KU LEUVEN

FACULTEIT SOCIALE WETENSCHAPPEN
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Is prevention better than cure?

An anthropological rethinking of prevention in the context of the Ghanaian health care discourse and the daily lives of its patients

Promotor : Prof. Dr. A. CASSIMAN
Verslaggever : Prof. Dr. F. DE BOECK

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Axelle MEYERMANS

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Abstract

As biomedicine has paved its way into the curative services provided by Ghana's public health care institutions, the area of health prevention and sensitization has not been left untouched. During my two-month ethnographic fieldwork at a Community-based Health Planning and Service [CHPS]-clinic in the village of Akim Gyadam in Ghana's Eastern Region, I was naively astounded by the significant amount of local villagers who did not act upon the preventive health recommendations offered by the nurses working at the health clinic. Going beyond my initial ethnocentric readings of this observed *non-compliance*, I argue that the bio-medically inspired preventive efforts of the nurses are not adjusted to local notions of health risks and illness prevention, nor to the cultural, social and economic living conditions of the target audience. Besides showing how biomedicine has been reinforced through hegemonic discourse, this master's thesis aims at an anthropological rethinking of the concept of prevention. While taking into consideration the hybrid healing reality of Ghanaian health care seekers and providers, local understandings of health risks and particular ways of preventing these uncertain health conditions are discussed.

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Abbreviations and acronyms

CHN	Community health nurse(s)
CHPS	Community-based Health Planning and Service
CWC	Child Welfare Clinic
GHS	Ghana Health Service
MoH	Ministry of Health (Ghana)
NHIS	National Health Insurance Scheme
PHC	Primary Health Care
TB	Tuberculosis
USAID	United States Agency for International Development
WHO	World Health Organization

Looking through the lens of health and health care: Introduction

Illness and health are at the core of every human culture and society. While sickness reveals what and who really counts, it is also a human experience that is intrinsically pervaded by ambiguity and inconclusiveness (van der Geest, 1995a; van der Geest & Krause, 2014). It is the calling of medical anthropologists to grasp the fluidity and ambivalence of these human experiences of health and sickness. However, while taking these individual narratives as a starting point, medical anthropology is engaged in yet another endeavor. By taking on a multilevel perspective, the discipline explores and examines conflicts of interest and cultural diversities in relation to health, on different levels of societal organization (van der Geest, 1995a). This is exactly what my master's thesis sets out to do as well.

However, before disclosing this central 'pitch' of my thesis, I must admit that my own introduction into the field of medical anthropology was not an easy one. When travelling to a small town in Ghana's Eastern Region in the summer of 2015 to undertake the ethnographic research for this thesis, I had not even picked up a classic academic work in medical anthropology yet. Instead, I initially set out to do research on another topic, which I will explain in greater detail in the methodology section below. However, confronted with the accounts of different health professionals who thoroughly informed me about the structure and organization of health care in Ghana, as well as captivated by the workings of a small health center in a neighboring village of the town where I was staying, I decided to abandon my previous topic of research and to take local perceptions of health and illness as the renewed, main focus of my ethnographic research. Subsequently, the small health center – Ghanaians call it a 'Community-based Health Planning and Service' [CHPS] center (shortly pronounced as a 'chips' center) – in the relatively remote village of Akim Gyadam, became the principal site for my research on these matters.

While still being new to the field of medical ethnography and anthropology, I was astonished by a particular observation rather soon after I had joined the nurses who staffed the CHPS center in their daily work. I was naively surprised to find that the attempts of these nurses to educate and sensitize the local inhabitants of the village on different health-related behaviors, generally seemed to fall on deaf ears, in the sense that the local population did not appear to act upon the preventive recommendations given by the health workers. This observation astounded me since these pieces of advice seemed – to my modest judgment – only to be in the benefit of the local villagers. At first, I felt a strong inclination to offer individual explanations for these types of behavior. As such, I wondered if people perhaps did not have enough time to invest in taking these preventive measures, or just outright were not interested in improving their health conditions. Gradually, however, I started to look at these observations with a whole new set of eyes.

After having read publications by different medical anthropologists, such as Krumeich and van der Geest (1989), Lock and Nguyen (2010) and Levine (2012), I realized that this observed tension could not be solely explained in individual terms. Instead, we have to employ this perceived discrepancy between 'desired' and 'displayed' health-related behaviors as a lens to look at broader societal phenomena. As such, the main argument of my master's thesis asserts that the bio-medically inspired preventive education and sensitization offered by the Ghana Health Service [GHS] – which becomes practically provided to rural villagers by nurses working in CHPS centers all over the country – often conflicts with local notions of health, illness and prevention. This relates to the way in which biomedicine not only takes on a hegemonic position in Ghana's public health institutions, but also has a concrete impact on the private and intimate lives of the Ghanaian people.

In this thesis, I will critically examine this permeation of biomedicine into the daily lives of the Ghanaian population and analyze the processes that have given rise to the hegemony of this biomedical framework. In this, the persistent dichotomy between scientific (biomedical) knowledge and indigenous ('traditional') knowledge takes on a crucial role. I argue that the two contrasting visions on the position of indigenous knowledge in the current development discourse – as a scapegoat for underdevelopment, or as a panacea for sustainability (Nygren, 1999) – are both essentialist representations of local knowledges and should be discarded as such. Moreover, this hegemonic domination of scientific, biomedical knowledge reflects the unequal distribution of power and resources in contemporary society at large (Filc, 2004).

It becomes clear that in this thesis, I will go beyond the dichotomous thinking of scientific versus ‘traditional’ knowledge, and instead will consider the reality of Ghanaian healers and patients as one which is ultimately hybrid and ambivalent (as is our biomedical reality for that matter). I conclude this thesis with an anthropological rethinking of the concept of prevention in the context of the Ghanaian health discourse. What are the local understandings of health risks and hazards? And how do they give rise to particular ways of preventing uncertain health conditions?

Following the field: Methodology

Taking off to Ghana in the summer of 2015, I had planned on doing a two-month research on quite a different topic, namely on the Ghanaian diaspora in relation to development. Because of previous travels to the South and contact with Ghanaian immigrants in Belgium, I was interested in the role of this Belgian-Ghanaian diaspora in the development of their country of origin. Especially the perceptions of local Ghanaian people on the various development projects that are set up by members of this diaspora seemed fascinating to me and I wanted to focus on this while undertaking my ethnographic research in Ghana. I got into contact with a Ghanaian NGO, named Community Livelihoods Support Organization (COLISO) who have a partnership with the Ghana Council in Belgium, and set out to Ghana to ethnographically research how local Ghanaian people actually perceive and think of these development projects.

As I arrived in the town of Akim Oda in Ghana's Eastern Region (Appendix 1), where I stayed in the house of Anastasia Atiogbe who is the Director of the local 'Birim Central Municipality Health Directorate' as well as one of the board members of COLISO, I devoted the first week of my stay to visiting several development projects of COLISO in the region. Even though this tour was very interesting, I gradually started to realize that the goal of my research was perhaps a bit too ambitious. How would I gain a meaningful insight into the perceptions of the local villagers on development projects without having a clear point of entry into their social networks in order for me to build up a good and, above all, honest rapport with them? This limitation was further reinforced by the restricted time I had to spend on the field, that is to say only eight weeks. While time is one of the greatest resources of the anthropologist, this is exactly what I was short of in my research. At the same time, I was already acquiring considerable amounts of information about Ghana's health care system through my local host, Anastasia, and COLISO's staff members who also thoroughly focus on health education and sensitization of local community members in the workings of their NGO.

I was in doubt about this problem, until, as the second week of my stay in Ghana was just beginning, the staff of COLISO took me to a neighboring village of Akim Oda, called Akim Gyadam (Appendix 1), to show me a small health center that was set up a couple of years ago with the financial help of the Ghana Council in Belgium who acquired funding of the City of Antwerp and some other Belgian organizations. This small health clinic is in fact called a 'Community-based Health Planning and Services' [CHPS] center, pronounced by Ghanaians as a 'chips'-center. I was immediately captivated by the workings of this CHPS center and realized that by working together with the nurses who man the health center I could get into direct contact with the village people of Akim Gyadam. Consequently, I decided to 'follow the field' and to take the CHPS compound in Akim Gyadam as the main research site of my ethnographic fieldwork for the remaining seven weeks of my stay.

Although I was excited to start my fieldwork in this context, I was also slightly worried about it. The theoretical framework I had built up for my start report was now rather useless and I had not read any anthropological literature on topics such as health, illness and healing practices. This lack of prior knowledge about my topic of research resulted in a particular way of thinking which turns the usual way of conducting and writing down a research upside down. Instead of doing an extensive literature research from which relevant research questions are deduced, the inductive nature of my research has allowed me to let the focus of my research depend on the things I have observed in the field as such. In this way, the main question that I pose in this thesis, namely how we can consider the position of prevention in the Ghanaian health discourse and the daily lives of its patients, is the direct result of one of the many things I was puzzled by in the field. I would now even say that my inability of conducting an anthropological literature study on the topic of health before my departure has proven to be rather useful and enriching for my research. It has allowed me to keep my eyes and ears open and to look at my observations with an open mind.

However, being in the field itself often was not an easy task. As I gradually realized that the romantic representation of the lonesome anthropologist living amongst 'natives' in rural Africa certainly is not a correct one, I learned that fieldwork first and foremost involves a long process of learning to cope with a new setting. Besides from being overwhelmed by strong emotions because of my own sense of isolation in a society which was completely out of the ordinary to me at first, I had a tough time being confronted with the generally harsh living conditions and health conditions of the Akim Gyadam villagers. In contrast to our society where proper health care is taken for granted, stories of people who could not afford a proper cure for their, sometimes serious, ailments, often moved me.

Furthermore, this sense of solitude I often experienced during my fieldwork, relates to the difficulties I first had with gaining the trust of the nurses and their patients as an anthropologist and above all *white* researcher. I would even say that my explicit treatment as a foreigner, which persisted during my entire stay in Ghana even though I tried to 'adapt' to the local customs and ways of communicating, further exacerbated my sense of being in a wholly 'different' place. This is exemplified by my own impressions of my first visit to the CHPS center as I have described them in my logbook:

As I first arrived in the CHPS center accompanied by the COLISO staff, all eyes were on us. Since it was Child Welfare Clinic (CWC)[1] *that day, the health center was quite busy and filled with mothers surrounded by their young children who were there to be weighed and vaccinated. Three nurses in brown uniforms were busily running around in order to get all this done. The whole scene came about as quite chaotic to me, all the women were sitting on plastic chairs in a muddled way while children were playing and running in the small porch of the CHPS center. The nurses greeted me in a rather suspicious and shy way since they didn't know what this 'obruni' (*white person *in Twi) was in their clinic for.* (Meyermans, logbook, 4 August 2015)

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[1] CWC is organized on a weekly basis and refers to a day at the CHPS center which is completely devoted to the immunization and weight registration of babies, toddlers and young children up to the age of five.

Slightly frightened by this reserved first encounter, I nevertheless went back to the CHPS center and stayed to work there for the seven following weeks. By joining the nurses in their daily tasks at the health clinic, their initial suspicion soon turned into confidence, as they trusted me with tasks such as taking malaria tests, measuring blood pressures and filing the diagnoses and treatments of the patients. They also took me on their home visits they conducted in the village through which I got to see the patients of the CHPS center in their home contexts. I grew accustomed to all of these daily tasks which after a while became a routine for me, as they were for the nurses. Besides of these practical tasks, the nurses also entrusted me with sensitive and confidential information about the health conditions and home situations of their patients, as well as with their personal life stories.

Although this information proved to be very useful to my research, I felt uncomfortable with being provided material of such a high confidential nature on several occassions. As I have described in my personal logbook (Meyermans, 10 August 2015), “I was confused by the willingness and eagerness of the nurses to give me personal information about the health conditions and intimate lifestories of various individuals, while these individuals had not explicitally consented with this”. It seemed to me as if the nurses were not worried too much about the ethical implications of transferring confidential medical information. I tried to resolve this tension by explicitally asking the patients of the CHPS center if they agreed with me being present at their consultations with the nurses. In practice, however, the answer to this question was often given by the nurses themselves which left the patient with no other option than to consent with me being there.

In this way, I frequently acquired intimate, medical information of different people without their explicit informed consent. Instead, the nurses at the CHPS center acted as ‘gatekeepers’ who felt legitimated to signal the agreement of their patients to partake in my research; a sense of legitimacy that most probably resulted from the rather unequal and hierarchical relationships that the nurses generally maintain with their patients[2] (Davies, 2008). As such, I was confronted with the limits of informed consent in a setting involving significantly unequal power relations, an issue also adressed by Bourgois (in Robben & Sluka, 2012).

Moreover, this author critically examines how we can reconcile effective participant observation with truly 'informed consent' (ibid.). How can building a 'good rapport' with research participants be conciliated with constantly reminding them that everything they say or do may be recorded in fieldwork notes? As Bourgois (in Robben & Sluka, 2012: 328) concludes: "it would be dangerous and arrogant to think that there are definite answers to any of these ethical/moral questions". Instead, we are better off negotiating, maintaining and adapting ethical research relationships in the field to the specifics of the situation or context (Sluka, 2012b). This is something I have tried to do as well during my fieldwork, and having continued to do while writing down this thesis.

However, similar ethical concerns arised in the difficulties I experienced with clearly defining my role as an *anthropological* researcher. Since I was able to assist the nurses in their daily tasks at the CHPS center, it did not take long before they saw me as 'one of them'; as a *nurse* that is. Although I tried to explain that I did not study nursing in Belgium and that I instead conducted a scientific, anthropological research on notions of illness and health in their community, I think they never quite got this. As such, I was always amazed when the nurses asked me to administer vaccinations to the young children at the Child Welfare Clinic (CWC) which I promptly refused because this is not a skill that has been bestowed upon me in my anthropology classes.

Indicating these struggles I experienced in clearly distinguishing myself from the nurses at the expense of my profileration as an anthropological researcher, allows me to touch upon the precarious balance between 'participating' and 'observing' when it comes to participant observation (Davies, 2008). As Davies (2008) remarks,

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[2] A point I will come back to in section 3.1 of this thesis.

anthropologists have frequently tended to place the greatest emphasis on their level of participation as an indication of the quality of their research, while, according to her, a more important expression of a good ethnographic inquiry is the nature, circumstances and reflexive quality of the observations made by the anthropologist. Indeed, my full participation in the field as ‘one of the nurses’ and my subsequent preoccupation with properly executing the daily tasks bestowed upon me, has sometimes hindered me from making patient and open-minded observations; when I for example neglected to make further inquiries about certain patients because I was so absorbed with the accomplishment of my other (nursing) tasks.

Nevertheless, it was even more difficult to position myself as an anthropological researcher instead of as a nurse towards the local villagers of Akim Gyadam. Because I got to know these people almost exclusively as patients of the CHPS center, it was not easy for them to see me outside of this medical performance as a nurse. Although this role of ‘being a nurse’ allowed me to ask all sorts of health-related questions to the local community members, I continued to have a great struggle with establishing a good rapport with these informants. This is not only due to myself being an ‘obruni’, but also to the vast language barrier between us (I do not speak the local language Twi, while many of them do not speak English either) as well as to the fact that I could only do research in their village for a rather limited amount of time.

This language barrier became especially significant when I, after a period of participant observation, decided to conduct interviews with patients of the CHPS center that had left me with the deepest impressions. Although there were a few exceptions, most of these people only had a little understanding of English and could not speak it themselves. Therefore, I was required to hire an interpreter – this was one of the staff members of COLISO, called Emmanuel – who could translate the answers of my interviewees for me on the spot. But even though Emmanuel knew how to properly approach and question the villagers, entirely relying on him to be able to talk to my informants also proved to be challenging. In this way, the use of an intermediary generated a certain distance between me and the person

I was interviewing, while it also became problematic to capture the nuances of what the person was saying, or to adapt and correspond my questions to what the interviewee was explaining. Also the fact that I was using a Dictaphone to record the interviews brought about a certain formality to the conversation, which could have increased the feeling of the interviewees that they could be held accountable for their statements in the interview later on.

The fact that the use of an interpreter and a Dictaphone generated such a formal tone in the conversations with my informants, was an important reason for me to somewhat limit the amount of semi-structured interviews I wanted to conduct to approximately nine planned interviews, while I chose to focus more on the information I acquired ‘off the record’ in semi-formal or completely informal conversations. Like this, I have acquired lots of data just by talking to the nurses and patients while routinely carrying out my daily work or during our one-hour taxi drives back and forth Akim Gyadam everyday, or by having late night conversations with my host, Anastasia (who is the Director of the local Health Directorate) and her two ‘nieces’ who both studied to be a nurse in a CHPS center as well. Also on my other field trips to hospitals, health centers, so-called ‘traditional’ (herbal and spiritual) healers and the half-yearly review meeting of health care providers in the region, I was provided with a lot of information that was gathered in an unstructured way.

This involvement in the research field goes hand in hand with detachment afterwards; an interplay which is at “the heart of the participant observation method” according to Powdermaker (in Robben & Sluka, 2012: 1). As Davies (2008) mentions, this withdrawal or detachment from the field is not simply a matter of leaving a physical place, but also involves a degree of emotionally and intellectually distancing yourself in order to be able to theoretically structure your data and develop theories. After having spent a limited time amount of eight weeks on the field, – I see this lack of time as one of the main limitations of my ethnographic research – I also ‘detached’ myself from the field, saturated by impressions and ideas but also hopelessly confused by them. It is the extensive literature study I conducted in the following weeks that has allowed me to adequately interpret and understand my own observations in the field. And although I wish there would have been a bigger interplay between ethnographic data and literature while being in the field itself, my master's thesis attempts to come to varied and meaningful evidence about health and health care in Ghana by letting my ethnographic data be guided and interchanged by anthropological insights and theories.

