. Each god has what it eats and what it doesn't eat. Sometimes, we easily get confused which god eats what. Other times, we even forget that other gods exist until we're reminded through illness". For this reason, most Traditional Dagaaba never want to leave anything (especially illness) to chance.

### 6.9.6 Respondent's Marital Status and Utilization of Health Services

**Table 6.16: Marital Status and Type of Service**

| Type of Service | Pre-Rites | | | Post-Rites | | | Total |
|---|---|---|---|---|---|---|---|
| | Married (%) | Single (%) | Widowed (%) | Married (%) | Single (%) | Widowed (%) | (%) |
| THS | 14 | 3 | 4 | 22 | 9 | 10 | **41** |
| | (40) | (23) | (33) | (63) | (69) | (83) | **(68)** |
| MHS | 21 | 10 | 8 | 13 | 4 | 2 | **19** |
| | (60) | (77) | (67) | (37) | (31) | (17) | **(32)** |
| **Total** | **35** | **13** | **12** | **35** | **13** | **12** | **60** |
| | **(58)** | **(22)** | **(20)** | **(58)** | **(22)** | **(20)** | **(100)** |

V = 0.16 V = 0.17

This statistical information suggests a situation of weak association between use of health care services and marital status. The reason why there is statistically weak association

is that almost everyone, no matter what marital status, goes to THS in post-rites period. How do we then explain the proportionally significant differences and/or similarities between pre-rites and post-rites data? For instance, while the table indicates an almost identical pre-rites data for married and widowed respondents, post-rites data suggest the widowed are most likely to use THS than the non-widowed (married and single). The almost identical pre-rites data for married and widowed respondents could have arisen from the fact that the widowed were married during pre-rites era. The strong post-rites association of the widowed with THS is not surprising. Since the Manlarla consider them to be closest to the spirit world, their spiritual bonding must be reflected in their health and use of health care services.

Arthur Kleinman (1988:6) observes that:

> ... it is an enormous success when chest pain can be reduced to a treatable acute labar pneumonia (biological reductionism). But that it becomes a disappointing failure when chest pain is reduced to chronic coronary artery disease for which calcium blockers and nitroglycerine are prescribed, while the patient's fear, the family's frustration, the job conflict, the sexual impotence, and the financial crisis go undiagnosed and unaddressed.

Similarly, it would be a disappointing effort to just conclude that utilization of health care services available in Manlarla society are dependent on the ritual status of the patients. There is need to compute the meanings that "lurk" behind post-rites behaviours as revealed in the use of health care services. The sections that follow deal with that.

## 6.10 Accounting for Change in Services Utilization Propensity

From section 6.9, it is clear that there have been changes in respondents' utilization of health care services since their participation in rites of death. We are also clear about the direction of change (a change in favour of THS). What, then, is the meaning of this change?

What does the change mean to the individual respondents? What does it mean to the society of which the individual respondents are active members? In short, how do we account for the change in respondents' utilization patterns of (or shift in propensity for) available healthcare services? In order to answer these questions, there is need to summarize respondents' propensities for healthcare services before and after participating in rites of death. It is argued in Chapter 5 that funeral rites are Manlarla attempts to negotiate goals with "powerful beings". If this argument is sound, then it can further be suggested that individual cognitive processes, as related to rites of death, are fundamentally social-spiritual; and that this social-spiritual influence must be so dynamic and powerful that it shapes and reshapes utilization behaviour of ritual participants.

Table 6.17: Summary of Respondents' Pre-Rites Services Utilization

| Respondent | THS | | MHS | | Total | |
|---|---|---|---|---|---|---|
| | N | (%) | N | (%) | N | (%) |
| Widow | 10 | (42) | 14 | (58) | 24 | (40) |
| Widower | 4 | (44) | 5 | (56) | 9 | (15) |
| Orphan | 1 | (11) | 8 | (89) | 9 | (15) |
| Heir | 4 | (33) | 8 | (67) | 12 | (20) |
| F/Head | 2 | (33) | 4 | (67) | 6 | (10) |
| Totals | 21 | (35) | 39 | (65) | 60 | (100) |

From the table, 21 of the 60 ritual participants reported they used THS prior to their participation in rites of death. They included 10 widows, 4 widowers, 1 orphan, 4 heirs, and 2 family heads. Pre-rites data show that widowers with 44% propensity were most likely than

any other category of ritual participants to use THS. This was closely followed by widows with 42%, while data for orphans show the lowest propensity of 11% for THS. This is consistent with the view that parents in Manlarla society are more likely to send their sick children (especially while they are non-participants) to MHS than they are likely to go themselves for MHS. How were these 21 respondents distributed along demographic variables in their pre-rites use of THS?

Table 6.18: Distribution of Pre-Rites Users of Traditional Health Services

| Characteristic | Widow (N=10) | Widower (N=4) | Orphan (N=1) | Heir (N=4) | F/Head (N=2) | Total (N=21) (%) |
|---|---|---|---|---|---|---|
| Age | | | | | | |
| Young | 9 | 1 | 1 | 1 | 0 | 12 (34) |
| Old | 1 | 3 | 0 | 3 | 2 | 9 (36) |
| Sex | | | | | | |
| Male | 0 | 4 | 0 | 4 | 2 | 10 (31) |
| Female | 10 | 0 | 1 | 0 | 0 | 11 (39) |
| Education | | | | | | |
| Illiterate | 6 | 4 | 1 | 4 | 2 | 17 (45) |
| Literate | 4 | 0 | 0 | 0 | 0 | 4 (18) |
| Religion | | | | | | |
| Traditional | 4 | | 1 | 2 | 1 | 11 (48) |
| Christian | 3 | 0 | 0 | 1 | 1 | 5 (25) |
| Muslem | 3 | 1 | 0 | 1 | 0 | 5 (29) |
| M/Status | | | | | | |
| Married | 6 | 2 | 0 | 4 | 2 | 14 (40) |
| Single | 2 | 0 | 1 | 0 | 0 | 3 (23) |
| Widowed | 2 | 2 | 0 | 0 | 0 | 4 (33) |

Data from the table suggest that clan, age and sex are not important intervening factors in the use of healthcare services, while education, religion and marital status appear

to be important mediating variables. For instance, it can be observed that non-literate respondents with a propensity of 45% for THS stand above their literate counterparts with only 18%. Similarly, Traditional respondents with 48% propensity lead their Christian and Muslem counterparts with 25% and 29% respectively. Finally, married respondents with 40% propensity remain on top of the singled and the "widowed" who show propensities of 23% and 33% respectively.

From these data, it could be said that respondents' religious affiliation, education, and marital status were possible intervening or predictive factors in their pre-rites health seeking decisions. However, dramatic changes in propensity are revealed after respondents participated in rites of death. These are reflected in their responses to questions pertaining to post-rites healthcare services utilization and are graphically summarized below.

Table 6.19: Summary of Respondents' Post-Rites Services Utilization

| Respondent | THS | | MHS | | Total | |
|---|---|---|---|---|---|---|
| | N | (%) | N | (%) | N | (%) |
| Widow | 19 | (79) | 5 | (21) | 24 | (40) |
| Widower | 5 | (56) | 4 | (44) | 9 | (15) |
| Orphan | 5 | (56) | 4 | (44) | 9 | (15) |
| Heir | 8 | (67) | 4 | (33) | 12 | (20) |
| F/Head | 4 | (67) | 2 | (33) | 6 | (10) |
| Totals | 41 | (68) | 19 | (32) | 60 | (100) |

From the table, 41 respondents reported use of THS first since becoming ritual participants. They are distributed as 19 widows (79 % of 24 widows), 5 widowers (56% of

9 widowers), 5 orphans (56% of 9 orphans), 8 heirs (67% of 12 heirs), and 4 family heads (67% of 6 family heads). These data thus suggest that participation in rites of death increases participants' likelihood of using THS and decreases the probability of using MHS.

In addition, attention is drawn to the different health impacts of ritual participation on different categories of participants. For example, while pre-rites data indicate 11% "orphans" reported using THS, post-rites utilization data indicate 56% orphans use them. This, representing an increase of 45%, places orphans on the top of the comparative scale. Similarly, pre-rites data indicate 42% "widows" reported using THS, while post-rites data indicate 79% widows use THS. This 37% increase over pre-rites data, places widows second on the scale. Widowers, placed on the top spot by pre-rites data, now fall to the bottom of the scale with an increase of only 12%, while data for heirs and family heads indicate increases of 34% from pre-rites data of 33% each for THS. What role do the different socio-demographic variables play on the increase in respondents' propensity for THS?

Table 6.20: Distribution of Post-Rites Users of Traditional Health Services

| Charac-teristic | Widow (N=19) | Widower (N=5) | Orphan (N=5) | Heir (N=8) | F/Head (N=4) | Total (N=41) | (%) |
|---|---|---|---|---|---|---|---|
| Age | | | | | | | |
| Young | 13 | 1 | 5 | 5 | 0 | 24 | (69) |
| Old | 6 | 4 | 0 | 3 | 4 | 17 | (68) |
| Sex | | | | | | | |
| Male | 0 | 5 | 1 | 8 | 4 | 18 | (56) |
| Female | 19 | 0 | 4 | 0 | 0 | 23 | (82) |
| Education | | | | | | | |
| Illiterate | 9 | 5 | 5 | 8 | 3 | 30 | (79) |
| Literate | 10 | 0 | 0 | 0 | 1 | 11 | (50) |
| Religion | | | | | | | |
| Traditional | 8 | 3 | 2 | 3 | 1 | 17 | (74) |
| Christian | 5 | 0 | 2 | 4 | 2 | 13 | (65) |
| Muslem | 6 | 2 | 1 | 1 | 1 | 11 | (65) |
| M/Status | | | | | | | |
| Married | 9 | 0 | 1 | 8 | 4 | 22 | (63) |
| Single | 5 | 0 | 4 | 0 | 0 | 9 | (69) |
| Widowed | 5 | 5 | 0 | 0 | 0 | 10 | (83) |

From the table, there is no evidence that post-rites propensity for THS is influenced by age. Twenty-four or 69% of young respondents reported they use traditional sources for their illnesses, while 17 old respondents or 68% reported same. Similarly, pre-rites THS utilization patterns were almost the same, 34% and 36% for young and old respondents respectively. Thus, we can conclude that both pre-rites and post-rites healthcare services use are remarkably similar in terms of age. The differences are not of great consequence. Consistent with these data, it can be argued that age is not a potential pre-eminent salient characterisitc of choice and use of healthcare service among ritual participants.

In terms of gender, while 18 males or 56% said they used traditional sources first, 23 females or 82% indicated they used traditional sources first. In comparison with pre-rites patterns, it is clear that while males show an increase of 25% over pre-rites data, females show an increase of 43% over pre-rites data. This has three implications worth noting. First, that there is notable gender differences in choices of health care facility. Second, that ritual participation has a greater influence on the choice of health care services for females than it does for males. Third, that females who participate in rites of death are more likely to use THS than male participants

Similarly, while data from non-literates show a post-rites increase of 34%, those from literates show a post-rites increase of 32%. Considering the fact that pre-rites data scored 18% for literates and 45% for non-literates, this 32% increase for literates appears to be phenomenal. The probable reason deduced from the data is that many educated Manlarla who participate in rites of death tend to adapt their educational training to local traditions and beliefs rather than vice versa which is characteristic of pre-rites times. Accounting for this change, one literate said, "since I became a head of the family, I 've been acting in ritual as a duty. Initially things were difficult for me. Thank God, I'm now more knowledgeable and thoughtful about the beliefs of our society". What is striking here is that, educated Manlarla do not appear to be inclined towards tradition while there are senior male members in the family. However, as they assume responsibility over their families, an awareness is created that they cannot survive with disdain for tradition while surrounded by it.

Religion leads with 87% post-rites inclination towards THS. Even though data from respondents of all three religious faiths indicate post-rites increases for THS, Traditionals still maintain lead with a 39%. Christians and Muslems show a post-rites increase of 25% and

26% respectively. Within the context of these statistics, it can be said that Traditionals are most inclined towards THS. As noted in Chapter 3, Manlarla society is not only predominantly non-literate, but it is also predominantly traditional with about 65% of them vigorously pursuing the course of Traditional religion. Based on these facts, it can be argued that fewer Manlarla will, therefore, be inclined towards MHS after ritual participation.

Marital status of respondents significantly influences the use of services. With 40% propensity, married respondents demonstrated the highest inclination for THS in pre-rites period. However, post-rites utilization data of 83% for widowed show a high correlation between that status and propensity for THS. Similarly, with a post-rites propensity of 69% for THS, single respondents now place second to widows. Implicit in these data is that married ritual participants are less inclined to use THS than their singled and widowed counterparts. Conjointly, while the widowed are more likely to use THS than singled ritual participants, the latter are also more predisposed to THS than married participants.

Under the circumstances, we could say by way of concluding the section that both THS and MHS that provide services to the Manlarla are socially and culturally constructed. As social and cultural constructs, they are forms of social reality (Berger and Luckman, 1966). Social reality signifies that transactional world of human interactions existing outside the individual, in which his/her everyday life is enacted, where his/her social roles are defined and performed, and in which he/she negotiates with others in established status relationships under a system of cultural rules (Kleinman, 1980:36). In other words, social reality is constructed within sociocultural framework of meanings and structural configurations.

Thus, the sociological interest in reality, Berger and Luckman (1966) suggest, lies in the fact of its social relativity. In other words, what is real to a Manlarla widow may not be

real to a Canadian widow. Similarly, what is real to a Manlarla orphan may remain unreal to a Manlarla non-orphan. Therefore, "specific agglomerations of reality", as Berger and Luckmann (1966:15) emphasize, "pertain to specific social contexts". To understand the content of this reality, we need to solicit the "subjective meaning that makes it "reality *sui generis*" (Durkheim, 1951). In this study, the sociological interest is to understand respondents' perceptions of how these socially and culturally constructed health care systems relate to their ritual statuses and illness experiences. Below are two tabular illustrations of respondents' subjective pre-rites and post-rites preferences for health care services.

## 6.11 Preference for Health care Services

**Table 6.21: Pre-Rites Preference for Health Services**

| Respondent | THS | | MHS | | Difference | |
|---|---|---|---|---|---|---|
| | N | (%) | N | (%) | N | (%) |
| Widow | 8 | (33) | 16 | (67) | 8 | (33) |
| Widower | 4 | (44) | 5 | (56) | 1 | (11) |
| Orphan | 2 | (22) | 7 | (78) | 5 | (56) |
| Heir | 3 | (25) | 9 | (75) | 6 | (67) |
| F/Head | 2 | (33) | 4 | (67) | 2 | (33) |
| **Totals** | **19** | **(32)** | **41** | **(68)** | **18** | **(30)** |

The thesis here is that individual behaviour and/or actions are influenced by meso-level sociocultural processes taking place in the context of specific social structures. That is, while structural conditions influence social processes, the latter shape behaviour and/or actions of

individuals who are part of the structure and actively participate in the processes. As Selznick points out, "...a true theory of social action would say something about goal-oriented or problem-solving behaviour, isolating some of its attributes, stating the likely outcomes of determinate transformations" (1961:934).

In the sample of 60, before respondents participated in rites of death, 32% indicated that they had preferred THS, while 68% indicated that they had preferred MHS. These preferences for healthcare services (19 THS and 41 MHS) were quite consistent with reported use of them (21 THS and 39 MHS). However, after participating in rites of death the preference for the two healthcare systems changed slightly, while significant difference was noted between indicated preference for and reported use of them. These are evident in the table below.

Table 6.22: Post-rites Preference for Health Services

| Respondent | THS N | (%) | MHS N | (%) | Difference N | (%) |
|---|---|---|---|---|---|---|
| Widow | 10 | (42) | 14 | (58) | 4 | (17) |
| Widower | 4 | (44) | 5 | (56) | 1 | (11) |
| Orphan | 3 | (33) | 6 | (67) | 3 | (33) |
| Heir | 5 | (42) | 7 | (58) | 2 | (17) |
| F/Head | 3 | (50) | 3 | (50) | 0 | ( 0) |
| Totals | 25 | (42) | 35 | (58) | 10 | (17) |

From the table, it is observable that while 42% indicate preference for THS, 58% indicate preference for MHS. Circumstantially, while post-rites preference for THS increased

by 6 respondents, post-rites preference for MHS decreased by the same margin. However, the interesting sociological issue to note is the difference between indicated preference for health care services and reported use of them. For instance, while 25 respondents (42%) indicate preference for THS after participating in funeral rites, as many as 41 respondents (68%) reported using them, thus generating a difference of 16 respondents (26%).

Given these statistically sequential relationships (pre-rites and post-rites utilizations), it is plausible to argue that ritual participants in general will have lower propensity for modern medicine than non-participants. This, as argued in Chapter 5, is due to the ritual control mechanism introduced to participants or the "constraints" imposed on them. The concept of constraint can be counterposed to that of choice (Burns and Cooper, 1971:77-86). Behaviour constraints, above all those of social and institutional nature such as funeral rites, serve to determine participants' access to health resources and action opportunities and, therefore, define the limits within which they make choices of health care services.

Comparing the two preference tables, we can see that while 2 respondents used health care services for reasons other than individual preference in the case of pre-rites data, post-rites data indicate that as many as 16 respondents use them for reasons other than individual preference. Put differently, while there is near correspondence between respondents' pre-rites preference for health care services and their pre-rites use of them when sick, the same cannot be said about their post-rites preference and post-rites use of them. Using widows as a more concrete example, we can observe that while 10 widows (42%) indicate preference for THS, 19 (79%) of them use THS. Given this large statistical discrepancy between reported use of and reported preference for THS, it can be said that for this category of respondents, the incongruence between individual preference for and use of health care services is great.

What force(s) is (are) behind this incongruence or inconsistency between healthcare services respondents indicate they prefer and healthcare services they actually turn to in time of illness? In other words, what is responsible for the change in utilization propensity for the healthcare services available in Manlarla society? Is it some kind of "pay-cheque" for the risk reality Manlarla accomodate by accepting jobs in the mines or it is a sign of inherent neurotic punctures in their cultural system?

## 6.12 Change in Utilization Propensity: An Occupational Nemesis or a Cultural Neurosis?

The Greek verb *nemein* has a very wide range of senses. It originally meant "deal out, dispense", a signification mirrored in the 16th century derived *nemesis* which etymologically means "the dealing out of what is due" (Ayto, 1990:365). The Collins English Dictionary associates the term nemesis with the Greek goddess of retribution and vengeance, which implies "a righteous wrath", and with *nemein,* which means "to distribute what is due". Ivan Illich (1975) introduced the term, medical nemesis, to designate a self-reinforcing loop of negative institutional feedback. As he said, "our contemporary hygienic hubris has led to the new syndrome of medical nemesis" (ibid.:28). In other words, medicine, its structures and procedures create more "illness, disease and suffering" than they eliminate. To this, he noted:

> One in 50 children admitted to a hospital suffered an accident which required specific treatment. University hospitals are relatively more pathogenic, or, in blunt language, more sickening. It has also been established that one out of every five patients admitted to a typical research hospital acquires iatrogenic disease, sometimes trivial, usually requiring special treatment, and one case in thirty leading to death. Half of these episodes resulted from complications of drug therapy; amazingly, one in ten came from diagnostic procedures (Illich, 1975:25).

Similarly, mining as an occupation has an important social influence on and significant

social implications for Manlarla society. It is an important structural characteristic of a stratified society. For instance, who are those working in the mines as underground labourers? Why are certain people over-represented in the mines? Why are certain workers killed on the job, while others are maimed and permanently incapacitated in their socially and economically productive life by falling shafts? Why do people live in overcrowded housing with poor sanitation while working in coal and gold mines that are capable of unleashing pneumoconiosis on them? Whether or not one lives or works in these kinds of environment depends on one's position in society.

A dominant characterisitc of capitalist oriented occupation is economic growth (or profit maximization). Social and economic policies practised in pursuit of this single goal of greater growth invariably neglect a variety of health hazards (McKinlay, 1984). Consequently, it is the opinion of the writer that the unpleasant facts of life (death, illness and incapacitation) suffered by Manlarla migrant miners and their families are partly attributable to the character of the mining occupation in Ghana. Hence, the term occupational nemesis is coined to define the situation in which mining has become a major threat to the health of not only miners, but also their families who have no direct access to the mines. However, if death, illness and incapacitation of Manlarla migrant miners and their families are considered, in part, as "a self-reinforcing loop of negative feedback" of the mining occupation and all that it entails (goals and policies), could the same be said about Manlarla low utilization of available healthcare services? To answer this question we need to look at another concept, cultural neurosis.

Neural is one of a wide range of words for which English is indebted to Greek *neuron* "nerve" (a relative of Latin *nervus*, from which English gets nerve). Out of this, the term neurosis was developed in the 18th century (Ayto, 1990:363). The Collins English Dictionary

defines neurosis as, "a relatively mild mental disorder, characterized by symptoms such as hysteria, anxiety, depression, or obsessive behaviour". The term cultural neurosis is used to denote those illness episodes and pains individuals in a given society suffer as a result of their status (or position) in relationship to the sociocultural structure of that particular society. It takes as its concern how individuals or groups of individuals in a given society perceive and react to the structural position and health status of others and the way these others themselves perceive and behave in the way they do.

