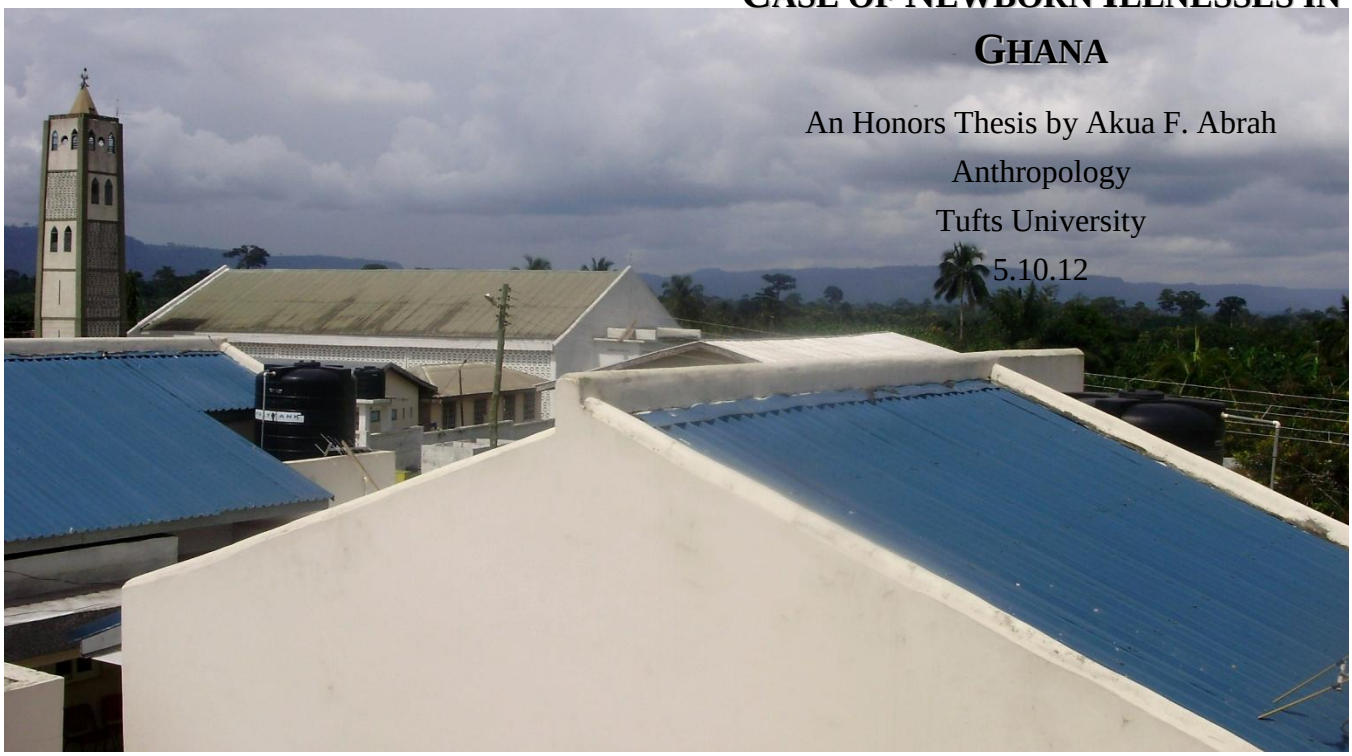
MEDICAL PLURALISM AND CONTESTED AUTHORITIES OF KNOWLEDGE: *ASRAM* AND THE CASE OF NEWBORN ILLNESSES IN GHANA



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ABSTRACT

This thesis focuses on the role of medical pluralism in a domain where both Western biomedical and local knowledge exist, and the implications that this has for the commensurability of both. I do this through an analysis of *asram*, both a classification and a diagnosis of potentially fatal newborn illnesses. The research was conducted in the Summers of 2010 and 2011 through interviews, group discussions, and participant observation in the village of Osiem, in the Eastern Region of Ghana. I examine how the basis of biomedical knowledge reconstructs a person into that which is appropriate to the medical gaze by classifying illness as "naturally occurring". This knowledge is limited to those trained in the biomedical field, and subsequently reduces or excludes the participation of others on the basis of their access, or lack thereof, to this knowledge. I compare biomedical knowledge and practice with an analysis of the concepts of personhood in Akan-speaking communities of Osiem. Here, health and wellbeing are shared responsibilities among every member of society. These responsibilities call for a different type of participation from a mother in response to *asram* than that found in medical practice at the Hawa Memorial Saviour Hospital. Through an analysis of infant head massaging, I posit that the biomedical and local basis of knowledge occupy different contexts of authority, that of the hospital and that of the home. These contexts of authority provide the means through which mothers can negotiate between local and biomedical practices in regards to their newborns health. This negotiation creates a gradient of knowledge that reveals that *asram* can be integrated within both the local and biomedical contexts.

CHAPTER 1: Introduction and Literature Review

When I went to Ghana for the first time in the Summer of 2010, I worked as an intern in the Maternity Ward of the Hawa Memorial Saviour Hospital (Fig. 1) in Osiem, my mother's home village. As was the intent of this trip, I witnessed the relationship between patients and their health practitioners. Because I wore an all white uniform, similar to those worn by many of the nurses and midwives (Fig. 2), patients often grouped me together with the health practitioners by calling me "*Mame Nurse*", Madame Nurse. Many of the health practitioners with whom I spoke cited some women's opposition to the use of hospital resources as a primary factor contributing to issues regarding maternal and infant health. When I returned to Ghana the following year, in the Summer of 2011, my intention was to understand local women's perspectives on natal care and their relationship to the newly established health facility in the village. Thus, when my aunt first mentioned *asram* to me in mid-June, an illness relating to the newborn, I didn't think too much of it, believing that it was separate from the information that I was seeking. It was not until I heard it a couple more times through conversations I had with women in Osiem that I found that through *asram*, women were working out the negotiation of multiple healthcare systems. In order to explore *asram* in the Southeastern village of Osiem, I must place it within the context of medical pluralism. I begin this thesis with a review of the literature on biomedicine and medical pluralism.

Biomedical Theoretical Approach to Knowledge

According to the Oxford English Dictionary, biomedicine is:

> The branch of medicine concerned with the application of the principles of biology, biochemistry, etc., to medical research or practice.

Biology, biochemistry, and other related sciences are classified as natural sciences, which Oxford English defines as:

> The branch of knowledge that deals with the natural or physical world; a life science of physical science, such as biology, chemistry, physics, or geology; (in *pl.*) these sciences collectively, in contrast to the social sciences and human sciences.

Biomedicine is inextricably linked with naturally occurring processes of the body and simultaneously uses the "naturalness" of such processes as an explanation of health and disease. Striking in this definition is the contrast that Oxford Dictionary poses between the social sciences and the *human* sciences. While biomedicine may concern itself with its application of "objective" measurements as forms of investigations (Hahn and Kleinman 1983b:306), social and human sciences posit that health and disease are very social, and are affected by factors beyond just biology.

In her study of *nervios*, a socially conceptualized way of expressing distress in Costa Rica, Setha Low writes that "medical knowledge has claimed legitimacy through its 'scientific' status and its supposed objectivity, effectiveness, autonomy, and the naturalness of its object of study" (1988:417). It is therefore no surprise that illness in the biomedical model is termed as disease, which is assumed a "'natural' object rather than a social construction based on social circumstances and cultural norms" (Low 1988:419). An individual who is evaluated without consideration of his or her cultural norms and social factors becomes just a body in which disease can reside. As Byron Good writes, the concern of biomedicine is to "understand surface phenomena with reference to a deeper ontological order, to link symptoms and signs to

physiological structure of functioning and to intervene at that level" (1994:83). Disease, In this framework, is no longer personalized.

Biomedical knowledge, in that it is grounded on the principles of the natural sciences, creates the tendency for those with this knowledge to "narrow the assessment of healing to biological and psychological change, and to play down the significance of social and cultural change" (Kleinman 1977:13). Disease as naturally occurring is promulgated early on in medical education through anatomy labs where medical students learn to adapt the ways in which they see the human body. This is such that a person is reconstructed into that which is appropriate to the medical gaze, be it as a "body, a case, a patient, or a cadaver" (Good 1994:73). While the reconstruction of the person allows the health practitioner to work within the capacity provided by the biomedical system, reductionism of illness threatens to transform clinical practice into what Arthur Kleinman calls a "veterinary endeavor" (1977:12).

Many medical practitioners believe that their practice and methods of medical investigations are completely distinct from notions of morality and aesthetics. Hahn and Kleinman posit, however, that biomedicine is a sociocultural system, albeit a unique one, that "consists of distinctive elements" (1983b:306). This system is "founded in a cultural framework of values, premises, and problematics, explicitly and implicitly taught by the communications of social interaction and enacted in a social division of labor institutional settings" (Hahn and Kleinman 1983b:306). This social organization is further enhanced via the distribution of knowledge known as "medical education" through a complex of "regular, rule following, and ritual social interactions" (Hahn and Kleinman 1983b:318). These social interactions are not limited only to the physicians and physicians-to-be, but they establish a separate type of relationship between health practitioner and patient.