1. Setting the scene: organization of health care in Ghana's Eastern Region

As I have indicated above, my research mainly took place on a very specific field site, namely the CHPS compound in the village of Akim Gyadam, and to a lesser extent also in other health care-related institutions in the Birim Central Municipality located in Ghana's Eastern Region (Appendix 1). As anthropology has long abandoned the conceptualization of small-scale societies as homogenous, bounded socio-cultural units, this chapter aims at showing how the local level of my field site is drawn into larger policy- and information-circuits that transcend regional and national boundaries (Schweizer, 1997). This is why I begin this chapter by providing a short overview of the national health care regulators and institutions in Ghana, in which the policies and daily workings of health care actors on regional and local levels are deeply embedded. I end this chapter by zooming in on the local level of the CHPS center in Akim Gyadam, and as such, introducing the prime participants and informants of my research, namely the community health nurses and their patients.

1.1 Health care actors in the Birim Central Municipality

Ghanaian health care is organized on different levels and is mainly decided on and coordinated by the Ghanaian Ministry of Health [MoH]. The autonomous executive agency which is responsible for the implementation of national policies under control of this MoH, is the Ghana Health Service [GHS] (Ghana Health Service, 2016). This institution partly operates on a national level, but also has regional and district-level health directorates as a result of decentralization efforts and health sector reform, of which the Birim Central Municipality Health Directorate in the town of Akim Oda is one (ibidem). This health directorate coordinates and controls the activities of the different health care providers in the Birim Central Municipality which are, in their turn, organized on three distinct, but interrelated levels (Appendix 2). Besides these official health care institutions, I also briefly mention other (inter)national and regional development establishments who operate on different levels to assist in providing health care services in Ghana, as well as the so-called ‘alternative’ health care providers that are present in the region.

Ghanaian Ministry of Health and Ghana Health Service

On a national level, the MoH and GHS are the two main players in the field of health care. As a result of the recent decentralization efforts and reorganization of the Ghanaian health sector, the Ghanaian health service currently operates on five distinct, but interdependent levels. In this way, the national players MoH and GHS govern and coordinate the actions of health institutions who operate on the regional, district (or municipal), sub-district and community level.

Whereas the MoH its primary goals are to formulate a coherent health policy and to provide strategic directions for Ghana’s health delivery services, the GHS is charged with the task of implementing these approved national policies and increasing access to good quality health services with a special emphasis on the provision of primary health care (GHS, 2016; MoH, 2016). It becomes clear that especially the GHS puts a substantive amount of effort in the prevention of disease and the promotion of a healthy mode of living and good health habits (ibid.). This focus on prevention lingers on in the lower-level health services coordinated by the GHS, such as in the daily workings of the Birim Central Municipality Health Directorate and eventually also those of the CHPS center in Akim Gyadam.

National Health Insurance Scheme

But before we turn to these regional and local health care actors, we have to take into consideration another important player in Ghana’s national health policy, namely the National Health Insurance Scheme [NHIS]. Established by the Government of Ghana, this is a social intervention program with the goal of providing financial access to quality health care for Ghanaian residents (NHIS, 2016). As Gajate-Garrido and Owusua (2013) mention, the NHIS was introduced in 2003 to replace the cash-and-carry system where paying for health care services happened at the point of receiving it. Since its creation, the NHIS has had impressive achievements in terms of increases in coverage, availability of health services and utilization of these services (Gajate-Garrido & Owusua, 2013). Whereas less than 1 percent of the population was enrolled in an insurance scheme before the creation of NHIS, this number now amounts to 99 percent when we consider the number of people that are insured under the District Mutual Health Insurance Schemes (DMHIS); which is the most popular insurance plan out of the three options offered by the NHIS (ibid.).

Despite of the fact that the NHIS has proved to have a significant impact in enhancing access to health care, especially for the poor, the low insurance premiums still form a threshold for some people to register in the scheme (Dalaba, Chatio & Akweongo, n.d.). The majority of those unregistered are the poorest and most vulnerable households who are least able to pay for health care when they need it (ibid.). To alleviate these negative effects, exemptions from the payment of these premiums have been introduced for those over age 70, pregnant women, children under age 5, the indigent, and those suffering from certain communicable diseases (Gajate-Garrido & Owusua, 2013). Although some authors such as Dalaba et al. (n.d.) argue for strengthening of this exemption policy, others like Derbile and van der Geest (2012) show that these exemptions are applied in favor of under-fives, antenatal care, the aged and public servants to the disadvantage of the poor. This observation poses critical questions to the ability of the NHIS to address equity concerns in health care, the very reason for which it was initially introduced (ibid.). Also the potential of the NHIS to produce incentive problems related to reduced prevention efforts must be taken into consideration, as I will come back to in the next chapter (Debebe, van Kempen & de Hoop, 2012).

Birim Central Municipal Health Directorate

On a district level, the GHS operates through their local Health Directorates. For the Birim Central Municipality[3], this Health Directorate is situated in Akim Oda, the town where I stayed during my fieldwork. In this town, I was lucky to reside in the house of the

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[3] A municipality in Ghana is situated on the same administrative level as a district, but has been upgraded to a municipality because of its elevated amount of inhabitants.

local District Director of Health Services. I accompanied her to the local Health Directorate on several occasions, where she thoroughly informed me of the mission, functioning and daily practices of the Health Directorate. In this way, she explained me that the Health Directorate works to deliver and supervise the curative and preventive services of health care establishments which operate on three distinctive, but interrelated levels in the Birim Central Municipality (Appendix 2). This three-tier referral system of health care providers exists out of hospitals on the highest level, health centers on an intermediary level (the Akroso Health Center in the Sub-District of Akroso, also situated in the Eastern Region, is an example of this) and CHPS compounds on the lowest level of medical care. Hence, when a patient cannot be treated in a CHPS center (an important note here is that the CHPS services only provide medical treatment for very basic ailments), he or she is referred to the nearest health center or hospital.

Whereas the local Health Directorate coordinates the health care facilities whose curative and preventive practices are based on the policies and guidelines of the MoH and GHS, the Health Directorate has no direct authority over other forms of health care provision, such as the so-called ‘alternative’ healers. Under this common denominator of ‘alternative’ or ‘traditional’ healer we can distinguish different types of healing practices. Apart from the herbal treatments that are offered in small private herbal clinics in the region, there are spiritual healers who cure their patients by praying to different gods and ancestors.

Although the Health Directorate puts some effort in forming alliances with these kind of healers, their registration remains very limited, which makes it difficult to estimate the amount and distribution of ‘alternative’ healers in the region. Hence, when asking people about the number of ‘alternative’ healers that were active in the surroundings of the CHPS compound in Akim Gyadam, I often received conflicting answers; some claimed that there were none, others that there were not any in Akim Gyadam itself but only in neighboring villages, and finally I learned from a couple of local villagers that there is one herbal healer active in the village itself. During my fieldwork, I was not able to make a visit to this healer in Akim Gyadam (since he had travelled to Accra), but I did visit another herbal center in the neighboring village of Oda Nkwanta, as well as a spiritual healer in that same village.

Other national and international health development organizations
Besides from these health care providers who are closely tied to the national health policy of the MoH and the GHS, it is essential to mention other health development organizations who operate in the district and who often intensively cooperate with and support the institutions led by the GHS. These numerous organizations include humanitarian organizations, governmental organizations and international and national NGOs. A few examples are UNICEF, USAID, the Red Cross etc., who make their support noticed by putting their logos on the various posters who cover up the walls in most health facilities.

These aforementioned international organizations not only provide different health facilities with necessary medication or equipment, but also support the preventive practices of these establishments by, for example, supplying free mosquito nets or food supplements. Also more regionally-based organizations, such as the NGOs COLISO and Herald Foundation, located in Akim Oda, are active in this field of prevention by organizing and supporting various health education and sensitization initiatives. In line with their goal of 'community empowerment', they organize different types of health promotion and prevention activities such as screening sessions or HIV-education sessions for youngsters. They also financially and logistically support the already-existing preventive and curative practices of the local Health Directorate.

1.2 Introducing the village of Akim Gyadam and its CHPS center

In addition to these health education programs and COLISO's efforts to improve the health conditions of Ghanaian people by setting up sanitation projects in different villages, the NGO has played a crucial role in the founding and funding of the CHPS compound in Akim Gyadam. By establishing a partnership with the Ghana Council in Belgium, a development organization set up by the Ghanaian-Belgian diaspora, COLISO has acquired funding for the CHPS center from the City of Antwerp as well as from a Belgian diamond company (which is implicitly linked to this Ghanaian region by the high presence of diamonds in its grounds).

Before the CHPS center (figure 1) was established on a compound on the edge of the Akim Gyadam village in 2012, this health center had been located elsewhere in the village; namely in the house of one of the villagers. Back then, the CHPS center only consisted out of one room which obviously was not enough space for the daily amount of patients, while the available equipment also left a great deal to be desired. This story has been told to me during an interview with Amma, an old woman (figure 3) who has been living in Akim Gyadam her whole life, and whose son was the owner and inhabitant of the house where the first CHPS center was accommodated. Besides this, she vigorously told me about the history of the village and its significant changes in the course of her lifetime. She recalled the time when electricity and running water were introduced into the village, and when the road from Akim Gyadam to the closest town of Akim Oda was constructed.

When I asked her about the ways in which they treated ill people before a road to reach the nearest hospital in Akim Oda and a CHPS center were established, she recollected the tragic event of a man that had accidently been shot in the village:

> There was this time when somebody had shot himself, mistakenly (…) This was in the middle of the night, so they quickly… Normally what we did when you were sick, we folded some big leaves, like that of the plantain (…) And we put the person flat on it and then a lot of people carried the person to the hospital, two in the front and two in the back, and people to change when the carriers got tired (…) To reach the hospital, it took several hours. Few people survived this road; by the time they got to the clinic, they were dead.

To treat people for more ordinary diseases, such as malaria, she mentioned the following:

> For example, when someone got malaria, we went (in our own initiative) to the forest, then we plucked some leaves and made medicine for the person.

Because of these, potentially life-threatening difficulties that one experienced in the village when they got sick, the old woman mentioned that she and her fellow villagers were very happy that the CHPS center had been established in their village:

> Even in those days when the clinic [the CHPS center] was in a small place there, when you are sick, and you go there, they can easily get you some medicine just to calm the issue down.

Figure 1. The CHPS compound at the edge of the village.

Figure 2. A view of Akim Gyadam's main road.

Figure 3. Amma as she is sitting in the courtyard of her house.

History and philosophy behind the Community-Based Health and Planning Services (CHPS)

After having briefly introduced the local context of the Akim Gyadam village through the eyes of a community member, let us now turn our attention to the institution of the CHPS. After all, as Amma pointed out in the interview as well, the establishment of these kinds of health centers over the whole of Ghana has been a fairly recent initiative. Having started out as an experiment in the Navrongo region in the early 1990s, CHPS is a national health policy initiative that was officially adopted by the Ghanaian government in 1999 (Baatiema, Skovdal, Rifkin & Campbell, 2013).

The roots of this initiative, which is focused on providing a community health care program, can be traced back to the Declaration of Alma Ata in 1978 where the concept of *Primary Health Care* [PHC] was made part of a global health strategy under the name of *Health for all by the year 2000* (Van Wolputte, Devisch, Le Roy & Lapika, 2002). This Declaration emphasized the unequal distribution of health in the world and underlined the limited access of people in poor regions to adequate health care facilities (ibid.). To tackle this issue, the Declaration introduced the figure of the *village health worker* as one of its main innovations; health workers, who enjoy the trust of the village people and are aware of their needs, receive an elementary training and return to their village afterwards in order to provide preventive and curative care (ibid.).

After having observed that the existing regional and district hospitals did not suffice in providing proper health care for all, the Government of Ghana set up the CHPS initiative, inspired by the Alma Ata commitment to the PHC-strategy (Baatiema et al., 2013; Ministry of Health Ghana, 2009). Inhabitants of remote and rural villages simply could not reach the existing health care facilities due to great distances and bad roads (Russell, 2008). Also the ‘outreach services[4]’ they provided significantly failed in providing suitable health care, especially to the poorest populations. Upon these failures, the Ministry of Health decided the following: “Well, if you want health services delivered at your doorstep, that is what you are going to get” (Ministry of Health Ghana 2009:6). Beginning with the poorest Upper East region in Ghana, CHPS centers were gradually set up all over the country, even in the most remote villages.

One of the core principles of the PHC-scheme, as is emphasized in the Alma Ata Declaration, is the figure of the community health worker (Nyonator et al., 2005; Van Wolputte et al., 2002). This aspect is also thoroughly featured in the philosophy behind the workings of the CHPS, of which I have been highly informed during my stay in Ghana. I was told that the Ghanaian Government, after having observed the unequal access of poor, rural populations to proper[5] health care facilities, thought it possible to address this issue by moving nurses directly into these community settings (Russell, 2008). In this way, the figure of the ‘community health nurse’ [CHN][6] has been called into existence. These CHNs are supposed to move into the village where they work, when adequate housing facilities are available[7]. Instead of ‘outreach’ services, these nurses provide ‘outridge’ services by making regular home visits to their patients in the village. As the

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[4] This is an activity of providing health care services to people who otherwise would not be able to make use of these services. These services did not improve access to health care significantly, because only those rural people who could effectively go to the points of outreach got access to health care (Ministry of Health Ghana, 2009).

[5] Here the word ‘proper’ refers to ‘orthodox’ or ‘biomedical’ types of medicine. ‘Alternative’ / ‘traditional’ healing practices have not been taken into account and have been largely ignored in this strategy; a point I will come back to in the third chapter.

[6] In this thesis, I will use the terms ‘community health nurse’ and just ‘nurse’ interchangeably, since the CHNs working at the CHPS center in Akim Gyadam were addressed as ‘nurses’ by everyone on a daily basis.

[7] This is not the case in Akim Gyadam. Because of the lack of proper housing for the nurses, they have to make an one-hour taxi ride back and forth the village every day.

District Director of the local Health Directorate explained me: “The nurses move to the clients, and not the other way around”.

The establishment of such a close rapport of the nurses to their patients is seen as a necessary precondition in providing appropriate primary health care services successfully. Instead of focusing on treatment and curative services, the CHNs are only trained to provide primary care for the most basic ailments, such as malaria, abdominal pains and headaches (Ministry of Health Ghana, 2009). Besides this curative dimension, the CHPS initiative is designed to emphasize prevention through the deployment of CHNs who visit and educate people in their home environment on how to avoid illness and stay healthy (ibid.). Having a good rapport with their patients, is important to the nurses in the sense that they expect that people can be better educated and given preventive lessons in the comfort of their own homes and by someone they have a trusting relationship with. I will discuss the concrete forms of these preventive efforts in the next chapter.

Although Amma and many other villagers in Akim Gyadam are very glad with the presence of the CHPS compound in their village, some authors take on a critical stance towards the implications and consequences of this specific initiative, and of the Declaration of Alma Ata and its focus on Primary Health Care in general (Bossert & Beauvais, 2002; Van Wolputte et al., 2002). Since the Declaration, the PHC-strategy has been very popular among African leaders and statesmen and as a result has been implemented in many different contexts (Van Wolputte et al., 2002). Critics argue that this has been a strategy for them to cut on government expenses and tackle the growing budgetary expenditure (ibid.). Also the ‘bottom-up’ philosophy of this concept and its emphasis on community participation are in reality hollow notions since the PHC-strategy is very ‘top-down’ in its practical organization (Van Wolputte, 1997). By imposing participation at the base by pressure from the top, the PHC-concept and the nation state strip the notion of basic health care from its essence (ibid.).

Also the concept of the CHPS comprises of such a top-down approach. As became clear when I gave a brief overview of the various health care actors in Ghana, the CHPS centers cannot function independently but instead experience a great deal of hierarchic control from executive and policy-making agencies on different levels, such as the local Health Directorate, the GHS and eventually the Ghanaian MoH. When it comes to financial and material support, they are even completely reliant on these institutions. Also Bossert and Beauvais (2002) take on a critical position when considering the decentralization of the health care system in Ghana. Their comparative analysis shows that the decentralization and delegation processes in Ghana have transferred the least choice to autonomous health services, compared to other African countries, which means that their decision-making space has reduced significantly because of these dynamics (ibid.). How this restricted decision-making space influences the performance of each health system separately, is, however, not yet known (ibid.).

Meeting the community health nurses

As I have indicated before, the community health nurses who work in the CHPS center in Akim Gyadam were among the primary informants of my research. As I worked with them on a daily basis for a couple of weeks, we got to know each other well and from merely being research participants the nurses went on becoming my friends. Since the postmodern critique on the nature of anthropological practice, this relationship between the anthropological researcher and its research ‘subjects’ has become increasingly relevant. The critique of ethnographic research, as being unethical and concentrating too much on ‘native’ people, “led to a call for reflexivity in the sense that studies of others must also be studies of ourselves in our relationships with those others” (Davies, 2008:13). As such, I am aware of the fact that my acquired ethnographic knowledge is not so much a result of my own ‘collection’ of ethnographic data, but that my fieldwork is an intersubjective construction which relies on the encounter between me and my research participants (Rabinow in Robben & Sluka, 2012). This is why I would now like to introduce the main research participants in my fieldwork, the community health nurses, in greater detail.