It is true that Manlarla are poor compared to most Ghanaians, especially those from the richer regions of the country. Because of this, some people may argue that financial constraints limit their use of modern medical services. It is also true that the systems of public and private transport are undeveloped in the region. Consequently, still others may argue that such realities inhibit their psychological readiness to take action on illness. However, from this study, it appears something else is more important than factors of economic accessibility, geographic proximity and undeveloped transport system. For instance, why was my mother refused immediate modern medical care when a pharmacist and a senior nurse from the regional hospital went in a vehicle to bring her to hospital at their own expense? Why was the labouring woman in Nanville village denied professional supervision for three days when the husband could buy a sacrificial ram the second day after labour started?

From these few illustrative questions, it appears logical to conclude that the "professional" inattention or late attention to illnesses among the people as observed by Banka (1986), has a deeper cultural significance, a significance that calls for explanation beyond financial constraints, distance prohibitions and transportation inadequacies. As demonstrated by the study, it is this cultural signification that first determines illness behaviour of a large

number of people in the region. Other considerations, including economic and geographic factors, become issues at a secondary level after the primary consideration has been deliberated upon. It is common knowledge that, the longer a patient stays with a disease before proper therapeutic measures are applied, the stronger the measures need to be and the smaller their chance of succeeding. In light of this, could the cultural signification that delays modern medical care to ritual participants be considered a kind of cultural neurosis?

While I was collecting data for the study, a patient brought this principle of cultural neurosis home to me. She was a farmer's wife in her early thirties from the village of Kpong-Paala, 8 kilometres away from the town of Wa (the UWR capital). Although this woman had been in difficult labour for two days, the elders did not find it necessary to seek professional assistance in the regional hospital. Her condition was a surgical emergency, requiring admission to the hospital, and, possibly, a massive dosing of antibiotics. I was on my way to the field when two young men (on their way to Wa) waved me to stop. I complied and after having told me the problem, they pleaded with me to render them my services. I felt the lives of two people were not only at stake, but were also now placed in my hands. There was no choice, I had to help. Thanks to the "God of Abraham", as one of the "passengers" relayed to his village colleagues who followed later on bicycles, "the woman and her unborn baby-girl were driven safely to Wa", where a surgical "evacuation" was successfully performed.

As custom demands, I paid them (mother and baby) a visit at the hospital. At this point, all (mother, baby, husband and other relatives) were happy and, so, I could ask my "stupid" questions without fears that I might become a victim of either a deadly blow or a sarcastic remark. Since these people did not constitute part of my sample, there was little organization and protocol in the manner in which I asked them questions. Nevertheless, I

managed to get them talking. Why did you people have to keep the poor woman and her innocent baby suffer for two full days without thinking of getting them to hospital? One elder, realizing how embarrassing their answer could be, called me aside and said, "O babile porkuore la ong de that is the uncle's widow he inherited". What is the relationship between inheriting an uncle's widow and delaying medical care for her and her baby? He answered, "E nyeng, te Waal-Daga yela mang ela galema bila. Keenang ba dang kyelihe ena tuyebe kpe you see, our traditional (Waale-Dagaaba) issues are very complex. And if you aren't careful you'll pass there and enter (die through them)".

Certainly, as nobody was prepared to die such a voluntary (or foolish) death, tradition was followed. The objective here was to preserve "lives" in order to perpetuate continuity of the social unit. Unfortunately however, the baby, whose life was equally (or should equally be) a concern for what both tradition and continuity appear to stand for, died exactly a week after evacuation. The cause of death, as diagnosed by professionals at the hospital, was infection resulting from the two days of "unhygienic" exposure. Other women from the village who came to the hospital emphasized that the baby lost by the woman was the first in four births, two of which were professionally supervised (while she was married to her first husband). By implication, these women wanted me to understand that the woman in question may have problems in child birth but is not the type that gives birth to Bileuwaare babies who die to be born again. The question, then, is, "What caused the baby's death, the tradition that denied her and her mother early professional medical care, the medical professionals that performed the evacuation availed to them late, or the infection resulting from the two days of unhygienic exposure?

There are no guarantees against the possibility of babies dying even if professionally

delivered and on time too. Nor are there guarantees against infections of babies delivered within the scientific walls and competence of modern professionals. However, as the Cuban doctor who performed the evacuation said, "the risk of death under professional situations could prove to be lower than those under unprofessional supervision". His position on this behaviour appears to echo the Canadian Medical Association's belief that "...a planned home delivery in the absence of the full range of normally available hospital facilities can jeopardize the safety of both mother and infant" (in Edginton 1989:22).

In this example, cultural signification tended to determine the response of the therapy management group to the woman's illness (difficulty in childbirth). As the elder who provided explanation to my questions in this case indicated, both the woman and her husband had participated in rites of death as widow and heir respectively. Perceived from a biomedical perspective, this behaviour of the people or change in propensity for MHS in favour of THS is irrational, unacceptable, incomprehensible at best. From the "social-spiritual" health perspective, however, there was no response that could possibly be more rational, acceptable and comprehensible than the line of action they pursued. We argued that the unusually high morbid situation of the Manlarla could be attributed to the socioeconomic realities in the UWR. Using the same threads of logic, it seems attractive and appropriate to attribute Manlarla unusually low utilization of available modern healthcare services to a neurosis of their culture. However, given the logic of N'taan be, such a conclusion will not only be hasty but also inappropriate.

Some scholars may argue that, unlike other living things, it is the prerogative of human beings to be able to exert choice. In other words, humans do not react blindly to external stimuli nor do they make decisions on the turbulences of life without reference to

"self-interest" or "self-gain". For this reason, it is often believed that human decisions are based on the maximization of rewards (gains) and minimization of costs (losses). For example, Homans (1967) suggests that, people are more likely to perform an activity (or do something) the more valuable they perceive the reward of that activity to be. In other words, before a human being deliberates whether to engage in an action or not to engage in an action, that human being considers, above all other possible considerations, whether it is in his or her best interest to do so or not to do so. While this is indisputable, it could be added that it is also the burden of human beings to be able to exert choice. Among the Manlarla, this latter philosophy appears to be a more compelling driving force behind actions. This is noticeable especially from the compliance with therapeutic interventions that are considered to be at variance with individual preferences.

We noted in Chapter 2 that a wife's status is primarily dependent upon her ability to perpetuate the continuance of her husband's patrilineage through bearing children. Under the circumstances, it appears realistic to say that a woman in Manlarla society would depend upon her children for status maintenance and enhancement. At the same time, Manlarla believe that the blessings of her children's paternal ancestors and deities are conditional upon her behaviour in a socially recognized marriage. This way, her children would depend on her for their prosperity and health. "Poriaga la anang veng ka O biiri yang la she is not worthy of a woman that is why her children are suffering" is a Manlarla household statement that summarizes the relationship between a woman's marital behaviour and the health status of her children. Therefore, in Manlarla society, a woman's decision (or action) to use THS or MHS, or her decision (or reaction) to comply with the type of healthcare service recommended for her illness is more likely to be located and understood within this framework of complex

interlocking reciprocity of blessings and status. One "secondary" widow confirmed this when she said, "M'biire yela mang mang sagi it's for the sake of my children that I comply". As noted before, an individual's life is considered empty without Biire children who are the Puore deme continuing generation. Undoubtedly, therefore, if children constitute a valuable asset for any mother or father, their actions (or reactions) are more likely to be oriented towards maximizing the "pleasures of these gifts of Naa-Ngmen" rather than maximizing their "own" selfish gains.

It is stated in Chapter 4 that most offenses, including disregard for traditional authority (decisions of elders and supremacy of ancestors) and custom, are believed to provoke spiritual correction in the form of illness. We also indicated that such spiritually induced illnesses affect people (blood relations, especially children) other than the offenders. If children are such an important asset, it follows logically that their health will equally be the most precious thing a parent will ever want to secure for them. Thus, in Manlarla society, whether or not a person takes action to comply with a given procedure of illness behaviour, in addition to ritual control, will depend on the parents' desire to safeguard against inviting illness upon their children. Under the circumstances, it is logical to suggest that ritual participants with children will be more likely to comply for the sake of the health of their children than those participants without children. Similarly, ritual participants with young children (who we argued are most vulnerable) will be more inclined to comply than those with grown up children. These issues were not explored in this particular study. They could serve as hypotheses for future inquiries.

## 6.13 Conclusion

In this chapter, we set out to examine three issues. First, to determine whether or not there is a relationship between participation in rites of death and use of available healthcare services in Manlarla society. Second, if there is a relationship to determine the direction of this relationship. Third, to examine the mediatory role of respondents' socio-demographic characteristics in the use of healthcare services.

In terms of the first objective, we have established that use of healthcare services in Manlarla society is influenced by the ritual status of the patient. In other words, participation in rites of death, to a large extent, determines both the healthcare sytem (THS or MHS) to use and the "medical" practitioner to consult. We also noted that even though the use of THS increased after ritual participation, certain categories of ritual participants are more predisposed to THS than others. For instance, we noted that Traditionals are more predisposed to use THS than non-Traditionals. Similarly, females, non-literates and the widowed were all found to be more predisposed to THS than their males, literates and non-widowed counterparts.

Among the Manlarla, whatever is hidden is highly valued and/or considered more serious since the most powerful and effective entity (God) is secret. For instance, the invisible spirit world is considered more powerful and effective than the natural and human worlds. Similarly, supernaturally-induced or caused (hidden) illness is conceptualized as more serious than naturally-caused (open) illness, while supernatural remedy is considered more effective (satisfying) than natural remedy. This secret/open dichotomy thus provides structural support for the hierarchical organization of Manlarla society in which the supernatural ranks above the natural, men above women, the old above the young, chiefs above commoners, initiates

above non-initiates, the dead above the living, and ritual participants above non-participants. Manlarla believe power depends upon knowing more about and having more control over others and not being known and controlled by them. Thus, relationships between subordinates and superordinates are felt to necessitate the latter having greater knowledge and more control (authority) than the former.

We noted that as people become ritual participants they frequently act in ritual. They become more knowledgeable as they begin to think more deeply about the beliefs of their society than non-ritual participants. More knowledge goes with more authority, authority that is sanctioned by tradition and sustained by customs. Implicit in all this is the notion of dialectical interaction between sociocultural processes and individual action. Individuals are seen to act out behaviours in Manlarla society. But they do not do so in a vacuum. Rather, they act within the context of a structure or organization of reality. The chapter that follows examines this structure or organization of reality within which the meaning of utilization decisions and behaviours of ritual participants can be contextualized.

# CHAPTER 7

# ANALYTICAL INTERPRETATION OF UTILIZATION DATA

***Understanding is the basis for all interpretations and since understanding is co-original with existence, it is present in every act of interpretation. Interpretation is then the mode of discourse that functions at the intersection of two domains, metaphorical and speculative. It is a composite discourse, therefore, and as such cannot but feel the opposite pull of two rival demands.*** **(Paul Ricoeur, 1977:303)**

## 7.1 Introduction

In Chapter 4 we discussed some aspects of Manlarla social-ritual processes with implications for health and health seeking. In Chapter 5 we made attempts to take the discussion away from general scenarios to specific issues by concentrating on a description of the ritual transformations of participants of funeral rites, transformations purported to enhance health by reducing pain and facilitating reintegration. However, we argued that such ritual transformations not only facilitate adjustment to the loss, but also nurture ritual control mechanisms which, in no small way, inhibit the use of MHS by ritual participants. This "double-edged face" of the rites of death at first glance appears to present a contradiction, a contradiction which, in times of illness, engenders an "internal" conflict that makes interpretation of the situation difficult for most patients in Manlarla society. As one widow metaphorically put it, "Fo ba mang bang ka fo na de fo saa bii ka fo na de fo ma you remain indecisive whether to pick your father or to pick your mother". It is a contradiction between the desire in many individuals of a preference for MHS and in their sense of obligation to maximize group solidarity.

Whether or not an individual ritual participant is indecisive about what to do in times of illness, the therapy management group that is traditionally responsible for and remains in control of the situation (with blessings from the invisible powers) is never in doubt as to what to do. In such "cultural scenarios" where beliefs and norms set terms for regularities of behaviour for all, the individual is subsumed to the collective, just as the personal is subsumed to the social. The same is true about the individual and the personal in Manlarla society. Many other African peoples are observed to practice the same level of existence and communal identity. For instance, Nzimiro remarks of the Igbo of Southern Nigeria that, "to exist is to live in the group, to see things with the group, to do things with the group. Life is not an individual venture" (1965:119).

Human behaviour (such as service utilization) in societies of this nature will most likely exhibit the properties of the community, though sometimes the subsumption manifests in a contradiction between individual preferences and normative behaviour (group expectations). The case of Manlarla ritual participants, as depicted in Chapters 6, clearly illustrates this point. In that chapter, we tried to establish a statistical relationship between ritual participation and utilization of healthcare services by using data from 60 ritual participants. We also pointed out possible and/or probable causes of inter- and intra-gender variations in the use of available health services.

In this chapter, we shall offer an explanation for the paradox broached in Chapter 1 within the context of utilization data arising from Chapter 6. In other words, we will provide a synthesis of the thesis that Manlarla search for health through funeral rites and the anti-thesis that ritual control of participants of death rites results in low utilization of MHS. This is accomplished by examining the social basis of both the thesis and anti-thesis. While doing

so, we shall, simultaneously, be dealing with areas of conflict and congruence between the traditional cosmology of the Manlarla and the gradually but steadily "usurping" modern world view, between traditional health culture and modern "scientific" health culture, between local practitioners and localized professionals. In short, the chapter attempts to weave an understanding of the varied interpretations for "the same phenomena". Understanding and interpretation are not only fundamental modes of human's being but, as Paul (1955) suggests, they also constitute the life-blood of health programmes such as the PHC which is currently "underused" in Manlarla society.

## 7.2 Significance of Rituals for Health care Consideration

Max Weber defines the discipline of sociology as "a science which attempts the interpretative understanding of social action...to arrive at a causal explanation of its course and its effects" (1947:88). Implied in this definition are two important issues. First, that social action (such as rituals and utilization behaviour) means action to which the individual attaches subjective meaning. Second, that the sociologist, while looking for causal explanations, is directed to interpret empathetically the meaning of the situation from the view of the subject. Within this framework, sociologists study how subjective definitions of social reality are constructed and how this reality is experienced and described by the social actors (Fisher, 1986; Eyles & Donovan, 1990). It is in this respect that Strauss (1959) suggests human beings create their social world.

In the sociology of health and health care, this paradigm or perspective of examining phenomena was stimulated by Lemert (1951) and solidified by Freidson (1970, 1979) into what is called "social labelling" or the "societal reaction" theory (Mishler, 1981) or the crisis

model of illness (Gerhardt, 1989). Akin to this model is what (Gerhardt, 1989) calls "negotiation", a paradigmatic position best exemplified by the work of Anselm Strauss. This model focuses on "social reaction" with the *proviso* that negotiation universally constitutes the social order (Strauss, 1978).The sociological problem to be understood and explained in this situation, as Weber (1968) suggests, is the meanings that individuals see in the actions of themselves, of others, and of institutions. Applying this to the sphere of medical sociology, Conrad and Schneider explained that "we cannot understand illness experiences by studying disease alone, for disease refers to the undesirable changes in the body. Illness, however, is primarily about social meanings, experiences, relationships, and conduct that exist around putative disease" (1983:205).

We illustrated in Chapter 4 that every traditional Manlarlo is convinced of the existence of three distinct but interdependent worlds: the supernatural, the natural and the social. In certain respects, the supernatural and the natural worlds differ from the social world. As analyzed in Chapter 4, both of them are perceived to be more powerful than the social world because they nourish it materially and guide it spiritually. Similar, although not identical, differences are conceived between the supernatural and natural worlds. In spite of these fundamental differences, Manlarla do not conceptualize these worlds as watertight or compartmentalized domains, but as "arms" of a single purposeful universe. Similarly, Manlarla view individual illness and health as a product of these worlds. For instance, the individual (as a natural entity) is composed of many physically (bodily) vulnerable parts, each serving different functions. In scientific terms, we will say the individual is a biological organism whose malfunctioning may be due to a "disease" of one or more parts. In addition, the individual is both a psychological system and a social being.

In Chapter 4, especially in Figure 4.2, we illustrated Manlarla's belief in the functional unity of the natural, utilitarian world with the supernatural (deified), unchanging world. This functional unity is expressed by them in the proverb: "Gorr mang peki la diri ka diri meng peki gorr the left washes the right and the right washes the left". Whatever exists in the visible, material world, they believe, has its counterpart, equally real, in the invisible, spiritual world. This principle of interdependence is the *terra firma* of Manlarla world view within which their ritual organization, especially the rites of death, is given prominence.

According to C. Kraft, a world view "is the central systematization of conceptions of reality to which members of the culture assert...It lies at the very heart of culture touching, interacting with and strongly influencing every other aspect of the culture (1979:53). From this definition, we see both objectivity (structural determination) and subjectivity (agent/choice determination) at work. Objectively, a world view is independent of any individual member of a culture, while subjectively, it only becomes a world view when it is internalized by the constituting individuals of that culture. As K. Jaspers summarizes, "what is ultimate and total in man both subjectively as life experience and power and character, and objectively as a world having an objective shape constitutes a world view" (1972:1-2).

Manlarla world view is simply how they see and interpret the universe and the various phenomena in which it manifests itself. In terms of health and illness, this implies what the individual *Manlarlo* senses as the attitude of the external realities of nature and society as well as the attitude of the supernaturals (gods, spirits, and ancestors) to him or her. We illustrated this relationship in Chapter 4 Figure 4.1. This perceptive notion of the universe and interpretations of inherent phenomena are not unique to the Manlarla of Ghana. John Mbiti observed that:

> For the African peoples, the invisible world is symbolized or manifested by the visible and concrete phenomena and objects of nature. The invisible world presses hard upon the visible: one speaks of the other, and African peoples "see" that invisible universe when they look at, hear or feel the visible and tangible world (1969:56).

This conception of the universe or world view by traditional Manlarla, though an important determinant of health care behaviour and medical efficacy, remains a silent "opponent" of the modern "scientific" world view. In other words, the scientific world view and its associated medical assumptions and practices tend to disregard the "popular" and folk medical traditions of the Manlarla. For instance, one traditional health professional, Sayibu, said "A gomina neng O bibiire ba bang ka te bebe the government and its organs (PHC included) are unaware of our existence". By this statement, Sayibu is not implying that the State and its health care apparatus are unaware of traditional health care practices. Rather, he implied that recognition is not given to their practices at the appropriate levels of PHC implementation.

To add insults to injury, Chief Woli said, "localized health and health related workers are trained to understand and view our health notions as false and superstitious". Their professional task then, as Obeyesekere said, "is imparting true and scientific knowledge to 'ignorant villagers'" (1979:20). Consequently, they often find themselves unacceptable to Manlarla traditional patients. It would be recalled that, in Chapter 1, discussions between the writer and the DOH in the UWR yielded such statements as "the communities are difficult" and "the people don't come". Respondents, however, appear to express views which go beyond the DOH's comments. For instance, a male respondent in his mid-40s said: "Kuong dang ba poo do tanga water has never flown up-hill"; and a 33 year female said: Fo ba buoro zima duoro daare you never look for fish by climbing trees".

These two illustrations are indicative of the type of health care system that Manlarla

will turn to for medical assistance or healthcare. A wrong turn, for them, is as meaningless and unproductive as the illness itself. Indeed, while living as a child among the Manlarla in the late 1960s and early 1970s, I used to hear people make reference to hospitals as "points of exit", "departure houses", and so on. As one respondent aptly put it, "only patients who wanted the shortest route out of this world went to hospitals". Implied in these views is that Manlarla do not consider most of their illnesses as problems for modern "professional magic". This is because they have a different notion or perception of illness causation. This conclusion parallels Wellin's (1955) observation about water boiling education in Peru. He said:

> A trained health worker can perceive "contamination in water because his perceptions are linked to certain scientific understandings which permit him to view water in a specifically conditioned way. A Los Molinos resident also views water in a specifically conditioned way, between him and the water he observes, his culture "filters" in...other qualities that are as meaningful to him as they are meaningless to the outsider (Wellin, 1955:100).

An important thing about all this is that, culture and world view are closely related concepts, a Siamese relationship that makes an analysis of one to the exclusion of the other very difficult. Smelser, for instance, suggests that "cultural patterns - including values, world views, knowledge, and expressive symbols - supply systems of meaning and legitimacy for patterned social interaction" (1967:690). Having said that, it seems plausible to conclude that peoples' world views pattern their culture which, in turn, determines their behaviour. In this regard, culture is, indeed, the learned patterns of thought and behaviour characteristic of a population, society or community. In other words, a community's *repertoire* of cognitive, emotional, and behavioural patterns constitutes its cultural foundation. Influenced by this definition of culture, Weidman defines health culture as "all the phenomena associated with the maintenance of well-being and problems of sickness with which people cope in traditional

ways within their own social networks" (1975:313). Health culture refers to the norms for and/or standards of health behaviour as well as the ideologies justifying or rationalizing the selected behaviour.

In the case of the Manlarla, health culture encompasses both their cognitive and social-system aspects of health seeking behaviour. Cognitively, this includes their health values and beliefs, guides for health actions and the relevant folk theories of health maintenance, disease etiology, diagnosis, treatment and prevention examined in Chapter 4. On the other hand, the social component refers to those structural-functional aspects of health related statuses, roles and sociocultural processes inherent in the collective social unit as detailed in Chapters 2 and 5. These statuses, roles and processes, this writer argues, are more influencial in utilization decisions of ritual participants than economic accessibility and geographic proximity. This is by no means a novel discovery. Saunders (1954) noted a similar relationship between cultural processes and hospital utilization among American-Mexicans.