The relationship between the medical student and the physician is structured with the physician's expectation that the student will one day also be in an authorized position to practice. There is an exchange of biomedical knowledge from the health practitioner to the student. In the physician-patient interaction, the patient is educated on his condition. When a medical practitioner disregards a patient's social, cultural, and personal factors and reasoning, he or she separates the patient's mind from the patient's body. This separation of mind and body is what René Descartes calls mind/body dualism. Descartes writes that the mind is a "thinking, non-extended thing" and the body, an "extended, non-thinking thing" (Skirry 2006). Because of the two distinct natures, the mind and body can exist apart from each other (Skirry 2006). If that is the case, then between the mind of the patient and the mind of the doctor, the body of the patient is the only "thing" shared. The body is shared because it rightly belongs to the patient, but it also serves as the site of medical practice for the health practitioner. While the patient is educated about his disease (albeit a limited education compared to that of the medical student), he is also educated on how to be a good patient. The patient is placed in a different social hierarchy to the health practitioner. This, I argue, encompasses the biomedical moral framework which I will expound upon through an analysis of the biomedical moral framework in Chapter 2.

People living in high-income countries are very much aware of, and accept, the biomedical explanations of health and disease. The development of technology and Internet forums, such as *WebMD,* has made self-treatment options that do not require the intervention of a medical practitioner relatively easy. Regardless of one's accessibility to this knowledge, only those with certified authorization can fully operate within the biomedical social system. Steven Feierman argues that "professionalization is a process in which an occupational group establishes control over medical resources, and achieves authority--broad public acceptance of its

knowledge and practice (1985:114). Situations requiring the interventions of a medical practitioner create a hierarchy of knowledge and status between health practitioner and patient. The patient is limited in how much he can reason with the doctor when it comes to treatment, even though the treatment is applied to his or her body. The physician, while seemingly listening to the patient and taking down his or her history, invariably participates in "medicalized tasks directed not at the patient's life world, but at diagnostic evidence" (Hahn and Kleinman 1983b:316).

Medical students acquire the skill of "organizing patients as [documents]" from their superiors. Good writes that "medical students' lack of concern about their conversations with patients is a result of their perception that the central speech acts in medical practice are not interviewing patients, but presenting patients" (1994:78). The patient, once within the biomedical domain, is therefore perceived as a body to be worked on, one that is completely devoid of social or cultural ties, save that of biomedicine which reduces it to a case study. This method of information distribution is what Bridgett Jordan calls a hierarchical distribution of knowledge in that it excludes or limits certain levels of participation based on one's lack of recognized authority (Jordan 1997:72). In the health system, the physician is the most authorized to determine a procedure or the course of a treatment. Medical training, as described by Hahn and Kleinman, is "'paternalistic', in which a logical necessity of medical disturbance is regarded as far more significant than the subjective judgment of the patient" (Hahn and Kleinman 1983b:316).

So far I have discussed how biomedical practice reconstructs the individual into that which is appropriate to the medical gaze, and places the individual in a certain hierarchy in relations to the medical practitioner. While the subjective judgment of the patient, as Hahn and

Kleinman state, may distinguish the "objective" process of biomedical practice as more valid, the subjectivity of the patient may validate or invalidate biomedical practice in a domain where multiple knowledge systems exist. A medical pluralistic system provides the capacity for individuals to integrate biomedical and local practices in varying degrees.

Medical Pluralism

I begin the discussion on medical pluralism with an analysis, first, of religious pluralism. Through an exploration of Michael Lambek's *Knowledge and Practice in Mayotte,* I show that while incommensurable ideas may exist within one domain, they may still contribute to the personhood of an individual as a whole. This is relevant to the study of medical pluralism because it reveals that different types of knowledge concerning the health and wellbeing of an individual can work on one body, irrespective of their incommensurability.

In his study on local discourses on Islam, sorcery, and spirit possession in Mayotte, Michael Lambek writes that knowledge 'can only be understood in the context of practice (and vice versa)" (1993:14). The *fundis* (those who hold great knowledge) of Mayotte present three different kinds of knowledge. *'Ilim fakim*, whose practice of highly textual sacred knowledge is ostensibly public, at times fails to legitimize the knowledge of the *'ilim dunia.* The *'ilim dunia's* use of the sacred text is only "locutionary" and their knowledge of cosmology, which is focused on the body, is much more secretive and objective in practice "(Lambek 1993:196). Whereas both of these types of knowledge rely on the objectivity of their proponents, the third and final type of knowledge, that of the *'ilim ny lulu*, is embodied by its *fundi.* This *fundi* is subjective to the spirit that he or she allows to possess him or her, and his or her knowledge derives its power from social relations.

In the domain of Islam, the practices of the three types of *fundis* address different aspects of society and personhood, such as one's prosperity and well being. Their knowledge therefore share equal authority. Conflicting ideas concerning a *fundi's* knowledge in determining one's fate, however, contribute to the incommensurability between spirit possession, cosmology, and Islam (Lambek 1993:397). Rorty writes that incommensurable "ideas or discourses are those not able to be brought under a set of rules which will tell us how rational agreements should be reached... [and] where statements seem to conflict" (as cited in Lambek 1993:396). Through the practices of these *fundis,* knowledge can be criticized on the basis of its practice just as much as it can be understood in the context of practice. While the incommensurability of *fundi* knowledge may be the case in Mayotte, people stress the importance that all three types of *fundis,* and the use of their knowledge, hold in the community. While some are consulted more than others, each *fundi* has a role to play in the lives of community members at various points and in varying degrees, depending on the situation.

In the case of health care, it would be difficult to find, in the world today, a place where only one knowledge system exists. Colonization, expansion, and technological advancements have contributed to the persistence of medical pluralism in the world. There are various implications that a pluralistic approach to illness has for an individual and for the treatment of an illness, just as religious pluralism has for the people of Mayotte. For the people of Tonga, as Barbara McGrath argues, this means that individuals and families can use both biomedicine and traditional medicine to their own discretion. McGrath writes that such pluralism allows for a very fluid process in cure-seeking, for, "If the intervention is not successful, there is little indictment of the therapy; it simply is not the appropriate one in that situation. If it is successful, then the cause of the illness can be discussed with certainty" (1999:483).

While McGrath's study argues that the efficacy of treatment determines the type of illness from which an individual may be suffering, Mary-Elizabeth Reeve's ethnography on illness and treatment practices in a Caboclo Community offers insight on situations where the opposite is true. In this Lower Amazonian community, curers are the individuals who determine the nature of an illness and its proper treatment. Although most people seek out medical doctors only if their traditional treatment fail, thus regarding the local health services as a last resort, community members still consult curers to direct them to the right treatment (Reeve 2000:102). Treatment methods may be of a spiritual nature or of a pharmaceutical one; therefore, in this belief system, "a clear dualism exists concerning the role of the curer and the role of Western medicine in the treatment" (Reeve 200:103).

Like McGrath, Reeve presents in her ethnography the fluidity of individuals or of families to choose between systems of practice, noting that often, community members use variations of both biomedical and traditional methods. Reeve stresses, however, that faith is as much a factor in the choice of treatment as it is in the efficacy of treatment, writing that people often cited traditional curers as more effective in the treatment of illnesses than medical doctors. The extent to which faith plays a role in the choice and outcome of treatment is further emphasized when medical pluralism is intertwined with religious doctrines and practices.

In her study of the interplay of biomedicine and Neo-Pentecostalism, Kristine Krause draws an interesting parallel between the medical treatment of psychiatric illnesses and the spirit exorcisms of patients by members of the Holy Ghost Anointing Fellowship at a psychiatric clinic in Ghana. Health practitioners belonging to this fellowship hold firm to the belief that biomedical and spiritual causation account for psychiatric illnesses and thus effective treatment requires both biomedical and spiritual interventions. Krause argues that in this vain, biomedicine

becomes "Godly medicine, which is at once scientific and spiritual" (2008:197). At its very core, then, Krause posits that when it comes to addressing psychiatric illnesses, biomedical and Neo-Pentecostal practices are very commensurable. Krause thus presents an interesting case to the discussion of commensurability, where health practitioners of the Holy Ghost Anointing Fellowship use the same rationale for exorcism as they do for prescribing pharmaceutical drugs in the treatment of psychiatric illness.

The example of *nervios* in Costa Rica presents a similar situation where health practitioners acknowledge both biomedical and social factors as contributing to anxiety and distress. In her ethnography, however, this dualistic approach to health is also mutually accepted by the local community members. Low writes that those suffering from *nervios* are encouraged by friends and family to consult a medical doctor because they are aware that the health practitioner treats in both a medical and social capacity. While medical pluralistic systems allow for a dualism in approach to illness and treatment, and thus flexibility in an individual's rationale, it risks creating a dichotomy between the various knowledge in which one is validated above others. As McGrath writes, "pluralistic systems continue to be described in terms of opposites: ethno- and biomedical, non-Western and Western, native and European, traditional and modern, local and cosmopolitan, indigenous and introduced, alternative and scientific, natural and allopathic, and so forth" (1999:484). Earlier in this chapter, I discussed how the biomedical model of knowledge creates a hierarchy between the health practitioner and patient based on the authorized knowledge of the health practitioner. I now consider how systems of authority are created among various types of knowledge found within the same domain, particularly in the domain of childbirth.