The health personnel on the CHPS compound in Akim Gyadam consists out of four CHNs; one senior nurse and three other nurses (figure 4 and 5). The senior nurse, who is in charge of the other ones, is called Justina; a woman in her early thirties with two young children. The other nurses are called Abigail and Comfort. Abigail is a twenty-something girl who lives alone in Akim Oda, and Comfort is in her late twenties and has a husband and children. The last nurse, Josephine, I have only met once on my first visit to the health center (when I started my fieldwork she had just gone on leave for a couple of weeks). She is the only one of the nurses who lives in the village itself, while the others have to travel back and forth every day. The dreadful state of the road from Akim Oda to Akim Gyadam makes this a challenging undertaking.

Figure 4. Comfort (left) and Abigail (right) at work at the weekly Child Welfare Clinic (CWC) where the young children are weighed and vaccinated.


Figure 5. Justina at work in the consultation room of the CHPS center.

In line with a quote I once read on the back of a T-shirt worn by a male nurse: “Proud to be a nurse. Nursing is honorable and dignified”, nursing is considered to be a good profession in Ghana (Böhmig, 2010a; 2010b). Not only because the qualities of being a good nurse, such as being observant, responsible, punctual and patient, correspond with the qualities of being a ‘good’ woman[8], but also because of the financial and occupational security the job has to offer in an economic uncertain environment (Böhmig, 2010b). During my visit to the community health nursing school in Akim Oda (figure 6), where future CHNs are being trained, I was made thoroughly clear that the

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[8] This European perception of the ‘good woman’ caring for the sick was not immediately translated in the Ghanaian context though. Initially regarded as something inappropriate for women, the acceptance of nursing as a typical female activtiy took place slightly later compared to other ‘typical female professions’ brought in from Europe (Böhmig, 2010a).

selection criteria for future students of the school are very strict, as well as the school-regulations once a student has been admitted.

However, the students told me that they were glad about this, since these strict selection criteria guarantee that all graduates will find a job as a CHN when they finish their training. The local Health Directorate assigns each one of them to work in a particular CHPS center in the region, whether this is one of their own choice or not.

Figure 6. Students in the community health nursing school during a class.

In this nursing school, the future CHNs are being trained to provide primary biomedical health care for basic ailments, such as malaria, abdominal pains, headaches etc. The guidelines for these biomedical practices, in school as well as in their work at the CHPS center, are specified by the GHS who implement the policies of the MoH. This hierarchal, top-down approach also became manifest to me by working with the nurses in the CHPS center at Akim Gyadam. The nurses execute their jobs in a very standardized way. They are trained to strictly follow medical protocols and to adequately record their activities in several logbooks. However, this top-down approach also comes forward on a more practical level. For the supply of material equipment such as Malaria Rapid Diagnostic Tests (RDTs)[9], vaccinations or medication, the nurses rely on the local Health Directorate, which is, in its turn, dependent on the financial resources given to them by the GHS. As a result, the nurses often run out of these resources with the risk of not being able to perform their work adequately.

To some extent, this top-down approach is also reflected in the work attitude of the nurses. Because of their dependence on these superior establishments and their limited autonomous decision-making space, the nurses often showed, in my opinion at least, a lack of taking initiative and responsibility. For example, when an eye screening was to be organized in the village, the doctors had to call the nurses to confirm the date of this screening. But when the doctor did not give them a call eventually, the nurses did not take initiative to reach him either and just left it at that instead. Also the picking up of new medication or RDTs in the office of the local Health Directorate often happened with the necessary delays.

Having said this, I would still like to nuance these observations by emphasizing my own (western) outlook on these events, which inevitably distorts my perceptions of their work ethos. It also needs to be mentioned that the nurses are motivated and work efficiently when it comes to other areas of their work. As such, I observed the close rapport they had with their patients, whom they not only provided of curative services, but also of a listening ear and psychological support when they needed it. The nurses also immersed in the home environments of their patients by their numerous home visits and outreach services, which they saw as an opportunity to educate and sensitize them about health-related matters. In the next chapter I will

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[9] Malaria RDTs: these tests assist in the diagnosis of malaria by detecting evidence of malaria parasites in human blood. They permit a reliable diagnosis of malaria even in remote areas with limited access to microscopy services (WHO, 2016).

take a closer look at how these preventive efforts are concretely organized and executed.

2. In the field: prevention and sensitization in practice

While I have tried to present a comprehensive description of the general practices of the CHNs in the CHPS center in Akim Gyadam in the previous chapter, I now turn my attention to the concrete ways in which the nurses try to offer preventive education and sensitization to the local villagers. After all, during my stay, I repeatedly noticed how the nurses systematically attempt to 'convince' the villagers of the benefits or damages that certain health-related behaviors may bring about. The *non-compliance*, as it is termed in the biomedical discourse, of the villagers towards these advices, as well as their seemingly indifferent attitudes, aroused my curiosity. In this chapter, I want to go beyond merely individualistic or culturalist explanations of these types of behavior, and instead go towards a more comprehensive understanding of this *non-compliance*. Like this, I arrive at the main argument of my thesis, which asserts that the bio-medically inspired preventive education and sensitization offered by the nurses in the CHPS center often conflicts with local notions of health, illness and prevention. I will further elaborate on this argument in the third chapter.

2.1 Sensitizing the people in the CHPS center and at home

From Ebola to healthy child feeding

In the PHC-strategy, which has laid out an important foundation for the current organization of the Ghanaian health system, prevention and sensitization take on a central role. As van der Geest, Speckmann and Streefland (1990) mention: "In broad outline the PHC document was a plea for prevention and for the greatest possible self-reliance in the field of health care." This emphasis on disease prevention and on informing local communities to their own possibilities of preventing illness, is not just a theoretical policy guideline, but also becomes practically embodied in the daily operations of several health care providers, among which the CHNs in the Akim Gyadam CHPS center.

As I have mentioned before, I frequently noticed, during my fieldwork, how the nurses systematically try to 'convince' the local villagers of the benefits and welfare that certain health-related behaviors may bring about. The nurses attempt to inform the people of these advantageous health behaviors on different occasions; on their consultations at the CHPS compound, during their home visits, or on counselling sessions, which are especially designated for this purpose of education and sensitization. The contents of these preventive efforts vary from teaching young mothers how to properly breastfeed their child to instructing villagers on how to prevent themselves from getting bitten by a malaria carrying mosquito. In order to grasp the wide range of these preventive services, I will present a few concrete examples in the following paragraphs.

In spite of the fact that no cases of Ebola have been recorded in Ghana, the Ebola virus disease outbreak in neighboring West African countries has received a lot of (inter)national attention. As such, the local Health Directorate in Akim Oda has taken initiatives to inform health care providers in the region about the dangers of this disease and how to keep it from spreading. In some places, such as the office of the Health Directorate and the community hospital, posters about preventing the transmission of the Ebola virus have been pasted on the walls (figure 7). However, on a more local level, for example in the community of Akim Gyadam, I did not observe many attempts of the nurses to educate the villagers on the Ebola virus and on how to keep its contagion within bounds.

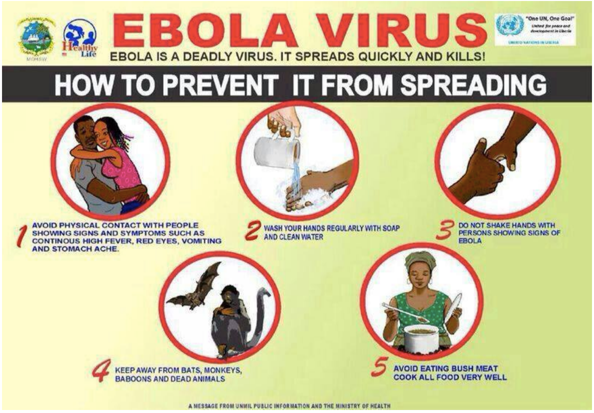
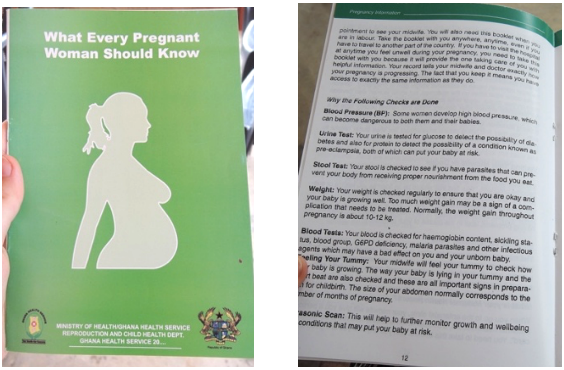


Figure 7. The poster on how to prevent the Ebola virus from spreading as I have seen it in different health institutions in Akim Oda, Ghana.

In contrast to the limited attention of the nurses to the Ebola virus, they put a lot of effort and time in educating people about preventing themselves against the much more common disease of malaria. The use of a long lasting insecticide treated net (LLIN) each night is promoted as one of the most effective ways to prevent malaria. Moreover, these nets are distributed to the patients of the CHPS center for free.

Besides this extensive focus on teaching people how to prevent themselves from getting malaria, the family life takes on an essential place in the preventive services offered by the nurses. Starting from educating young women and men about reproductive health and family planning (figure 9), the nurses provide pregnant women with information about being pregnant and delivering the baby in the Antenatal Care (ANC) – program (figure 8). A considerable amount of attention is also placed upon informing young mothers on how to properly feed their child. In order to accomplish this, the nurses take with them flip charts with pictures of proper breastfeeding techniques or adequate nutrition for young children on their home visits (figure 9). Also the weekly organized Child Welfare Clinic (CWC) provides a good platform to sensitize the mothers about these topics, as well as the counselling sessions which are organized on a monthly basis and take place on different locations in the village in order to reach as many young women as possible.



pointment to see your midwife. You will also need this booklet when you are in labour. Take the booklet with you anywhere, anytime, even if you have to travel to another part of the country. If you have to visit the hospital at anytime you feel unwell during your pregnancy, you need to take this booklet with you because it will provide the one taking care of you with helpful information. Your record tells your midwife and doctor exactly how your pregnancy is progressing. The fact that you keep it means you have access to exactly the same information as they do.

Why the Following Checks are Done

Blood Pressure (BP): Some women develop high blood pressure, which can become dangerous to both them and their babies.

Urine Test: Your urine is tested for glucose to detect the possibility of diabetes and also for protein to detect the possibility of a condition known as pre-eclampsia, both of which can put your baby at risk.

Stool Test: Your stool is checked to see if you have parasites that can prevent your body from receiving proper nourishment from the food you eat.

Weight: Your weight is checked regularly to ensure that you are okay and your baby is growing well. Too much weight gain may be a sign of a complication that needs to be treated. Normally, the weight gain throughout pregnancy is about 10-12 kg.

Blood Tests: Your blood is checked for haemoglobin content, sickling status, blood group, G6PD deficiency, malaria parasites and other infectious agents which may have a bad effect on you and your unborn baby.
eling Your Tummy: Your midwife will feel your tummy to check how baby is growing. The way your baby is lying in your tummy and the t beat are also checked and these are all important signs in prepara for childbirth. The size of your abdomen normally corresponds to the mber of months of pregnancy.

asonic Scan: This will help to further monitor growth and wellbeing conditions that may put your baby at risk.

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Figure 8. The brochure 'What Every Pregnant Woman Should Know', which is given to pregnant women on their first ANC-visit in the CHPS center.

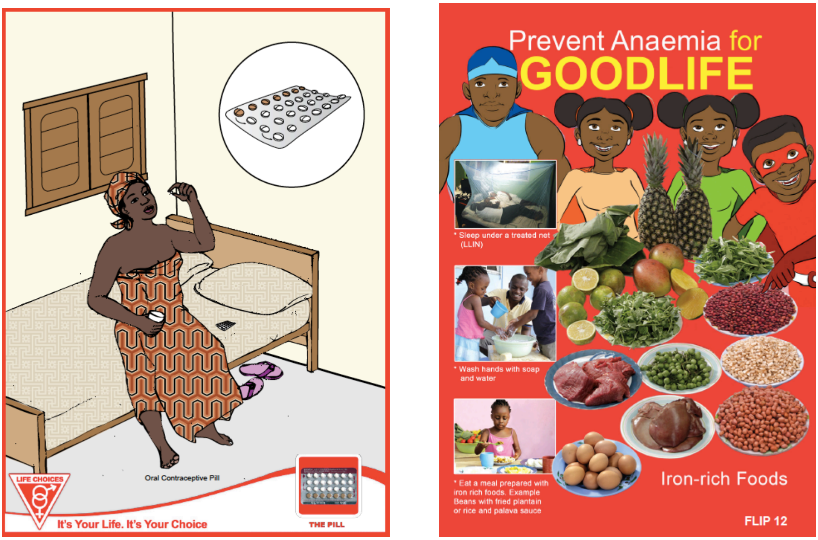

Figure 9. Fragments out of the flip charts about reproductive health and family planning (on the left), and healthy child feeding (on the right). The nurses use these pictures to educate people on such topics.

Living the GoodLife in Ghana

Some of these prevention materials, for example the flip charts on family planning and healthy child feeding, as well as the malaria prevention materials, are part of the larger GoodLife prevention campaign (Tweedie, Ciloglu & Davis, 2016). This national sensitization campaign, which ran from 2009 to 2014, was implemented under the Ghana Behavior Change Support (BCS) project (ibid.). BCS sought to increase the demand and use of biomedical health services as well as to promote positive behaviors related to six key health areas: family planning, malaria, maternal and child health, nutrition, water and sanitation, and HIV (ibid.). By asking, “What is your Good Life?”, the campaign encouraged the Ghanaian people to link their personal happiness to the practice of these healthy behaviors (ibid.). Through music videos, a quiz on television, as well as radio and television broadcasts, the GoodLife campaign tried to get this message across (The Health Communication Capacity Collaborative Youtube Channel, 26 November 2014).

This large-scale prevention project was funded by the American development agency USAID and managed by the Baltimore-based Johns Hopkins Center for Communication Programs in partnership with the Ghanaian MoH and the GHS (Tweedie, Ciloglu & Davis, 2016). By taking the origins of the project into consideration, it becomes clear that this national campaign was almost completely American-made as regards to its funding, producing and managing. The implementation and distribution of the campaign materials fell under the responsibility of the GHS. As such, a strong top-down approach becomes apparent; many of the prevention and education materials employed by the nurses in their daily activities at the CHPS center, are initiated by the MoH and GHS with financial assistance and support concerning the content from foreign development agencies and institutions. These projects, designed at the top of the health system, are then implemented on the regional and district level in order to eventually trickle down to the community level.

A gender bias

Besides these reflections on the top-down nature of the prevention and sensitization initiatives presented above, we can make another critical observation as regards to the preventive efforts of the nurses. Although prevention materials relating to six key health areas are available, the preventive services offered by the nurses on a daily basis are extremely focused on everything that relates to the ‘family life’. Family planning, reproductive health, maternal and child health, as well as healthy child nutrition are the subjects that take on a central place in the sensitization and education programs of the nurses.

By putting these topics forward as the main areas where a change in health-related behavior is required, women become the prime target audience for the prevention initiatives of the nurses, since the family life traditionally is a woman’s business in Ghanaian society. Because men are generally left out of the picture, women become solely responsible for bringing about positive changes in these health-related behaviors. On the one hand, this places a great burden on their shoulders since their bodies are the ones that are placed under a great deal of control and pressure to be compliant to the ideal health behaviors as they are represented in various prevention campaigns. On the other hand, this emphasis on the decisive role women can play in generating positive changes in health behaviors and conditions, puts them at the center of social change which may provide them with an agency that stretches far beyond the health-related domain. We must, however, not exaggerate these possibilities of agency for Ghanaian women. In a society where frequently reported gender inequalities result in limited access to education, health care and the public decision-making space on the part of women, female patients often cannot make decisions about how and where to seek health care without the consent of a male family member (Akotia & Anum, 2015).

This focus on women and their children cannot only be observed in the nature of the prevention projects implemented by the GHS, but also on a daily basis while working in the CHPS center. As such, I noticed that the majority of the patients at the clinic were women and children. Also on the home visits of the nurses, pregnant women and young mothers were the ones that were being visited most frequently. Moreover, during my period of fieldwork at the CHPS center, I have never even observed a young man being informed on topics such as family planning, reproductive health or healthy child nutrition. Likewise, the monthly counselling sessions were primarily organized for young mothers(-to-be). As I have mentioned before, this observed ‘gender bias’ may entail negative as well as positive consequences for the women in question.

2.2 *Non-compliance* of the villagers?

Not following the nurses’ advice

After I had attended the half year review meeting of the Birim Central Municipality Health Directorate, I described the following event in my logbook:

After the Health Director had showed slides with disappointing figures of the barely increasing number of women who chose to give birth in a hospital rather than at home during the last half year, one of the CHNs at the meeting responded agitatedly. She vigorously explained that the nurses themselves have great problems with *convincing local women to deliver their baby in a hospital instead of at home. According to her, the nurses did everything they could to get the potential dangers and risks of a home birth across, while the final decision still remains to be taken by the patient herself. As a result, the nurse concluded that they could not be blamed for the unsatisfactory figures.* (Meyermans, logbook, 5 August 2015)

This incident shows that the CHNs sometimes deem it difficult to convince the local population of the advantages of certain health-related behaviors, in spite of their extensive preventive and educative efforts. The fact that the local villagers are not always convinced of the benefits of certain behaviors or practices, and not always follow the recommendations of the nurses, is something I have observed numerous times as well during my fieldwork. I present a couple of instances of these *non-compliant* behaviors here below.

I was, for example, informed by the nurses that it was often difficult to convince people to sleep under a treated bed net every night as a protection against the bites of malaria carrying mosquitos. One time, a young woman came to the CHPS center with her five-year old daughter who was sick with malaria. During the consultation, the nurses seemed agitated and a little upset. They sternly advised the woman to sleep under a treated mosquito net with her daughter every night. After the consultation, they explained me that the five-year old girl had already had malaria seven times; a condition which is potentially obstructive and dangerous for the normal growth and development of the child. Still, it remained difficult for the nurses to convince the mother to sleep under a treated bed net with her child.