> Suppose a doctor wants a Mexican-American woman to enter the hospital but her husband, whom she has been taught to obey, tells her to stay out of this strange, fearsome place and stay home and take care of the children. What does she do? As a good wife, she does what her husband tells her to do. To scold the husband is useless, he must be persuaded that his wife needs to enter the hospital (Saunders, 1954:76 emphasis mine).

Of relevance for our analytical purpose is that this Mexican-American couple, like the Manlarla ritual participants we have been examining, cannot be entirely held responsible for their actions. That is, it will be unrealistic to hold these "victims of cultural circumstances" irresponsible because as Ruth Benedict observed:

> The life history of the individual is first and foremost an accomodation to the patterns and standards tradition handed down in his community. From the moment of his birth the customs into which he is born shape his experience

> and behaviour. By the time he can talk, he is the little creature of his culture, and by the time he is grown and able to take part in its activities, its habits are his habits, its beliefs his beliefs, its impossibilities his impossibilities (1971:3).

In Chapter 2, for instance, we examined the orderly, patterned and enduring relationships that hold Manlarla society together. These orderly formations or social facts, as Durkheim (1951) calls them, exist in their own right, *sui generis*. They are objective, eternal and thus not available for change at the whim or caprice of any particular individual(s). Within this constraining schema in Manlarla society, like in every other social system, are countless number of statuses, roles and processes. In conventional sociological theory a status may be ascribed or achieved. An ascribed status is assigned to an individual regardless of personal merit. They are normally fixed by birth and/or by inheritance. Among the ascribed statuses are those of race, ethnicity, and sex. Achieved status, by contrast, is associated with either "personal" achievement or "personal" failure. These are "earned" social positions which include educational and most occupational positions. For instance, being a medicine man or woman, a husband or wife, a professor, an assembly man or woman, or an ex-convict is an achieved status.

For purposes of this study, however, a third type, imposed status, must be distinguished from the other two. Imposed status is neither ascribed nor achieved. It is neither fixed at birth, inherited nor earned (through success or failure). Rather, these statuses are social-spiritual in nature and are imposed on individuals by fate (as in death). These statuses include widow/widower (at the death of a spouse), orphan (at the death of a parent), or heir (at the inheritance of a kinsman's widow). Associated with these statuses are sets of behaviours (social-spiritual roles) that the respective incumbents are expected to play or act out. A social-spiritual role, therefore, is the expected behaviour associated with a particular

social-spiritual position in a particular social-spiritual system. According to R. Linton,

> A status, as distinct from the individual who may occupy it, is simply a collection of rights and duties...A role represents the dynamic aspect of status. The individual is socially assigned to a status and occupies it in relation to other statuses. When s/he puts the rights and duties which constitute the status into effect, s/he is performing a role (in Turner, 1974:157-158).

Among the Manlarla, the death of a husband (or wife) leaves the surviving spouse occupying a social-spiritual status, widow (or widower). As a widow or widower, albeit an imposed status, the incumbent is expected to play a corresponding social-spiritual role within the social-spiritual system. Nobody will doubt the importance of spiritual-roles in Manlarla social system after an examination of their world view. For instance, through the effective playing of social-spiritual roles a great deal of interaction is ordered and, to some extent, social presentations become predictable. In other words, these roles legitimate social order and provide for social integration. However, these statuses and roles can and, do indeed, sometimes generate problems, the most frequently experienced being status inconsistency (Smelser, 1967) and role incongruence (Homans, 1967).

Status inconsistency implies "a situation where an individual's position on one social hierarchy does not match his (or her) position on another social hierarchy" (Smelser, 1967:256). In this particular case, status inconsistency will arise when the spiritual statuses of ritual participants in the social-spiritual hierarchy do not match with their positions in the health hierarchy. Ritual participants, as noted in Chapter 5, are part human and part spirit. As spirits, they are not expected by society to become easy victims of natural and social environmental "pressures". Thus, to be labelled sick is to be inconsistent with the social-spiritual status, an inconsistency that can only be mediated (diagnosis and treatment) by a spiritual (ritual) expert. Such spiritual experts are not to be found within the "scientific" walls

of scientific PHC structures. Rather, they are to be located within the walls of what is often termed by localized health professionals as traditional myths and superstitions.

Role incongruence may arise from either status inconsistency or status incongruence (Homans, 1967:59). In either case, role incongruence involves an instance where roles played by incumbents of social positions are inconsistent or incongruous with normative behaviours of those positions. For example, respondents emphasized that the incumbents of social-spiritual statuses [widow(er), orphan, heir or family head] are expected by society (as prescribed by tradition and custom) to avoid unnecessary curses and quarrels, to observe necessary taboos, to make prescribed sacrifices, and to perform appropriate rites. However, not all incumbents of these positions have the capacities and resources of fulfilling their ritual obligations without error. Such ritual errors or role inconsistencies, aside from the psychological tensions developed in individuals committing them (Lenski, 1966), are strongly believed by the Manlarla to generate illness (or even death) in other members of the social unit. These types of illness obviously have a supernatural etiology, an etiology which localized professionals of PHC with scientific gadgets, unable to verify, simply classify as mystical and unworthy of any further commitments.

The conventional reality in Manlarla society is that ritual participants constitute a distinct and major social-spiritual group. As a social-spiritual group, there are certain behavioural expectations that are prescribed to its members. These expectations define for them appropriate and inappropriate behaviours and guide their interaction with the rest of the "world" (in its material, social and spiritual existence). Thus, these norms and expectations of the ritual group are not only internalized by ritual participants, but they are also routinized in conformity with the social norms and cultural "values" of the entire community or society

as the case may be. Decisions and behaviour of these people are, therefore, defined or channelled by a multi-level system of influence and confluence as illustrated in Figure 7.1.

Within the micro-level of the figure, for instance, individual ritual participants may have different models of reality , values, knowledge and preferences among others. But we argued in Chapter 5 that ritual participants are also both ritual and social agents. As ritual agents, they represent the spiritual world and receive and carry out ritual instructions and obligations on earth (the human or social world). As such, rule systems for decision making, social action, and self-transformation exist for them as individual ritual participants and also as a ritual group. As social agents, they are still part and parcel of the larger unit (society - macro-level) and so are subject to its general social norms, beliefs and concepts of reality, and cultural values (institutional and cultural formations). These macro-realities of corporate existence manifest their aggregate effects on such variables like social integration, divine intervention, existential certainty, and social control as explained later in this chapter.

Cultural values are indigenous constructions of preferred, desirable and worthwhile ends in social actions, relation and being within a defined social structure. "Structure", as analyzed in Chapter 2, refers to the relationships among cultural categories and units in society exhibiting properties of continuity, transformation, reciprocity and replacement. The processes identifying the relationship between cultural values and social structure within the context of an actually functioning society are crucial to a successful PHC programme. In examining the world views and health cultures of Manlarla society, therefore, the essential issue is not to assert what is scientific or unscientific, what is good or bad, what is appropriate or inappropriate, what is true or false. Instead, we should aim at revealing what is congruous and incongruous, peculiar and different, consistent and explanatory. For what makes their

world view which, in turn, determines behaviour (such as utilization of services), cannot be located in individual units but in the collective attributes of their "society" such as the interaction settings.

Within the framework of our multi-level system for decisions and behaviour, the interaction settings constitute the meso-level, which manifests at two sub-levels: interaction processes and social action. The Manlarla health care system, to paraphrase Evans and Stoddart, "combines the functions of thermostat and furnace, interpreting its environment (interacting settings), determining the appropriate response (action), and responding (acting)" (1994:34). The character of response is determined by the "paths" to care that the society has designed and provided for the different strata of its members and for the different illness classifications inherent in it. These paths depend on the availability of both physical resources (health care institutions, personnel, quality and costs of care) and social resources (sociocultural systems - such as social rules and procedures, social opportunities and constraints - that determine which patients are qualified for what physical resources under certain conditions). Given the case of Manlarla ritual participants, it can be argued that the social resources have primacy over the physical resources. This is, perhaps, the case because social resources, which generate cohesion and sustain social integration of the corporate group, must be appropriately distributed.

### 7.2.1 Social Integration

All societies develop stories about the way the world works. M. Mead once remarked: "humans will have their cosmic stories as surely as they will have their food and drink" (in Swimme, 1987:83). The "stories" that dominate interpretation of reality in any society are

thought of as sets of cultural lenses which provide the structure for meaning and social action. Any changes in this structure of meaning and social action distorts aspects of this reality and may even lead affected people "astray" without corresponding reinterpretations. For instance, we noted earlier in the chapter that disruption of familiar reality and/or meaning can sometimes generate stress for the "victims". We also learnt from the Manlarla that funerals are organized partly to incorporate the dead among the ancestors and partly to re-integrate the bereaved within their communities. Against this understanding, it could be said that funeral rites are, therefore, communal and/or public activities of protective value against possibilities of spiritual alienation or rejection for the deceased and social isolation and stress for the bereaved.

In Manlarla society, if a woman loses her husband, a familiar pattern of relationships has not only been disrupted, but it may also provoke a fundamentally ambivalent reaction in the widow. For instance, her will to adapt to the change in status has to overcome an impulse to restore the past. In other words, the need to sustain familiar attachments and understanding, which make life meaningful, is as profound and important as the will to adapt to the change in circumstances. "There is no Wahala stressor as devastating as this ambivalence", one female respondent emphasized. Whether this crisis of disorientation affects only an individual, a group, or society as a whole, it has a fundamentally similar dynamic - conflict between contradicting impulses - to return to the past, and to forget it altogether. This is by no means an easy adjustment process. As Msgr. Kyemaalo told me in a private conversation, "it calls for a reweaving of new strands of meaning tying the past, present and future together to ensure effective reintegration and cohesiveness of the social unit".

From this perspective, the foundations of integration in Manlarla society cannot be

based on fluctuating emotions. Rather, it appears reasonable to look for them in more abiding factors such as group values and social goals. Essentially, we have argued that the central goal of the Manlarla is ensuring equilibrium and internal homeostasis of the overall system. Their aphorism, "N'taan be mang be colleagues' existence defines my own existence" or to put it more philosophically, "We are; therefore, I am" introduced and explained in earlier chapters summarizes it all. In Chapter 2, for instance, we identified individual existence with corporate existence. In other words, we noted individuals are simply part of the corporate group that "makes, creates and produces" them. Such collective comprehension and interpretation of reality are the main-springs that motivate and inspire Manlarla and integrate them within their communities. For instance, a family head may have to subsume "all" his interests and aspirations under one goal: fostering and maintaining order and harmony among members within his sphere of influence.

Just as the norms define or specify actions and refine behaviours that are needed to accomplish group goals, so does the accomplishment of group goals shape self-conception, define identity, refine the individual and enhance human dignity. Identity (or identifying) with a group, therefore, as Matthews (1983:24) suggests, is an important basis for commitment to corporate values and goals. Thus, the individual identities of ritual participants in Manlarla society are tied with the corporate identity in a socially constructed manner (Matthews, 1983:22). Identifying with the group brings pressure to bear on ritual participants to conform to the rules and obligations of their status vis-`a-vis the group and its corporate goals. That is, members or "action units" of the system are regulated by consensual aspirations or "central values" and "universal orientations" (Parsons, 1951). Against this order of things, the Manlarla are able to achieve concerted action and facilitate group life.

Undoubtedly, the above analysis suggests that shared beliefs, common interests (or goals) as well as the dominant ideology or cultural lens in any particular society will be an important determinant of what goes on in that society. They are particularly important in the development of a sense of solidarity and belongingness in times of life crises such as illness. In developing a sense of solidarity, people need to be reassured that they are worthwhile and that they are not alone in their agony. This is illustrated by the Manlarla expressions "Poryeni bie ba dire dogee one woman's child doesn't suffer" and "Ninyeni ba biere baalong an individual is never sick". With this understanding, individual patients (with few exceptions) in Manlarla society are neither left alone nor held entirely responsible for their ailments or disabilities. Manlarla therapeutic arrangements and procedures, as illustrated in Chapter 4, are attestations of this point. These processes do not recognize individual patients as personal failures. Rather, they are, in many respects, considered as "agent-victims" of disharmonious relationships of a more wider dimension that can only be restored through divine intervention.

### 7.2.2 Divine Intervention

Manlarla traditional religion can be defined as a cultural system that governs and directs life in their society. However, it is now being challenged by the Christian and Islamic religious belief systems which were introduced to the people from "abroad". Despite the fact that these new religions are gaining firm grounds in certain communities of Manlarla society, the traditional religion still occupies a fundamental position and is still very influential in Manlarla cultural and social life. For instance, we noted that the "laboratory" of the ethnographical descriptions carried out in Chapters 4 and 5 are divinations, prayers, sacrifices, petitions, offerings and purifications among others. These rites contribute to our

understanding of the processes involved when Manlarla wish to solve social problems such as death and illness. In Chapter 4, for instance, we came across Manlarla's use of the Kpiintige ancestral altar to communicate lineage affairs to the ancestors. During these rites they also request for peace, fertility and above all health for the living lineage members. Through this ritual communion, the ancestors remain in intimate contact with their descendants.

Manlarla believe that such ultra-human entities like the ancestors, spirits and deities are representatives of Naa-Ngmen. We underscored this in Chapter 4 and also established a direct (or indirect) cause-and-effect relationship between human disability or illness and Divine will. In the same chapter, we noted popular Manlarla names such as Mwinsage God wills or permits, Mwin-nie God's person, and Venkomwine leave it to God. Consistent with all these is the conviction that God's interaction with "believers" and His intervention on behalf of the weak constitute a fundamental organizing principle. To substantiate this conviction, one male Christian respondent quoted from the Bible: "If you will diligently hearken to the voice of the Lord your God, and do that which is right in his sight, and give ear to his commandments, and keep all his statutes, I will put none of these diseases upon you, which I have brought upon the Egyptians: for I am the Lord your healer" (Exodus, 15: 26). Analogous direct effects of divine judgements on the disobedient or unworthy in Manlarla ritual are evident in deaths deemed unfit for normal rites or people suffering from "incurable" illnesses. Evidence of this is also observable in the sacrificial citation of traditional Manlarla and the burial pledge of Manlarla Moslems. The central purpose of Naa-Ngmen in all these instances is in accord with His will to order the universe and salvage human beings in general and His "own people" in particular

It is against this background of order that the Manlarla locate illness. Illness is that

which is "wrong" or out of order with ordained order. The linkage between illness and "wrong-doing" is so explicit among the people that one should not only look for "herbal inductions", but should also purify the heart (soul) by offering generous sacrifices in order to regain divine favour. This reveals the moral implication of ill-health in Manlarla society. People are sick because they (or others) have gone wrong or erred in their interactions within the universe as ordained. Put differently, human action of some kind "causes" illness. Within this schema, Chief Woli said, "for us traditional Manlarla, divination to know where we are wrong and sacrifice to appease the angered deity or spirit constitute the heart and soul of our religious faith and cultural identity'. In other words, remove divination and sacrifice and the traditional religion and culture are almost emptied of their contents.

Considering the central place of religion in Manlarla conception of health and illness, we should, then, have no difficulty in understanding why divination is such a necessary process in the discovery of "hidden" causes of illness, and prayer and sacrifice essential for the efficacy of healing. If there is significant relationship between illness and wrong-doing, then there should be another link between healing and the forgiveness of wrong-doing. This is why Manlarla (Traditionals, Christians and Muslems alike) strongly believe that while humans may cure patients, Naa-Ngmen heals them through forgiveness. Even though I noticed differences (in faith) as I moved from one religious expert to another, evidence about healing from the three religious persuasions indicates a combination of material consumption (such as herbal potions) and spiritual fulfilment (such as prayer and sacrifice). That is, divine action, either directly or indirectly (through intermediaries), to heal the human patient is shared by all Manlarla. Consequently, it could be concluded that the ultimate health of the Manlarla resides in their orientation towards transcendental and invisible powers.

However, "all too often...these cultural beliefs of patients are viewed by orthodox providers of care as irrational or superstitious, negative, and as a symptom of ignorance. They are, therefore, not taken into account in diagnosis and treatment" (Weidman, 1979:137). In Ghana, for instance, some localized professionals located at various levels of the PHC structure refer to indigenous medicines as "native poisons", and sometimes patients, brought to their health facilities with evidence of having taken indigenous remedies, are sent back home without treatment. A respondent lamented this when she said, "Ka foo wa ta asibite ba mang soro la zie fo nang gaa te de tiin kye bara bong nang era fo at the 'hospital' they ask where you've been for treatment and not what is wrong with you". Even some western trained Ghanaian medical academics express similar embarrassment and misgivings about indigenous healers. For example, the head of the department of medicine and therapeutics at the University of Ghana Medical School ever stated that:

> ...indigenous/traditional medicine...is fundamentally based on primitive theories which over the years have been condoned by ignorance, sanctioned by superstition, and sustained by belief in magic and witchcraft. Under such circumstances, even the rational use of effective therapy is frequently ascribed to be supernatural guidance or intervention (Dodu, 1975:5).

Many of these negative attitudes about THS are based on developments and writings of 19th century social and medical philosophers. For instance, while Spencer (1896) generated the concept of the "primitive" or "savage" and of the "primitive mind", Descartes (1967) helped to lay the foundation for medical science by separating the mind and the body. Such "alien" orientations are obvious constraints in accounting for the significance of procedures and processes in everyday life of traditional Manlarla, orientations E. Evans-Pritchard condemns as unpardonable scientific mistakes. He said:

> It is ...a mistake to say that "savages" (traditional people) perceive mystically or that their perception is mystical (or superstitious). On the other hand, we may say that savages pay attention to phenomena on account of the mystical properties with which their society has endowed them, and that often their interest in phenomena is mainly, even exclusively, due to these mystical properties" (in Jenks, 1993:42 emphasis mine).

The argument presented here is that positioned in-between policy makers and recipient communities such as the Manlarla, the deliverers of primary health care, knowing little of either, are unable to serve as effective cultural mediators or brokers required by the PHC programme. The perspective of the PHC officials, far from encompassing either the national policy or rural reality, is shaped largely by the professional and bureaucratic environments in which they work. "They embark on 'missions' of PHC with their own perspective of what is essential in healthcare services (Willms, 1984). As such, PHC instead of being a community "supportive" rather becomes a community "oppressive" programme as it undermines their existential reality.

### 7.2.3 Existential Reality

Quite evident in our study of the Manlarla society and thus worth noting is how existence is understood and interpreted by the traditional and modern healthcare systems. "Existence" comes from the Latin root *ex sistere*, which means literally "to stand out", to emerge. Everything from an ant to the `zombie' "stands out" from being in general to the extent that it has individual existence. In the context of the study, discussions in this domain have ranged from the theory of ritual identity and body-soul relationship to the immortality of the soul, from personal and collective immortality to the problem of the ultimate reality, Naa-Ngmen. Manlarla interpretation of existence and the corresponding behavioural patterns

appear to stand in direct contradiction and/or confrontation with the tradition perpetuated by PHC professionals in their society.

Consistent with this mode of thought, Manlarla folk medical practice rests upon a foundation of beliefs about life in its material, social and spiritual dimensions. These beliefs are shared by all and inculcated at a very young age through socialization. For instance, materially a medicine man or woman cures a particular natural reality called Bierong disease and thus answers the clinical question "How" a patient becomes sick. Spiritually, however, it is Naa-Ngmen that heals and restores the patient and his or her network of complex social-spiritual relationships to a functioning equilibrium. These healing and restoration acts are possible only after the "Why" question of the sickness has been answered and the appropriate sacrifices and purifications performed (or at least promised). To be successful in meeting the expectations of Manlarla society and patients, therefore, medical practitioners must provide both an answer to the "Why" and an antodote to the "How" a patient is ill.

Since the THS reflects the natural, social and spiritual taxonomy of disease causation, so must the methods for dealing with them. Naturally-caused illnesses are considered appropriately treated by either the local popular health sector (if illness is considered not life-threatening) or at the MHS (if perceived to be serious and/or life-threatening). Manlarla traditional practitioners appear rarely successful in the second because their training and experience do not equip them enough to provide answers to the clinical question "How". Modern "scientific" medicine is believed to be strong here as acknowledged by 72% of respondents. On the other hand, supernaturally-caused illnesses are considered appropriate for religious and/or spiritual experts. Here, traditional practitioners appear more successful because their training and experience equip them to provide a ready answer to the spiritual

question "Why". Supernaturally-caused illness with clear physical or clinical manifestations is recommended for treatment at the level of both spiritual experience and scientific expertise as demonstrated by the overlapping (shaded portion in Fig.8.1) of the two healthcare systems.

In Chapter 1, we noted that most scholars on utilization determinants frequently show accessibility to Western medicine significantly determines whether or not it is utilized. This implies that if a PHC facility (clinic or hospital) is more than a few miles away, mothers may be unwilling to walk a sick child on her back or a husband may be unwilling to pedal a bicycle with his wife on it (Zeller, 1975). It is under such instances, they contend, that traditional practitioners are consulted. Our study among the Manlarla tells a different story. Traditional health practitioners are consulted on the basis of the perceived cause of illness and on their pre-eminence insofar as ritual participants are concerned. For Manlarla ritual participants, there is no other practitioner that surpasses their own traditional practitioners as the point of first contact and, therefore, of "social control" (Parsons, 1951).