In her ethnography of obstetrics and midwifery in Yucatan, Brigitte Jordan argues that some knowledge may carry more weight than others in a domain where many knowledge systems exist. This unequal weight of knowledge leads to the creation of a dichotomy that legitimizes one type of knowledge while others are devalued or dismissed (Jordan 1997:56). In health related practices, legitimate knowledge, or what Jordan calls authoritative knowledge, is biomedicine. Stacy Pigg includes a discourse on biomedical authoritative knowledge through an analysis of NGOs and the issues posed by their top-down approach to training traditional birth attendants in Nepal. She specifically addressed the maintenance of local childbirth practices, writing that:

> Cross-cultural research on childbirth has shown just how historically specific the notion of medically managed childbirth is. A medicalized construction of pregnancy and childbirth dictates that these states must be managed and monitored by specialists. In North America, in fact, women who give birth without professional management are accused of negligence (Tsing 1990) and obstetricians tend to treat women in labor as unruly workers who must be monitored. Authoritative knowledge therefore creates an unequal distribution of knowledge (Pigg 1997: 247)

According to Pigg, the medicalization of pregnancy and childbirth has inevitably invalidated women's knowledge of their own bodies, and dismissed their preference in how to go about the process of childbirth. As stated earlier in this chapter, "professionalization" creates a hierarchy in which a professional group establishes control over medical resources and achieves authority (Feierman 1985:114). The method through which this professional group practices is in accordance with scientific methods. In a community where there is also local knowledge, which integrates social life and medicine, proponents of the scientific epistemology assume that "[local] healers may well possess a stock of potentially useful herbal cures, [but that] their explanations of illness are hopelessly embedded in a magic-religious theory of causation which is not amenable to testing in laboratory or clinic" (Wyllie 1983:46). Biomedicine is concerned with

bodies in disease (Hahn and Kleinman 1983b:312). By conceptualizing disease as naturally occurring, "western scientific medicine may be quite effective in dealing with the naturally-caused illness... [and not those] caused by spiritual agents" (Wyllie 1982:47). Biomedicine, therefore, "constructs a medical reality in that it informs both patient and practitioner about how symptoms and conditions are distinguished, what courses they run in syndromes and why, how these conditions may be ameliorated, and how symptoms and their dynamics fit in a larger order of agency, power, and value" (Hahn and Kleinman 1983a:16).

Fieldwork

I conducted my research in the Summers of 2010 and 2011 predominantly in the village of Osiem, located in the Fanteakwa District of the Eastern Region of Ghana. The Eastern Region is one of ten administrative regions in Ghana. There are four major ethnic groups that make up this region: the Akans, Ga-Dangmes, the Ewes, and the Guans. I stayed in the part of Osiem known as "SDA" because the central Seventh-Day Adventist (SDA) church of Osiem was located in that part of town. To the left of the Public Transportation Station of Osiem was Zongo, the Islamic community, and to the right was the Chief's Palace and *Gydi*, the community of the Saviour Church of Ghana. In between these sites were other communities such as "Presby" (Presbyterian) and Methodist. These locations, like SDA, are named based on the major religious structures (churches or temples) found in those parts of the town, and are not intended to segregate the community based on religious practice. Christianity, Islam, and Indigenous Religion make up the major religions in Osiem, and community members of different faiths and denominations live and interact with each other daily.

Osiem is located about ten miles northeast of the municipal capital, Koforidua. This small, rural village serves as the national headquarters for the Saviour Church of Ghana, or *Gydi* in Akan Twi, the vernacular tongue spoken by the largest ethnic group in the village, the Akans. The Saviour Church built the Hawa Memorial Saviour Hospital (HMSH), a relatively new health center that was completed in October of 2009. Stationed in the Maternity Ward as an intern, I was able to conduct unofficial observations of health practitioner-to-patient relationships. I also interviewed the five nurses, three midwives, and one doctor in charge of the Maternity Ward, the local Chief of Osiem, and the Osiem Assemblyman. The Assemblyman's role was to voice community members' concerns so that they may be addressed by those with the resources.

Osiem is my mother's hometown, so many of my informants were my very own extended family members. I stayed with my mother's youngest sister, Auntie Ma, who owned a small kiosk across from the Seventh-Day Adventist (SDA) Primary and Junior Secondary School. Both this kinship relationship and my ancestral heritage in the community served as a means of integrating me in Osiem, beyond the medical community of the hospital. At the same time, the difficulties of being both a member of the community through kinship and a researcher, who had just come from abroad, informed how I collected and interpreted my material.

My 2010 fieldwork revealed the existence of a discourse about "ignorance" when the health practitioners talked both to and about women from Osiem who came for natal care. I found that when I spoke with the health practitioners, many would point to the mother's "ignorance" as one of the underlying factors contributing to maternal and infant health problems. According to them, mothers would rather listen to the influences of others at home whose suggestions were sometimes against what the health practitioners had prescribed. To them, this

was especially worrisome in light of Ghana's National Health Insurance Scheme (NHIS), which the Ghanaian government adopted in 2003.

According to its mission statement, the NHIS intended "to ensure equitable universal access for all residents of Ghana to an acceptable quality of essential health services without out-of-pocket payment being required at the point of service use" (Ghana Ministry of Health 2004). In July 2008 the NHIS took an important step when the former Ghanaian President, John Kufour, declared maternal mortality a national state of emergency. This compelled the government to implement free health care for pregnant women as part of its health scheme. The insurance now offered free antenatal care (ANC), routine drugs, free delivery, and free postnatal care for mothers and their newborns. Reporting on the success of the NHIS in *Ruhr Economic Papers*, Joseph et al. (2009: 14) wrote that women (under the plan) were more likely to use the services of the hospitals, leading to a reduction in birth-related complications and infant deaths. Increased access to affordable health care and health facilities were shown to be crucial in an overall improvement of maternal and infant health. In Osiem, there was a general assumption among some health professionals and community leaders that with the increased access established by the NHIS, women would be more likely to use hospital resources. When women did not come for ante-natal care, hospital births, and post-natal care, they were deemed "ignorant".

I returned to Ghana in 2011 with the intent of understanding natal care from the perspectives of community members—especially mothers—in Osiem. It was through daily interactions in this community that I became aware of the local knowledge of *asram.* My 2011 conversations about *asram* were mostly with women, many of whom were married or had been married (some were widowed). They were more knowledgeable on the matter because they had

the greatest responsibility of taking care of the newborn, beyond the financial support provided by the father. By saying that *asram* was "not a hospital sickness", the method of treatment that many women prescribed was herbal medicine, *abibidro*. Some strongly asserted that even though the doctors thought that they knew how to treat *asram*, in actuality they really couldn't. To some women, health practitioners were "ignorant" about *asram.* The problem, they said, was that doctors would call it something else, like malnutrition, inferring that health practitioners medicalized *asram* and would treat it based on its new definition. This method, they would say, didn't work. The ineffectiveness of biomedical knowledge, to them, was based on its inability to cure the illness.

In this thesis I seek to examine how medical pluralism and contested authorities of knowledge work to produce a gradient of knowledge in Osiem. I analyze how different modes of healing both draw upon and create moral frameworks, as well as determine the capacity through which people can respond to illness and the means through which they choose to do so. I discuss how community members, both health practitioners within the Hawa Memorial Saviour Hospital, and local community members beyond the hospital, are able to negotiate multiple healthcare system in addressing newborn illness.

CHAPTER 2: "This is not a hospital sickness"

Sitting with my Aunt Lucy in her kiosk by the side of Begoro Road in Osiem, she began to tell me the story of how my cousin, Kwaku, became sick early in his infancy:

> They say it's like a cat and plantain that we've broiled. You know what I mean right? When you put the plantain in the fire, it begins to wrinkle. That's how he was. Very small, and thin. And his cry was like a cat, very weak. We thought he was going to die. Then we took him to a man in *Gydi*, who told us that it was *asram*. He picked some leaves to make medicine, and that's what we gave to him. He got much better, but when it came time for Kwaku's father to go and pay the man, he didn't. When the man saw this, he became angry and took the leaves that he used to make the medicine, and burned them in the fire. The illness came back again! It wasn't until Paapa (my grandfather) and your uncle went to *Gydi* to pay the man did Kwaku get better. It's a terrible illness!

Many of the community members that I interviewed told me that *asram* "is not a hospital sickness". They said that it was rather an illness that affected newborn infants and was caused by bad people, *nipa bonifoɔ,* out of spite and greed. Many of the health practitioners that I spoke with at the Hawa Memorial Saviour Hospital (HMSH), however, said that *asram* could be a number of newborn illnesses. This chapter is a description of *asram* in the local community followed by a description of how health practitioners in the hospital conceptualize it. I argue that the local model and the hospital model are both influenced by and create moral frameworks in the way that they conceptualize *asram*.