Likewise, young women often do not follow the recommendations of the nurses as regards to healthy child feeding. As such, I remember the case of a young woman with a five-months old baby which had been born prematurely and was therefore much below the normal weight of a child of the same age. Because of this, the nurses urged the woman to exclusively breastfeed her daughter until she was six-months old. But during one of their home visits, the nurses caught the woman red-handed while she was feeding her child porridge instead of breast milk.

Also the counselling sessions, organized by the nurses once a month to inform young mothers(-to-be-) about safe deliveries and healthy child nutrition, proved to be rather fruitless. Even though the nurses set up these gatherings on three different places in the village[10], in order to reach as many people as possible, not many showed up. The one time I went with them, only three woman turned up on the first location, in the two other areas of the village nobody appeared.

Self-medication practices

On other occasions, people choose to diagnose themselves instead of going to the CHPS compound, and to use medicines they still have at home from the treatment of a previous illness. This behavior is called self-medication and may result in an over- and misuse of drugs that should be used with caution (Donkor, Tetteh-Quarcoo, Nartey & Agyeman, 2012). Also self-medication with antibiotics is a fairly common practice, even though it may cause significant adverse effects (ibid.). In the same way, I once observed a young child at the CHPS center who the nurses diagnosed with malaria. The mother of the child mentioned that she had already gone to a drugstore the day before to buy aspirin and antibiotics to treat the child in the meantime. The nurses explained her that the medication she bought was not suitable for curing her child from malaria, and that she should immediately come to the clinic the next time, instead.

In the village of Akim Gyadam, different drugstores are located, where people can purchase biomedical drugs without prescription. Besides these pharmacies, rural villages are sometimes visited by so-called 'drug men' who travel from village to village to sell their pharmaceutical products, also without prescription and often at a high price. The sales men or women at these local pharmacies or the 'drug men' usually lack a medical or pharmaceutical education, but still make a diagnosis when someone comes to their shop with specific complaints. The drugs that they propose to their customers can be potentially harmful since these shopkeepers are often ignorant of the

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[10] On market day, when most people are in the village to sell their farming output on the market instead of being away to work on the fields.

possible side effects of certain medication, and of the dangers of taking different medicines at the same time as a result of their interaction effects.

Although I have presented a whole list of cases, here above, where people do not act upon the advice of the nurses or simply do not consult them, I find it important to clarify that I have also observed numerous instances of people who did adopt and conform to the recommendations of the nurses. Still, the cases of *non-compliance* drew my attention and aroused my astonishment. Also the strong, often upset, reactions of the nurses on these instances of *non-compliance* and their general inability of assessing why people did not follow their recommendations, have caused me to elaborate on these occasions in such great detail.

The astonishment of an anthropologist

Personally convinced by the benefits of the health-related behaviors promoted in the preventive 'lessons' of the nurses and by the health hazards they possibly avert, I was naively surprised to find that many villagers do not follow this 'good' advice offered by the nurses. This observation astounded me since it seemed to me to be only in the interest of the people to adopt the nurses' recommendations. Consequently, this astonishment marked the onset of this thesis, in which I want to overcome my own western outlook on these observations of *non-compliance*, as it is termed in the biomedical discourse. In such a way, the next part of this chapter aims at gaining a more comprehensive understanding of these *non-compliant* behaviors by going beyond superficial individualistic or culturalist explanations. Instead, interpretations that scrutinize western notions of prevention, sensitization and *non-compliance*, as well as take into account the broader organization of health care in Ghana, are presented.

2.3 Going towards a deeper understanding of this *non-compliance*

Even when taking a rather superficial look at the prevention materials used by the CHNs to educate and sensitize the local villagers, it is not difficult to understand why these preventive efforts often do not succeed in their objectives. This is maybe best illustrated by the, without any doubt, white woman who is depicted on the cover page of the 'What every pregnant woman should know' brochure (figure 8), as well as on the 'Maternal Health Records' booklet (figure 10). For African women, it must at least be challenging to identify with this 'ideal' female image. Also the simple fact that the brochures are written in English and contain somewhat difficult medical terminology does not contribute to the sensitization of these often illiterate and uneducated women.

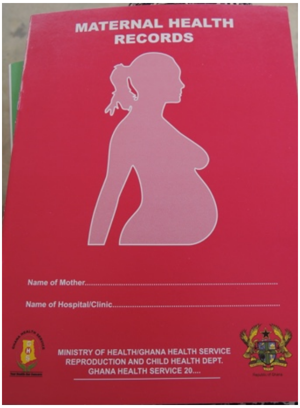

Figure 10. The obviously white woman on the 'Maternal Health Records' booklet.

Even though these obvious facts already partly inform us about the reasons for the unsuccessfulness of some preventive methods, other various, but interrelated explanations can be given for this observed phenomenon of *non-compliance*, which I will present here below.

'Ex-ante' moral hazard

Notwithstanding the fact that the establishment of the NHIS has improved the general access to health care services for a large part of the Ghanaian population, some authors have raised concerns about the possible negative outcomes this type of health insurance scheme can bring about (Dalaba et al., n.d.; Debebe et al., 2012). Like this, Dalaba et al. discovered that community members, health providers and NHIS officers are aware of various behaviors and practices that constitute abuse of the Scheme. These 'moral hazard' behaviors may include frequent and 'frivolous'[11] visits to different health facilities, impersonation, and feigning sickness to collect drugs for non-insured persons on the side of the local community members, as well as over-charging for services provided to clients, charging clients for services not provided, and over-prescription of drugs on the side of the health

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[11] Since many services provided in 'government-funded' health facilities are free because of the NHIS, people may bring visits to these health providers even when they are not really sick.

care providers. These behaviors may endanger the sustainability of the Scheme (ibid.).

These ‘moral hazard’ behaviors, which are partly inherent to the provision of free health care, may also be related to the reduced prevention efforts I observed amongst the local community members (Debebe et al., 2012). In this way, Debebe et al. (2012) claim that enrolment in an insurance scheme, such as the NHIS, can bring about an incentive problem with regards to taking preventive efforts (ex-ante moral hazard). In their article, they examine the presence of ex-ante moral hazard with reference to malaria prevention in Ghana. The results of their study support the hypothesis that enrolment in the NHIS negatively affects ownership and use of the insecticide-treated bed nets which are distributed for free (ibid.). Since free health care is being provided in health facilities close to home, such as the CHPS compounds, these results cannot be found surprising. If people receive a free and relatively easy treatment when they are sick of malaria, their incentives to sleep under an, often uncomfortably warm, treated bed net will subside considerably (ibid.).

Because I did not conduct an explicit study on these ‘moral hazards’ behaviors in my specific research context, it is difficult to say whether these ex-ante moral hazards were also at play in the village of Akim Gyadam. While visiting another CHPS center[12] in the surrounding area, I was, however, informed by the head nurse that enrolment in the NHIS had significant effects on the behavior of his patients. Not only did they deem the services offered in the CHPS center of a lower quality when they do not have to pay for them immediately after receiving care, the nurse also mentioned that people often make frequent visits to the CHPS clinic for ailments against which they could have easily protected themselves in their home contexts.

Prevention as a form of biopolitical control

Besides this rather economist explanation of the observed *non-compliance* among the local community members, clarifications for

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[12] For the sake of completeness, I mention that this CHPS center was situated in the village of Badukrom.

this phenomenon can also be sought by considering the possibility that the villagers may conceive the preventive efforts of the nurses as a form of control, exerted upon their daily lives. After all, the advices and instructions offered by the nurses touch upon daily (bodily) practices that are often situated in the very private and intimate domain of human life. From prescribing young mothers how to properly breastfeed their baby to intervening in the sexual life of young women through birth control recommendations, the nurses try to change behaviors that belong to the most intimate spheres of life. Although we can assume that these sensitization efforts are well-intended and genuinely attempt to bring about positive health changes for the people involved, it is not difficult to imagine that the local community experiences these interventions as obtrusive or as some kind of control mechanism.

The top-down character of the prevention materials used by the nurses may contribute to this feeling of control and intrusion. Because it is quite clear that the sensitization messages are drawn up by the national government, it becomes apparent that the Ghanaian government tries to influence, change and potentially control the health behaviors of its population even in the most intimate domains of their lives. As such, considering the preventive efforts of the nurses and other health care providers as a form of biopolitical control exerted by the national government, might help us to understand the unwillingness and reticence of the local community members to comply to these prescribed health behaviors.

We can broadly understand the notion of ‘biopolitics’ as a political rationality that takes the life of the population as its object (Lemke, 2011). Under the expression of “making live and letting die”, Foucault denotes the concept of biopolitics as a historical process by which ‘life’ has emerged as the center of political strategies (ibid.). The scholar distinguishes two basic forms of this power over life exerted by the dominant political class: the disciplining of the individual body as well as regulatory control over the population (ibid.).

The prevention and sensitization materials drawn up by the Ghanaian MoH aim at both objectives. They not only want to adjust individual health behaviors, but also wish to regulate the collective body of the population whose 'health' is expressed in notions such as birth and death rates, health status, life span, and the production of wealth and its circulation (ibid.). This last idea is nicely expressed by the well-sounding slogan of the Ghanaian MoH: "Creating Wealth through Health" (Ministry of Health Ghana, 2007). After all, their relatively new health policy comprises a paradigm shift from curative action to health promotion and illness prevention, as to transform the broader disease profile and mortality patterns of the whole country and the 'collective body' of its population (ibid.).

This emphasis of the Ghanaian state on the health of its population and the regulation of their bodily behaviors, cannot only be regarded as a new objective of the state, but also as a new political rationality (Zeiderman, 2013). This rationality is directed at protecting people's lives from threats and risks; a biopolitical imperative that lately has become central to politics in many developing (and developed) countries (ibid.). It is within this domain of biopolitical security that poor and vulnerable populations engage in relationships with the state, which may reconfigure their citizen rights as such (ibid.).

These political technologies of security, like prevention campaigns for example, start from the construction of a category of people as being at 'high risk' (Zeiderman, 2013). Subjects are classified along this criterion and are accordingly dealt with (ibid.). This is exemplified in the study of Briggs (2003) on cholera prevention campaigns initiated in Venezuela in the early 1990s. In this context of a cholera epidemic, health professionals targeted certain social groups, such as poor barrio residents and indigenous people as being 'at high risk'. Conceptions of these people as being ignorant and rejecting biomedicine, unhygienic and unconcerned with the health of their families became naturalized, while at the same time health education messages portrayed women in well-equipped kitchens demonstrating cholera prevention measures (ibid.). This discrepancy between this 'ideal audience' and the real target groups of the campaign limited the effectiveness of the cholera prevention efforts.

Likewise, in the context of the Akim Gyadam village, some groups of people, especially poor and illiterate families, are presumed to be at a 'higher risk' of ill-health than others; at least in the eyes of the official health care facilities and professionals steered by the health discourse of the MoH and GHS. Still, the prevention materials offered by the nurses are not adjusted to the real experiences of these people and instead represent an 'ideal' image of family live and its accompanying health behaviors which cannot easily be complied with by many local villagers because of their often poor and deprived living conditions. I will further address this discrepancy, as well as the (usually maladjusted) biomedical nature of these prevention and sensitization campaigns in the section here below.

Prevention and 'non-compliance' according to the biomedical discourse

As van der Geest et al. (1990) note in their article about the PHC-strategy viewed from a multi-level perspective, the most primary objective of the PHC-plan was to adjust the achievements of medicine to the economic reality of the countries concerned, i.e. development countries in the global South. It was hoped that this goal would be attained by putting the importance of disease prevention forward and by rendering local communities responsible for their own prevention of illness (ibid.). As such, more self-reliance and more attention to prevention as a solution were framed as crucial answers to health care problems existing in the global South. However, as the authors critically remark: "it is odd that this plea for self-reliance does not come from those who should be self-reliant but from the international health planners" (van der Geest et al., 1990:1027).

Whatever its critiques, the PHC-strategy has been adopted in the national health policies of many third world countries, among which Ghana. Hence, the "Creating Wealth through Health" – objective of the Ghanaian MoH (2007) is set to be attained by a shift from curative action to health promotion and illness prevention. This focus on prevention and sensitization lingers on in the daily practices of health workers all over the country, as it also does in the everyday actions of the CHNs in the CHPS center in Akim Gyadam. Nevertheless, as van der Geest et al. (1990) critically observe, local communities in different contexts are not at all pleased with this strong emphasis on prevention which is, in their opinion, provided at the expense of curative aid. If self-reliance means that they have to fend for themselves from now on, then these people do not desire this form of autonomy (ibid.).

Besides from the fact that this extensive focus on prevention often does not match the expectations and wishes of the local community members, the prevention and sensitization possibilities offered by local health professionals are usually interpreted in a quite restricted manner. By this I mean that some health behaviors or practices are unequivocally recommended as if no other alternatives are conceivable. Furthermore, these suggested health behaviors often stand a long way from the daily realities and practices of the local villagers, which are mostly characterized by hardship and dictated by a sense of 'survival'. This is exemplified by one of the events I described in my logbook:

On CWC-day, babies and toddlers are weighed on a monthly basis and their weight is recorded on a 'Weight-for-Age' curve in a booklet containing their personal health records. Today, I weighed a five-months old baby whose weight had declined in comparison to the month before, from six to five kilos; a case of underweight which is regularly recorded in the CHPS center. The nurses advised the mother of the child to breastfeed her baby every time she asks for it until the age of six months. The woman answered that this is practically impossible to her, since she either has to leave the village to go and work on the fields, or to sell her farming goods on the market or on the street. While she is working, she leaves her baby in the care of family members. Instead of proposing another solution for the woman's problem, the nurses just kind of left it at that and went on with weighing the next baby. (Meyermans, logbook, 11 August 2015)

Bio-medically speaking, there is no doubt that exclusive breastfeeding up until the age of six months is the most advantageous for a child's health in an environment where clean water, which is suited for bottle- or formula-feeding the child, is scarcely available. Still, this proposed 'rule' of exclusive breastfeeding is practically not feasible for many women living in these circumstances. Out of economic necessity and deprived of social rights such as maternity leave, they are left no other choice than to go to work and leave their young child in the care of others. The excessive emphasis of the nurses on the guideline of exclusive breastfeeding therefore reflects the fact that the proposed, bio-medically inspired health behaviors are often miles away from the real lives of the local community members.

Furthermore, preventive practices and behaviors are often conceived as individual responsibilities; it is the young mother who bears the responsibility of exclusively breastfeeding her child or making sure that the child sleeps under an insecticide treated bed net every night. As Frankenberg (1980) indicates, under the hegemony of Western biomedicine, preventive medicine is reduced to a curative, individualistic model which reinforces general capitalist views on how social problems should be treated. Also Scheper-Hughes and Lock (1987) mention that, in biomedical contexts, health is increasingly viewed as something that must be individually achieved instead of an ascribed status. Each individual is expected to ‘work hard’ at being strong, fit and healthy (ibid.). The vision that illness is the result of someone’s individual incapacity of ‘living right’, is emerging in the Ghanaian health context as well, and points at the hegemonic powers of biomedicine accompanied by a neoliberal, individualistic orientation. As Feierman et al. (2010) point out, in reality, important health decisions in African contexts result from collective decision-making processes instead.

In their article, Feierman et al. (2010) equally scrutinize terms such as ‘patient non-compliance’. He claims that the standard interpretation of *non-compliance* – a patient’s withdrawal from a formal medical program – does not capture the complex social realities, characterized by elements of hopelessness and incoherence, which give rise to the specific nature of the patient’s response. Therefore, instead of holding on to the biomedical term of *non-compliance*, we should gain an understanding of the pressing dilemma’s – often guided by difficult living conditions – faced everyday by people who live and work far from the centers of policy-making power (ibid.). I observed these kinds of dilemma’s almost everyday during my fieldwork on the

CHPS compound in Akim Gyadam: from a mother who could not pay a tetanus-injection for her wounded daughter because of financial difficulties, to a man with tuberculosis [TB] who was conflicted between the advice of the nurses to continue his TB-treatment and his family who recommended him to visit a traditional healer instead. It is only when we try to grasp these daily worries that we begin to realize what it actually means to walk in these people's shoes.

Also other authors like Maskovsky (2005) and Macdonald (2012) critique the generally accepted notion of *non-compliance* as something which is situated within biomedical protocols and bears the assumption that the patient is a passive object that has to submit to the authority of the biomedical health care provider. In contrast, the 'adherence' model suggests that the patient is the active agent in his or her care (Maskovsky, 2005). However, this concept is not a value-neutral one either, since it generally overemphasizes the role of the individual in being responsible for his or her own health condition (ibid.); a conception that does not align with the daily realities of collective health decision-making in many African contexts (Feierman et al., 2010).

By scrutinizing these biomedical interpretations of the terms 'prevention' and 'non-compliance', which evidently do not align with the everyday realities and living conditions of the local Ghanaian population in Akim Gyadam (and supposedly elsewhere in rural Ghana), it becomes apparent that we need to work up towards a rethinking of these notions. In chapter 4 of this thesis, I will discuss how prevention is not an exclusively Western idea, and in fact takes on a central place in the practices of many 'traditional' forms of healing. Local conceptions of prevention, in relation to a reality of hybrid healing practices, will also be discussed. But now, I turn my attention to the origins of the biomedical understandings of these notions of 'prevention' and 'non-compliance' which have become so hegemonic in their dissemination.