## 7.3 Social Control: The "Contradiction"?

Social control refers to the techniques and strategies for regulating human behaviour in any society (Roberts, 1986). Among the Manlarla, there is always the conscious or unconscious aim of reworking experiences of previous relationships, such as death and illness, in which security and mutuality are damaged. The structural arrangements and institutional set-ups examined in Chapters 2 and 4 illustrate this point. We noted, for instance, from their organizing perspective that these social structures and institutions, and inherent relationships all stand for social continuity and cohesion. And since they embody the notion of the supremacy of the dead (the invisible world) over the living, we could say that they all function

to preserve the product of earlier experience in the face of modifying influences of more recent history. In that case, they are to be seen as bearers of traditions, agents of social stability and, above all, mechanisms for social control.

Their embeddedness within beliefs about and rites of death, for instance, serve to regulate and constrain the behaviour of individual ritual participants. As E. Gellner put it, "...beliefs are themselves, in a sense, institutions amongst others; for they provide a kind of fairly permanent frame, as do other institutions, independent of any one individual, within which individual conduct takes place" (1974:115). In some respects, these beliefs may facilitate good physical health, positive familial and interpersonal relationships. For example, the dos and don'ts of Manlarla rites of death are such that they generally prevent participants from indulging in behavioral tendencies and lifestyle choices that ultimately are stress inducing. In this study, two distinct mechanisms within ritual performance were identified to be especially important in regulating these aspects of personal conduct.

First, individual ritual socialization results in the internalization of ritual norms regarding lifestyle choices and personal conduct. Thus, the prospect of violating these deeply held values induce feelings of psychological and even physical discomfort. This threat of alienation is strongest for persons who are enmeshed within social networks of co-ritualists. A widow, for instance, noted that "Porko-saambo mang ko la O bibiire aning O sira degri a widow's violation of a ritual code of conduct makes her orphan children and her new 'husband' impure". Impurity, as noted in Chapter 5, exposes people to the dangers of witchcraft and sorcery. Any person who exposes relatives to the dangers of witchcraft and sorcery is considered worse than a witch. Quite frequently, this role in family vulnerability is reinforced by a second set of regulatory encounter - the need to maintain the family "honour". As Weber

(1948) noted, deviants confront the threat of embarrassment, or diminished reputation and loss of social esteem in society. Among Manlarla ritual participants, this encounter extends to the other world, thereby, creating not only a condition of social separation but also a situation of spiritual alienation.

Manlarla rites of death also promote "collective catharsis" in ways that facilitate the reduction of tension and the release of emotional distress. They provide opportunities for the articulation and management of both personal and collective suffering. Through mourning dirges, for instance, ritual participants express their inner feelings without much inhibition. McGuire (1987) emphasizes that ritual language (such as demonstrated in dirges) and nonverbal symbolism ( as illustrated by Yaga) provide not only a sense of order and control but also a sense of personal empowerment that may be health enhancing. As stated in Chapter 5, funeral rites are inevitably occasions for summing up an individual's social personality by a restatement not only of the roles s/he has filled, but also of the general way in which s/he has conducted himself/herself during his/her lifetime. Funeral rites thus involve, directly or indirectly, the reformulation of social norms that serve as sanctions on behaviour.

The rites, as examined in Chapter 5, are multifaceted with each facet corresponding to a specific cluster of values, norms, beliefs, sentiments, social roles, and relationships within the total cultural system of the Manlarla "community". For example, a person in a period of "impurity" (caused by death) partially withdraws from society and is expected, among other things, to be soft spoken, control his/her emotions and avoid sexual intercourse. Some 57% of respondents indicated that failure to observe these rules can turn a person into either a sexual pervert or a neurotic syndrome (such as speaking or singing when s/he should not). What is important here is that these sanctions are cast in psychological terms. In other words,

the emotional stresses that may be generated by death are prevented by diverting focus from unpleasant individual experience to a complexity of community ritual behaviour.

From the foregoing it appears the traditional socioeconomic formation and traditional kinship-based social relations prevalent in Manlarla society provide for a safeguard against the emergence of problems. The customary social order, for instance, grants an existential minimum to every member of the society. It grants the satisfaction of individual basic psychological and physical needs, and provides for an artistic outlet and challenge to individuals' identity by supporting them in all their major life crises. However, certain problems are still evident in Manlarla society. For instance, sometimes there is discrepancy between the behavioural norms of the objectively recognizable Manlarla culture and the subjective life experience of the individual members. How are these contradictions addressed in terms of health and illness?

### 7.3.1 The Individual

The death of a spouse, a parent or a child, a brother or a sister produces stresses, strains and frustrations for the surviving relatives. Some of these negative products of death may leave physical and/or psychological imprints on their "hosts". Chapter 5 gave a detailed account of how Manlarla organize to restore smiles and hope in times of such crises. However, in Chapter 6 we observed that participation in rites of death can also produce similar negative trends. A case in point is the woman who lost her professionally evacuated baby because of her ritual status as a widow. For such physical human losses and the associated social-psychological consequences, one may question the appropriateness of such rituals. An examination of the appropriateness of such rituals is beyond the scope of the

present study. However, during the collection of data it was not uncommon to observe ritual participants of primary rites frantically yelling "Abobo mang meng kpe where do I also belong?", "N'meng ire wala what should I also be doing?".

The issue here is that weakened by fear, uncertainty and illness, individual ritual participants are immediately placed under strong pressure to conform to a variety of imposed schemas. No doubt, structural factors play a role in this. But ritual participants who become overconformists, one young orphan suggests, "are motivated by their own insecurity (about themselves and close relations) and the ensuing fears about the attitudes and opinions of elders and the invisible powers". Fear, as McDougall (1970) suggests, may make a human being conciliatory in his/her relations to others. This suggestion occasions no surprises in this study as we argued that individuals in Manlarla society are evaluated on the basis of how well they follow tradition and observe customary practices.

All societies rely on rules and regulations of behaviour for stability and for the maximization of health. However, when the rules and regulations become the most important structural source of security, individual liberty is compromised and their intent to advance health and human dignity is defeated. People who become overly concerned with rules of behaviour that are very rigid can have an obsession with "doing things by the rule". This may be seen as a kind of ritualistic personality syndrome (RPS). In this syndrome, conforming behaviour tends to severely limit personal initiative and individual determination of what is appropriate. Such is the case of ritual participants in Manlarla society where social accountability to community's "well-being" (as prescribed by tradition) takes precedence over personal responsibility for illness (as preached by PHC professionals). Under these circumstances, the real malady (low service utilization) is neither to be located in

unavailability of health care services per se nor in individual psychological proneness. Rather, it is to be accounted for in the chronic incongruence of health care cultures.

Rites of death, as the analysis so far suggests, alter social statuses and transform human consciousness. This other world of undisclosed realities (consciousness) is mediated by ritual specialists through diverse representational acts such as divination, purification and cleansing. The metamorphosis from non-ritual participant to ritual participant may be accounted as an act of either belief conversion or belief confirmation resulting from the sustained operation of a combination of social-ritual influences. These may include the following reasons: (1) fear and anxiety caused by death as evidenced in such ritual expressions as "Abobo mang ire what do I do?" and "N'ire wala what should I do?"; (2) guilt arousal arising from the death of a loved one expressed as "Bo mang e fo what did I do to you?"; (3) isolation from familiar social support as social rewards, feedback, information, and identity are all temporarily severed. Ritual participants express this in various ways including "O nang da bebe mangbe his/her existence was interwoven with mine", "Bo mang bang what do I know", "O nang da tonna N'nyovori he/she used to 'prolong' my life", and "N'yong la yaa, N'weyeng I 'm alone, I 'm wasted / finished".

But are the bereaved really finished? Not at all. When they were asked the meaning of these ritual utterances, 63% said they are expressions of the loss of "freedom" associated with death rites (the freedom to eat and wear whatever one likes, freedom to associate with anybody, and the freedom to use health care facility of one's choice when sick). Manlarla society and culture are clearly not individual-based but community-based. Thus, an individual so bereaved is never alone. As part of the corporate group, the individual's agonies and worries become the corporate responsibility. The corporate organizes for the bereaved's

reintegration. The individual in Manlarla society is subsumed within the requirements of the community. Similar observations have been made about most African traditional peoples. For instance, I. Nzimiro remarks about the Igbo of Southern Nigeria that, "to exist is to live in the group, to see things with the group, to do things with the group. Life is not an individual venture" (1965:119).

### 7.3.2 The Community

There is an unspoken myth among the Manlarla that whoever controls the spirituality or is the representative of the ancestors controls the earthly family. In other words, the person who represents the ancestors and makes petitions and sacrifices on behalf of the living has authority or power over other members of the family. However, the family does not just refer to those living members of the unit. The ancestors as well as the unborn are considered important segments of the family (see Chapter 2). As segments of the social unit, family, each segment (represented by their heads) has an important role to play in the social-spiritual system. For instance, by informing their descendants of the underlying relation between illness and socially disruptive behaviour or failure in a ritual obligation, the ancestors play a very important "medical" role in the social system. The living members, on their part, serve as a useful bridge linking the spiritually departed to the earthly unborn. Through this network of relationship, a comprehension of the mystical bond which forms the basis of the incorporative social (community) structure and relations described in Chapter 2 is furthered.

Consistent with this network of complex relationships is the conception that a "spoiled" or disharmonious relationship at any level of the community may cause a corresponding illness. That is, deviations in different kinds of social-spiritual relationships

cause different kinds of illness. Thus, the classification of causes of illness, as analyzed in Chapter 4, parallels the classification of social-spiritual relationships within the community. This is how illness is understood and managed among the Manlarla, an experience that provides examples of the many ways they search not only for wellness or health, but also for meaning to social-spiritual events (such as death). As illness is thought to result from a constellation of disturbed relationships within the community, the patient must be brought into "a fresh, dynamic balance to effect the cure" (Barasch, 1993:56). By contrast, the usual mandate of PHC professionals when confronted with a patient broken beneath the visible blows of life, as Barasch suggests, is to "patch it up and return it to the anvil" (ibid.:56).

The Manlarla of the UWR conceive of funeral rites as rituals of journeys, sometimes actual and sometimes virtual. In other words, the journey as a metaphor highlights the experiential and the reflexive nature of day-to-day living. In elaborate funeral rites, for instance, the community elders transfer the deceased's soul to its other-worldly domain while striving to reintegrate or resettle the bereaved on earth among their living relatives and friends. This lies at the heart of Manlarla ritual organization not only because death and "illness" are the most specific of misfortunes, but also because decisions about them involve "collective" discussion and determination. As one elder emphasized, "an individual may decide to become a Christian or a Muslem, but when that individual becomes ill or dead, it is his/her Baloo, kinsfolk (both dead and living), who determine how s/he should be treated".

The right of the Baloo to determine how the patient is treated is jealously guarded and periodically reasserted against PHC authoritarianism. The principal and regular field of social interaction among Manlarla comprises people they know, immediately and in a manifold way. Their social world is, therefore, predominated by "the person-to-collective and collective-to-

person" situations. Customary and kinship norms, social roles and rules are learnt within the context of this social interaction. The "rise and fall" or health and illness of an individual within the system depends on this predominant mode. But professional workers of PHC programmes preach the gospel according to Western scientific medicine and individual responsibility for health. It is quite clear that when rights or values of traditional authority are taken away, either through the erosion of the belief system, or worse still, the loss of trust in its control mechanism, social cohesion may be badly damaged and self-esteem "involuntarily" deflated. In this case, self-recrimination may sky rocket, while confidence in continuity and in oneself may plummet as the "family or lineage honour" is surrended.

Within the philosophical principle of "Ntaan be", the community defines what is right and socially appropriate, and produces adherence to these ideas through such techniques as social rewards, threats of punishment or ostracism, and various other pressures towards conformity. In other words, the community provides mechanisms for balancing and reconciling deviations and for the maintenance of healthy relations. Through these mechanisms, the community appears to behave like an "authoritarian democrat", providing for individual needs and, at the same time, depriving them of "real" choice. No physical compulsion is applied. Individuals are allowed latitude to choose between adherence to Dunnee nuong the collective good and Yong be baalong individual struggles (survival). However, the cultural mandates (morals, norms, customs, taboos and sanctions) of the community make "deviation" almost impossible if not unthinkable.

## 7.4 Conclusion

The chapter has been concerned with an interpretation of utilization statistics of ritual

participants in Manlarla sociocultural context. To be a human being is to be able to communicate with others in language and other common symbols, to have and share a sense of identity. To have and share a sense of identity is to share in common norms and values. In the case of the Manlarla (especially the ritual participants), we noted a strong sense of community, emphasis on immemorial custom and symbolic importance of the past, and primacy of the sacred. These tendencies and emphases make the society, the interactions and interrelationships communalistic, mechanical and traditional.

"Modernization" in Manlarla society has been accelerated in recent times and the focus of life and healthcare is gradually shifting towards "rationalism". Obviously, the traditional healthcare rituals are transforming but less strongly than may be assumed. The norms of behaviour are still mainly enshrined in traditional cosmology. The best way to act is the way Naa-Ngmen, the ancestors, iconic gods, religious experts and family heads have ordained, while guides to proper conduct are enunciated in proverbs. Legitimacy of healthcare practices is largely based on customs, inherited traditions and religious beliefs and practices and not on "rationality" and scientific determination of pathology and treatment.

However, PHC emerged in the world of "scientific" medicine, a social institution sanctioned internationally as being ultimately responsible for the health of national populations (Weidman, 1979). From its birth in Manlarla society, therefore, PHC appears to reflect the high values and norms of science, professionalism and modern technology. The material, historical, and social world in which Manlarla are living and dying has no seat within the interactions of PHC professionals and patients. Underlying this unique status of "orthodox" medicine is the difficulty of healthcare professionals to learn about patients' world view and healthcare culture which they consider "traditional" and "unscientific". Weidman (1976:346)

aptly captured this when he observed that: "Only scientific knowledge is valid in-so-far as matters of health are concerned. I (modern healthcare professional) have scientific knowledge; therefore, I have knowledge. You have no scientific knowledge; therefore, you have no knowledge". This "fallacy of empty vessels" (Polgar, 1962) was, therefore, brought to bear on the formulation and implementation of the PHC programme.

Specifically, PHC formulation and implementation in Manlarla society was linked to scientific conceptualisation of health and beliefs about etiology of disease and appropriate treatment. Interpretations attached to disease symptoms, etiology and interventions by local Manlarla health "professionals" were accorded no place in the programme formulation and are largely ignored during routine health education. Manlarla interpretations are considered trivial, inappropriate and "primitive". This attitude may be valid in organic terms but produces a communication barrier as the people hold beliefs and interpretations of health and healthcare which make most biomedical recommendations illogical, inappropriate and bizarre.

It is clear from the above that PHC designed objective of ensuring equity in healthcare and sustainability in socio-economic productive lives remains a distant objective among the Manlarla. The reasons are essentially sociocultural - manifested in a disregard for Manlarla cosmology. Associated with this disregard are tensions between the two healthcare systems (THS and MHS) and cultures, tensions that have caused great apprehensions to the extent that one may ask if the two healthcare cultures are an impossible synthesis? The study suggests that they are not an impossible synthesis. However, a synthesis will depend on compromises, cultural negotiations and intermediations, the effectiveness of which is dependent upon an unbiased appreciation of the complementarity of the two healthcare systems.

# CHAPTER 8

# UNDERSTANDING: THE KEY TO COMMON GROUND

***Understanding and altering our thinking about cultural artefacts have implications for social interventions. Without an awareness of the influential power of these cultural artefacts on people, it is very difficult to care for, educate, assist, or even learn from them if their cultural experience has been significantly different from one's own.***

## 8.1 Introduction

As demonstrated in the preceding chapters, ritual events in Manlarla society, no matter how unscientific they may appear in the broad sweep of conventional medical platforms, pose several general theoretical and empirical issues for students of intervention and utilization studies. For instance, we noted that rites of death are intimately linked with ideas, values, attitudes and themes that repeat in many aspects of their life. These observations confirm a close relationship between Manlarla ideology and system of belief, constituting what McIntosh (1989) terms a "symbolic reservoir". In this chapter, we offer an examination of this symbolic reservoir within the context of the PHC programme in Manlarla society.

To do this, a summary of the major findings has been advanced. With these findings, suggestions are made for the integration and facilitation of the two healthcare systems at the levels of policy, PHC healthcare professionals, and community leaders and specialists. Finally, a model for understanding and explaining utilization decisions in Manlarla society (especially, among ritual participants) has been outlined. To systematize our presentation and analysis, it is, perhaps, more appropriate to begin with an understanding of where we are.

## 8.2 Where are We? The PHC Implementation Strategy

This section deals with the major implications arising from the data of preceding chapters. It addresses the question: What major implications do the data of preceding chapters hold for the PHC programme in the UWR of Ghana? Respondents were asked about their impressions as regards the PHC programme. Although responses varied from respondent to respondent, they, nevertheless, pointed to one thing: the inappropriateness of the programme's implementation strategy. For instance, one illiterate widow said, "we're told to disregard our traditional ways of doing things, but these are what we know from childhood". Another respondent, a male Muslem said, "they don't respect us and our beliefs, our wives are insulted anytime they go to the clinic". A family head from Nyimbale said, "their gods of healing are different from ours; they say our gods belong to Sutaane Satan but they forget that our gods are Teng sanga yele our ancient pride". These voices of the people imply that PHC professionals and the Manlarla operate from different levels of medico-social-spiritual consciousness.

Although there have been numerous redefinitions and reformulations of the original definition of PHC (Walsh and Warren, 1983), for many it still implies health care that responds to a community's perceived health needs, is geographically and financially accessible. It is undeniable that PHC in Manlarla society is a response to community perceived health needs. It is also relatively accessible in geographical and, perhaps, financial terms. But is it enough to provide health structures and personnel and make them financially accessible to communities? Data from Manlarla ritual participants suggest that it is not enough; that a community must be prepared to utilize services provided by the programme. Utilization implies acceptance; but acceptance depends on a number of factors including the suitability

of policy, and its implementation and management strategies. In that case, the programme must be available in a socially and culturally acceptable form.

From this standpoint, it appears utilization will depend on the nature of health-culture negotiation between the "deliverers" (professionals) and the "receivers" (community). This is often given less attention. Stone (1986) observes that, much attention in PHC is often paid to financial, logistic and political factors. Having established the importance of social and cultural acceptability of programmes of intervention, the fundamental questions to consider now are: (1) Was the design and implementation of PHC programme in Manlarla society perceived as if traditional structural networks and local medical knowledge mattered? (2) Is the translation of the programme into reality pursued in a manner that enlists local support and community involvement? How is the MHS (the implementors) adapting the policy to the local healthcare culture and subcultures? To answer these questions in the context of the framework of this study is to pitch Manlarla traditional cosmology and the inherent healthcare culture against the PHC programme and its implementing strategies.

### 8.2.1 PHC Implementation: Implications for Convergence

Given the organizational structure of the Ghanaian society, certainly representatives at the level of international policy formulation sponsored by WHO in Geneva in 1982 were Secretaries of State and senior officials of the health bureaucracy. However, those responsible for planning and implementing the programme at the local level were no where near the "gates" of Geneva. Also, neither the officials who made the policy commitment in Geneva nor those responsible for planning and implementation were familiar with rural realities. With their usually Western oriented perceptions of realities, these officials were likely to disregard local

orientations and perceptions. Willms (1984), for instance, observed that in Kenya reticence and uncertainty on the part of the MOH towards traditional communities could be attributed to the rootedness of the ministry in Western clinically-based medicine and the authority that this system of healthcare is known to invoke.

Perhaps, the most ill-understood determinant of service utilization in Manlarla society is the interpretation the patients and therapy groups attach to disease symptoms and illnesses. As noted in the study, few Western oriented PHC "professionals" even elicit such information during routine health education and interventions. However, Kleinman (1980) emphasizes that appreciation of these differences are relevant for both treatment decisions and in our perception of the cultures involved as co-cultures. Perceiving them as co-cultures implies pursuing the necessary negotiations and intermediations in an atmosphere of peaceful co-oexistence and parity. Parity does not mean the cultures are the same. Rather, it implies the justaposition of cultural systems that provides the basis for comparison of congruent and non-congruent elements in their respective health dimensions (Weidman, 1979:210).

The Manlarla example tells us the importance of the power of social-spiritual influence in the use of services. Therefore, rather than viewing the low utilization of MHS as an individual aberration, we should recognize the power of this social-spiritual influence. The utilization problems confronting them, as Skinner suggests, "... are not to be found in them but in the world in which they live, especially in those environments we call cultures (Skinner, 1975:49). This heterogeneity of meanings in human societies is not a recent problematic. It is a problem with deep ontological roots. Since all human societies, and all they are made of, are endowed with shared meanings by their members, it can be said that social living is not given but produced, created, and constructed. "Every society can be seen as a precariously

put together fabric of meanings by which human beings seek to find guidance for their lives" (Berger and Kellner, 1981:74).

The traditional basis of Manlarla social living, as indicated in Chapter 4, is found in the philosophy of N'taan be, life which emanates from their culture. This philosophy of life is aimed at the perpetuation of life itself - life of the individual, life of the community. It is the quest for this life which bolsters magico-religious beliefs and practices the *sin qua nom* of their social order. Within this social order, illness is not considered as just the result of pathological change. Rather, the supernatural is invariably invoked as the main causal factor. Consequently, their concepts of etiology of health and illness, as we argued, are far more social-spiritual and relational than biological and universal. These beliefs and practices are handed down relatively intact from generation to generation. Because they are beliefs and practices of the past, the present and, hopefully, the future, they are deemed right, and are prescriptions to be followed. In short, they serve as the "standard of standards, the legitimating principle integrating the various elements of culture and social structure, protecting the integrity of the system, maintaining its stability, and warding off any 'system-disturbing' influences".