A Local Understanding of *Asram*

The term *asram* has no equivalence to any known illness in the United States. There are, however, very distinct traits associated with it, per the descriptions that some of the local community members gave:

Some children, the head becomes very large and it looks like it is divided in two. It is very soft. It can kill sometimes too. It is a wicked illness. (My aunt, Auntie Ma)

Asram, it is a sickness that you see that the child becomes very wrinkled, his bowel movements are strange, and there are many things on his body, and he becomes very small and pale. That shows that the child has *asram*." (Woman 1 at the Women's Ministry meeting in SDA).

There are others where it affects their head. They can't eat, they can't cry. It shows that they have *asram*" (Woman 2 at the Women's Ministry meeting in SDA)

Others, when you look at them, they are dark. Then all of a sudden they become yellow, then dark again. They keep changing. This happened to Afia" (Auntie Ma. Afia is her second daughter).

According to these descriptions, symptoms of *asram* usually include yellowish skin color, large head, large eyes, or the newborn growing very lean, with a weak cry. Many women acknowledged that these different symptoms meant that there were different types of *asram*, although they were not sure of just how many.

Some people say that a child is susceptible to *asram* up to the age of three months. When I asked about the possibility of someone giving *asram* to a one-year-old, Auntie Lucy, Auntie Ma's older sister, responded with a very strong "*Oh no, no, no! By that time the child is too old. No one can give asram to the child*." An older child, even as young as six months, who falls ill would hardly be thought of as having *asram*. An older child may, on the other hand, suffer the consequences of an *asram* that was never treated in his infancy. There was a child in the village who had large, protruding eyes, and whose head was larger than those of other children in the village. Auntie Lucy pointed out that this child had suffered from *asram* in her infancy, but that it was not diagnosed early enough. After the child's parents realized that it was *asram*, they began to apply the herbal medicine prescribed by an herbalist. This reduced the symptoms, but "*If they had caught it early,"* Auntie Lucy said, "*then they would have been able to cure it*." As a child grows, he or she becomes less susceptible to *asram*, but it also becomes more difficult to

treat any symptoms of *asram* that may not have been detected in infancy. *Asram* is both a classification and a diagnosis of newborn illnesses and it is imperative to not only be able to detect it, but to treat the illness as soon as it is confirmed.

"**Wicked People"**

After telling me about the various ways that *asram* could manifest itself in the newborn, Auntie Lucy exclaimed that "*Some people are very wicked!"* By this statement, she connects the illness with the types of people believed to cause it. A mother who believes in the existence and local pathology of *asram* may conclude that someone has given this "wicked illness" to her child, if the child exhibits any of the previously mentioned signs. This concept of "wicked people", *nipa bonifoɔ*, and conversely "good people", *nipa papa,* is intrinsically connected to a person's relationship with others in society. An action that springs from compassion, translated in Akan as *tima,* and that is conducive to the wellbeing of others is considered good, and its initiator a "good person". On the other hand, one who does not have *tima* and whose actions bring misfortune to others are regarded as "wicked".

The community members with whom I spoke did not know exactly how "wicked people" caused *asram*, but many of them mentioned that it had to be done through some extra-human power. It is *honhom*, they would say, a spirit that gives them this ability. When I asked my father, who was a psychiatric nurse in Ghana, he mentioned that there were some people who were acquainted *suman boni*, small gods who were very mischievous:

> I am not disputing the fact that there are people who can cause *asram.* They have *suman boni,* bad gods that use *sukusare*. They do this by casting spells. I know it. We dealt with these cases."

At a young age, my father assisted his father (my grandfather), Nana Yaw Appah, an herbalist and well respected local medicine man, in treating cases of *asram*. The *sukusare* that he mentioned can be loosely translated as powerful dark magic used by these mischievous gods to bring about the illness. Others said that people could gather herbs, say an incantation, and throw the herbs in the fire to cause *asram*, but that some spiritual agency was still a key factor. A person in and of himself cannot bring illness upon another person without an extra-human agent. Whether through *honhom* (spirit) or a *suman boni* (mischievous god), there is a cooperative relationship between a person's will and the extra-human agent's power in order to cause *asram*. The intent that leads a person to seek such spiritual agency to fulfill a will meant to bring misfortune to another, classifies that person as wicked, an *onipa boni,* and the illness also becomes "wicked" by association, a *yareƐ boni*. Many of my informants were devout Christians and framed the illness within the context of Christianity, calling it a *bonsam yareƐ*, a "devilish illness". Here, the spiritual agency is the devil, the author of all things wicked and the complete antithesis of a benevolent God, according to Christian ideology. "*A true Christian can never do this*," they would say. By true Christian, they meant one who aspired to the characteristics of a compassionate God, which would in turn deem them a "good person", an *onipa papa*.

While in local understandings *asram* is considered a "wicked", "devilish", and "terrible" illness, there is no such thing as a "good" illness. A "good" person, who has compassion for humanity, *tima,* could never wish to bring illness upon another member of society. There were, however, illnesses that the community members did regard as naturally occurring due to their commonality and the shared knowledge of their causation; these illnesses are not specifically associated with good or evil. For example, malaria is common among both adults and children in Ghana and community members accept the disease as originating from a mosquito. *Asram* as

a diagnosis, on the other hand, is much more anonymous in nature and has many more variables associated with its cause such that spiritual agency is the most probable explanation.

By claiming that *asram* is not a hospital sickness, some women believe that health practitioners cannot treat *asram*. As my Aunt Lucy described it to me, "*There will be no cure for it, except that that person who gave the illness to the child tells you, and gets money from you.*" That is, if a wicked person causes the illness, then *asram* does not require a biomedical cure because the cause is not biomedical. While I found that people generally agreed on this point, it was also said that one can never really know the identity of an *asram*-causer. Some said that the only indication that a person with *asram* needs for the location of the infant is the cry of the child. Others mentioned that *asram* can be easily given if wicked person sees the child or comes into contact with the child. Indeed, even the fetus can be attacked, which gives insight to the types of agency a mother has in protecting herself and her child. I will expand on this point through an analysis of maternal agency in Chapter 3. The only way that a mother would be able to know the identity of an *asram*-causer is if that person offers the cure for her child's illness or if someone else informs the mother that "Madame So-and-so" or "Papa So-and-so" has the cure. If spite or jealousy wasn't the objective that people believed drove a person to give *asram* to a child, greed was always mentioned. For example a person thought to give *asram* is also said to posses its cure. In exchange for the cure, the mother of the afflicted child would pay that person in cash.

An individual's possession of a cure for *asram* may seem to prove one's suspicion about whether that individual caused the illness, but this is not a guarantee as the situation is complicated by the fact that there are *asram* healers. These healers are very knowledgeable in

curing the illness, yet they are not necessarily the ones who give the illness. Take for example the following account by Auntie Ma:

> When you just give birth to the child, in a little while he will change, sometimes the color will change, or the crying. Some also know how to detect *asram*, so you can take the child to them and they will tell you. This happened to Afia. There was a man in *Gydi*. As soon as we took her to him he knew it was *asram* and gave us the medicine for it. There are those who deal with *asram* and are able to detect it and can give you the medicine. Remember that your grandmother, *Mame* Yaa Ataa, knows how to treat *asram*.

Auntie Ma did not consider a *medical* cause when her newborn daughter changed from a healthy brown color one day to a yellowish, pale color the next. This was not a problem that she believed immediately required a hospital cure. After consulting with the herbalist in *Gydi*—the site of the Hawa Memorial Saviour Hospital and the National Headquarters of the Saviour Church of Ghana—who informed her that it was indeed *asram*, she took the necessary steps to cure it. The anonymity of the person who gives *asram*, and the fact that there are healers who are recognized locally as having knowledge of cures, make the possession of a cure for *asram* an unreliable basis for a mother's suspicion. Anyone is capable of causing this illness, and therefore anyone is capable of being an *onipa bonifoɔ*, a wicked person. It is because of this belief that a mother, when pregnant, must take preventative measures to protect her child. Auntie Ma's response to Afia's sickness alludes to how moral frameworks inform the role of a mother in regards to the treatment of *asram.*

A Good Mother

Popular treatment for this illness, according to many women, was through the use of herbal medicine, *abibidro*. Even if *asram* originated from outside of the body, via spiritual agency, once a child has it, *asram* manifests itself into a physical ailment within the child. The

method of treatment that a mother chooses, then, addresses this now physical illness of the child and not any spiritual problem within the child. The herbalist treats the symptom specific to the type of *asram*, and in so doing treats the illness of *asram*. Some mothers with whom I spoke strongly asserted that even though the medical doctors thought that they knew how to treat *asram*, in actuality they really could not. To some women, health practitioners were "ignorant" about *asram*. They said that doctors would call it something else, like malnutrition, inferring that health practitioners medicalized *asram* and would thus treat it accordingly. This method, they would say, did not work. The ineffectiveness of biomedical knowledge, to them, was based on its inability to cure the illness.