3. The hegemony of ‘white’ medicine

Allow me to begin this chapter by recounting one of my experiences in the field, recorded in my logbook as follows:

On one of our home visits today, the nurses and I ran into a young woman who had just become a mother and suffered pain in one of her breasts which made it difficult for her to breastfeed her newborn child. When the nurses proposed to travel to the hospital in Akim Oda in order for her to be cured over there, she refused and mentioned that she is already being treated by a local herbalist. This herbalist instructed her to stop breastfeeding her child with the ‘sick’ breast, while the nurses pointed at the importance of continuing the breastfeeding with that breast because the milk production would cure the breast naturally. Walking back to the CHPS compound after these home visits, I inquired the nurses about these ‘traditional’ healing practices that exist in the village and what they thought about this. Abigail answered me: “They ***believe*** *it. We can’t forbid them to do it, so we go along with it and continue to check up on them on our home visits”.* (Meyermans, logbook, 11 August 2015)

The word that stands out for me the most in this short ethnographic narrative, is the verb “believe”. By using this word in her statement, the nurse frames the ‘traditional’ healing methods used by the villagers as a ‘belief’, by which she implicitly opposes this form of health care against the biomedical modes of curing which are, in contrast, seen as scientific and therefore unconditionally true. In this chapter, I aim at addressing the historical and societal processes through which these biomedical practices have been institutionalized as the one ‘true’ form of medicine and have become hegemonic in their universal curing capacity; while so-called ‘traditional’ medicine has remained a ‘belief’ instead, and consequently is not considered as having the same universal applicability.

3.1 Biomedicine as a way of becoming ‘modern’

Even though the nurses did not explicitly use terms such as ‘modern’ or ‘traditional’ to describe the health care context in Akim Gyadam –

this distinction was only verbally made when I inquired them about it – they, by making statements such as the one mentioned above, create a difference between themselves, as ‘modern’ health professionals, and ‘them’, the ‘traditional’ local inhabitants of the village; a difference which is also being produced in their daily practical tasks. In this section, I discuss how biomedical healing practices are perceived as a means in becoming a ‘modern’ subject, an image that is opposed against the ‘traditional’ (and so-called ‘backwards’) curing methods of the rural population.

Protocols and standardization

One way of a modern nation-state to ensure the distribution of limited resources in the realm of health and medical care is through a standardization of services, which is made possible by designing protocols based on biomedical practices (Human, 2012). The capability of any given health care provider, such as the nurses at the CHPS center, then becomes equalized to his or her ability to follow up these protocols; protocols which also structure, rationalize and prioritize certain, mostly biomedical, forms of knowledge (ibid.).

These kinds of protocols and standardized practices also existed in the context of my fieldwork at the CHPS center in Akim Gyadam. I often observed how the nurses strictly adhere to these medical protocols, which reflect a more impersonal and ‘bureaucratic’ approach. In the same way as Human (2012) illustrates the limits of the cognitivist model upon which these protocols are based, I explore the ethical implications of following a protocol too strictly, which can bring about negative consequences, especially when a rather ‘exceptional’ patient is involved.

Let me illustrate this by depicting one of my personal experiences with the negative results these protocols can have, which was rather shocking and made me quite angry at the time:

When my fieldwork at the CHPS center was almost coming to an end, a 6-year old girl came to the clinic with her mother because she was suffering from a very high fever. She was delirious with fever and was very scared of the nurses; she started crying and screaming before *they had even examined her. Even I, who had only been working in the clinic for 6 weeks, knew that this girl probably had malaria because of the high fever she suffered. I also realized that, even if the malaria test was negative, the nurses would treat her for malaria anyways out of precaution. Because of these reasons I suggested the nurses to skip the malaria testing, since this involves a small prick that is given in the finger of the patient to get some blood, which would distress the little girl even more. In spite of my plea, they continued with the malaria testing which made the girl so upset they had to hold her down with three people in order to get her finger pricked. Eventually they succeeded in taking the malaria test, which turned out to be negative, but as I predicted they treated the girl for malaria anyways because of the obvious symptoms.* (Meyermans, logbook, 4 September 2015)

By telling this story, I certainly do not wish to lapse into a 'yes or no'-story in which I was supposedly right and the nurses supposedly wrong (although I think it is fair to admit that it did *feel* like that at the time), and it would be a mistake to interpret this event as a lack of empathy on the side of the nurses who often have a very good relationship with their patients. Instead, this incident allows us to ask critical questions about the utility of certain biomedical protocols that are difficult to adapt to patients' real-life experiences (Feierman et al., 2010). As Human (2012) mentions, health care providers must often break with protocol when they are confronted with a rather exceptional case, in order to diagnose the disease effectively.

Furthermore, this event can show us *why* it is so important to the nurses to follow these standardized protocols. For them, this may constitute a way of expressing and performing the 'modernity' of their medical practices – although this 'modernity' is not explicitly addressed by them as such. In the discourse of the Ghanaian MoH (2007), upon which the local practices of the nurses in the CHPS center are largely based, these 'modern' biomedical practices are perceived and imagined as the 'best' possible way of delivering health care; a category to which the nurses are eager to belong. As Human (2012: 20) points out: "Protocols illustrate a particular, idealistic view of medicine. This is medicine in a perfect world (…)". For the CHNs at the CHPS compound in Akim Gyadam, medicine in a 'perfect' world takes on the form of biomedical technologies. This is why they are so keen on consistently applying the standardized protocols which are based on this cognitive framework in their everyday practices.

Us versus them: 'modern' versus 'traditional'

As I have mentioned above, the nurses actively (but probably unconsciously) produce a division between themselves and the local villagers by pointing at the fact that these people *still* make use of 'traditional' and 'old-fashioned' healing methods. The 'us versus them'-sentiment which is hereby created, relates to the generally unequal and hierarchal power relations that exist between the nurses and their patients. As mentioned by Feierman et al. (2010) it is difficult for those with less power to communicate their knowledge, while potentially important, to those above them. Like this, it is also troublesome for the locals of Akim Gyadam to persuade the nurses of the benefits that some of their 'local' healing practices may bring about.

Still, it is necessary to nuance this observation by referring to those instances where the nurses did not show any objections to the local villagers making use of 'traditional' medicine, although this tolerance strongly depended on the perceived seriousness of the case, as becomes apparent by the occasions documented in my logbook as follows:

One day, when it was CWC at the CHPS center, the nurses noticed that a little girl of 18 months old was still not able to walk. They inquired the mother about this and she told them that her daughter was currently under the treatment of a herbal healer who attended to this problem. The nurses regarded this as an adequate treatment for the little girl and did not think it was necessary to refer her to a hospital. However, when the nurses found out that a man who suffers from tuberculosis [TB] had stopped taking his medicines because of the serious side effects of these drugs, they immediately instructed him to stop the herbal treatment he had started instead. They successfully convinced the man that a herbal treatment is not sufficient for curing TB and that he had to start taking his regular medicines again in spite *of the uncomfortable side effects, which he eventually did.* (Meyermans, logbook, 17 August and 28 August 2015)

Although the nurses occasionally tolerate the usage of ‘traditional’ herbal and spiritual healing practices by their patients, their general sentiment towards these forms of medicine points to a condemnation and rejection of these healing methods. While biomedical health care seems a reserved right for educated and ‘modern’ people, ‘traditional’ medicine is conceived as an outdated and backwards ‘belief’. This idea of ‘being modern’ involves power relations between a societal elite who can afford the best biomedical care, and local peasants who have to make do with the care provided by local herbalists, spiritual healers or others ‘traditional’ healers (Pigg, 1996). As I have briefly mentioned before, when referring to the article of van der Geest et al. (1990), people residing in rural villages also strive at belonging to this, often urban, elite by renouncing their own ‘old’ methods and demanding their fair share of biomedical curative facilities such as doctors, hospitals and proper medicines.

Meanwhile, their ‘traditional’ healing methods remain being framed as a ‘belief’. As Farquhar (2012: 153) notes, these forms of ‘indigenous’ knowledge have appeared as a threat against the rigid positivism of biomedicine because of their ability to make us “face a hard choice, not only between ways of imagining reality but also between courses of action”. When these indigenous and ‘traditional’ knowledges are reduced to being a mere ‘belief’, instead of being considered as a form of true knowledge, this threat is eliminated considerably (ibid.). As such, medical students learn that the biomedical system has certain core universals and defining characteristics, that its knowledge base has been systematised and that its practitioners have been tested and accredited according to standardized international measurements (Gibson & Oosthuysen, 2012). At the same time, taken to represent ‘tradition’, village healers and ‘credulous’ villagers are usable symbols in the construction of this ‘modern’ biomedical project (Macdonald, 2012). As Pigg (1996: 178) points out, the word ‘traditional’ then signals a world of shared and unquestioned beliefs, “a kind of collective mental prison in which villagers are trapped”.

These notions of ‘modern’ and ‘traditional’, and their supposed dualism, have also become central buzzwords in the international development discourse (Pigg, 1996). Here, development is conceived as the ‘modern one’, mobile and active, directed at listing and eradicating the ‘wrong beliefs’ of the villagers (ibid.). As such, the term ‘traditional’ with regard to medicine is not only misleading and naïve, it is also a revealing adjective since it throws together every type of thinking and acting that differs from biomedicine; in this it reveals the ethnocentrism of the observer[13] (van der Geest & Krause, 2014). Furthermore, Appadurai (1996) states that these words and their opposition are products of modernisation itself. In my opinion, the next step consists of examining how this ‘modernisation’ project, of which biomedicine has always been a central part, has become dominant and even hegemonic in the Ghanaian context; an issue I will address here below.

3.2 Introduction of biomedicine in the Ghanaian context

The introduction of Western (bio)medicine in Ghana dates to the end of the 19th century (Böhmig, 2010b). Imported by the British colonial administration, successes in treatment and professional opportunities led to a growing acceptance of this new medical system (ibid.). Also in the international health development discourse this system was confidently supported, often at the expense of local African healing practices which were largely ignored and marginalized (Khatri, 2004). Still, it remains to be seen if the recently observed ‘renaissance’ of the importance of ‘indigenous’ and ‘traditional’ knowledge in the international development discourse, truly changes the status of these ‘traditional’ healing practices in the sense that they are genuinely placed on an equal footing with biomedicine.

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[13] However, in this thesis, I will continue to use the term ‘traditional’ to denote the long-established healing practices of the Ghanaian people, since an acceptable alternative is hardly available (van der Geest & Krause, 2014).

Biomedicine as the ‘silver bullet’ of colonialism

Throughout colonization, when the British administration built the first hospitals and health posts and soon opened them up to the whole population, evidence grew that biomedicine could ‘work’, even for natives who were heretofore assumed to be immune to tropical ailments (Böhmig, 2010b; Lock & Nguyen, 2010). This opened a door for biomedicine to be used as an ideological tool, a way of winning the locals’ ‘hearts and minds’ and of showing the ‘beneficial’ effects of colonialism (Lock & Nguyen, 2010). This introduction and dissemination of biomedicine also justified the colonial enterprise as a kind of ‘hygienic enlightenment’ (ibid.). In the form of improved hygiene, proper etiquette and enhanced lifestyle, colonial powers could be seen as bringing progress with the biomedical healing system as their showpiece ‘par excellence’. This evolution went hand in hand with the common assumption on the part of health care planners that indigenous medical practices would soon die out or would be incorporated into a worldwide ‘cosmopolitan’ (bio)medicine (ibid.). As time has shown, this assumption could not have been further from the truth, as indigenous medicine is still alive and well.

Apart from being a physical project, aimed at treating the sick and maintaining a healthy living environment for both European colonists and Africans, the installation of the biomedical system on African soil certainly was a moral enterprise as well (Lock & Nguyen, 2010). Nowhere this became more apparent than in the pervasive bio-medicalization of childbirth and childrearing which opened up the possibility for biomedical technologies to colonize the most intimate sphere of domesticity (ibid.). The newly introduced obstetrical practices were linked to campaigns that sought to teach women the ways of ‘proper’ and ‘hygienic’ motherhood, along with the encroachment of a normative view of how children were to be raised and cared for (ibid.). The morals of the African mother had to be transformed accordingly (ibid.). This extensive focus on the domestic sphere and the intimate life is something which can still be observed in the current hegemonic project of the biomedical system. As I have noted in the second chapter of this thesis, the CHNs who are ‘used’ as local representatives of this bio-medicalization project, also put these topics of reproductive health, childbirth and –rearing, all belonging to the most intimate spheres of life, central in their prevention and sensitization efforts.

Like this, it becomes evident that biomedicine has not only been the ‘silver bullet’ of the colonial administration, but still functions as a flagship policy of nation-states as well as development agencies, NGOs and other humanitarian efforts that seek to improve the health of the global poor (Lock & Nguyen, 2010). As Lock and Nguyen (2010) point out, in the 1960s, biomedicine began to be used as an emblem of nation-building and modernization by newly independent African countries. This era of nationalist health care systems quickly passed when most states found that they could not afford tertiary care for all but a wealthy few (ibid.). Thus, the stage was set for an intensified focus on *primary* health care provisions mainly devised and financed by international development agencies, and to a lesser extent by the nation-state itself (Van Wolputte et al., 2002).

Biomedical desocialization of disease

The ‘bio-medicalization’ processes discussed above have (had) a deep impact on how health professionals and ordinary people understand and perceive health, sickness, its causes and cures. How my own Western (and biomedical) outlook on these subjects differs from the way in which the local Akim Gyadam villagers see these matters, is nicely illustrated by the following excerpt out of my logbook, based on notes that I had taken after an interview with a local man who suffered from TB (figure 11):

One of the interviews I have done today was with a young man who has TB, and has stopped taking the medication they prescribed him in the hospital because of the severe side effects he suffered from these drugs. Before I asked him about this, I inquired how he had discovered that he had TB. He started telling me a long story about how he went to Accra, about the family he was staying with and how he got into a fight with some other men who had severely beat him up. This story lasted for at least 5 minutes and I started to wonder what this all had to do with him having TB. Eventually he explained that he went to the doctor when he returned to Akim Oda because of a severe stomach pain that was caused by the fight. At that examination, the doctor *diagnosed him with TB. I understood his story but during the rest of our conversation I was wondering why he found it necessary to inform me about the long chain of events that preceded his diagnosis of TB.* (Meyermans, logbook, 1 September 2015).

Figure 11. A picture of the man diagnosed with TB after the interview.

It is only later, while reading several publications in medical anthropology, that I realized that the account of this man relates to the different ways in which Ghanaian people regard matters relating to health and sickness. As Van Wolputte et al. (2002: 24) state about the perception of health in the context of Kinshasa: “Health is not defined as the absence of disease, and not even as the well-being of the individual body. Health is a relational quality […]”. As the man with TB revealed in his story above, he perceives his illness as the outcome of relations with certain people, and of his own relation to his broader life-world (Van Wolputte et al., 2002).

This holistic and relational view of health and sickness is at odds with the way the sick body is perceived by the biomedical ideology. As Taussig (1980) argues, the biomedical conception of illness considers the signs and symptoms of diseases as ‘objective’. They are seen to exist independently from theoretical perspectives and social relations, even though “they are *not only* biological and physical, but *are also* signs of social relations” (Taussig in Filc 2004: 1277). As a result, the illness is seen as located in the individual body (Filc, 2004). The denying of human relations embodied in signs, symptoms and therapies of sickness, brings about a process which is termed by Taussig (1980) as ‘reification’. In sustaining this reification of the human body, “disease is recruited into serving the ideological needs of the social order, to the detriment of healing and our understanding of the social causes of misfortune” (Taussig, 1980: 3).

Also Ivan Illich expressed a stinging critique on this ‘reification’ or medicalization of the sick body in his famous publication “Medical Nemesis”, in which he poignantly argued that due to overmedication, biomedicine may inadvertently produce disease; a process known as *iatrogenesis* (Barnet, 2003; Lock & Nguyen, 2010). He also asserted that due to overmedication, biomedical treatment often creates negative, even serious side effects in the human body (ibid.). This worry has been also uttered by the man in Akim Gyadam who suffered from TB:

> During the taking of the TB medication, my body felt very strange as if my blood was no longer flowing. I could not eat anymore which made me feel very weak because I became very skinny. When I stopped taking the medication, I immediately gained weight and felt stronger again. You see … now my nails are pink, but they were white; there was no blood anymore.

When considering this account, it is not difficult to imagine that this man felt compromised in his autonomy of dealing with his pain and illness; an almost necessary consequence of medicalization according to Illich (Lock & Nguyen, 2010). Moreover, in order to regain this lost autonomy, the man decided to stop taking the prescribed TB medication and turned to a ‘traditional’ healer who treated him with herbs instead. The severe side effects he endured while taking the TB medication went away, but he also realized that he was not healing from his specific TB complaints. At the end of our interview, he assured me that he was planning on taking the (biomedical) TB treatment again in spite of the distressing side effect it causes.

This ‘desocialization’ of disease brought about by the biomedical conception of illness, according to which signs and symptoms of disease are seen to exist independently from the social relations and broader life-world of the sick person, is closely related to a particular outlook on the human body (Taussig, 1980). As Scheper-Hughes and Lock (1987: 8) describe: “A singular premise guiding Western science and clinical medicine (…) is its commitment to a fundamental opposition between spirit and matter, mind and body, and real and unreal”. Although this dualistic phenomenology is partly responsible for the ‘awesome’ efficacy of biomedicine, it ignores certain questions that the sick body asks and the physician is unable to answer: “Why me?”, “Why now?” (Scheper-Hughes & Lock, 1987; Taussig, 1980).