Given the spiritual and relational realities, similar biological processes may be observed in different people and assigned different meanings according to their social-spiritual statuses. The implication is that diagnosis is, therefore, to be viewed as an active interpretive work within the context of the individual's spiritual status rather than, solely, or principally, as a standard technical procedure. Rather than seeing diagnosis as the measurement and assessment of specific deviations from biological norms, it should be seen as a process through which certain signs are evaluated as having cultural significance and the "meaning"

of a disease. Only after this cultural signification of a disease has been accounted for that intervention may have the appropriate meaning and desired effect.

With the failure of the PHC programme to account for cultural significations, can we say that the promise of a better life for the Manlarla remain an illusive goal? Does the vision of both architects and implementors of PHC threaten to remain a mere platitude because it has not been successfully adapted to fit Manlarla local health culture? If the international and national commitment to "health for all" (HFA) by the year 2000 still remains effective, then something has to be done to keep the programme on course in Manlarla society. It must be realized that work within PHC in the UWR, as a whole, has a limited sphere of influence. As such, the programme will never be able to change their fundamental traditional parameters through a uni-dimensional (biomedical) approach.

As we noted, a set of normative behaviour influences Manlarla patterns of services utilization. In concert with this, both the patient and the therapy group expect coherent explanations for illness episodes that confront them. Manlarla THS appear to offer a more coherent explanation for most illnesses, while modern PHC, as implemented now, only provides basic drugs without any comprehensible explanation. The actual policy does not appear to seek an integration of the two health cultures or systems. They appear to be evolving as separate concerns. Given this trend, what are the implications for the future relative to efforts for improving health in Manlarla society? What are the implications for PHC which, in theory, is being universally accepted as the guiding concept for improved HFA by the year 2000?

Our selective treatment of sociocultural determinants of utilization does not do justice to the complexity of values and beliefs among the Manlarla, nor does it exhaust the myriad

of complex relationships between their cultural practices and healthcare. Nevertheless, it does establish the foundation of their cultural practices and the basic normative orientations of their traditional healthcare delivery system. This distinct character and world view of the Manlarla thus offers challenging lessons for policy formulation, health promotion and socioeconomic development. As such, it is the recommendation of this study that a strategy should be developed that aims at transforming the two healthcare systems gradually and reciprocally. This implies appropriate culture negotiations, mediations and intermediations at the levels of both policy formulation and programme implementation. As Hyder (1984:4) suggests, apart from the mathematical probability of favourable operation, an extensive negotiation and intermediation brings about the necessary exchanges of information and resources.

## 8.3 Negotiations, Mediations and Intermediations

As noted earlier, in furthering the effectiveness of PHC programme in traditional Manlarla society, attention has been paid to efficacy, effectiveness and cost efficiency (economic viability) rather than cultural validity and social vitality (Matthews, 1983). If understanding and interpretation are fundamental modes of humans' being, then, it seems to me cultural validity and social vitality should constitute the basis for these modes. Perhaps, this explains why in sharp contrast to economists and biologists, sociologists propose policies that address the social sources of low utilization (Freidson, 1970; Mechanic, 1989). Nevertheless, as demonstrated in Chapter 3, the sociological perspective in utilization is not a unified enterprise. A variety of policies derived from different sociological explanations such as sub-cultural, social support, and resource theories (Phillips, 1990) have been proposed to deal with the substantive problem of utilization.

Differentials in utilization underscore the general point that it is not autonomous. Rather, it reflects the structure of the larger society. Utilization, like the causes of illness, is distributed along the main lines of social stratification (Freidson, 1970; Kleinman, 1980; Mechanic, 1989; Mishler, 1981:86). The world as a meaningful reality is constructed through human interpretative activity (Mishler, 1981:141). Thus health, illness, and medicine are social facts. They are socially constructed categories that define and give meaning to certain classes of events (such as ritual participation), certain categories of people (such as ritual participants) and certain human actions (such as use of health care services). Whether or not a particular behaviour or experience is viewed by members of a society as a sign of illness depends on cultural values, social norms and culturally shared rules of interpretation (ibid.). This is in contradistinction to the biomedical model of disease as defined by reference to universal, culture-free criteria currently in vogue among Manlarla PHC professionals.

Cultural variations exist in the specification of behaviours as signs of illness, in taxonomies of disease, and in the procedures for taking health related actions. The biomedical definitions by PHC professionals represent only one such culturally based set of illness and illness behaviour, and the Manlarla social-spiritual definitions represent another. Yet the PHC strategy was delivered to the Manlarla in a ready-made biomedical form. This was, perhaps, unavoidable. But is it also unavoidable that its implementation should be inseparably bound to this biomedical philosophy and culture? Our understanding of how psychological and cultural factors affect the incidence, course, experience and illness outcome among Manlarla ritual participants suggests serious limitations to this approach in two ways. First, it suggests limitations in the determination of what data are clinically relevant. Second, it suggests limitations in the determination of where therapeutic intervention should occur. However,

these limitations are not without a positive side; they reveal to us the entry point in any integrational endeavour.

## 8.4 Implications for Integration

The plight of majority of Manlarla derives solely from social-spiritual forces which are culturally constructed. Yet their society is rife with a health care model derived in and designed from an entirely different cultural background and level of development of the forces of production and production relations. This imposition has failed to trigger the magic bullet of service utilization and improved and sustained socioeconomic development. For instance, as we noted earlier, biomedical factors accessible to analysis in action terms are involved in the etiology of many illnesses in Manlarla society, and conversely, though without exact correspondence, many conditions are open to therapeutic influence through biomedical channels. This is incongruent with traditional Manlarla cosmology of spiritual influence and ancestral domination.

In concert with this cosmology, it is customary for the Yidaana elder of the lineage, the Naa chief, or the Tendaana earth-priest of the community to ask favours of the ancestor spirits to avert illness and/or restore health. A community like this certainly will accept an innovation that respects its cosmology. So what must be done? Since any proposal is likely to be as meaningless and ineffective as the current PHC is to the Manlarla if it fails to reflect ground realities, respondents were asked what they propose for change and/or reform. Again, responses varied but suggest an indication for integration. For example, one family head said, "they should bring their 'whiteman's magic' (medical practice) to us, they shouldn't leave it on top of trees". Another said, "they should accept us and the way we think about health and

illness; they should understand that we are following the path of our ancestors". Finally, a young Traditional man said, "we should be trained in their Suolong magic and they should be trained in our Tiin medicine".

### 8.4.1 Major Findings of the Study

The study found the underlisted realities to be very important in our understanding of the perception and conception of health and illness among the Manlarla as well as their use of healthcare services.

1. Tradition and custom set down the hierarchical relations and reciprocal duties between husbands and wives, parents and children, elders and juniors, superordinates and subordinates, leaders and commoners, males and females, the supernatural and the natural, the dead and the living, the invisible and the visible, the sick and the healthy, the deceased and the bereaved, the soul and the body, the sacred and the secular, the holy and the profane, as well as spiritual medicine and natural medicine.

2. Manlarla rituals conserve models of public behaviour that are consistent with such conditions as are provided by ecological, economic, or political factors. However, beyond these wide horizons lurks the tacit acknowledgement that human destiny is in the hands of Naa-Ngmen, who administers the universe through the relics of spirits and ancestors. That is, these spirits and ancestors are in delegated control working out a divine purpose for the benefit of all.

3. Manlarla perceptions of both the cause and severity of many illnesses differ remarkably from those of modern healthcare professionals. For instance, illness is believed to have a variety of causes, natural (noxious environmental agents), social (enmity of other

persons) and supernatural (disfavour of the gods and ancestors incurred by unwitting offenses against them). In its totality, illness is perceived as a social-spiritual control mechanism.

4. Associated with 3 above is the basic belief that there is a mysterious, inexorable network of forces in the realm of Manlarla traditional medicine; and only the initiated and/or religious expert are able to exploit this network for personal and/or social benefit or block it for personal and/or social protection.

5. The propensity to use health care services generated by the modern health care system is low in Manlarla society, especially among ritual participants. Variations in utilization propensity are also found to exist within different strata of sub-groups in the society.

6. Access to and availability of culturally acceptable health care services constitute a problem and appears to manifest in low use of services. For example, cultural and/or ritual inhibitions are not accounted for in existing modern health care services.

7. Decisions to seek health care take place in a complex web of relationships. Tracing the relevant communication patterns and decision making process is never a simple matter. In other words, the Manlarla evidence of what Janzen (1980) calls the "therapy management group" is very strong.

8. Decisions to seek health care can be made by the patient, by the spouse, parent, the village elder, and/or other family member or community members. Even though this may sometimes depend on the nature and severity of the sickness, this study found that for ritual participants it is almost always dependent on their ritual status.

9. An important barrier to health care utilization relates to the conflict between biomedical and traditional (magico-religious) conception and articulation of health phenomena. This includes notions of disease causation, grouping of symptoms into syndromes

or diseases, and perceptions of appropriateness of care (see Appendix D).

10. Cultural beliefs and preferences surrounding illnesses are particularly strong and resistant to change. Among the Manlarla, as the study revealed, prolonged labour, for instance, is believed to be punishment for a woman's infidelity.

11. Manlarla have a holistic approach to healing. It involves "confessions, atonement, and forgiveness" (Appiah-Kubi, 1981:3). Within the philosophy of N'taan be, if one person is ill, the entire community is considered ill. Thus, traditional Manlarla healing is holistic covering the entirety of the individual, his/her family and the society.

12. Finally, the operations of modern healthcare professionals in Manlarla society largely reflect the old philosophy of individual responsibility for health. Associated with this mechanistic, individualistic and reductionist tendency in medicine is the model that normal health is restorable only through mechanical procedures, and technological and pharmacological "fixes". This biomedical philosophy, according to Bolaria & Bolaria (1994), is weak on two counts. First, that it is based on a superficial understanding of the determinants of health related behaviours. Second, that by focusing on behaviour, it overlooks other important factors (such as social structures and cultural processes) that influence behaviour (ibid.:375).

Given these findings, it could be argued that while PHC provides physical resources (opportunities for potential utilization) in the society, Manlarla patients require social resources (which are enshrined in custom) to "cement" actual utilization. As such, making healthcare as culturally appropriate as possible is an important stimulant of utilization. But cultural appropriateness implies an evaluation of cultural practices and beliefs on an individual basis to determine their medical significance. Medically beneficial or benign practices (Mburu

et al., 1978), should be incorporated into modern health care delivery services. To do this, an understanding of the complexities of the Manlarla sociocultural realities is essential. This will afford opportunity for the determination of appropriate cultural practices, the patterns of distributing social resources and the target audience for appropriate health education.

In devising an overall perspective for this study, I have drawn inspiration from medical anthropology (A. Kleinman), and qualitative medical sociology (E. Freidson and D. Mechanic). These traditions posit illness and health seeking behaviour as socially constructed and culturally distributed social facts. In the social and cultural loci of Manlarla death rites, illness and health care, for instance, we noted how meanings are constructed in order to realize and maximize collective goals under a variety of conditions and constraints. In other words, Manlarla health seeking behaviour, based on these meanings, lend form to both their social organization and spiritual relationships. Understanding of this rather complex epistemological issue should be a useful focus of action for both policy-makers and health care professionals. As one celebrated malariologist said, "if you wish to control mosquitoes you must learn to think like mosquitoes" (in Paul, 1955:1).

### 8.4.2 The Policy-Makers

The importance of the malariologist's advice is clear. If you wish to help the Manlarla improve their health, you must learn to think like the Manlarla. In other words, before asking them to assume new health care culture, it is important to at least ascertain their existing health care culture, how the health care system is linked to their other cultural systems, and what they mean to them. An appropriate approach to the PHC programme is calling for adoption, an approach which can utilize Manlarla indigenous approach to health and

healthcare, and disease and death. Put differently, it is critical that policies of interventions show "respect" for Manlarla descriptions and perceptions of their conditions, as well as the cultural context of their experience with and articulation of illness.

May be, one best way to deal with this is to involve community leaders and healthcare providers in active decision-making processes. Local community leaders and healthcare providers should be actively involved in making policy decisions (at the local level) and designing programmes to prevent, detect and treat the numerous illnesses in their society. As Roose-Evans (1994:157) notes, "what is most urgently needed is actual experience with modes of symbolic action that are not characterized by split between `active-interventionist' and `passive-consumptionist' ideologies, but by `active receptivity'". In other words, PHC goals, objectives and targets should not only be clearly identified and articulated, but must also relate to existing ground realities. Probably, this will increase the realization of the notion that PHC staff should "work with the people rather than for them". To accomplished this, the following are recommended:

1. PHC design and implementation should be preceded by careful research and planning, with due consideration for sociocultural contexts. This provides opportunity for the incorporation of local realities into the model and strategies of intervention. Health education, for instance, should be education in the health beliefs of the Manlarla. Manlarla should not be told to change their behaviour as currently done, but emphasis should be on understanding those cultural forces that cause them to behave the way they do.

2. The different categories of programme beneficiaries should be identified, consulted and involved in PHC activities from the very early stages using a participatory approach. By "refocusing upstream" (McKinlay, 1979), the PHC programme is more likely to be

transformed into a community-based health care (CBHC) (Shaffer, 1984).

3. During implementation, the implementing team should demonstrate effective co-ordination, appropriate leadership and management capabilities. To do this, the role of implementors should be clearly defined, and the implementing team should be carefully selected, trained and coordinated to work as a cohesive group. Divisions among members of an implementing team render implementation complicated and uncertain (Hyder, 1984:4).

4. There must be an in-built mechanism for effective monitoring, evaluation and follow-up, which should involve beneficiaries as well as other stakeholders. This may generate capacity enhancement by ensuring effective communication and sustaining confidence within the structure between beneficiaries and other stakeholders, and between localized (modern) health professionals and local (community) health practitioners (see Appendix B).

5. "Reality is always richer than the theoretical models we invent to comprehend it" (ibid.:17). As such, our approach to implementation should be flexible and experimental, with due regard for the sociocultural environment. Empasizing flexibility and experiment does not imply an advocacy for a totally unplanned strategy but rather an evolutionary one (Found, 1992:4). As Barrett & Fudge (1981:25) point out, implementation "is a policy-action continuum in which an interactive and negotiative process is taking place over time, between those seeking to put policy into effect and those upon whom action depends".

6. Finally, the PHC programme must be designed within the parameters of economic viability, local political efficacy, technological reliability, social vitality and above all cultural validity. This will permit transformation without severe disruption of ordained structures which, in turn, may stimulate and sustain community enthusiasm and participation, the basis of programme sustainability and a condition for an improved socioeconomic life.

### 8.4.3 The Modern Healthcare Professionals

This study has sought to close the gap between local healthcare practitioners and localized PHC professionals, to improve the use of services, and to develop practical mechanisms for community-based diagnosis and treatment with available resources. To have the greatest impact, programmes must assess the health problems in Manlarla society from both an epidemiological approach (medical reality) and a sociological approach (social reality). Interventions must fundamentally be based on the medical and social realities of people's lives. For instance, the cultural context of illness is crucial in the development of education programmes for the community and for the healthcare providers. While the biomedical approach may provide data on different utilization rates within Manlarla society or even differences in use of MHS by individuals, it cannot, because of its acultural and ahistorical methodology, provide adequate explanations for such differences. Consequently, the underlisted points are essential for professionals of MHS.

1. It is important for PHC professionals to note that while people believe in supernatural forces as the cause of some of the diseases, there is also an awareness of natural causes (see Appendix B). It is therefore wrong to assume that when people go to diviners, or other spiritualists, they are doing so because they are ignorant of the natural causes of their illnesses. Rather, the supernatural must be acknowledged as a major dimension of the lives of the people and a factor intrinsic to their psychological concept of health. To ignore this is to ignore one crucial element of their health related decision making.

2. Causes of common illnesses like waist and back pains should be traced and explained to the people. For instance, should they be traced to the use of the hoe as the main implement of farming, then the possibilities of introducing appropriate technology, affordable

and acceptable to the people, like the bullock/donkey plough, which can eliminate these should be explored.

3. As noted by the MOH (UWR), during Sienkpe pala many people go a long period without food. It is during this period that stomach and/or abdominal pains are said to be among the most common diseases (Ghana, 1994a). Investigations could be carried out to see if these complaints are some form of stomach ulcers; and if they are, what could be done about them. For instance, the MOH could team up with the Ministry of Agriculture (MOA) to come up with a package for food security in communities suffering from chronic food shortage. These measures may include the provision of dug-outs dams for dry season gardening, seed loan and food support programmes. In addition, there is the need to educate people on the need to increase protein intake, especially beans and animals during this period, as these may be the only available resources.

4. Home treatment or self-medication should not be frowned upon for it is a practice which will not go away as long as people can buy drugs or herbs in the market. Rather, it points to the need for health education in communities for a better understanding of the causes and cures of their illnesses. Greater understanding means greater chance of better self diagnosis and prescription. The education programme must, however, acknowledge that ordinary people have a fair idea of the causes, signs and symptoms of their illnesses. Even though they may get certain things wrong, what they know is something to build on. Health staff at the clinics should, therefore, help people build on what they know rather than make them feel like idiots for any misconception they have. There is the need for change in attitude on the part of these health staff towards patients, especially those without formal education.

5. Healthcare providers of the MHS should acknowledge and work with their "opposite numbers" in Manlarla society (see Appendix C). For instance, pharmacists should work with the herbalists and drug sellers, midwives with traditional birth attendants (TBAs), the orthopaedic department staff with the bonesetters. As the study revealed, the existence of these "opposite numbers" is not only acknowledged but they are often more trusted than the imported and unfamiliar systems of modern medicine.

6. "Where respect is missing, the healthcare system won't work well", one respondent stressed. Patients need to be treated as the intelligent people they are instead of ignorant "illiterates". They must be seen as active partners in the improvement of their own health rather than recipients of a service which can only be provided by educated "experts". Indeed, participation of the patients is the key to success; but this is possible only if they are understood and facilitated by the modern healthcare professionals.

7. "We also need to be supported", a nursing staff emphasized. Modern healthcare professionals also need to feel valued. One way of doing this may be to give these professionals specific and detailed feedback which affirms what they do well and makes suggestions about how to improve on their weaknesses. This could be done through a combination of community feedback and supervision from the DHMT.

8. The practice of modern healthcare personnel looking down on traditional practitioners and their clientele as if they were backward people living in the dark ages should stop. This will provide an opportunity for them to refer specific cases to traditional specialists, especially when their healing techniques offer something that modern medicine lacks. In other words, traditional practitioners should be given formal status in the framework of the national healthcare system.

### 8.4.4 The Community Leaders and Specialists

Community leaders and specialists constitute an important segment in community life and experiences. But with the exception of the Makadjia all other leaders in Manlarla society are males. Whereas both males and females operate within the same cultural and ritual frameworks, Manlarla males appear to dominate the society both socially and conceptually. They make major decisions about health and illness, and believe themselves to be pure, clean and right, while living in a world threatened by many forms of supernatural danger inherent in females (see Chapter 4). For example, one male respondent said, "I can never be healthy while I'm threatened everyday by the infidelity of my wives". In another instance, while a young man was clearly drinking himself to death (as later established by scientific diagnosis at the Jirapa Mission Hospital), his illness had been blamed on his wife's unproven infidelity. Manlarla males, therefore, believe that, while women can sometimes be dangerous to the health of their husbands, it is never envisaged they could ever be dangerous to the health of their wives.

While some Manlarla men and women may not individually think of themselves in these terms as described above, their self-concept is not given public recognition; their world view remains muted by comparison. This point finds expression in a welcome address delivered on behalf of the Women's Co-operative Development Association of Nyimbale by the Assembly Member of the locality, P. N Seidu. It was delivered before the Nadowli District Chief Executive, the U/W Regional Minister and several representatives of the Canadian High Commission in Ghana. One significant thing about the address was that it emphasized the need to stop viewing women as "social vampires". For instance, the message read:

> ...the wall that prevents our men from seeing us as important partners in health and development is cracked beyond repairs. What is needed is a new wall; a new wall that will change old conceptions about us (women); a new wall that will generate new mentalities and put us (men and women) in one united kraal of bulls and cows, for in unity lies our strength (Nyimbale Women's Association: 17 July, 1994).

The women's message is loud and clear. They are inviting the male leaders and the local specialists to a vision of a different social order, a social order that calls for a redistribution of power and enlists their participation in such vital activities as illness and treatment decision-making. Against this background, the following recommendations are quite useful.

1. Traditional practitioners should acknowledge the limits of their skills and competence and refer patients promptly to the modern health care system for further review. One important objection of modern medical personnel against traditional practitioners has been the "failure of the latter to acknowledge the limits of their skills and competence" (Chiwuzie et al., 1987:240-4).

2. Most elders and traditional specialists are old and have established reputations for themselves and for their medicine. Some of them also have demonstrated vested interests in the status quo, which implies an unwillingness on their part to stimulate changes in their practice. This is where community leaders constitute an important link as agents of change in their communities. As secular and/or religious leaders, they not only understand the networks of vested interests in their communities but they also have authority to initiate change and exact compliance.

3. The study reveals that a fraction of respondents are in favour of and practise simultaneous use of health care services. At the moment no negative consequences are being

experienced by such people and, hopefully, may never be experienced. Given this reality, community leaders and specialists should draw lessons from that and encourage the practise of simultaneous use of healthcare services. There is no guarantee that simultaneous use of healthcare services will prevent death, but it may increase the chances of surviving life-threatening illnesses. If this was the practice, probably my mother and the baby from Kpong Paala could be counted among their living kinsmen and women today.