If the mother thought that the child had *asram*, then she should tell her husband. *"He is the one that gives you the money to get the medicine,"* Auntie Ma told me. A husband was rarely the person to blame if the infant became ill, because the financial burden would inevitably fall on him, unless he neglected his spousal duty to his wife and, consequently, his paternal duty to his child. I will address the husband's role in pregnancy and childbirth in Chapter 3. Besides her husband or her mother, a mother would find it very difficult to determine who the perpetrator was. After speaking with my mother about the decisions a woman has to make in regards to her child's *asram*, I learned that one of my uncles, my mother's younger brother, had the illness when he was a baby:

> We didn't go to the person that we thought might have caused it. Instead, we went to this man in *Gydi*, and he was able to cure it. You as the mother, you don't have time to figure out who may have caused it, because while you're doing that, your child, who is sick, is also dying.

When I asked Auntie Lucy whether such a perpetrator could ever be caught, she responded with a strong *"No!"*

> This is someone with an evil spirit. You can't just go to the police or to the chief to go and catch this person. How could you? [...] There is nothing you can give to the police to say that this person gave your child *asram* because it is spiritual so it will bring about many problems. All you can do is pray that by God's grace your child will be well.

I established earlier that while a mother may suspect a person of causing *asram* because that person possesses the cure, this is not a valid method of confirming one's suspicion. This is because of the knowledge that there are also *asram* healers who are not *asram* causers. The moral framework that classifies a person as "wicked" based on the social consequences of his or her actions, is also used to classify a mother as either "good" or "bad", based on the consequences of her actions.

Just as local understandings of *asram* are entirely social and subjective, and draw from, as well as create, moral frameworks, the hospitals model of newborn illnesses is likewise social. In the biomedical model, practitioners expect mothers to bring their sick infants to the hospital, where doctors have the authority to both diagnose and treat the illness. Biomedicine creates a moral framework constructed around the mother's response to the physician's regimen, which could label her as either a good mother or a bad one. I address the biomedical moral framework below.

The Medical Practitioner's concept of *Asram*

I remember a conversation that I witnessed during my 2011 fieldwork in the hospital between a doctor and a mother who had brought in her sick two-year old. While during my fieldwork in 2011 I interacted more closely with the women and mothers, I occasionally interned at the hospital, as I had in 2010. I was not working on this particular day, but decided to go the

hospital to speak with Dr. Asiedu, a pediatrician. In his office sat two fourth-year medical students who were also interning at the HMSH that summer. Thinking about the information that I had gathered thus far from mothers in the community about *asram*, I decided to ask Dr. Asiedu whether he knew of the illness. The following is the conversation that ensued:

Doctor: Of course I do. (He pauses) It is tetanus.
Medical Student A: No, they have another name for that: *asensen.*

(The doctor and the two medical students go back and forth for about a minute deliberating about what asram could be, while the mother sits patiently across from them)

Doctor: It is malnutrition.
Medical Student B: No, they call that something else (although he couldn't recall what that something else could be)

(The doctor then asks the mother)

Doctor: Mame, do you know what is called *asram?*
Mother: Yes. It is an illness that grips the child, and he becomes very wrinkled. He'll keep losing weight…
Doctor: But that is malnutrition…
Mother: No, that is different. You have to get medicine for this and the child will keep having bowel movements before he is healed of the sickness.

In the doctor's view, the illness described by the mother correlated with malnutrition, but in the mother's view, the illness was *asram,* which placed it in a context the required treatment beyond that which biomedicine could offer.

I asked this same question on another occasion while speaking with one of the senior midwives at the HMSH. The following is her response:

> Well, it is their belief. It could in fact be neonatal jaundice that if not treated could become severe jaundice. This could kill the child because it affects the liver. If they don't clean the cord well, but use the traditional medicine, then it could get infected and the child could get tetanus or septicemia. They believe that if a person, say you, pass through the back of the house, and the child begins to cry, then you have given him an illness. The fact that it was you who walked behind the house and caused the child to cry means that you had a bad spirit and gave the illness to the child. So then they say "Ey! The child is going to die!" So they go and prepare herbal medicine to cure the child. Instead of coming to the hospital for treatment, they will use herbal medicine. And those herbal medicines, they don't work, so they don't take proper care of the child, and eventually he dies. Therefore, what they believed, that the child will die, has

> come to pass because of the person who passed behind the house and brought the illness to the child. Because of that person and his evil spirit, the child has died.

The health practitioners with whom I spoke were all Ghanaian, and many were from the town of Osiem. By calling *asram* "their belief", the midwife separates herself from others, namely the local women, based on how they conceptualize the illness and thus treat it. By asserting that it could be jaundice, she medicalizes *asram*, stressing that the proper treatment needed would be to bring the child to the hospital. A hospital is not *treatment* however; rather, it provides the capacity through which health practitioners are able to work. The counter method of using herbal medicine is then inappropriate and ineffective ("they don't work"), and is even considered a harmful alternative as it eventually leads to the death of the child. In her explanation, the midwife mentions that according to local belief, it is expected that *asram* is fatal. It is evident that she believes that this can be prevented if the proper treatment method is used. *Asram* is therefore fatal only if wrong choices regarding its treatment are made i.e any other option besides medical practice within a health facility. In this example, the biomedical moral framework calls for the doctor to act in the capacity in which he or she has been trained, for the best possible health outcome of the infant. For the mother, biomedicine requires her to adhere to the health practitioner's reasoning and resources to act in the interest of her child.

In their study of *asram* in the Brong-Ahafo Region of Ghana, Okyere et al. (2010: 322) acknowledged the unclear biomedical equivalence of this illness, yet devised a list of fourteen different types of *asram* based on their characteristic symptoms and causes. This included *asram ntos* (tomatoes), which were small multiple swelling resembling roasted tomatoes on the infant's skin. *Asram ntos* was distinct from *asram npompo*, which were boils on the body. My father mentioned to me that in the past, Ghanaian ancestors used systems of classification to identify and make sense of various illnesses. In his words, they saw that there were certain illnesses

specific to the newborn, and out of these observations came *asram*. "*At the time, they did not know what caused it. So, to make sense of it, someone else with a bad spirit was the cause. But now, we know that viruses, bacteria, and genes play a role in these diseases"*. My father is very knowledgeable in biomedicine; he was a practicing psychiatric nurse in Ghana, and has thus participated in both the biomedical and local social organizations. I quoted him earlier in the chapter when he described how some people had *suman boni,* mischievous little gods, who used *sukusare,* powerful dark magic, to cause *asram*.

There were perhaps one or two other instances in which a key informant told me of occasions on which a health worker told them that *asram* could not be treated in the hospital and rather encouraged treatment through herbal medicine. For the most part, health practitioners did not accept local concepts of *asram* as valid diagnoses of newborn illnesses, and treatment based on this knowledge was believed to further exacerbate the problem. They believed *asram* to be any of a variety of newborn illnesses that required technical interventions. As my father also said, technological advancements have increased the knowledge of the role that genes and microorganisms play in disease-causation. The health practitioner's range of *asram* diagnosis and treatment focuses on the newborn as an individual and the illness as a disease residing in the newborn. Many health practitioners who spoke with me did not recognize an overlap in causation patterns of *asram* nor did they encourage an implementation of both local and biomedical treatments. Increased medical knowledge encourages a reclassification of ancestral categorizations of illness, such as *asram*, into this new type of knowledge. Whereas some local mothers said that *asram* was "not a hospital sickness" illness, to the nurse, midwives, and doctors of the Hawa Memorial Savior Hospital, *asram* must be treated biomedically for the best results and to prevent further complications of the disease. It was entirely a "hospital sickness".

In his study of the social roots of health and healing in modern Africa, Feierman (1985:110) writes that social relations are integrated in local medicine and biomedicine, and thus the two are forms of ethnomedicine. These social relations have very distinct elements that demand various types of engagement from their participants. In Osiem, the consequences of one's actions can deem one as either a good person, *onipa papa*, or a bad person, *onipa boni*, respectively. For a mother with a sick child her moral obligation is to her newborn in that she must focus on finding a treatment and not revenge. Biomedicine, in the way that it operates, also creates a moral framework constructed around the patient's response to the physician's regimen.

In this chapter, I have outlined a local model of *asram* and how this is understood by health practitioners in the hospital as a variety of newborn illnesses. I briefly touched upon how these explanations have various implications for treatment of the illness, particularly in regards to the role of the mother. In Chapter 3, I analyze how the local illness explanatory model and the hospital explanatory model provide varying capacities for the mother to act in response to her sick newborn.