In this conception of the ‘body proper’, given wholly by nature and separated of the mind and social life-world, biomedicine is unique (Lock & Nguyen, 2010). Biomedical explanations are, comparatively speaking, reductionist and mainly focused on the detection of named entities or signs internal to the body (ibid.). According to Kleinman (1995), this radical reductionist value orientation of biomedicine, caused by the set of deep dualisms upon which this medical system is based, is not only “ultimately dehumanizing”, but also ultimately situated and highly dependent on its historical context. Thus, it is essential to realize that biomedicine, even though its ideology and practice have successfully spread throughout the world, is, like any other form of medicine, “both the social historical child of a particular world with its shape of experience and an institution that has developed in its own unique form and trajectory” (Kleinman, 1995: 40).

It is exactly this acknowledgement of the specific nature of biomedicine which should make us question the presupposed universality of this biomedical system and its hegemonic reinforcement in almost every part of the world (Filc, 2004). As Filc (2004: 1276) argues, the hegemonic articulation of this medical practice takes place on different levels: on the level of medical ideology, the popularization of biomedicine, the organization of medical institutions and the medical encounter. Moreover, he argues that the hegemonic domination of this scientific and biomedical knowledge reflects and reproduces the unequal distribution of power and resources in contemporary society at large (ibid.).

Also in the realm of health education and prevention, the main focus of this thesis, the biomedical framework has proved to be hegemonic (Krumeich, Weijts, Reddy & Meijer-Weitz, 2001). As such, “health education has been criticized for its ethnocentrism and its self-evident acceptance of the superiority of Western (scientific) culture” (Krumeich et al., 2001: 122). The dominance of Western (biomedical) health practices in the prevention and sensitization efforts offered by the CHNs in Akim Gyadam is something I have also observed and have described in the second chapter of this dissertation. As Krumeich et al. (2001) argue, anthropology plays an important role in overcoming this Western bias in health education attempts. Through practicing ‘thick-description’, ethnography can shed a crucial light on relevant aspects of local cultures that otherwise escape attention (ibid.). A different take on risk and illness perceptions is necessary; an issue I will address in the next chapter.

3.3 From exclusion to inclusion of ‘traditional’ healing practices

But les us first consider another outcome the hegemonic dominance of the biomedical system has brought about. In challenging the rigid positivism of biomedicine, other medical systems have appeared has a threat and have consequently been framed as *beliefs*, opposed to the scientific, biomedical framework as the one true form of *knowledge* (Farquhar, 2012). ‘Traditional’ healing practices, as they are condescendingly termed, are subsequently seen as ‘backwards’ and ‘un-civilized’ (Khatri, 2004). In the global development discourse, these forms of indigenous knowledge became a scapegoat for underdevelopment and were excluded from international health development strategies (Khatri, 2004; Nygren, 1999).

Integration in the international development discourse

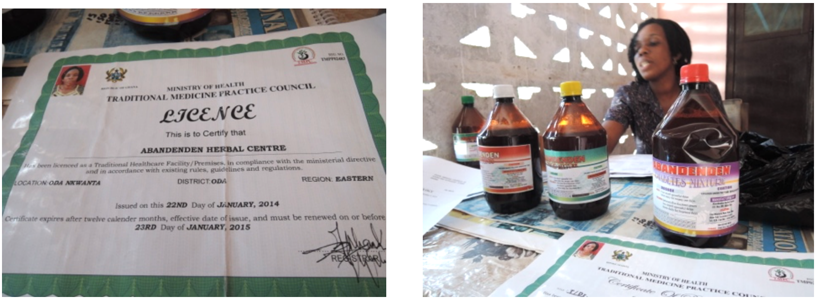
However, in recent years, global development strategies have radically changed in this respect (Khatri, 2004). As people's participation and inclusion are now high on the development agenda, the inclusion of indigenous knowledge is the latest trend in this change (ibid.). Once seen as a barrier to development, 'traditional' knowledge forms are now considered a panacea for sustainability and are accepted as such by most leading development organizations (Nygren, 1999). This renewed positive attention to 'traditional' health care is related to the WHO's PHC-strategy as it was designed in the late seventies (Bichmann, 1979). As is mentioned in the Alma-Ata Declaration (WHO, 1978: 2) itself: "Primary health care relies on (…) traditional practitioners as needed, suitably trained socially and technically to work as a health team and respond to the expressed health needs of the community".

On the basis of this resolution, many developing countries have taken action to develop policies and programs aimed at the *integration* of traditional systems of medicine into their national health care system (Hyma & Ramesh, 1994). Also some academic scholars, such as Tsey (1997) and Hyma and Ramesh (1994), are advocates of the integration of 'traditional' medicine into the public health policies of nation-states and argue for a better understanding of 'traditional', 'African' notions of illness causation and preventive health which should be incorporated into the current health policies.

During my fieldwork, I have also observed the concrete shapes these efforts to integrate 'traditional' healing practices into the 'official' system of health care, take on. In this respect, the Director of the local Health Directorate in Akim Oda, informed me that they strived at working together with 'traditional' healers by providing them with 'proper' – this is to say, biomedical – training opportunities, and by gaining a more comprehensive oversight of their diverse healing practices in the region. Apart from this, the *integration* of traditional medicine into the official medical system often entails a translation of traditional healing practices into the national project of biomedicine, as is nicely illustrated by the following event:

On a hot afternoon, I visited the 'Abandenden Herbal Center' (figure 12) in a neighboring village from Akim Gyadam, called Oda Nkwanta. I had already heard a lot about herbalists in Ghana, but this was to be the first time to actually see one at work. Full of prejudices about the limited curing capacity of these herbs and wondering why local people still believed in these kind of practices, I set foot in the herbal center. While talking to the woman who owned and managed the herbal center, she eagerly showed me all sorts of certificates she had received from the Ghanaian Ministry of Health and from scientific laboratories in Kumasi. These documents not only confirmed her permission to work as a traditional herbal healer, but also the fact that her herbal mixtures had been tested in a laboratory where the curing capacity of the mixture was scientifically verified (figure 13). I left the herbal center somewhat later, pleased and reassured by the scientifically proven efficiency of her herbal medicines. (Meyermans, logbook, 2 September 2015)

Figure 12. The Abandenden Herbal Center-sign on the side of the road.



MINISTRY OF HEALTH
TRADITIONAL MEDICINE PRACTICE COUNCIL
LICENCE
This is to Certify that
ABANDENDEN HERBAL CENTRE
Has been licenced as a Traditional Healthcare Facility/Premises, in compliance with the ministerial directive and in accordance with existing rules, guidelines and regulations.
LOCATION: ODA NKWANTA DISTRICT: ODA REGION: EASTERN
Issued on this 22ND Day of JANUARY, 2014
Certificate expires after twelve calender months, effective date of issue, and must be renewed on or before 23RD Day of JANUARY, 2015
REGISTRAR

Figure 13. A certificate that recognizes the Abandenden Herbal Center as a certified 'traditional' herbal healing center (on the left) and the scientifically tested herbal mixtures (on the right).

When considering this fragment, we first have to note that the conceptions of herbal healing practices I displayed back then – and just to clarify, have radically changed by now – are equal to what a lot of people in the West (and outside the West) think about this method of healing; namely that herbal remedies are a backward and irrational way of trying to cure an illness (Nygren, 1999). However, apart from this, this narrative also points at the pressures directly or indirectly placed on indigenous healers to systematize and standardize their practices, and to subsequently 'biomedicalize' themselves (Lock & Nguyen, 2010). Like this, the herbalist mentioned above not only experienced pressure to be certified as a 'traditional' healer by the GHS, but also to have her herbal mixtures be scientifically tested in laboratories in Kumasi.

Still, 'traditional' herbal healers should not be considered mere passive victims of these outside pressures of bio-medicalization. As I have observed, they often are ready and willing to let their herbal remedies be tested in laboratories since they see this as an opportunity to gain certain additional benefits. Like this, the herbalist in Oda Nkwanta mentioned that she can charge more for her scientifically tested herbal mixtures and that her client base has expanded far outside the village because of the good reputation of her medicines. Besides, it allows her to keep up good relationships with outsiders, such as the Ghanaian MoH and the GHS.

Nevertheless, this account should make us wonder if *integration* of 'traditional' healers into the national health care system in reality does not often result in an actual story of submission. As van der Geest (1985) asserts, this so-called integration proves to be an entirely one-directional affair. Indigenous practitioners learn the alphabet of Western biomedicine and thus become primary health workers in this tradition (ibid.). In this way, the desired integration of 'traditional' medicine indeed ends up in a "fatal embrace" (ibid.). Moreover, as van der Geest (1997) poignantly mentions, this integration of 'traditional' healing into the official health services is not even longed for by the local population when other biomedical health care provisions are not improved correspondingly. Instead, people ask for "(…) more accessible services, more dedication and respect from doctors and nurses, more medicines and personnel" (van der Geest, 1997: 910).

An actual story of submission?

'Traditional' healing practices, and indigenous or local knowledge in general, are looked upon in two diverging and contrasting ways: dogmatic opposition and romanticization (van der Geest, 1995b). The former sees indigenous knowledge as a scapegoat for underdevelopment and rejects it a priori because its practice is not based on natural science premises, while the latter understands 'traditional' knowledge as a panacea for sustainable development and a priori beliefs in its effectivity (Nygren, 1999; van der Geest, 1995b). From exclusion of 'traditional' medicine in the global development discourse, this has led to a current surge of interest in indigenous knowledge by development practitioners and theorists (Agrawal, 1995). 'Indigenous knowledge' is now one of the more glamorous phrases that colonizes their lexicon (ibid.).

As many authors argue, these two opposing conceptions of indigenous knowledge, regardless of their actual accuracy or falseness, are basically two wrong attitudes towards 'traditional' medicine (Agrawal, 1995; Khatri, 2004; Nygren, 1999; van der Geest, 1995b). In this way, Agrawal (1995: 413) asserts that "both the concept of indigenous knowledge, and its role in development, are problematic issues as currently conceptualized". In his article, he refutes the essentialist visions of local knowledge by showing that the dichotomy between scientific and indigenous knowledge is not as stark as many authors and development workers would like to think. Thus, a classification of knowledge into 'indigenous' and 'Western' categories is bound to fail not just because the intra-group differentiation is stronger than the real difference between these categories, but also because the reified and essentialist view of 'traditional' knowledge cannot be supported.

Likewise, Ellen and Harris (2000) criticize the tendency to define indigenous knowledge in relation to Western knowledge, since this still raises Western science to a level of reference to which all other knowledge forms must be compared. Also the decontextualization of indigenous knowledge, which is inscribed in the scientific documentation of this knowledge, concerns them. The decoupling of local knowledge from the wider cultural context in which it is produced, will generate an essentialist view on indigenous knowledge in which this is presented as an invariable and homogenous whole of ideas and practices. Also Nygren (1999) is critical towards the characterization of human knowledge as being composed of two opposed archetypes: western science as reductionist and theoretical knowledge, against its non-western, holistic and practical counterpart. When we continue sustaining this discourse of otherness, the hegemonic dominance of the western, scientific framework of knowledge will keep on existing, whilst a true form of agency for the so-called indigenous people will keep on being obstructed (Nygren, 1999).

By now, it becomes apparent that the so-called *integration* of ‘traditional’ healing practices in the international health development discourse does not succeed in breaking down the hegemonic discourse of ‘modern’ science over ‘traditional’ knowledge; a discourse that emphasizes the otherness of these two approaches. As Filc (2004) argues, this observed hegemony points to the unequal power balance between the global North and global South at large; a political and economic story of which health care makes up a central part. Like Fassin (2007) indicates in his influential book about AIDS in South Africa, health should be seen as a political issue, and we should cease to presume that sick people and doctors always share the same interests or that everyone thinks that prevention is better than cure. As such, global health is not only about ideas, problems and concerns, but also about actors whom we must clearly identify and whose interests we should accurately analyze (Fassin, 2012).

In this way, we should also turn our attention to actors who have the power to define and execute various prevention and sensitization programs in different contexts, such as in the context of my fieldwork site; the CHPS center in Akim Gyadam. These actors, identified as the Ghanaian MoH, GHS and other international development agents, assert, in line with the PHC-strategy, that prevention should always be preferred over cure, and infringe their bio-medically inspired conceptions of sensitization and prevention onto the local circumstances of the Akim Gyadam village. Especially in this realm of prevention, which is seen as a crucial undertaking because it allows nation-states to cut down on their expenses for the provision of curative services, local notions of health risks and of ways to avoid these health hazards are passively ignored, or even actively suppressed; even though it is ever so necessary to take into account these cultural conceptions of health risks and illness prevention methods to make health education programs actually work and be of real benefit to local people (Krumeich et al., 2001). This is why, in the next chapter, I will attempt to come to a rethinking of prevention based on local notions of health hazards and disease prevention methods in the Akim Gyadam village, whilst bearing in mind the hybrid reality of their different healing practices.

4. A rethinking of prevention

The foregoing discussion about the rather precarious position of ‘traditional’ healers in the international health development discourse, incites me to talk about the ‘traditional’ healers I have met on the field myself. In my conversations with them, the ‘bad versus good’-dichotomy – of indigenous healing as a backwards practice in contrast to it being something which allows for more community participation and bottom-up development – which is often so overwhelmingly present in health development programs, became pointless. Instead, I noticed a great complexity in their ideas and practices related to health, sickness and cure, in which elements out of ‘traditional’ medicine and ‘modern’ biomedicine are pluralistically combined with each other. So, as van der Geest (1985) pertinanly asks himself:

> “Why all this fuss, one could ask, about integration? In their heads, clients of health care have already achieved an 'integration' of medical traditions. They have an elaborate arsenal of ideas as to which practitioner is capable of treating which illness. In their heads, a complex 'referral-system' between various medical institutions exists. Why not leave it at that? Is a peaceful-coexistence of medical traditions not the most felicitous form of 'integration'?”

This existence of a complex ‘referral-system’ within people’s minds is something I have observed as well. While some diseases are deemed to be curable by ‘traditional’ healers, others are perceived as requiring treatment in a biomedical institution. This categorization is not as rigid as we might think and is probably related to and based on local notions and risk perceptions of different ailments and illnesses. Hence, in this chapter, I will first give thought to these local perceptions and realities of healing which are characterized by hybridity, as well as a pragmatic adaptation to local realities and conditions. These considerations will allow me to look at prevention in a different light, based on the endogenous conceptualizations of this notion.

4.1 Dealing with a hybrid reality of healing

'Traditional' healing practices in and around Akim Gyadam

As remarked before, in many African contexts, among which Ghana, health is not defined as the absence of disease, and not even as the well-being of the individual body (Van Wolputte et al., 2002). Instead, health is a *relational* quality and as such, refers to the set of social relationships and broader life-world someone is part of. In this sense, illness itself is seen as a symptom of dissolving (social) relationships, and often considered a retaliation, punishment or sanction by the ancestors for breaching an interdiction or a taboo (ibid.). In this perception of illness, the *why*-question is pivotal, in opposition to the biomedical conception of sickness in which we mostly wonder *how* the disease has been brought about. This centrality of the why-question also came forward in an interview I had with a spiritual healer (or 'priestess') situated in a neighboring village of Akim Gyadam, called Oda Nkwanta (figure 14):

> People come to me with illnesses related to spiritual matters, for example when they are bewitched by a spell or a curse. But also people with physical complaints come to me, when they think these complaints have a spiritual origin. After an assessment of these complaints, we [the priestess and her assistants] pray to God. Through these prayers, I can see the past, the present and the future, and I receive a revelation that shows me *why* the person got sick (…), if the origin of the sickness is physical or spiritual. When the illness is spiritual, I treat the person [i.e. through giving certain herbs, letting the person bathe in blessed water, lifting up a spell through prayers]. When the origin of the complaint is physical, I tell the person I cannot help them and that they should go to the hospital instead.

This account contains a number of interesting elements. It, first and foremost, shows how illness and health, in Ghana (and beyond), are associated with cyclical processes of (re)generation, growth and decay ("through these prayers, I can see the past, the present and the future"), and how therapies in Sub-Saharan Africa present themselves as a kind of re-birth, as is illustrated by some of the therapies used by this priestess in her *revival* church (Van Wolputte et al., 2002). Through praying or bathing in blessed water, the sick person is being (almost literally) stripped of their old state of illness, and is being made ‘whole’ again; their vital life-force is restored (ibid.). Secondly, this narrative refers to the complex ‘referral-system’ van der Geest (1985) has talked about and reveals a complicated reality of hybrid and pluralistic combinations of different healing methods. After all, when the priestess finds that the origin of the sickness is not spiritual, she willingly refers the person to the hospital instead, without experiencing this as a compromization of her capabilities as a healer.

Figure 14. The priestess standing in the courtyard of her house where she performs her healing practices, and a commercial sign of her revival church on the side of the road (above left).

In addition to the revival church of this spiritual healer, the village of Oda Nkwanta has a herbal center, which I have already talked about in section 3.3 (see figures 12 and 13). When I interviewed the woman who owns this center, she also alluded to things which point to the existence of a complex 'referral-system' between her herbal center and other health care institutions.

> *I: How does a consultation take place?*
> When a sick person arrives in my 'clinic' [the herbal center], they first have to fill out a registration form. After this, I ask them about their complaints and make a diagnosis. Then, I oblige the patient to go to the hospital in Akim Oda in order to be tested, and to verify if my diagnosis is correct. The person has to bring these test results from the lab with them when they come back to the center, for confirmation. Then I can start the herbal treatment.
> *I: Then why don't people just get treated in the hospital if they're already over there to be tested?*
> Some people *believe* that certain medicines won't cure them. They don't feel comfortable with modern medicine, so they prefer to be treated with herbs.