## 8.5 Bringing it All Together: The Proposed Model

Our analysis of available literature on the utilization of healthcare services reveals little agreement on approaches or models. Moreover, several problems abound these approaches to the extent that their utility for the purposes of utilization analysis has been reduced. These were examined in Chapter 3. What is intended now is to propose an approach that is likely to overcome, to the extent possible, many of the existing problems associated with utilization of healthcare services in traditional Manlarla society. Essentially, this study suggests a processual model for understanding utilization mechanics in these societies (see Figure 8.1). This model is proposed in the belief that more facilitation of programme effectiveness could be achieved if the major processes that influence utilization were understood.

Viewing rituals, especially funeral rites, as purposeful social processes, promotes attention to their structural elements and the regulative effects of structure on individual ritual participants. While emphasizing the salience of structure, sociologists also employ a socio-pyschological orientation to document the fact that ritual participants themselves are purposeful. They creatively adapt to the regulative contingencies of the ritual structure. This concern with human agency opens awareness to the conception of rituals as dynamic

processes located in community of traditions and customs instead of static processes operating in a vacuum.

It goes without saying that rituals can be fruitfully viewed from a variety of perspectives: religious, anthropological, psychological and sociological. Indeed, each informs the others about their unique notions and meanings of rituals. The unique contribution of sociology should be identified in its ability to integrate the structural aspect of rituals with the "underlife" and the "overlife" of rituals - those contextual aspects which advance an understanding of rituals as purposive social processes. For this reason, it is proposed here that intervention and utilization research should combine structural (macro), prossessual (meso) and individual psychological (micro) components to advance the formulation of utilization models. Within this process model of utilization, low utilization may be understood as structured and organized not by the "blind forces" of "brute nature" or "ignorance", but by the social-spiritual environments within which people live and die.

This approach to understanding utilization of healthcare services in Manlarla society consists of two related parts. First, we will briefly examine the three interrelated dimensions that are believed to be the essential components of the human being. The examination will be pursued with a view to understanding the appropriateness of these dimensions for an analysis of utilization. Following from this examination, we will present an analytical framework which organizes the various related aspects of reality that influence health related decisions. This way, it is hoped, we will be providing a useful model for the facilitation of an understanding of the dynamics of utilization in any particular society.

### 8.5.1 A Multi-Dimensional Perspective

In view of the complexity of utilization determinants and the proliferation of models explaining them, it appears most appropriate to use a multi-dimensional (natural, social and psychological) approach in designing and expounding our model. A multi-dimensional approach is useful for two fundamental reasons. First, this approach appears to be consistent with the Manlarla conception of the universe (and for that matter, their understanding of the location of the human being). Second, it is also useful especially as we are attempting a search for some common ground among the existing diverse views on the subject.

#### I The Natural Dimension

Consistent with Manlarla conception of the universe, this model proposes that every human being is to be seen as a product of three dimensional environments - the natural environment, the spiritual environment, and the human environment. As a natural product, the individual is seen as a biological entity or organism with different body parts performing different but interdependent functions. A breakdown or malfunctioning of any one or more of the parts constitutes ill-health in the form of a disease. This conception of the human organism (where mind and body are compartmentalized), Rossdale (1965:82-90) suggests, can be likened to an automaton (a self-propelling machine). It is at this level that the health professionals (local and localized) visualize illness as natural (or biological) and occurring within an individual. Manifested symptoms are examined, the illness is labelled (or diagnosed) and isolated as a foreign object (or an invader) that must be attacked and, if possible, removed. Treatment here is aimed at restoring functional health and is, therefore, pursued on an individual "bio-chemo-surgical basis" (Kelman, 1975:628) at either a traditional or a modern health care centre.

## II The Psychological Dimension

A second aspect of our multi-dimensional approach to the analysis of utilization is the psychological dimension. Fundamentally, every society is a psychological structure. As a psychological structure, its institutional opportunities and constraints "affect individuals' perceptions and reactions to their bodily processes" (Waitzkin & Waterman, 1976:20). In this sense, we could conclude that the individual is also a product of the psychological dimension of his/her society. Within this schema, stress and vulnerability or illness, for instance, are not to be seen essentially as the psychologic traits of individuals (Mechanic, 1968). Instead, they are to be seen as "feelings emerging from the painful qualities of social structures (and processes) within which the individual must function on a day-to-day basis" (Waitzkin & Waterman, 1976:21).

From our study, rituals of death, inheritance and so forth were noted to be frequent sources of great stress, vulnerability and illness to individuals (and the community). Under the circumstances, illness behaviour represents an adaptive response to the "system-disturbing" influences. In other words, decisions of utilization are to be seen, at least in part, as a "reflection of patients' (or the community's) stressful experience with the institutions with which they deal" (ibid.:21). "The experience of oneself as the object, rather than the subject, of one's existence" (Fromm, 1955:111) compels the Manlarla to make choices "not on their own terms, but rather under circumstances directly encountered, given, and transmitted from the past" (Marx, 1963:15).

## III The Social Dimension

At the level of the human environment, the individual biological organism and psychological system becomes a social being interacting with other social beings. Here the

individual may be a father or a mother, an elder or a junior, a son or a daughter, a widow or a widower, an orphan or a heir. An incumbent of any of these statuses is assigned social roles. While the effective performance of them maximizes the health of the community, ineffective performance constitutes a sickening community. At the same time, Manlarla believe that misunderstanding is a "foreigner", coming and going at irregular intervals. Its presence in the midst of humans' interactions poses a threat to healthy relationships (that is, it can break down relationships). If the breakdown of relationships are manifested at only the social level, treatment takes the form of reconciliations carried out by elders and social experts under laid down guidelines and procedures. However, if clinical manifestations are present, both reconciliations and functional repair of the affected body part(s) must be carried out.

### 8.5.2 A Framework for Service Utilization

Figure 8.1 summarizes the model or path to service utilization in Manlarla society. As a product of the natural environment, the biological organism's health is "invaded" by a foreign entity called "disease". As a product of the spiritual environment, the individual biological organism becomes a psychological system individually experiencing illness as a result of a disturbance within his or her psychological structure. And as a product of the human environment, the individual biological organism and psychological system is visioned as a social being. As such, s/he interacts with other social beings not only for the satisfaction of private ends but also for the attainment of corporate goals. Interaction is systematized by assigning roles to the various interacting social beings according to their statuses within the "social corporation". And since the social beings are working for the social corporation, any incapacitation (sickness) on the part of one member renders the entire corporation

momentarily incapacitated (sick).

Once the viability of the "corporation" is based on the viability of the individuals, the welfare of the latter necessarily becomes a corporate affair thus, the philosophy of N'taan be. So, the sickness of a member must be appropriately acknowledged through collective determination. Depending upon the outcome of the determination, the individual may or may not assume the "sick role". Assumption of the sick role by the sick member implies a reciprocal duty on the part of the others to offer support by constituting a therapy group and providing the necessary social opportunities for recovery and/or reconciliation as the case may be. The corporate involvement or, at least, those members in position of "social trust" in times like this, is vividly illustrated by the Manlarla expression Ninyene ba biere an individual is never sick.

Basically, therefore, three levels of interacting factors determine utilization decisions of available physical resources and influence the choice of treatment facility. First, the "machine" body must show signs of malfunctioning, adjusting or coping failures with its environment (disease) that require repair or readjustment. Second, the psychological system which experiences ill-health alone should be able to provide an approximate articulation of his or her feelings to the corporate hierarchy. This is especially true either in times of lack of visible symptoms or in times of novel symptoms, otherwise resources may be inappropriately commissioned. Finally, the corporate group must be physically and psychologically prepared to assist. For instance, physical incapacitation may limit both the quantity and quality of available social resources. Similarly, psychological unpreparedness of a corporate head may generate delays in the distribution of available resources for health related matters of other corporate members. This was especially the case with my mother and the pregnant widows

from Nanville and Kpong Paala. This should be the first entry point for health education.

However, once these three levels coincide, resources for potential utilization are deemed to be at hand. The next hurdle to clear, then, becomes the type of health facility (traditional or modern) to use. Here, the predispositioning factors to actual utilization (belief structure, status of patient, interacting setting and significant social groups) are then brought to bear on care deliberations and considerations. Beliefs about disease etiology (cause) and appropriate cure, as we noted from respondents' responses, clearly point to where (A or B) to go for cure (where A=THS and B=MHS). But in the determination of disease etiology and, therefore, of its cure, the ritual status of the patient (and associated roles and network of spiritual relationships) remains the single most influential variable. An explanation for this has already been offered in preceding chapters and will not be repeated here. Suffice to emphasize, however, that the status of the patient defines the interacting setting and determines the significant social groups that all combine to exert influence on the last "decision" of the processes of utilization deliberations. To improve integration, therefore, health education should emphasize simultaneous use of healthcare resources of A and B.

## 8.6 Conclusion

> Illness is a gestural way of searching for the bottom, the ground of things. As such, it requires that the lairs be opened, carefully, but nevertheless opened. Ritually, an illness requires not only its opposite, cure or idealization of health, but reflections of illness as well. So the nest of symbols made for a patient should include repressed or rejected images - not just the whiteness of purity but the blackness of night, not just the orderliness of numbers and charts but the babel of names, not only the smell of disinfectant but the odor of earth, not just the solemnity of professionals but the antics of clowns (Roose-Evans, 1994:156).

What does our discovery of Manlarla social-spiritual realities (social indicators)

suggest to us as students of sociology of health and health care? Just as an observable change in the colour or texture of a compound might indicate an underlying chemical reaction or relationship for a chemist, so the sociologist can observe changes in social indicators in order to determine relationships among social facts (Durkheim, 1951). Ghana adopted PHC in order to solve some of the problems arising out of the injustices and imbalances within the conventional health delivery system. However, its designed objective of ensuring equitable distribution of health resources remains an unproven hypothesis among the Manlarla of the UWR. The reasons are of varied nature but essentially cultural. Unless and until appropriate culture mediation, compromises and intermediations are pursued at the level of parity (co-culturalism), success of PHC in Manlarla society does not appear to be in sight.

If there is a merit for this study, it is the key lesson (the social-spiritual significance of events and human actions) it offers to social scientists, health related policy makers and programme implementors. The real challenge to a culturally sensitive policy-making is a recognition of variation in cultural principles. As Peter Glynn, then assistant deputy minister of Health and Welfare Canada, noted: "services and activities will have to be dramatically altered to recognize the role of culture in human health and disease" (in Beiser, 1990:6).

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APPENDIX A: Ethnographic Field Guide

A. BASIC DEMOGRAPHIC DATA OF RESPONDENTS:

1. Name of respondent [ ]

2. Name of respondent's household [ ]

3. Village community of respondent
   - Loho [ ]
   - Nanville [ ]
   - Nyimbale [ ]

4. Clan of respondent
   - Emo [ ]
   - Eko [ ]
   - Eto [ ]

5. Status of respondent
   - Community civic leader [ ]
   - Ritual specialist [ ]
   - Local/localized health professional [ ]
   - Funeral ritual participant [ ]
     - Specify status within category [ ]

6. Sex of respondent
   - Male [ ]
   - Female [ ]

7. Age of respondent
   - 15 - 39 [ ]
   - 40 + [ ]

8. Education (formal) of respondent
   - Literate [ ]
   - Non-literate [ ]

9. Religion of respondent
   - Traditional/ancestral [ ]
   - Christianity [ ]
   - Islam [ ]

10. Marital status of respondent

| | | |
|---|---|---|
| Married | [ | ] |
| Single | [ | ] |
| Widowed | [ | ] |

## B. GENERAL QUESTIONS ABOUT FUNERAL RITUALS

1. What in your opinion is the reason for funeral celebrations?

2. What are some of the rituals associated with celebrations of the dead?

3. Are all such rituals important? If yes, why? If no, which ones do you consider important? why? which ones do you consider unimportant? why?

4. Have you experienced any funeral ritual observance in your household? when? whose?

5. Has such funeral ritual observance affected your life? If yes, how? If no, why not?

6. Has such funeral ritual performance affected life in your family? If yes, how? If no, why not?

7. Has such funeral ritual performance affected life in your community? If yes, how? If no, why not?

8. Are there any sanctions and/or taboos associated with funeral rituals? what are they? how do they influence your daily activities? negatively or positively or both? how?

9. Could you do without these sanctions and/or taboos? If yes, how? If no, why not?

10. Can you easily overlook some of these sanctions and/or taboos? If yes, which ones? If no, why not?

11. Which aspects of these funeral rituals would you want to see changed? maintained? emphasized/strengthened? why?

## C. GENERAL QUESTIONS ABOUT HEALTH SITUATION IN THE COMMUNITY

1. What in your opinion is health?

2. What are the most common health problems in your family/community? why?

3. What do you think causes these problems?

4. Can and/or should anything be done about these problems? If yes, what can and/or should be done? If no, why not?

5. Is anything being done about them? what is your assessment of whatever is being done?

6. How do you maintain good health?

D. GENERAL QUESTIONS ABOUT ILLNESS AND HELP SEEKING

1. What in your opinion is illness?

2. How do you know when you are sick?

3. What do you do when you are sick? why?

4. How do you keep yourself from getting sick?

5. How do you know if a member of your family is sick?

6. What factors determine your decision to seek for help?

7. Who makes decisions regarding illness in your family?

8. Supposing you wish to seek for help, who and where would you go? why?

9. Do you sometimes wish you had gone to a different person for help? why?

E. GENERAL QUESTIONS ON HEALTH SERVICES UTILIZATION: PROFESSIONAL: CONSULTATION WITH HEALTH CENTRE (PHC)

1. Have you ever consulted at the health centre? If yes, why? If no, why not?

2. Do other members of your family consult at the health centre? If yes, who? If no, why not?

3. Have you or any member of your family been to the health centre in recent times? If yes, for what symptoms?

4. Was any diagnosis made? If yes, what was it?

5. How did you feel about the diagnosis? why?

6. Was any treatment recommended? If yes, what was the recommended treatment?

7. Do you think the recommended treatment was appropriate for the symptoms displayed? If yes, why? If no, why not?

8. How often do you and/or other members of your family consult at the health centre? If very often, why? If infrequently, why?

9. What is your assessment about the services provided at the health centre in your community?

## F. FOLK: CONSULTATION WITH TRADITIONAL HEALERS

1. Have you ever consulted at the traditional healer? If yes, which traditional healer and why? If no, why not?

2. If you wish to consult a traditional healer do you consult with some other person before? If yes, who and why? If no, why not?

3. What factors determine which of the traditional healers to consult? why?

4. Have you and/or any member of your family consulted a traditional healer in recent times? If yes, for what symptoms?

5. Was any diagnosis made? If yes, what was the diagnosis?

6. How did you feel about the diagnosis? why?

7. Was any treatment recommended? If yes, what was the treatment recommended?

8. Did you consider the treatment appropriate to the symptoms as displayed by you and/or other members of your family?

9. How often do you and/or other members of your family consult traditional healers?

10. What is your assessment about the services provided by traditional healers in your community?

## G. POPULAR: HEALTH SEEKING BEHAVIOUR

1. How often do you experience ill-health?

2. What symptoms do you usually experience?

3. Do you normally consult anyone for help regarding the symptoms you experience? If yes, who and why?

4. Do you consult this person for all symptoms experienced or just for some? If for all symptoms, why? If for some, which ones and why?

5. What motivates you to seek help?

6. How long does it take you after symptom recognition to seek help?

7. Does it take the same time period in all symptoms/cases or it varies? If it varies, why?

8. If you do not normally consult anyone for help, what do you do? why?

## H. ILLNESS CAUSATION, DIAGNOSIS AND TREATMENT OR MANAGEMENT OF ILL-HEALTH

1. What do you think causes ill-health? why?

2. How do you think ill-health is caused by (1) above?

3. What are the implications of your illness or symptoms for other members of your family? why? why not?

4. What implications do the illness or symptoms of other members of your family have for you? why? why not?

5. How do you think ill-health is diagnosed?

6. What procedures are normally followed to diagnose your illness? what about illnesses of other family members?

7. Who makes the diagnosis when you are ill? why?

8. Have you been sick in recent times? If yes, what diagnosis and/or cause was made about your illness?

9. How did you feel about the cause and/or diagnosis?

10. Did the cause and/or diagnosis have any effect on you? If yes, what were these effects? how did you deal with them?

11. Did anyone else know the cause and/or diagnosis? what was their reaction to the cause and/or diagnosis?

12. Do you think the cause and/or diagnosis were appropriate?

13. Was some treatment administered? what was the treatment?

14. Do you think that the treatment was effective? If yes, how?

15. If no, what kind of treatment do you think you should have received? why?

16. Do all members of your family go through the same process of diagnosis, and treatment? If no, can you explain the differences and why?

APPENDIX B: Glossary of Manlarla Medical Terms.

| Local Manlarla Term | Literal Meaning | English Equivalent |
|---|---|---|
| Beraa | poison | poisoning |
| Bidogituo | difficulty in child birth | difficulty in labour |
| Bigbere | lame -child | polio |
| Binkuong | watery faeces | diarrhoea |
| Binkuongkpeng | big watery faeces | cholera |
| Binzing | bloody faeces | dysentry |
| Birituo bangyiraa | bitter breast toilet | diarrhoea |
| Dambu | bone disturbance | fractures/sprains |
| Dogiguo | premature birth | miscarriage |
| Dunbaalong | mosquito sickness | malaria |
| Eng-Tulong | hot body | fever |
| Eng-Orr | bodily chop | bodily pains |
| Gbe Miila | tiny legs | AIDS |
| Gelmwane | snail | |
| Gyima/Nobile | spirit sickness | convulsion |
| Guma | bending | hunch back |
| Konkonne | fail to have fingers | leprosy |
| Korong | folding | TB of the spine |
| Korihii/haahii | big cough | whooping cough |
| Kor-Orr | bone chop | rheumatism |
| Kpiilong | hips | hips pains |
| Kpugraa | swelling | hernia |
| Kunkunne | falls | epilepsy |
| Kuonduma | diseases of water | drowning |
| Lombo-Orr | side chop | side aches |
| Lomboro | | pneumonia |
| Lorba | local missile throwing | |
| Mansugo | river mess | amoeba |
| Mundi | eaten anus | anal prolapse |
| Mune | red anus | |
| Muora | penis trap | |

| Local Manlarla Term | Literal Meaning | English Equivalent |
|---|---|---|
| Natire | shooting sore | boils |
| Natu | big leg | elephantiasis |
| Nimbibaalong | eye sickness | sore eyes |
| N'-Orr | body chop | bodily pains |
| Nyaa!e | small chest | asthma |
| Nyabi-Orr | rib chop | rib pains |
| Nyiile | itching | guinea worm |
| Nyimpole | | |
| Nyin-Orr | chopping teeth | dental caries |
| Nyofiir | blow nose | catarrh |
| Nyugongo | crooked neck | cerebro spinal meningitis |
| Nyulong | bent neck | stiff neck |
| Nyuobaalong | navel disease | navel pains |
| Pogbaalong | woman's diseases | gonorrhoea |
| Pobaare/Po-Orr | stomach chop | abdominal pains |
| Po-Paale | swollen stomach | bloated belly |
| Sankpana | skin rashes | scabies |
| Saaduma/saatanno | diseases of lightning | lightning |
| Seba/Siba | | "jaundice" |
| Siyi | soul loss | |
| Suolong | bewitching | |
| Tagigana/Tagikyur | stretching | measles |
| Tensugbaalong | night sickness | night blindness |
| Tiire | vomiting | |
| To-Orr | ear chop | ear ache |
| Wa-dung | snake bite | snake poison |
| Werduorung | horse urine | jaundice |
| Were | snail | |
| Womo | | rashes |
| Zagu | | cold |
| Zamakokore | | ring worm |
| Zing-Kpire | sit sleep | |
| Zudi | head taking | |
| Zu-Orr | head chop | head ache |

APPENDIX C: Glossary of Manlarla Healthcare Service Providers.

| Local Manlarla Term | English Equivalent |
|---|---|
| Bugbugra | soothsayer/diviner |
| Bugbugriba | soothsayers/diviners |
| Bugbugri-Tiin-era | soothsayer-healer/diviner-healer |
| Bugbugri-Tiin-eriba | soothsayer-healers/diviner-healers |
| Karimuga | Muslem diviner/healer |
| Karimugre | Muslem diviners/healers |
| Kor-nyogra | bonesetter |
| Kor-nyogriba | bonesetters |
| Kontonbuola | spirit medium |
| Kontonbuoliba | spirit mediums |
| Lor-ire | local missile extractor |
| Lo-iribe | local missile extractors |
| Naasaal-Tiin-era | modern (localized) health professional |
| Naasaal-Tiin-eriba | modern (localized) health professionals |
| Pordogra | traditional birth attendant |
| Pordogriba | traditional birth attendants |
| Samasama | environmental/hygiene worker |
| Samasamare | environmental/hygiene workers |
| Tiin-era | healer/herbalist |
| Tiin-eriba | healers/herbalists |
| Zamberisoba | blacksmith |
| Zamberideme | blacksmiths |