CHAPTER 3: A Mother's Relationship to her Newborn

I met Nurse Ruth in the Maternity Ward of the Hawa Memorial Saviour Hospital (HMSH) during my 2010 fieldwork in Osiem. At the time, she was completing her clinical rotation in nursing. In December 2010, she finished her coursework and became a certified community health nurse. Ruth called me a month later, in January 2011, telling me of her marriage to her fiancé, Edward. I was surprised to see her already four months pregnant when I returned to Ghana six months later. After her certification, Ruth became a permanent employee of the HMSH and was placed in the Outpatient Department (OPD). Unless I went to the OPD, or she stopped by the Maternity Ward, I rarely saw her on the days that I went to the hospital. I promised her that because we barely saw each other, that I would treat her out to lunch at the hospital's canteen (which was the dining area). On one particular Thursday, I decided to fulfill this promise. There had been an unusually large number of cases that day, both at the OPD and in the Maternity Ward, so it wasn't until about 1:30PM that we were able to step out. As we made our way to the canteen, the two of us marveling at how difficult it had been for us to coordinate this outing, Ruth mentioned that she would like her meal packaged so that she could eat it in the privacy of her home. My initial intention was for us to be able to catch up on life while we sat and ate. "You know I can't eat outside", she said, meaning she couldn't eat in public. It was here that I remembered conversations that I had with numerous women where I was told that pregnant women should not only be careful of what they eat, but more importantly where they eat. A pregnant woman should never eat in public, where the general public can see her, and where anybody could harm the child in her womb.

This chapter is an exploration of agency through the mother's role in relation to *asram* in the local community, and her role in relation to newborn illnesses in the hospital. I argue that in the former model, she has a greater capacity to make decisions and to act in the best interest of her child. In the latter, she assumes the role of a patient who must adhere to the regimen of the medical practitioner for the best interest of her child.

A Mother's Responsibility

A mother's responsibility to her child begins as soon as she knows that she is pregnant. Pregnancy in Ghana is a joyous time, especially if it happens within the bounds of marriage. During my interview with John, one of the medical students in Dr. Asiedu's office that I quoted in Chapter 2, he stated: *"If I find out that my wife is pregnant, then Hallelujah, praise the Lord! It is expected."* Indeed, it is an expected moment of a woman's life, specifically that of a married woman, and calls for congratulations to the mother-to-be from her neighbors and friends. Yet within this very public event is found a realm of extreme privacy. This privacy is guarded by the woman in the early months of pregnancy by informing only her husband and a few selected kin. This kin could be her mother, a sister, and maybe a close friend. Once the belly "begins to show", meaning once it is obvious that she is pregnant, a woman must be even more careful of how she carries herself. The reason for this great care, as described to me by some local women, is to prevent any human or extra-human agent from harming the child in her womb. One of the ways that she can enable these agents is by exposing her belly or by eating in public, which could be used as methods of harming the fetus. This was one of the ways how, even in utero, a child could contract *asram*.

Nurse Ruth came from the next town over from Osiem, in Tafo. I am not sure of who, within the vicinity of the hospital's canteen, she thought could harm her child, or if the fear of *asram* was even what prompted her to request for her food to be packaged. As a young, Ghanaian woman expecting her first child, Nurse Ruth still acted in accordance with local customs expected of a mother in ensuring a healthy baby. As a nurse trained in the understanding of the importance of biomedical practice, she was very adamant about going for

antenatal check-ups and taking her routine drugs. For her, not eating in public was just as important as going to the antenatal clinic.

To understand the types of responsibility required of the mother during pregnancy and how this relates to *asram*, consider the following conversation that I had with members of the Women's Ministry Group at the Osiem Seventh-Day-Adventist (SDA) Church. There were about seven women present at this particular meeting. Except for my aunt, Auntie Ma, who offered a personal experience of her child who was stricken with *asram*, the other women offered their ideas based on what others had said, and on local knowledge that was shared among them.

Woman 2: There are some [people] that when they give it [*asram*] to you, the mother who has just given birth, they will give it to you in your breasts so that when the child breastfeeds, it will pass to the child.
Woman 6: Or others, when you are pregnant, and they see you eating, they can give it to the child.
Woman 3: Which is why when you are pregnant, you shouldn't eat carelessly. Maybe you are outside, and you got some food, and you are eating it carelessly, someone with *asram* who sees that you are eating outside can give it to you.
Me: So the medicine that...
Auntie Ma: It is on him.
Me: It's on him?
Auntie Ma: It is on his body, and so as soon as he sees you, he gives it to you.
Woman 2: Those who have the medicine to cure it, they are the same people who give it.
Woman 1: You see, when he gives it to you, he'll get money.
Woman 3: This is why a woman, when you are pregnant, you have to dress well. There are some, if you don't dress well, and they see even your exposed body, they can give you *asram.*
Woman 2: Don't expose your belly.
Woman 3: You shouldn't wear anything that will be too tight on the belly button. Always the clothing should be loose (the other women echo "loose"), yes so that the child can have some fresh air. Because if the person [with *asram*] sees your belly button through your clothes, then he will give you *asram.*

The anonymity of the person who causes *asram*, and the ambiguity of how the illness will manifest itself, further reveals how imperative it is for the mother to protect herself even when she is still pregnant. Particularly, some of the women spoke of it as if it were a communicable disease. In Chapter 2 I established that *asram* could affect the child after (s)he was born, especially if the baby was healthy one day, and then all of a sudden fell ill the following without any understandable line of causation. The conversation that I had with the SDA Women's

Ministry reveals yet another aspect of the illness where the health of the baby, whether good or bad, is ascribed to what the woman does in the months of pregnancy. Appiah-Kubi writes that "health and disease are inextricably connected with socially approved behaviour and moral conduct" (1989:213). If a woman is attentive to social norms regarding how she carries herself in pregnancy, then she is actively protecting her child. These local traditions provide the means through which she can exercise agency in protecting her child while still pregnant.

Prenatal Practices

Where one eats and how one dresses are important determinants of a healthy pregnancy. The reasons for the importance of these practices were explained to me by the local community members, even though they were generally accepted by health practitioners as well. Because someone can harm the fetus through the mother, the mother must be especially careful about eating and dressing practices. Any unexplainable abnormalities present in a newborn at delivery are typically linked to what may have happened while the mother was pregnant. Some time ago, I brought up an article about hydrocephalus on *Wikipedia.org* to show my cousin, MaAdwoa. Based on the descriptions that I gathered of the illness, I had my suspicion that a type of *asram* could be biomedically classified as hydrocephalus. Upon seeing the image of the baby with the enlarged head, MaAdwoa exclaimed *"Ey! This is...oh, what do they call it...it is an illness that they give to children."* She then called in Auntie Ma, who also exclaimed with "*Ey!"*, an emphatic exclamation of shock in this context. "*It is asram*. *They gave this one to him when he was in his mother's womb,"* Auntie Ma said, triggering MaAdwoa's memory, *"Yes, asram*". Having heard two exclamations of *"Ey!"*, my remaining three cousins came running into the

room that the three of us were in. Within a few seconds, there was a chorus of three additional *"Ey!"*. *"It is asram*," MaAdwoa informed them. My cousin Kwaku, who Auntie Lucy and Auntie Ma both attested was stricken with *asram* in the first few weeks after his birth, exclaimed, "*So this is what asram looks like"*. I never asked him whether he knew that he had had a variation of this illness when he was younger. *"Yes."* Auntie Ma said, *"They gave it to him when he was in his mother's womb"*. While the health practitioners that I spoke with rarely made this connection, it was evident that some social norms pertaining to pregnancy were accepted knowledge. I will elaborate more on the significance of accepted and practiced local knowledge by biomedical practitioners in Chapter 4.

Even though there are some generally accepted responsibilities for pregnant women in Ghana, there are a number of variations. These responsibilities may be on an individual level, or within a small community. Immediate kin are often particularly influential in determining a woman's responsibilities. When speaking with her about her pregnancy experience, my cousin, Hannah, who had just given birth to a baby boy, mentioned the importance of "home advice". She said:

> You can't just have the hospital, you also have to have home advice. My elders in the community were telling me that when you're pregnant you shouldn't go out at night because there might be some bad spirits. The child also sees, even though he is in the womb. We also live by a body of water; you shouldn't walk by water because there are certain things that water doesn't like, like pregnant women. Every body of water is a spirit.