On the one hand, this account shows how ordinary people, as well as health practicioners, easily combine different healing practices; after being bio-medically tested in a hospital – on the advice of the herbalist herself – people choose to receive a herbal treatment instead of a biomedical one. On the other hand, this narrative may disclose an unwillingness on the part of some people to be bio-medically cured for certain ailments. In this respect, the herbalist used the term 'believe' which may point to a certain disapproval or condemnation of 'modern' medicine.

This sense of rejection and criticism can also be observed the other way around; when people renounce the use of 'traditional' healing practices, such as the services offered by the priestess and herbalist mentioned above. In this way, I observed that some Ghanaians, especially those who live in an urban environment and have received a higher education (such as my host, the Director of the local Health Directorate or 'urbanites' I met while visiting the capital Accra), were as surprised as me to find that ‘traditional’ healing practices are *still* widely being used by people, principally in rural contexts. These Ghanaians were often firm proponents of ‘modern’ biomedicine and criticized ‘traditional’ cures as backwards and irrational practices that should be eradicated, or transformed into scientifically approved treatments.

A highly pluralistic, contested and hybrid medical arena

This hybrid healing reality does not only exist among these ‘traditional’ healers, but also in the CHPS center in Akim Gyadam, I observed people making use of different medical systems at the same time, pragmatically combining their diagnoses and treatments; from a mother who consulted a herbalist because her young child was not able to walk yet, whilst also asking the nurses for advice on how to properly nourish the child – to a young woman with an ailment at her breast who was simultaneously treated by the nurses, as well as by a herbal healer. Dynamic, eclectic and creative ways of combining different healing methods are part and parcel of the daily lives of a large part of the rural (and urban) Ghanaian population (Aikins, 2005; Tabi & Hodnicki, 2006). In the meantime, the practice of ‘healer shopping’ – the use of a second healer without referral from the first one – has become a central notion in many academic writings on the hybrid use of healing methods in Africa (Aikins, 2005).

Also on the side of the healers and the health care personnel themselves, the pluralistic and hybrid combination of diagnoses and remedies belonging to different health care systems has become a widespread practice (Hampshire & Owusu, 2013). Not only rural, but also urban ‘traditional’ healers selectively adapt, adopt and modify elements of biomedical and ‘local’ healing practices in eclectic and creative ways (ibid.). By positioning themselves in the highly pluralistic and globalized medical arena, they end up, not only transgressing therapeutic boundaries but also stabilizing and emphasizing them in order to legitimize their own healing practices (ibid).

Also Marsland (2007) discusses the ‘intentional hybridity’ of healers and demonstrates their ability to transcend, contest and make use of the constructed categories through which they are imagined. As such, this author focuses on the ways in which 'traditional' healers work to reposition themselves within the 'modern' medical space, for example, by appropriating biomedical techniques or emphasizing similarities between their own medicines and biomedical pharmaceuticals. This longing to be a part of the 'modern' sphere – and also partly the desire to attract more clients and to be able to charge more for their services – is something I have also observed while visiting the herbal healer situated in Oda Nkwanta. This herbalist was very proud to show me the official certificates that recognized her as an accredited herbal healer and demonstrated the scientific effectiveness of her herbal mixtures.

It becomes apparent that neither 'traditional' medicine, which is generally used as a generic term for *all* healing practices that do not fall under the common denominator of biomedicine, nor 'modern' biomedicine itself, which is represented as a more or less monolithic enterprise, are as clearly demarcated and homogenous as we might think (Gibson & Oosthuysen, 2012). Both healing systems are not rigid or self-evident, but are instead shaped to the constraints and possibilities of the local setting (ibid.). As such, the dichotomy between 'traditional' and 'modern' proves to be no longer sustainable when considering this hybridization in the thinking of patients and practitioners between what is associated with 'tradition' on the one hand and with 'modernity' on the other (Lock & Nguyen, 2010).

Then how can we consider these different knowledge domains, from biomedicine to 'traditional' healing methods, without taking on an either essentialist or relativistic stance (Gibson & Oosthuysen, 2012)? As Macdonald (2012) argues, it would be a mistake to frame all sorts of 'traditional' healing practices as 'cultural beliefs'. This positioning not only ignores evidence for individual and social skepticism, but also brackets 'belief' off to one side of medical practice, leaving the dichotomy of truth and falseness intact (ibid.). Instead of seeing 'harmful cultural beliefs' as a hindrance to patient adherence and an explanation for their 'non-compliance' within biomedical protocols, Macdonald (2012) uses the idea of 'hybrid skepticism' to show how villagers are not mere passive believers but skeptical agents who are ambivalent about their healers and adapt their health-seeking behavior accordingly. As such, public health discourses should acknowledge this role of skepticism in people's choices for different health care options, in order to truly improve patients' compliance to biomedical and other treatments (ibid.).

Also Aikins (2005) notes that 'healer shopping' choices of people do not exclusively depend on (cultural or other) theories of illness causation, nor on the fact that biomedicine does not recognize the spiritual underpinnings of certain diseases, but also, and more crucially, on the severity and timeframe of the illness and on the cost, availability and accessibility of different medical services. Like this, a more pragmatic explanation of so-called patient 'non-compliance' imposes itself on us. As I have observed during my fieldwork at the CHPS center, some people just outright say that they do not wish to step foot into the hospital of Akim Oda and want to go to a 'traditional' healer instead, while for others limited resources and disadvantageous practical conditions significantly restrict their opportunities to choose between different health care facilities. These observations, which can offer a possible explanation for the patient 'non-compliance' I observed during my fieldwork, will be the topic of the next section of this chapter.

Towards a framework of 'situated' knowledges?

But first, we have to recognize that it has become thoroughly clear that the 'indigenous – scientific' knowledge divide, which is presumed in many public health discourses, is clearly not adapted to the hybrid healing reality of Ghanaian health care providers and their patients. Hence, the question still stands: if either a negative vision on indigenous knowledge (as a backward form of tradition), nor a positive outlook on local knowledge (the ideas and practices of the 'noble savages' as a blueprint for sustainable development) are able to free 'traditional' knowledge forms from its subordinate role to modern science, then how can we still consider indigenous knowledge? How can we break out of the hegemonic discourse of modern science over 'traditional' knowledge; a discourse that emphasizes the otherness of these two approaches?

Nygren (1999) asks the same question in her article and challenges the static oppositions of local versus universal knowledge by emphasizing the heterogeneity of different knowledge repertoires. To escape from the stifling polarization between modern/global and traditional/local, she presents an alternative view of ‘situated knowledges’ which are simultaneously local and global. Because “all knowledges were made up of diverse elements and combined within a world of multiple actors” (Nygren, 1999:277), we cannot draw sharp boundaries between different knowledge regimes. Instead we should start to recognize the shifting, contested and hybrid nature of every knowledge form. Also Agrawal (1995) asserts that knowledge is never a homogenous, monolithic block of ideas and practices. Instead, we should consider the intra-group differentiation in a certain knowledge repertoire even more since this will provide us with more insightful observations (ibid.).

As such, Nygren’s (1999) framework of ‘situated knowledges’ provides another way of looking at different forms of knowledge, the variation between them and within. This perspective provides an outlook that is much more closely connected to the real lives of Ghanaian and African healers and patients than the dichotomous view of ‘traditional’/indigenous versus scientific healing practices. As I have illustrated above by means of different ethnographic examples and observations, medical knowledge is a mishmash of different, often discrepant and fragmented, epistemologies and practices and is therefore ultimately ‘situated’.

4.2 Endogenous conceptualizations of health risks and prevention

Now we have taken a look at how Ghanaian health professionals and their patients perceive health, sickness, its causes and cures, differently from the biomedical discourse, and have gained an understanding of the ‘situated’ nature of their hybrid knowledges, it is not hard to realize that the preventive methods of the villagers in Akim Gyadam are related to their local notions of (health) hazards and risk prevention. As such, when illness appears as a symptom of a broken, disturbed or deviant relationship, it is often considered a retaliation, punishment or sanction by the ancestors for breaching an interdiction or taboo (Van Wolputte et al., 2002). In this way, the birth of a disabled child can, for example, be attributed to the non-observance of do's and don'ts during pregnancy (ibid.). As such, if illness is viewed upon as a sanction for (consciously or unconsciously) breeching or breaking a rule or norm, in contrast to the rather desocialized outlook on illness in the biomedical ideology, the prevention of this sickness will also conceived of differently. These endogenous conceptualizations of prevention will be explored in this chapter.

Prevention in 'traditional' medicine

Health care systems, their worth and efficiency, are often evaluated in terms of their preventive capacity (Krumeich & van der Geest, 1989). Under the saying "prevention is better than cure", a greater quantity and better quality of preventive services in developing countries has become one of the main objectives of the PHC-strategy (ibid.). This PHC-scheme does not only presume the failure of Western health care in the area of prevention in developing countries, but also the conception that local medical traditions in these developing countries are even less preventively oriented (ibid.). A fatalistic outlook on the naïve and carefree 'savage', who lacks a sense of orientation towards the future and therefore does not have any preventive traditions, has long been prevailing in the works of many medical anthropologists, active in the 1950s and 60s (Krumeich, 1989; Krumeich & van der Geest, 1989). Besides, the fact that prevention in developing countries often is a part of the inconspicuous, daily family life, has caused it to fall largely outside the radar of medical anthropology in general (Krumeich, 1989).

As a consequence, we have acquired the overall impression that significant preventive health care is mostly absent in non-Western cultures, while this assumption could not be further from the truth (ibid.). After all, van der Geest (1997) sees the orientation to prevention as one of the fundamental characteristics of most African medical traditions, adding that this is probably "a surprise to most readers". Also Xu and Chen (2011) recognize the fundamental role of 'traditional' medical systems in the area of prevention, and emphasize that we must not forget that these kind of 'traditional' health care systems were the only ones available to the prevention and treatment of diseases in different societies for centuries on end.

Van der Geest (1997) goes on to argue that, in many African contexts, prevention is central in people's everyday life and logically follows from their preoccupation with religious and social values. As we have seen before, 'traditional' healers concentrate on the deeper origins of illness, by asking themselves the 'why'-question (Van Wolputte et al., 2002). Consequently, these healers insist that something should be done about these causes of illness to avoid a repetition of the misfortune (van der Geest, 1997). They provide their patients with moral and social guidelines to prevent them from catching the same illness again (ibid.). However, this preventive character of 'traditional' medicine is hardly recognized by outsiders who do not consider illness as having a social and religious roots (ibid.). After all, this conception of prevention in 'traditional' medical systems as well as its practical realization, significantly differ from biomedical interpretations of prevention which focus on individual responsibility as the main prerequisite of successful preventing a disease (Maskovsky, 2005).

This discrepancy between 'traditional' and biomedical notions of prevention can also be observed in the diverging ways in which these medical systems conceive of risk and danger. As Krumeich (1989) refers to the insights of Mary Douglas, every 'culture' (society) is preventively-oriented in the sense that rules to avoid risks and avert danger exist everywhere. These conceptions of health risks and hazards can, however, vary greatly across different societies and communities (Krumeich & van der Geest, 1989). As Douglas and Wildavsky (in ibid.) note: "risks are selected", and the preventive measures taken by a community adjusted to these 'selected risks'. Also Wisner, Blaikie, Cannon and Davis (1994) partly refute the realist approach that considers risk solely as an objective hazard and instead, acknowledge the way in which these objective risks are always mediated through social and cultural processes. Moreover, they point at the importance of remembering that ordinary people already have knowledge and experience of certain health risks and hazards inherent to their environment. This makes the 'bottom-up' mobilization of knowledge and efforts at the neighborhood and village level even more critical (ibid.).

Furthermore, the top-down approach which becomes apparent in many of the prevention and sensitization efforts taken by nurses in the CHPS center in the Akim Gyadam community, is, as argued by Wisner et al. (1994), not suited to face a number of potential health disasters. As I have clarified before, these prevention campaigns are initiated by higher organs, in general the Ghanaian MoH or GHS, often with financial and logistical support of different international development agents. As such, it is not difficult to imagine how the conceptualizations of health risks and dangers as they are represented in these campaigns, may significantly differ from the ones of the villagers who live and work in a considerably different context. This is illustrated in an interview I conducted with one of the villagers, a young mother who suffered from considerable pains in one of her breasts (figure 15). I asked her why she had not come to the CHPS center with her ailment immediately, but first went to a herbal healer instead:

> I thought it was a common problem. Something that a lot of women have when they get pregnant and have a baby. We know this illness; it is always treated with herbs. That's why I also went to a herbalist for this. But the problem didn't go away. The pain in my breast disappeared but my children still prefer the other breast [to be breastfed].

It becomes clear that this particular ailment that a lot of women experience when they are pregnant and deliver a baby, is not perceived as a dangerous disease by many women in Akim Gyadam. It is not seen as an illness for which a biomedical treatment is required; a herbal cure suffices. As such, the prevention of this disease is not understood as imperative. Besides this ailment, malaria is not perceived as a dangerous affliction either, like one of the nurses, named Comfort, explained me:

> People in Ghana don't see malaria as a dangerous disease. They just come to the CHPS for their medicines and then, three days

> later, they already feel better. This is why they don't use the bed nets [the nurses distribute them at the CHPS center for free], because they don't think about the complications that young children can get when they have malaria.

Figure 15. The young mother I conducted the interview with (on the left), sitting with her mother and latest-born daughter (on the right).

Two studies by Ahorlu et al. (1997) and Ahorlu, Koram and Weiss (2015) support this statement made by Comfort. Their studies confirm that only few people in rural Ghanaian villages sleep under insecticide-treated bed nets, and that knowledge about malaria transmission keeps on being shrouded in many misconceptions. In short, these authors show how local experiences and meanings of malaria influence help-seeking behavior, which either promotes risk of infections or prevention.

As Pylypa (2009) demonstrates with regard to dengue fever prevention campaigns in Thailand, local perceptions of the risks and dangers of this disease do not match the ways in which this illness is represented in the government-initiated prevention programs. According to this author, this explains why these campaigns have been largely inadequate to prevent dengue fever transmission. I have observed a similar process with regard to the preventive efforts taken by the nurses at the CHPS compound. The conceptions of illness, cure and prevention as they are represented in the prevention materials made available to them by the GHS, are clearly not adjusted to the local notions of rural villagers as the ones in Akim Gyadam. As a consequence, the observed *non-compliance* of the locals should be understood in this respect[14].

Besides from understanding the *non-compliance* of the Akim Gyadam villagers in a more comprehensive way, it is crucial to gain some insight in how they themselves organize prevention based on their local notions of illness and well-being in general, and health risks and hazards in particular. To be fair, my thesis falls short of this aspiration. Due to the limited time amount I got to spend on the field, my main point of focus has stayed the observed *non-compliance* of the villagers and its possible explanations. I have not been able to observe how the Akim Gyadam locals concretely take preventive measures against the health risks and hazards that they deem dangerous and worth of preventing. It seems most probable to me that their preventive efforts are based on 'traditional' healing notions, as well as on the bio-medically inspired advices of the nurses, and are as such fitting to the hybrid healing reality with which they are confronted in their daily life-world. It would be interesting if future research would take on this crucial hiatus in my study.

Still, I did observe that social and, especially intergenerational relationships play a crucial role in the transmission of medical advice in the local context of the village. In this way, the man who was infected with TB, and had stopped taking his medication because of the severe side-effects he experienced, mentioned that he ended up in the care of a local herbalist as his mother had "forcefully"

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[14] I have already explained this in greater detail in paragraph 2.3 under the section 'Prevention and *non-compliance* according to the biomedical discourse'.

recommended him. During my fieldwork, I also noticed how (grand)mothers thoroughly advise their daughters on matters such as pregnancy, breastfeeding, or proper nutrition for their young children. Sometimes these pieces of advice were rather the opposite of what the nurses saw as 'good' mothering practices, and were quite difficult to shake off. After all, these maternal instructions compose a way for elderly women to maintain and reproduce their relationships with their daughters; an effort to which the preventive messages of the nurses are deemed to be subordinate (Livingston, 2007).

Also in the academic literature there is evidence that many 'African'[15], and other communities indulge in daily or frequent 'traditional' health maintenance (Meassick, 2008). Like this, Meassick (2008) mentions that use of various preventive herbal treatments is common in many families, as she remembers, while growing up, that her grandmother made her drink one of these bitter herbs herself. She concludes that: "Africans do have their own well-developed strategies of maintaining good health based on their own cultural understanding of health, illness and healing that does not necessarily include biomedical understanding, explanations, and screenings" (Meassick, 2008: 182). Krumeich's (1989) elaborate account of the religious-medical preventive system in a 'Kariben'-village in Suriname is another example of these kinds of local conceptions and measures of prevention, as well as John Ford's (in Lock & Nguyen, 2010) study of how Africans prevented sleeping sickness through agricultural practices that isolated humans from tsetse flies, thus breaking the cycle of infection.

A practical necessity?

Besides the fact that the prevention and sensitization messages, as they are dispersed by the nurses at the CHPS compound, are not adjusted to indigenous notions of health, illness and prevention, it is essential to acquire a sense of other, more practical reasons why prevention is

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[15] By using this generic term I certainly do not wish to generalize accross all African societies, but want to denote the fact these kinds of 'traditional' preventive efforts are not only found in rural Ghanaian communities, but also in other African communities, as is mentioned in the academic literature.

not always put first in the daily lives of the villagers. This is exemplified in an interview I conducted with a mother (figure 16), who did not sleep under an insecticide-treated bed net with her children, even though her two-year old daughter had already been affected by malaria several times. First, this woman denied the allegation that she did not sleep under a treated bed net with her children, but after asking some supplementary questions, she explained the following:

> Sometimes, we [she and her three children] sleep outside, because of fresh air… for sometime. And it even gets late sometimes before we go back to sleep in the house [points at the house which only consists of one room where they live, eat and sleep]. Because we sleep outside for a long time, before going inside, I think that is what is giving my child malaria (…). Or we leave the door of the house open, but then the mosquitos can enter. (…) It's because the room sometimes becomes warm, that we sleep outside.