## APPENDIX D: Some Diseases, their Causes, Symptoms, Treatment and Prevention in Manlarla Society

| Diseases & Causes | Signs & Symptoms | Time of Occurrence | Treatment & Prevention |
|---|---|---|---|
| Pobaalong Abdominal pain | | | |
| bad food, raw food, defiling Tengbane, disobeying ancestors and traditions, witchcraft & sorcery | navel & waist pains, unable to sit upright, abdominal noises | all year round but common during Siengo | consult diviners regularly, perform appropriate rites, apply appropriate medication (herbs & leaves, e.g danvag-tuo bitter roots) & clinic |
| Maarong Malaria: | | | |
| maarong cold weather<br>dunne mosquitoes | headache, joint pains, dizziness fever, rashes (sometimes) | very common during Siengo | clinic, leaves of datuo bitter tree (nim tree), consult diviners, offerings (sacrifice & almsgiving) |
| Gyima Convulsion: | | | |
| maarong malaria, engtolong fever, nyugli sogla black bird or sazu bong "above thing", birpuore ancestor "neglect", suolong witchcraft & sorcery | shrilled loud cries at night<br>warm body | occurs all the year round<br>common during Uonne dry season | consult diviners regularly<br>herbs mixed with tobacco for rubbing as pomade<br>observe necessary rites |
| Engtolong Fever: | | | |
| maarong malaria, dunne mosquitoes, disobeying ancestors, ancestor "neglect"/"warning", witchcraft & sorcery | warm body<br>weak body & pale looking | all year round<br>very common during Siengo wet season | consult diviners & make sacrifice to ancestors<br>herbs mixed with shea butter & send patient to clinic |

| Diseases & Causes | Signs & Symptoms | Time of Occurrence | Treatment & Prevention |
|---|---|---|---|
| Korong Whooping cough: | | | |
| maarong malaria, nyaale asthma, salenbogi goldmines, disobeying the spirits, sorcery & witchcraft | patient is pale patient is lean or bony with body weakness | occurs all the year round common during Siengo | consult diviners regularly & perform rites appropriately bath leaves of the Kepog tree, herbs and attend the clinic |
| Muni bo: | | | |
| eating soil/sand, eating dirty or uncovered food, defilement of Tengbane Earth god, sorcery & witchcraft, inheritance | eat much and defecate worms patient is lean with protruding abdomen | occurs all the year round very common during Uonne | consult diviners, bath herbs, pacify ancestors with sacrifice (to be determined by a qualified diviner), and attend clinic |
| Si-Orr Waist pain: | | | |
| fever, strenuous work, menstruation, pregnance ancestor disregard, sorcery & defilement of Tengbane | cannot walk upright, severe pains | Siengo, especially sienkpe paalaa at the beginning of the season | mansugo herbs, taa-wiele mistelto on sheanut tree, rest, rites, naamuo shrub boiled and drank, aberiwa be bo ball old will play ball leaves, clinic |
| Wirduorong Jaundice: | | | |
| severe cold, poisoning, ancestor anger, disregard for spirits, witchcraft & sorcery | yellowish eyes, joint pain, body is weak & pale, feels sleepy | Uonne, especially tulong sanga when very hot | gopila nyaga roots, dawadawa seeds soaked and drank, samadabuo or zinzalaazuuri herbs boil, add sugar & drink, respect tradition & the gods |
| Bonkpaga Boils: | | | |
| touching corpse with same disease without usual rites, defilement of Sa-Ngmen Rain god or Naamane River god, breaking taboos/oaths, witchcraft & sorcery | itching, burning sensation, bodily pains | all the year round, but very common during sienkpe paalaa | consult diviner, obey tradition, avoid unnecessary promises, avoid eating anthrax meat, clinic (hospital) for incission and injection |

| Disease & Causes | Signs & Symptoms | Time of Occurrence | Treatment & Prevention |
|---|---|---|---|
| Mundira Pneumonia: | | | |
| severe cold, breaking taboos, oaths, moral conduct, sorcery & witchcraft, defilement of gods, disobeying traditions | whitish eyes, spinal ache, waist pains, sore anus, weak & appetite loss | all the year round but very common during Siengo | boil the bark of dawadawa tree and pour in anus or grind ginger with pepper & put in anus, follow tradition, consult diviners & clinic |
| Eng-Orr Rheumatism: | | | |
| cold weather, disobeying traditions, disobeying ancestors, sorcery & "cold blooded" people (God sent) | painful joints, inability to pick things, feels very cold | during Siengo when weather is very cold | use nubie anuu" five fingers herb, boil & bath while part is pounded and robbed on body, consult diviners, clinic (but no cure for it) |
| Binkuong Diarrhoea: | | | |
| improper cooking, sucking exposed breast, natural teething, disregard for taboos, misconduct, witchcraft & sorcery, ancestor "warning | patient is weak and pale<br>patient has sunken fontanelle | occurs all the year round<br>very common during Siengo | consult diviners, observe taboos and appropriate rites<br>nvuo kvir give marks around navel; herbs (kuntaa, kolmo, naazuo & mwambiri) & guava leaves for bloody stool |
| Bigberi Polio (lame child) | | | |
| hereditory, gods & spirits, unfulfilled promises to "things" responsible for pregnancy, witchcraft & sorcery | lower body is inactive, cannot stand up to walk | can occur anytime during the year | fulfil promises made to overcome 'barrenness', no cure and no known way of preventing it |

*Figures 1.1/1.2: The Upper West Region of Ghana and its Administrative Structure*