Hannah moved from Koforidua, the municipal capital of the Eastern Region, to live with her grandmother Maggie in Osiem. Grandmother Maggie, who is also my grandmother, is a traditional birth attendant (TBA) who successfully delivered two of her own seven children. I spoke to Hannah around the time that my family was preparing for the one year anniversary of

my late Grandmother Mary's passing. Relatives from all across Ghana came to pay their respects, so there were a lot of aunts and uncles staying at our residence in Osiem. On Friday, in preparation for the thanksgiving meal for Sabbath the following day, several of my aunts were gathered in the front porch cooking. While stirring the big pot of spinach stew, I asked them about what Hannah had told me earlier that week. To the question of whether it was acceptable for a pregnant woman to walk by water, the youngest of my aunts immediately responded with "*It is a lie. So what if you are sitting in a car and you drive over a bridge? Then what? It is not true"*. To the question of whether it was not advisable for a pregnant woman to walk out at night, again the youngest aunt responded by saying that that too was not true: *"What if you're coming back from a hospital appointment and it is nighttime?"* She then thought about the question again and added, *"Ok, well maybe if she is in her own home and she wanted to step out at night. You can't see well, but the spirit can see you and he can spoil the child"*. My aunt agreed with the statement that every body of water is a spirit, and even gave her own story about how one was discovered under a body of water in her hometown of Kwahu. She described this spirit as a strange creature that looked like a large fish, with breasts like those of a woman. My aunt also agreed that it was not good for pregnant women to sleep on the floor, another requirement that Hannah mentioned. While this is a common practice in Ghana, my aunt was referring to a pregnant woman sleeping on the bare floor, saying *"The cement [of the floor] will grip your sides and you will find it hard to breath. You'll get cold and the child will also get cold"*. Another woman, who lived near the Public Transportation Station in Osiem, was very shocked at the latter statement when I mentioned it during our one-on-one interview. For her, sleeping on the floor was the most comfortable way to sleep while she was pregnant, especially during the last trimester. *"Hm, maybe I didn't know,"* she remarked nonchalantly. This type of

"home advice" wasn't something that anyone had told her about, nor did she really believe that it affected her pregnancy. She gave birth to a baby boy who, at three months of age at the time that I conducted the interview, was still vibrant and healthy. Some "home advice" may to some extent be shared advice among fellow community members, while other home advice may be disputed or may not share the same level of acceptance.

Perinatal Care

Prevention of harm and promotion of a healthy baby in the prenatal stage of pregnancy are both maternal responsibility; similarly, there are some aspects of the childbirth process that may also be attributed to the mother. When I conducted field research in 2010, I saw the frustration of the health practitioners in trying to understand why some women did not go to a health center for prenatal care, delivery, and postnatal care. Initially, I thought that it was because childbirth in the hospital was a much more isolated event than in the home, but my 2011 fieldwork revealed that this was not so. Through my conversation with Grandmother Maggie and Mame Yaa Ataa, one of her sisters, who is also a traditional birth attendant (TBA), I found out that that the process of childbirth in the home was experienced only by the woman giving birth and the TBA delivering her child. This parallels the birth experience in the hospital, where it is only the woman and the health practitioners within the delivery room. All other family members are purposely excluded for reasons explained below. In some hospitals in Ghana, there may be variations in which the woman may be able to have a family member in the delivery room with her (such as her husband or mother), but according to my grandmother, the TBA, this was never allowed in home delivery. The reason, as described by my grandmothers, is that

"some people have bad eyes". By "bad eyes" they mean that some people are wicked in their intentions for both mother and child. Whether this wickedness is fueled by jealousy or hate, *"They can do evil to the child"*, Grandmother Maggie said. One of these evils is *asram*. Because of this possibility, the TBA calls in only the woman's mother to see the newborn after she has delivered the child. The father may also be called, but only after preparations are made; these preparations involve cleaning the baby, suturing the mother, and cleaning the delivery area.

It was during my 2011 fieldwork that I came to learn of the legacy that my family has as TBAs in Osiem. When speaking with her, Grandmother Maggie emphasized how good my family members are in the business, saying that they rarely have deaths or complications: *"If we came to deliver your baby and it didn't go well, then it is from your own house."* By saying that the problem comes from the woman's house, meaning her own kin, the TBA is relieved of all responsibility for a poor delivery outcome. It may not necessarily be that my grandmother was blaming the mother for a complicated delivery, yet if blame is placed on her kin, then the mother does become responsible for the outcome by extension through her kin. This situation again emphasizes that while kin may play an important role in birth outcome, the mother holds the greatest agency in pregnancy and childbirth.

Postnatal Confinement

I previously stated that while pregnancy is a joyous and publicly celebrated moment in a woman's life, the mother must still maintain a certain measure of privacy to ensure a safe pregnancy. She may restrict those allowed to know about the pregnancy to only her husband, mother, sister, or close friend in the first trimester. At this time, there is a faint distinction that

she is pregnant, but when it becomes obvious that she is pregnant, a mother must become more careful in how she carries herself in the public realm. Likewise, the delivery of a child is a joyous moment, but occurs within a realm of privacy that requires the mother to act as protector from an external capacity because the child is no longer a part of her own body.

While she is pregnant, the mother takes care of herself and upholds local taboos in order to protect the child within her body. Once the baby is born, mother and child are placed in a one-week period of confinement. If she delivers at a hospital, then her period of confinement begins once she arrives home. For the woman, this serves as a time for recovery and a time for those around her to monitor her condition. Having just given birth, a number of complications can occur and so she is encouraged not to do extraneous work, such as cooking or cleaning, or to travel far from the home during this period. According to the Pastor of the Saviour Church, *"anything can happen within that week so she must remain indoors so that we can keep a close eye on her."* It is not unusual for a woman to relocate to her mother's home or for her mother to come and stay in her home for the final three months of pregnancy and to have her kin assist her in weeks following delivery.

The confinement of the mother is relatively flexible in that she may move about the compound of the house and well-wishers can visit to congratulate her on a successful delivery. The confinement of the newborn within the first week is not as flexible and may be restricted to a private part of the house. As Auntie Ma put it: "*The mother who has just had a baby, she'll remain in the house for one week. Even if she wants to leave, the child cannot leave the room. This is because the baby is new".* The concept of "newness" is associated with vulnerability. The "newer" the child, the more susceptible he is from external attacks, whether by human or extra-human agency. This explains why, even if someone gives *asram* to the mother with the

intention of attacking the fetus, the woman may not suffer from the illness, and may therefore not be aware that such an attack had occurred. A child born with some unexplainable abnormality was probably attacked in the womb, and one who becomes ill in the first weeks or months of life was most likely attacked right after birth, when the baby was new and vulnerable. This fetus, then, is considered the most vulnerable being, in comparison to his or her mother. The strict one-week confinement period, placed in this context, becomes absolutely necessary.

I have established that *asram* could be caused by anyone, at anytime during the prenatal, delivery, and postnatal periods. It can manifest itself in a variety of different ways and the perpetrator remains anonymous, for he or she does not need to be physically close to the newborn to inflict *asram*. If a newborn becomes ill while (s)he is in the period of confinement, a mother who accepts local understandings of *asram* will not try to seek out the person who may have caused it. She may use deductive reasoning to determine who she contacted while pregnant, who may wish her harm, who may be jealous of her happiness in delivering a healthy baby, or who may have come in contact with the baby after (s)he was born. However, she is not compelled to seek out such a person. While her husband and her mother may be in constant contact with her and the baby, and while she may acknowledge that anybody can cause *asram*, the mother will rarely suspect her husband, or her mother, of causing *asram*. She will not suspect them because of the responsibilities that they also have to the child.

Pregnancy is a heavily female-oriented event, but a husband is expected to support his wife financially before and after birth. As one SDA Church Elder said:

> The man has much responsibility from the time the woman tells him that she's pregnant until…[pause] I'm not even sure when, because when he's an adult he is still your child. Only unless the man doesn't want to take responsibility

The church had just held a baby dedication for the Elder's three-month old son, a joyous addition to his family of four. In *Gydi*, where the use of contraception is heavily frowned upon, and where women are in a subordinate position to men, a husband who behaves irresponsibly to his pregnant wife commits an offense that may require an intervention from church officials. As the Church Pastor in *Gydi* told me:

> Many of the problems arise when the husband doesn't take responsibility and is uninterested in the pregnancy. You have to take responsibility and attend to your wife so that she remains healthy, but if you don't then you will have problems. Since we've built the hospital we've never had a maternal death, so in fact if we find out that you the husband are not taking care of the wife, if she brings this complaint to us, then we'll threaten to excommunicate you from the church. There is no reason that a woman should die from pregnancy, and if she is not well then you the husband are at fault.

When a man impregnates a woman, he is expected to provide for her. This is especially the case if pregnancy happens within the bounds of marriage. One of my uncles jokingly said that once he impregnates his wife, his job is done. That is, save for his financial support for any provisions that she may need for a healthy pregnancy and healthy baby. My aunt concurred, laughingly saying *"Your uncle! Ha! All he had to worry about while I was pregnant was sleeping, eating, and going to the bathroom."*

"No, I did more than that. I gave you money when you needed it." He added, rather embarrassed.

"Yes, that is true. But besides that I did everything myself. You see I was a strong woman."

Responsibility to the wife through financial support was synonymous with responsibility to the baby.

In local models of *asram* in Osiem, the mother and her kin play a large role in diagnosing a newborn's illness and finding a treatment. Diagnosing the illness is a shared responsibility, and because *asram* can be any newborn illness, the local model places a relatively large demand on the mother to find a cure rather than to find the perpetrator or seek revenge. This is the compassion and sympathy, *tima*, expected of her in her social obligation to her newborn. By going to the healer, who would make a diagnosis that would confirm or dismiss her suspicions, the mother takes charge of her maternal duty in addressing the physical ailment of her newborn. In prayer, she addresses the spiritual causation by leaving vengeance to God. By these actions, she is deemed both a good and selfless mother; this is in contrast to the selfish motives of the person deemed wicked because (s)he brought harm to a child.