Figure 16. The mother and her three children standing in front of their one-room house.

The undoubtedly hard living conditions of this woman, who is very poor and has had her children on a very young age (while their father has remained absent), probably play a vital role in the fact that this mother does not put malaria prevention forward as one of her main priorities. Also other women in the village experience difficulties in living up to the rather idealistic, and often unattainable representations of a ‘healthy’ family life that are being propagated in the sensitization efforts of the nurses. Out of practical considerations, such as being compelled to work on the fields all day or to go out and trade their goods on the market, these women cannot always comply with – what appears to them – unfeasible standards like exclusive breastfeeding or healthy child nutrition.

By discussing the pervasive consequences of these practical considerations on the preventive behaviors of the villagers, it becomes apparent that it is inaccurate to completely attribute the observed *non-compliance* of the locals to their so-called wrongful ‘traditional’ cultural beliefs. As Fassin (in Ingold & Nguyen, 2010) notes, health care authorities frequently cite these cultural beliefs as the reason why people choose not to cooperate with the modernization of health care practices. However, he stresses, based on a case study in Ecuador, that poverty and inability to travel to biomedical facilities on the part of many indigenous people often have a much greater explanatory power in accounting for their apparent *non-compliance*. I have made the same observation in the village of Akim Gyadam; in the villagers’ pragmatic health care choices, factors such as travel costs and time investment, are often far more decisive elements than the idea of embedded cultural resistance. The same aspects have a compelling effect in the area of prevention as well.

Also the relative inaccessibility of 'modern' basic health care facilities in Ghana can account for the bending back of local people on their own preventive measures and solutions. As many African governments have cut back their health budgets due to reduced export revenues, maintenance of infrastructure, provision of medicines and training of health personnel to improve primary health care services have all suffered (Wisner et al., 1994). While people in rural settings lack a sufficient household income, as well as assets to provide adequate nutrition and to treat illness or injury, their search for proper preventive and curative services is thwarted by inadequate and inaccessible public facilities (ibid.). The rather horrible state of the road from Akim Gyadam to the nearest town Akim Oda is a good example of these kinds of poorly managed public infrastructures, which makes it especially challenging for local villagers to reach the nearest hospital (figure 17).

Figure 17. The road from Akim Gyadam to the nearest town (and hospital) of Akim Oda.

5. A few final reflections

Biomedicine has made its way into the daily lives of people living in Ghana’s rural areas. Through a hierarchal health system biotechnologies are being applied in the most basic and lowest-level health care facilities, such as the CHPS center in the community of Akim Gyadam. Through its strong dissemination, biomedicine has been ascribed a worldwide success, not only in terms of curative services but also with regard to prevention. In the international health development discourse, biomedical healing is seen as the ‘one true’ form of medicine (Lock & Nguyen, 2010). Under the motto “prevention is better than cure”, local CHPS centers in Ghana and the CHNs who work there, invest quite some time and resources in dispersing preventive and sensitizing messages, which are based on this biomedical framework, to the local community.

Nevertheless, I was naively surprised to find that the attempts of the nurses to educate and sensitize the local inhabitants of the village largely seemed to fall on deaf ears. This observation led to a challenging of the wide-spread assumption that biomedicine possesses a universal healing and preventive power that will ‘conquer’ and replace all other forms of medicine. As I have observed in the field, biomedicine often fails to ‘convince’ people of its benefits in the area of prevention. The bio-medically inspired preventive messages, spread by the nurses, are not adjusted to local notions of health and illness, nor to the cultural, social and economic living conditions of their target audience. In this hybrid healing environment, where cultural dispositions cut across pragmatic considerations and practical restraints when it comes to health care choices, it becomes clear that biomedicine cannot live up to its promise of delivering “health for all”.

These observations go against the common assumption that biomedical technologies, if equitably distributed, will dramatically improve the health and well-being of people everywhere (Lock & Nguyen, 2010). However, in general, I do agree with this statement. As I have noted, one of the main reasons that the Akim Gyadam villagers feel thwarted in their ability to comply to the preventive advices given by the nurses, is because of the inaccessibility of some crucial health facilities, like for example a hospital. From practical barriers, such as the long and difficult drive to the nearest town with a hospital, – while most people do not own a car, and would rather spend their money on food then on a cab fare – to experiences of social exclusion, since these rural villagers often feel alienated by practices of biomedical health professionals that do not align with their indigenous notions of well-being, illness and healing, elementary access to biomedical health care facilities is being obstructed. This unequal distribution of, and access to biomedical health care opportunities thwarts the medical system's capacity of improving the lives of a significant amount of people, especially in the global South.

Still, this is not to say that an unquestioned 'translation' of biomedical practices into the local healing realities of rural Ghana should be encouraged, since such an unthinkingly appropriation has proven to be rather problematic, as we have observed in the context of prevention. In stark contrast to the common assumption about the scientific neutrality of biomedicine, medicine is a deeply social, cultural, economic and political enterprise, which makes an outright translation of this medical framework into other contexts precarious (Lock & Nguyen, 2010). In confrontation with the soaring health inequalities in Ghana, it might seem unfair that I, as a white researcher in a privileged position when it comes to health and health care, would question the dissemination of life-saving biomedical practices. But instead of unequivocally renouncing biomedicine, what I mean to show is that this medical system, when taken for granted in its universal healing and preventive capacity, can be rather counter-productive at times (ibid.). As Levine (2012: 8) so poignantly states: "the discipline of medical anthropology would hardly have a reason to exist if biomedical hegemony could explain human suffering and offer patients universal certainty."

Also Lock and Nguyen (2010) mention in their book that improving global health is unlikely to succeed if it is simply assumed that making more medicines and health services available to more people is purely a technical or logistical matter. Instead, we should keep in mind that human bodies are not the same everywhere, but are products of historical and contemporary social changes and their local environments (ibid.). Furthermore, the kind of social and economic infrastructure to ensure appropriate application of biomedicine may very well not exist in every context. These differences – in bodies and in social, political and economic situations – should be taken seriously to truly improve global health and make health a basic human right (ibid.).

5.1 The engaged anthropologist

As medical anthropologists have become increasingly sophisticated in their critiques of inequality and oppression, a crucial subgenre known as critical medical anthropology has been developed (Inhorn & Wentzell, 2012). The activist impulse to "do good," "help others," "save lives," and "make a better world" has always been a running theme within medical anthropology. In spite of the contested ability and desirability of anthropology being active in policy-making[16], the intention to apply research findings to improve health and well-being has been part of the discipline since its very beginning (Inhorn & Wentzell, 2012; Singer, 2012). Still, it remains a precarious question whether or not the critical insights I have gathered in this thesis can possibly be applied in the public health policy arena.

After all, Singer (2012) mentions that it can be easily argued that medical anthropology is less effective in the policy arena than it should be. Over the years, anthropologists have expressed frustration that their research findings, however relevant, have been ignored by policy makers. This is usually because the complex results and conclusions our research produces are out of harmony with the official, simplistic guidelines formulated by those with influence in the policy-making domain (ibid.). Also in the case of the research evidence of this thesis, an unequivocal translation to clear policy guidelines will prove to be challenging. If bio-medically inspired prevention does not *work* in a rural Ghanaian context, then what kind

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[16] This distrust in anthropology’s policy-making abilities descends from its historical role as “the handmaiden of colonialism”, in which the discipline functioned as an instrument of dominance by providing knowledge “useful” to colonizing powers (Sluka, 2012a).

of prevention is needed instead; what specific content and form will it take on? Moreover, an even more fundamental question is how anthropologists can ensure that this matter indeed ends up on the agenda of politicians and policy makers, while our research oftentimes implies new actions and strategies that are overtly or implicitly detrimental to the dominant capitalist class (ibid.).

In this light, the chapter by Singer (2012) presents a strategy for expanding medical anthropological influence on health-related policy. As such, he sees a possible solution for the common problem of ‘engaged anthropologists’ in significantly expanding relations with potential allies in the policy arena, namely community-based organizers and activists. While, in the modern state, policy impinges on all areas of life and increasingly shapes the way individuals construct themselves as subjects, the joining up of anthropology with direct service, policy- and advocacy-oriented community-based health organizations can provide the popular pressure that is needed to ensure the implementation of adequate government policies addressing health inequities (ibid.).

Conclusion

The onset of this thesis was marked by one of my own observations in the field. While working together with community health nurses at a small CHPS center located in a rural village of Ghana’s Eastern Region, and assisting them in their primary curative and preventive health services on a daily basis, I was naively surprised to find that the attempts of the nurses to educate and sensitize the local inhabitants of the village were unsuccessful in a considerable amount of cases. Guided by my own anthropological subjectivity, I aimed at understanding this observation by establishing a dialogue with the local villagers and by truly listening to their personal stories of being ill, the feelings of fear and uncertainty this brings along and the search for a cure, whether or not riddled by several obstacles and misfortunes.

However, my intention was also to go beyond these individual narratives, and in doing so, this thesis has remained close to its initial ambition to take personal stories of health, illness and healing as a lens to look at more wide-ranging societal phenomena. As such, by focusing on the topic of prevention, and on why the preventive messages of the nurses do not seem to *work* in this rural Ghanaian context, it becomes apparent that biomedicine has hegemonically made its way into the daily lives of Ghanaian patients and their health care providers. The bio-medically inspired prevention and sensitization efforts of the nurses, as they were designed by the Ghanaian MoH and GHS, have the – we have to admit, admirable – aim of providing “health for all”, but instead often conflict with local notions of health, illness, risk and prevention, as well as with the social and economic living conditions of their target audience.

By taking a closer look at the hybrid healing environment in (rural) Ghana, where cultural notions of health, sickness and risk cut across pragmatic considerations and practical restraints when it comes to health care choices, I aimed at an anthropological rethinking of the concept of prevention by deconstructing ethnocentric conceptions of so-called ‘traditional’ healing practices, in which prevention is assumed to absent. Pointing at preventive practices in ‘traditional’ healing contexts throughout Ghana and Africa, I have shown that the reality stands far from this assumption instead.

If we are confronted with a Ghanaian (and African) reality of people who are actively engaged in determining health risks and preventing them from happening, then why does biomedicine claim to be the ‘one true’ form of medicine? Tracing back its history into the era of colonialism, it becomes clear that the introduction of biomedicine in the African context was more than a mere effort of improving the living quality and life span of the local people. It also was a biopolitical story of control, and, to a certain extent, I dare to say that it still is. Functioning as the ‘silver bullet’ of colonialism, biomedicine served as a moral project of bringing modernity, development and progress; buzzwords that are still very present in the global health development discourse today. By working itself into the most private and intimate areas of human life – for example by prescribing ‘proper’ forms of sexuality and reproduction, as well as setting the standards of being a ‘good mother’ – biomedicine not only desires to ‘save lives’, but also intends on ‘winning hearts’. In its self-assigned superiority, biomedicine was assumed to conquer and exclude ‘traditional’ forms of health care. Instead, we have ended up in a hybrid African healing context where biomedical prevention strategies do not seem to properly do their job.

Furthermore, this discussion, as well as my daily observations of health, sickness and prevention, allow me to link up to broader debates in (medical) anthropology and beyond. As such, these considerations of biomedicine’s hegemonic capacity, relates to the persistent dichotomy between scientific (biomedical) knowledge and indigenous (‘traditional’) knowledge. Although still very present in many health development discourses of Western and African governments and other international development organizations, anthropologists tend to agree that this dichotomy is false (Agrawal, 1995; Nygren, 1999). In their opinion, it is only when recognizing the subjective and ‘situated’ nature of biomedical knowledge as well as its cultural and social embeddedness, that we can start to overcome the alleged superiority of this scientific frame of mind, and perhaps, eventually the unequal distribution of power and resources in contemporary society at large (Filc, 2004; Nygren, 1999).

Also the structure-agency debate is not left untouched in this thesis, as I ask myself to what extent local villagers still have agency to make their own health care decisions within this bio-medically dominant framework of healing? In general, the ‘official’ biomedical discourse of the Ghanaian government does not thwart people in opting for other health care possibilities, such as herbal or spiritual healing. Still, it is important to note that these pragmatic combinations of different healing practices are not always a matter of ‘free will’, but are often dictated by living conditions characterized by economic, financial and social hardships. As the ‘official’ health care institutions regularly fall short of material and financial resources, or prove to be inaccessible to a large part of the rural population, sick people are sometimes compelled to attend to another healer.

Challenging the familiar saying “prevention is better than cure”, biomedical prevention is not always a leading priority of the local population. Considering the fact that they already have their own conceptualizations of health risks and concrete methods of prevention, the excessive focus on prevention by the Ghanaian MoH is not always appreciated by the locals, who demand better and more accessible curative biomedical services instead, as well as the preservation and recognition of their local medical traditions (van der Geest et al., 1990).

As such, biomedicine’s universal healing capacity should not be taken for granted, as it is, like all other forms of medicine, a deeply social, cultural and political enterprise (Lock & Nguyen, 2010). When health policies or international health development projects truly strive at ‘making people better’ and at ‘helping’ them, they should be aware of the fact that this is not solely a technical or logistical undertaking, and should recognize the ‘situatedness’ of all medical practices, among which biomedicine, instead. In raising this awareness, the engaged anthropologist can play a vital role, although it can sometimes prove to be challenging to convert complex anthropological findings into straightforward policy guidelines (Singer, 2012).

However, this master's thesis has inspired me to engage in discussions of health and development that stretch far outside of the anthropological domain, as it will continue to do in my further endeavors. I can only hope that it inspires the reader to the same extent.

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Appendices

1. Map of Birim Central Municipality[17] with indications of the town Akim Oda and the village Akim Gyadam

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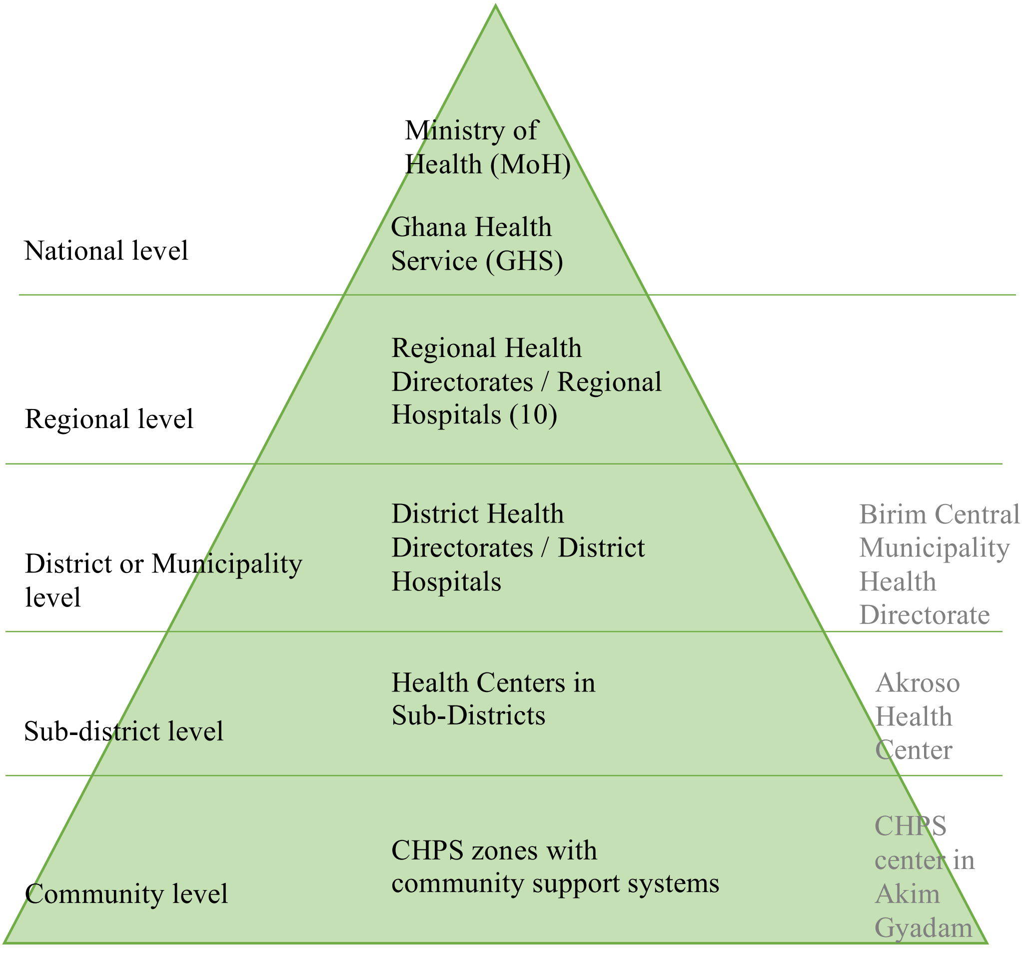
[17] These maps are retrieved from: Ghana Statistical Service. (October 2014). *District Analytical Report. Birim Central Municipality* & [Map of Ghana with pin marking Birim Central Municipality] (2016), by Google, alterations mine. Copyright 2016 by Google. Retrieved from https://www.google.be/maps/place/Birim+Central+Municipality,+Ghana/@8.1256435,-1.9775504,7z/

2. Schematic overview of organization of health care system in Ghana[18]



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[18] This schematic representation of the Ghanaian health system is drafted by myself, based on what I learned about the system during my stay, as well as on additional information acquired from various websites (Ghana Health Service ICT Department, 2016; Ministry of Health Ghana, 2016).