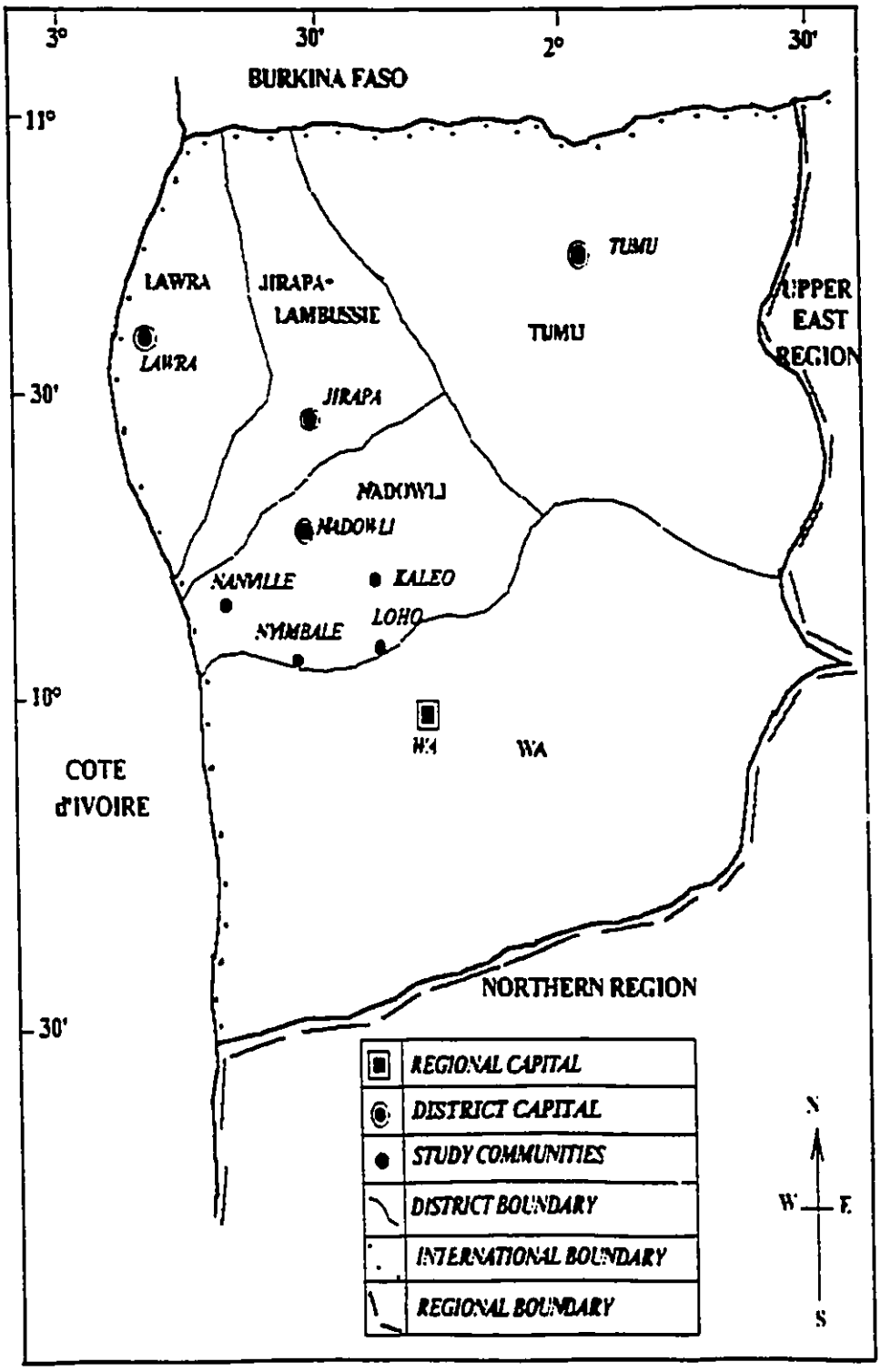

*Figure 1.3: Health Institutions in the Upper West Region*

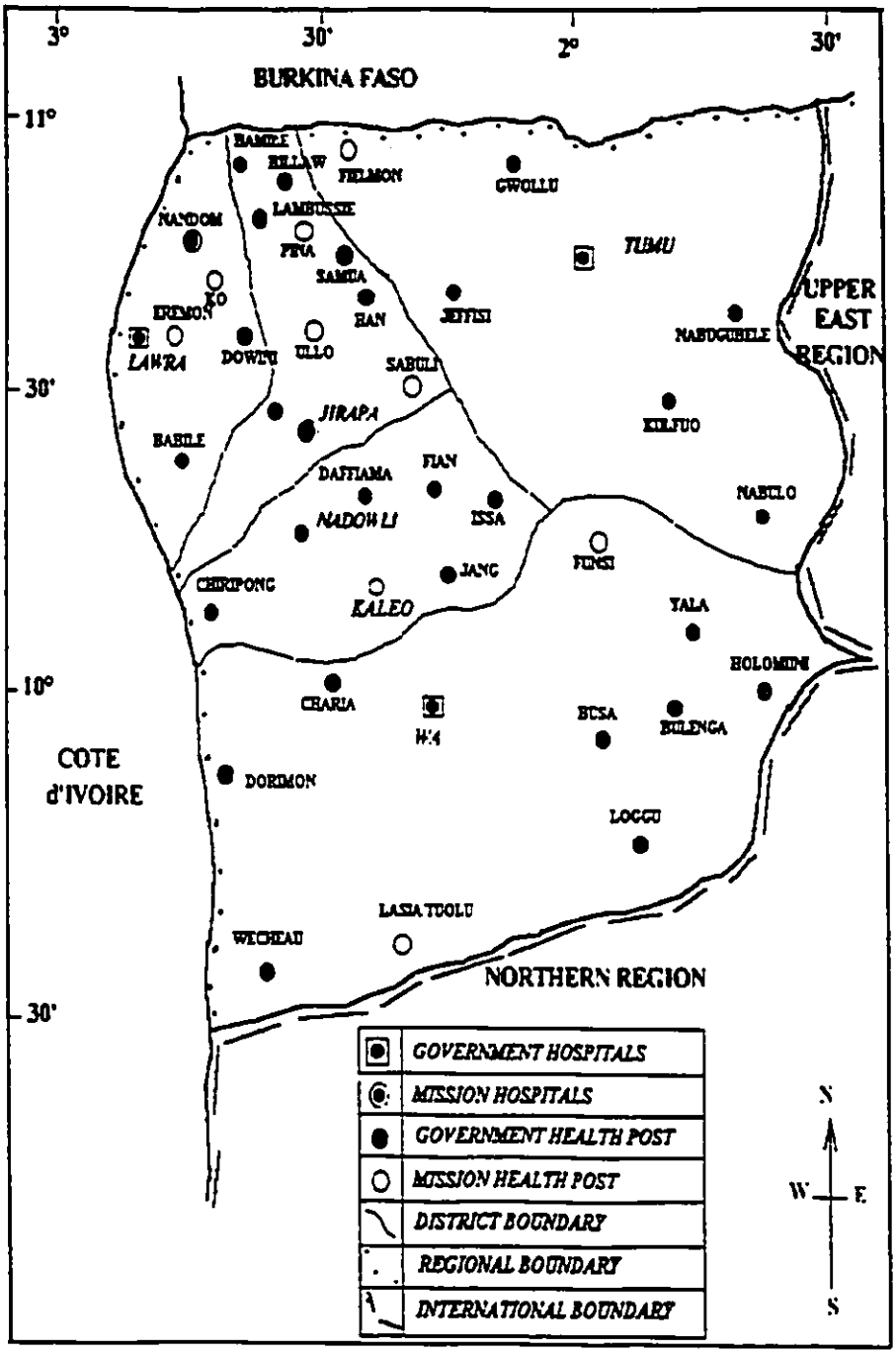

*Figure 1.4: The Sample Community and Mining Towns*

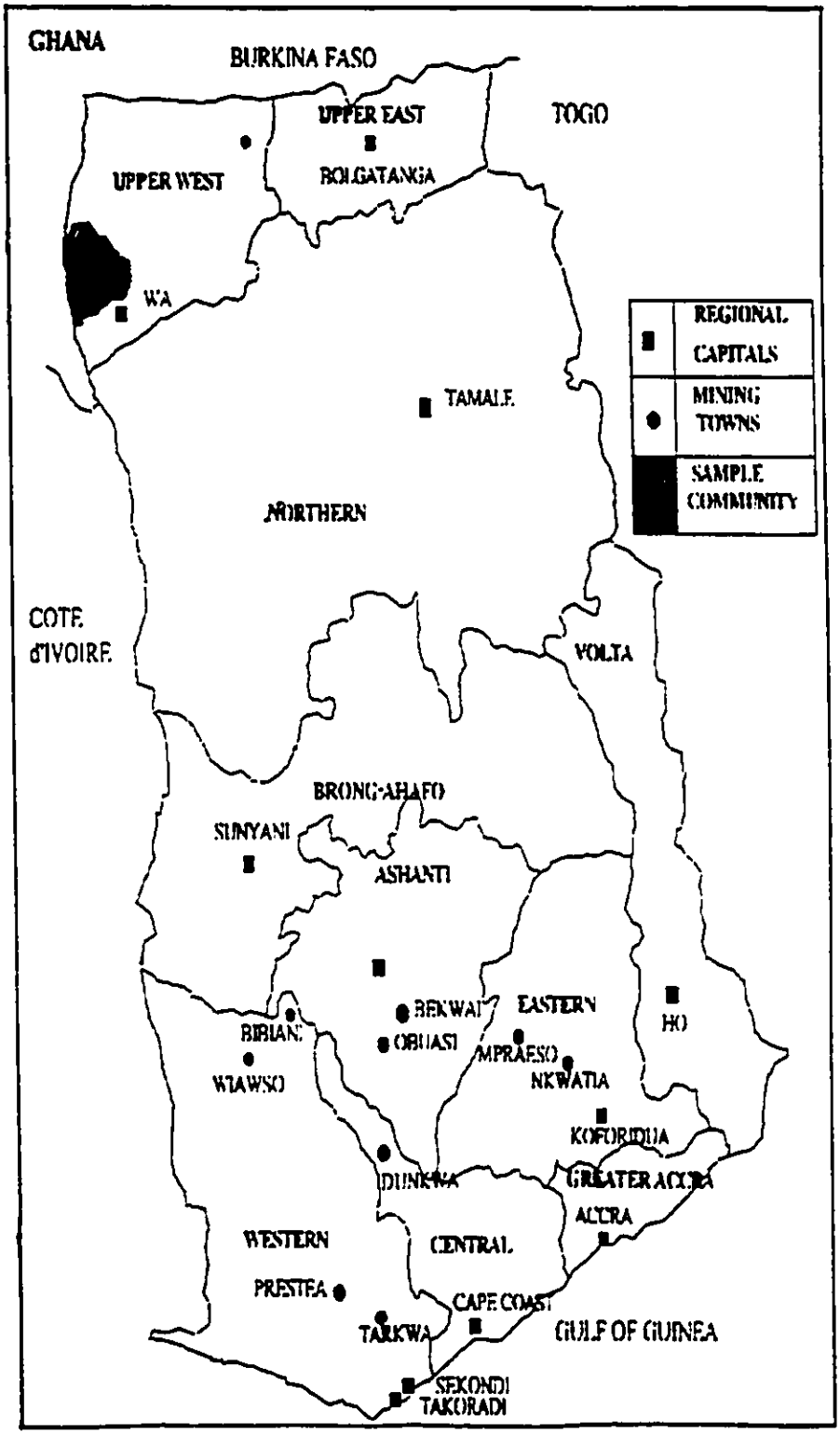

*Figure 2.1: Relative Position of the Dagaaba*

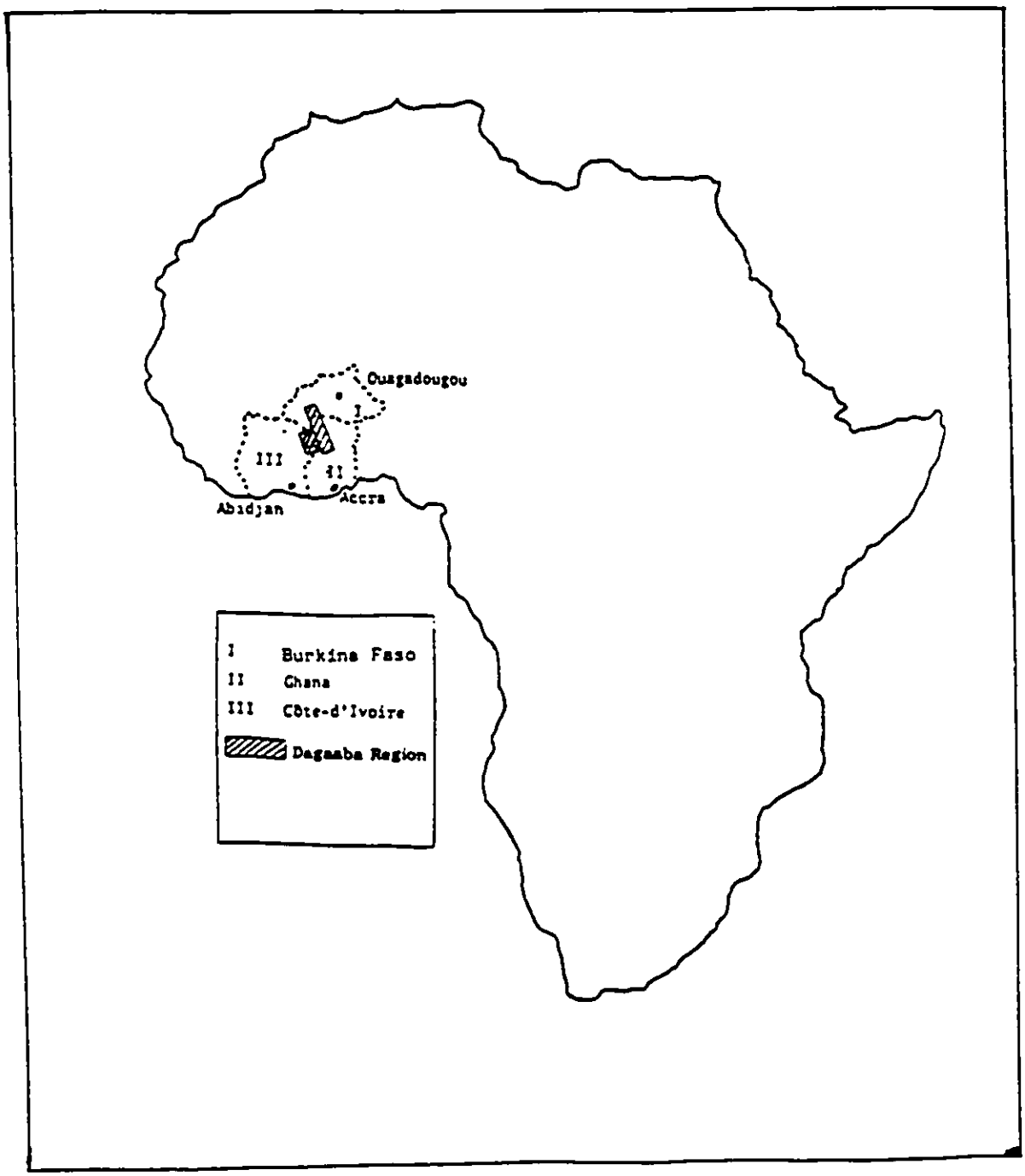

*Figure 2.2: Major Dialects of the Dagaare Language*

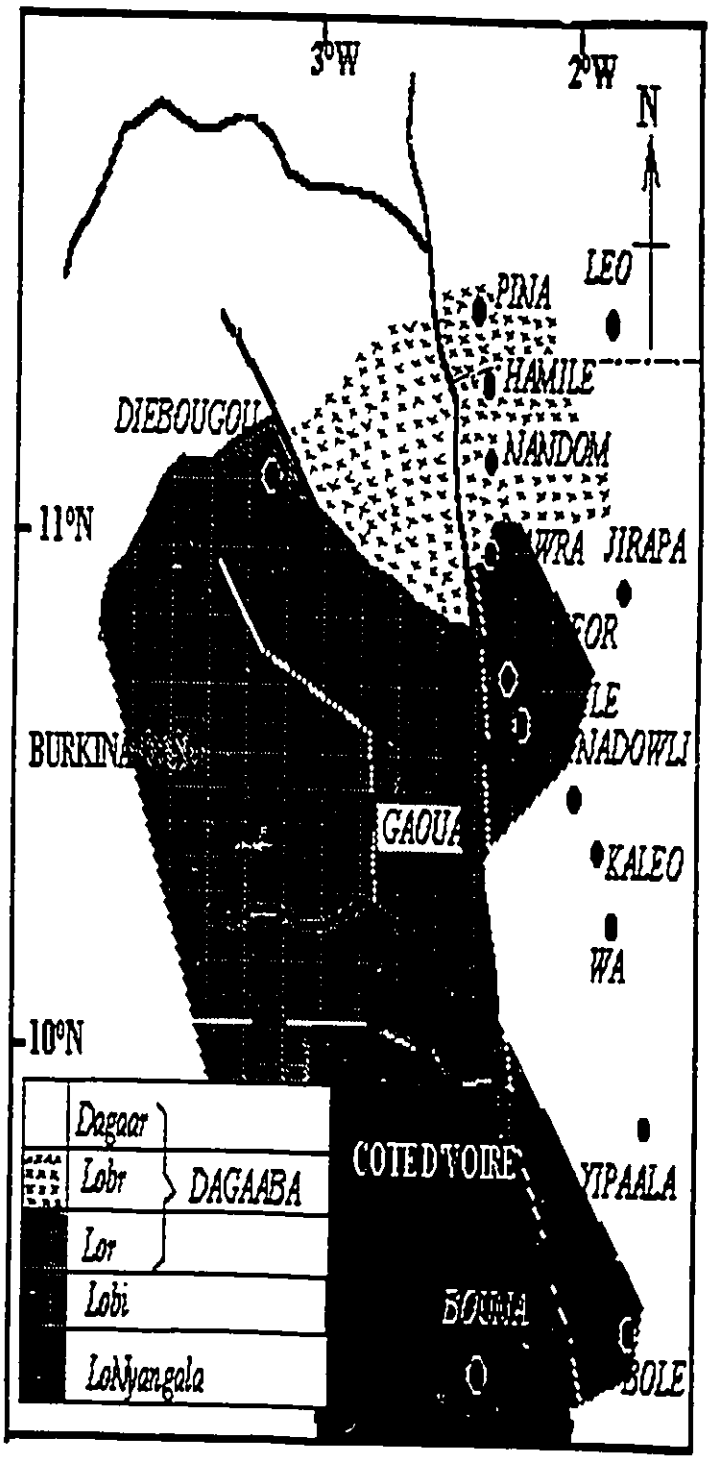

*Figure 2.3: Dagaaba Migration Patterns*

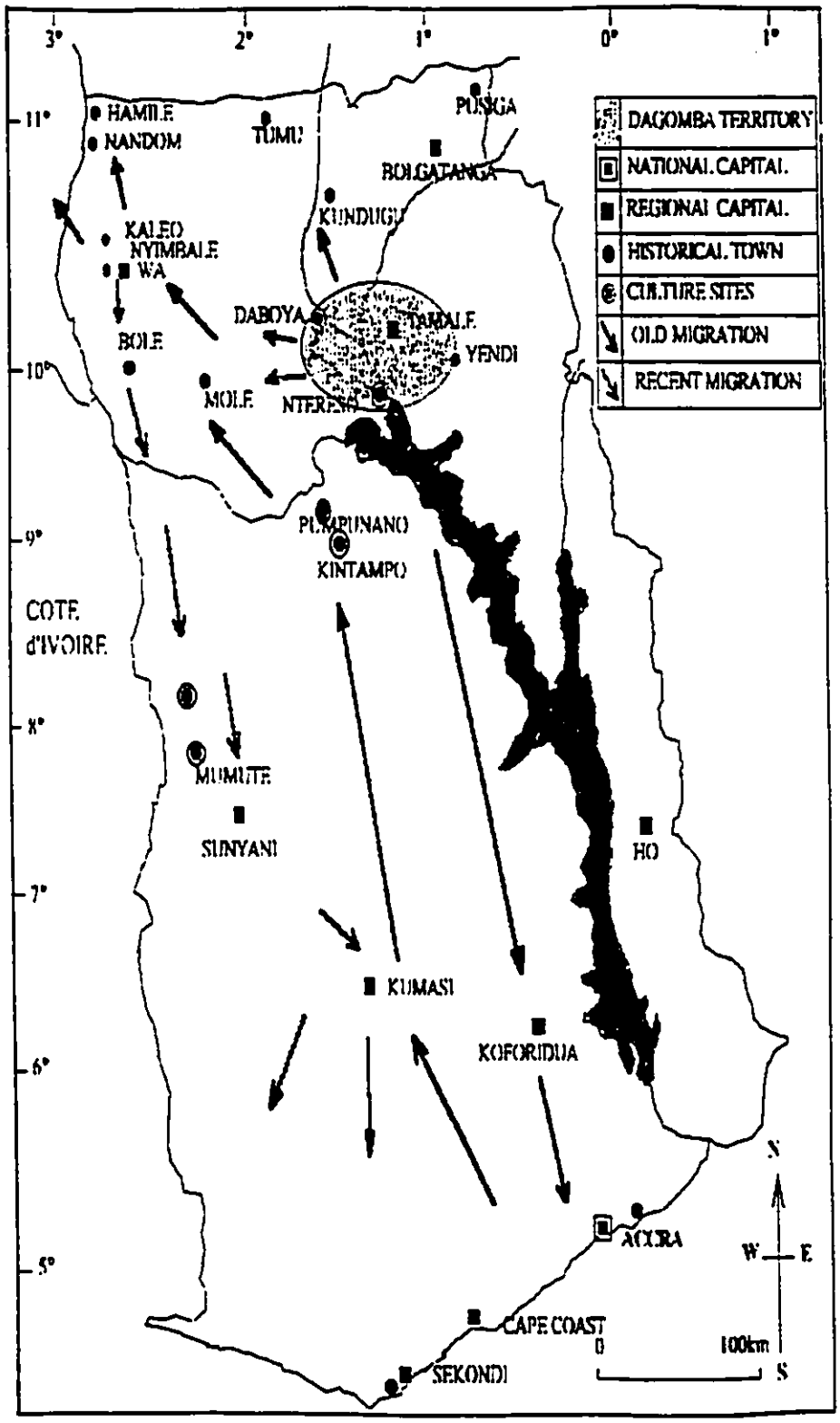

*Figure 3.1: The Conceptual Framework*

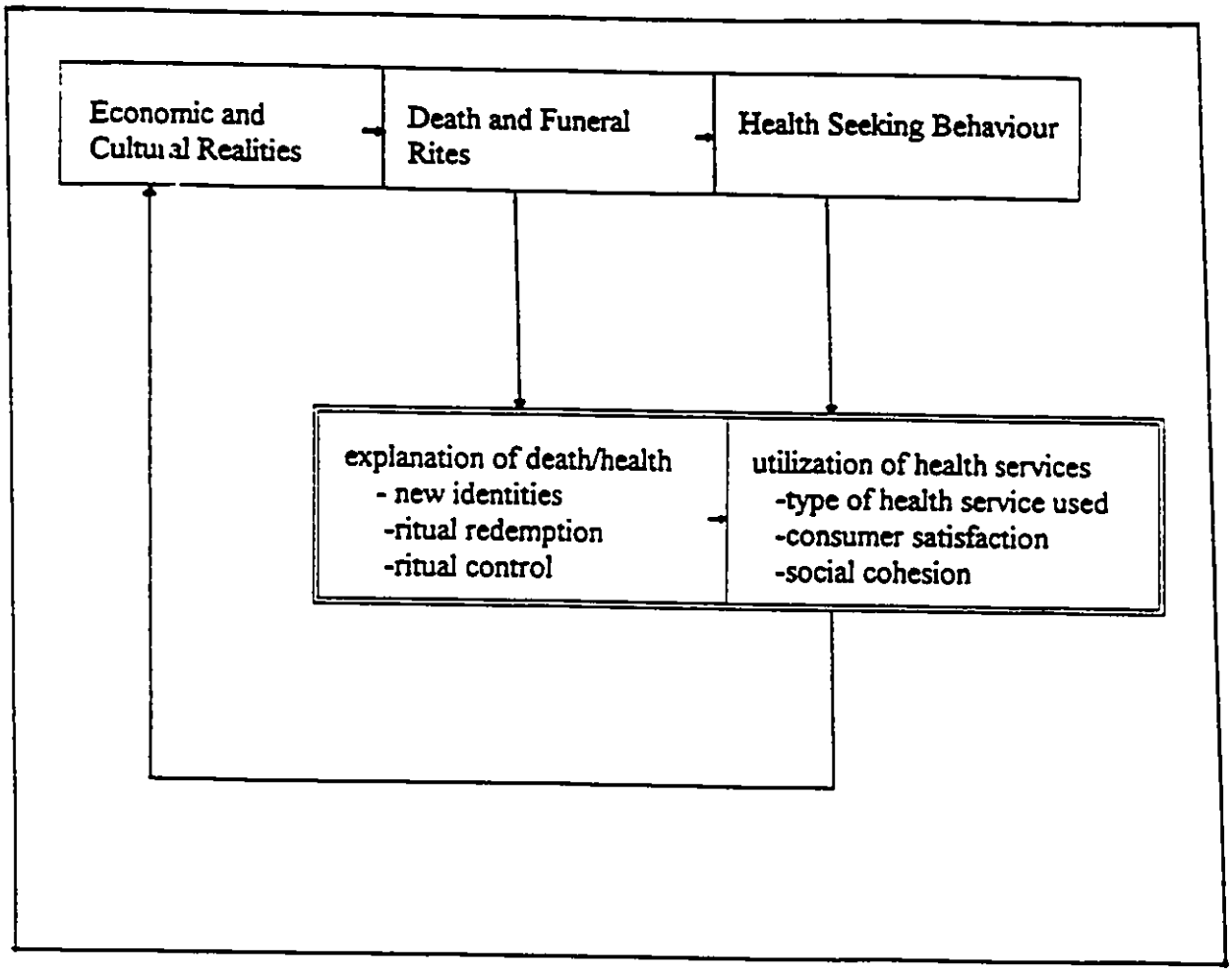

*Figure 4.1: Manlarla Conception of Health and Illness*

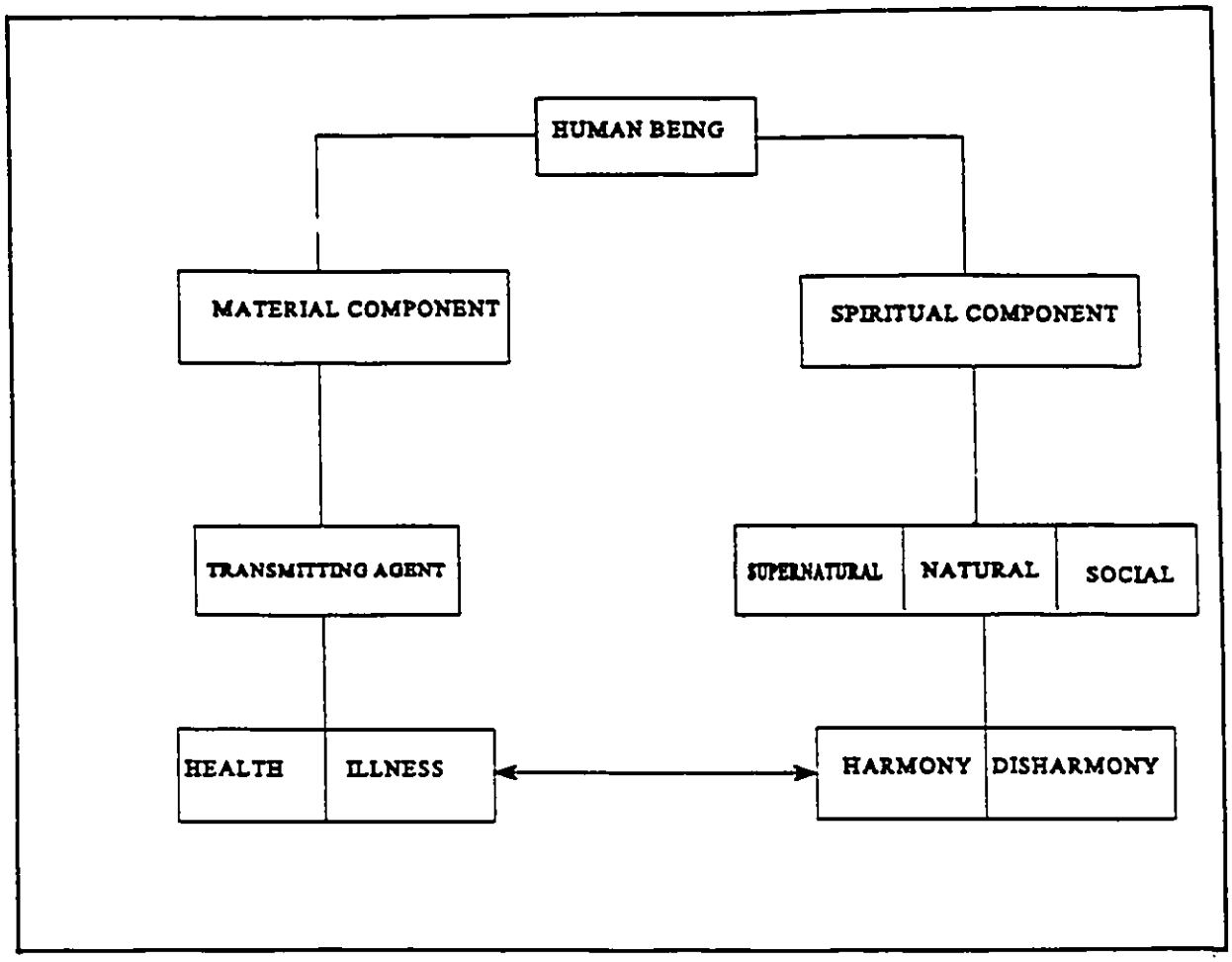

*Figure 4.2: Manlarla Conception of the Universe*

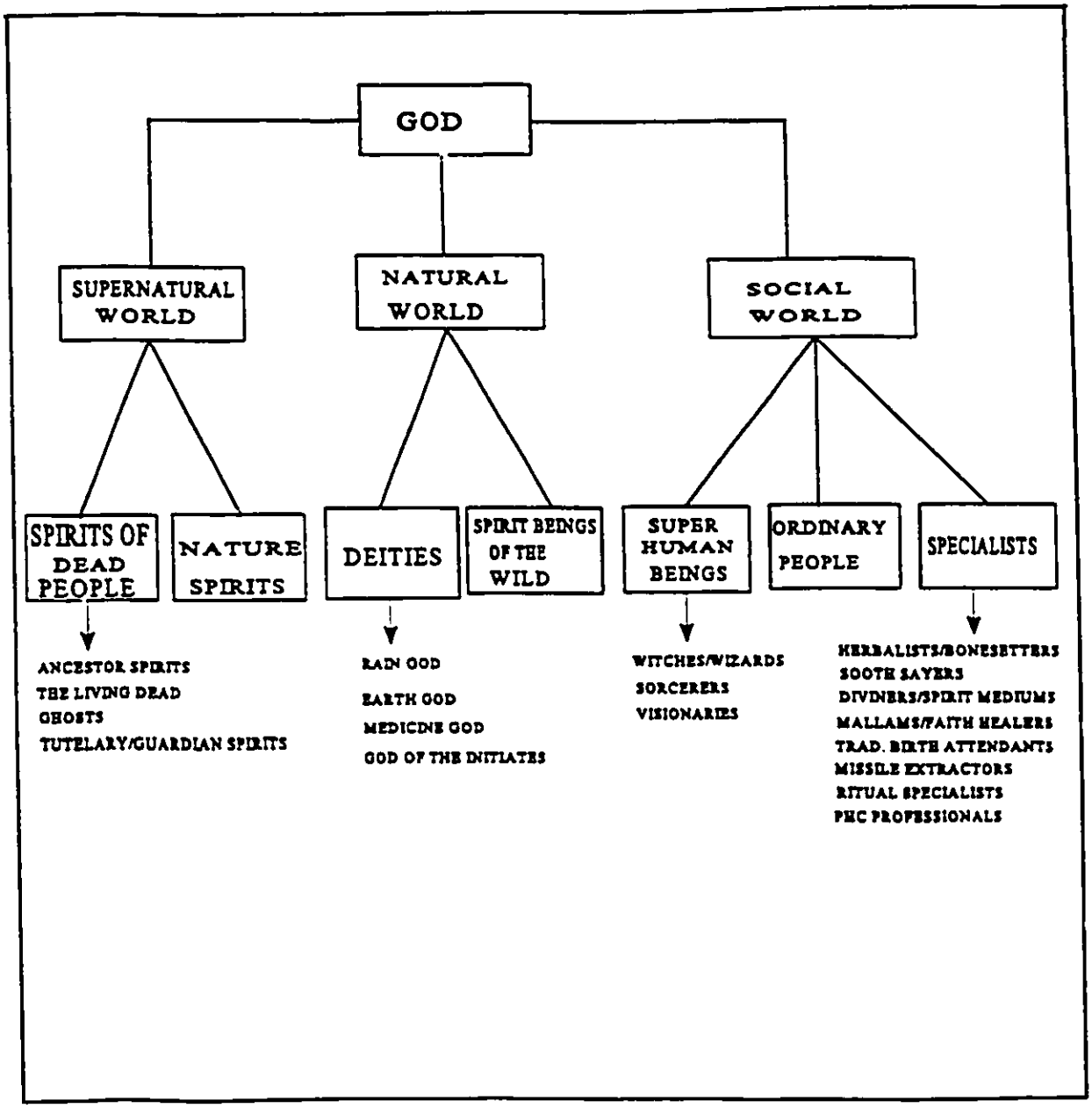

*Figure 7.1: Multi-Level Model for Decisions and Behaviour (Adopted with modifications from Burns et al. 1985:14)*

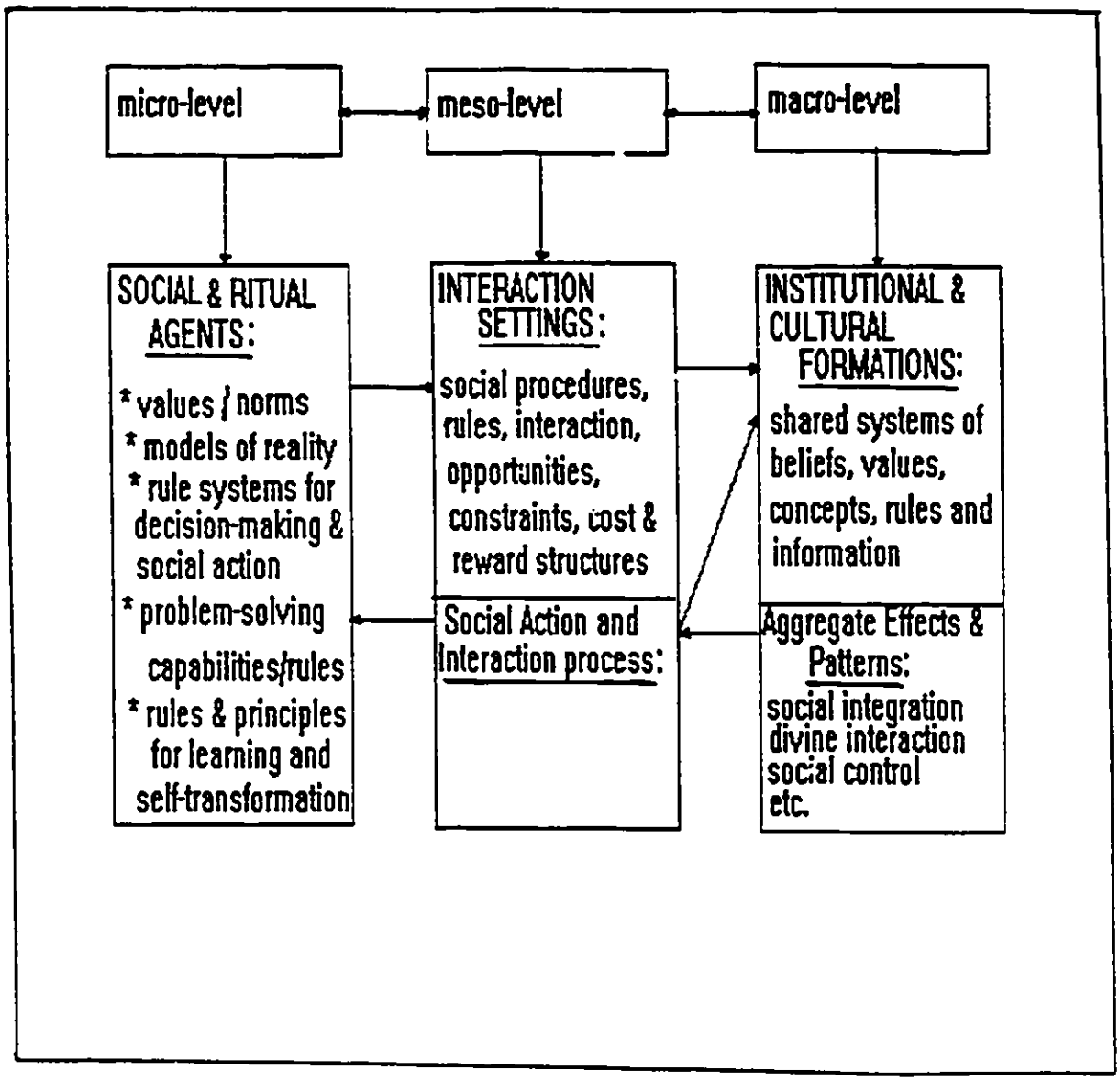

*Figure 8.1: The Path to Health Services Utilization*