Practitioners of the HMSH require a different type of participation from the mother, compared to what local understandings of illness require of her in relations to her sick newborn. I address the mother's capacity to act in the biomedical model below.

Biomedicine and the Question of Ignorance

Health practitioners emphasize that giving birth in a medical facility is extremely important, but routine antenatal care visits and postnatal care are equally as important for healthy birth outcomes. My 2010 fieldwork revealed the existence of a discourse about "ignorance" when some health practitioners talked both to and about women from Osiem who came for natal care. I found that when I spoke with them, some health practitioners would point to a woman's "ignorance" as one of the underlying factors contributing to maternal and infant health problems. According to them, mothers would preferentially listen to the influences of people other than

biomedical practitioners, mainly people at home whose suggestions sometimes contrast with what health practitioners prescribe.

Besides the HMSH, which is located in the part of Osiem called *Gydi* (the Saviour Church of Ghana), there was also the Black Cat Clinic, built by the Osiem Assemblyman many years prior to the establishment of the hospital. Facetiously called by his nickname "Black Cat" (due to his slyness in escaping from trouble when he was a youth), the Assemblyman saw the need for a community clinic in his town. Regarding women's childbirth practices, the Assemblyman had this to say:

> There are those who deliver at home. We told them that they should all go to the clinic so that we can educate them so that death rates of the infants will decrease. I've warned them that that's what they should do.

My conversation with the Osiem Chief, my grandfather, echoed the Assemblyman's concern when he said: *"We encourage them to go to the hospital. By all means you'll have some pregnant women who deliver at home, so you won't get 100 percent"*. Like the health practitioners, community leaders such as the Assemblyman and the Osiem Chief held very idealistic opinions regarding women's health practices in relation to the hospital. Both pointed to practices in the past, where women's prenatal, delivery, and postnatal care were done at home due to the lack of affordable healthcare. In their opinion, the National Health Insurance Scheme (NHIS) has taken care of most of those problems. It is an accepted fact even among TBAs that home births have drastically decreased since the hospital's establishment. When I attempted to speak with one of the few TBAs still consulted by some women in *Gydi*, she immediately refused to interview with me, saying that *"What can I tell you? Now, because of the hospital, the business is dead."* While health practitioners and community leaders may acknowledge that home care practices concerning childbirth may have decreased, and while they may accept that

not every woman will use hospital resources, the fact that healthcare accessibility has increased, both financially through the NHIS and geographically by the newly-established hospital, makes those who do not take advantage of these resources inexcusable. These are they whom some health practitioners call "ignorant".

The question of ignorance is relevant to a mother's agency, in the biomedical model, regarding her newborn's illness in two ways: ignorance of the mother herself, and the ignorance of those that she consults. For one week in July during my 2010 fieldwork, I joined the Black Cat Clinic's Child Welfare Program. In this program, a community health nurse and I went to various parts of Osiem--*Gydi*, SDA, Zongo (the Islamic Community), and the Chief's Palace--to carry out child weighings and immunizations. These settings were highly social in nature as our task was done in the open air, near homes, churches, and schools. Nurse Sarah is a community health nurse who had the task of bringing biomedical care to the local community. I asked her for her opinion of mothers' use of herbal medicine, especially if they went through the entire ANC and delivery process in the hospital:

> Influence from others is also a problem. For example, although we might have told her at the hospital how best to take care of herself and her child, the woman will go home and relatives will persuade her otherwise. The elderly women, the grandmothers, who bathe the baby will also sometimes use concoctions without the mother knowing. These were the concoctions that were used in their days and since they are still alive why shouldn't they still be in use now?

The Oxford English Dictionary defines *ignorant* as:

> 1. Lacking knowledge or awareness in general, uneducated or unsophisticated.

In the case presented by Nurse Sarah, it is not so much a "lack of knowledge" or lack of "awareness in general" that would make such a woman ignorant. Rather, her comment alludes to

a difference in epistemology and proof found within local care versus proof found in biomedicine, which Nurse Sarah herself may not acknowledge. The use of concoctions by the elderly, however unbeknownst it may be to the mother, renders them as ignorant. It is not that the grandmothers do not have knowledge, but that rather their knowledge is not accepted in the biomedical context and not conducive to biomedical practice. It may in fact complicate matters. To prevent such complications, mothers should comply with the regimen prescribed by the health practitioners, particularly pertaining to their newborn's health.

Power Dynamics and Social Boundaries

Contrary to the local framework where mothers and their kin have the responsibility to diagnose their newborn's illness and then find a healer for confirmation and treatment, the biomedical framework calls for the doctor to *both* diagnose and treat. Between the doctor, the mother, and her sick child, the newborn is the one receiving treatment. Yet, in a context where the patient cannot effectively communicate with the doctor, except through body language, and whose every need is taken care of by his or her mother, the newborn becomes an extension of the mother, and the mother takes on the role of the patient. Her responsibility to her newborn is as that of a patient whose own body is being treated, and that is to adhere to the doctor's regimen. Again, I refer back to Descartes' mind-body dualism that I quoted in Chapter 1. There is a power dynamic created between patient and doctor based on education in Western biomedical practice, which establishes the social boundaries of both. The authority predicated by his or her education places responsibility on the health practitioner to act in the manner that (s)he finds most appropriate to treat the newborn. To emphasize this responsibility, Dr. Asiedu, the

pediatrician that I quoted in Chapter 2, had this to say about childbirth: *"A woman should never die from childbirth. It* [childbirth] *is natural. If a woman dies during childbirth, then it is the fault of the doctor, not the woman."* This contrasts with what Grandmother Maggie said regarding poor delivery outcome where she placed blame on a woman's kin. Dr. Asiedu's comment echoes the modern Hippocratic Oath, an oath taken by physicians to practice ethically. The concluding part of the oath states:

> May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help (Tyson 2001).

Just as much as the mother is obligated to adhere to the medical practitioner's regimen, so is the health practitioner required to act in the best interest of his or her patient based on the biomedical context in which the illness is placed.

In order to understand *asram* as treatable, health practitioners have to take it out of its social context and medicalize it, calling it by a different name. While the local model of illness places *asram* in a social context and calls for the mother to use her own reasoning and resources to treat her newborn, she cannot act on her own reasoning in the Western biomedical model if it contrasts with that of the health practitioner. Thus, the body of the newborn, on which treatment is applied, is shared between the doctor's reasoning and that of the mother. By treating the illness, the health practitioner educates the mother by correlating recovery with his treatments, saying that "by administering this" or "by prescribing that", the symptoms of the illness will lessen. Through this process, however, the mother is a limited participant in biomedical knowledge. Diagnosis is not a shared responsibility between mother and doctor as it is between mother and kin in the local model, and treatment is a shared responsibility only as far as her acceptance of the prescribed regimen is concern. To what extent, then, is the mother able to

understand her participation with respect to the health practitioner, and how receptive do the health practitioners think that the mothers are?

Limited Participation in Knowledge

Some of the nurses who spoke with me mentioned their frustration with women not listening to them. They explained this behavior by saying, *"They think we talk too much"*. By this phrase, nurses meant that women thought that they complained too much, and that this was seen as being too boastful of their knowledge; mother would therefore not listen. To the nurses, this was willful ignorance. However, some women asked me questions about advice from health practitioners that demonstrate that they really do not know or understand the reasons for the advice they receive. There is a genuine gap in communication between health practitioners and mothers. This means that health practitioners are essentially asking mothers to take their advice on faith, without providing understandable reasons for the advice.

After I interviewed community members, I would ask them whether they had any questions for me. Mothers would often ask me questions like *"Why do they say that we shouldn't massage the baby's head?"* Or *"Why do they say that we can't give the baby water?"* At one point during a visit with Grandmother Maggie, she said, "*They tell us to clean the cord with that medicine. Me, I use hot water and put Shea butter on it."* By "that medicine", grandmother was referring to the mentholated spirit that mothers were advised to use to clean the umbilical cords of the newborns. While my goal for the 2011 fieldwork was to spend more time in the local community and dissociate myself from the label of "*Mame Nurse*" (the informal name used to address any female nurse), community members still saw me as an employee of the HMSH, and thus someone who was able to understand the reasoning of health practitioners.

In the massaging of the baby's head, an elderly woman, usually a grandmother who has had years of experience, uses a cloth dipped in hot water to apply pressure to the head of the infant. Before women are discharged from the hospital, midwives or nurses tell them to not put hot water to the head of the infants, alluding to this practice of head massaging. For the longest time I did not know what they meant by this because the advice was not followed by an explanation, at least not on the days that I was at the hospital. It was not until I took the initiative to ask one of the midwives that I found out. While the women may know what the midwives mean by "not putting hot water to the baby's head", the lack of explanation provided as a follow-up to the advice maintains the power dynamic between health practitioner and mother. The same situation occurs when mothers are told to not give water to their newborns. There is, however, justification given for the benefits of breastfeeding exclusively for six-months, or sleeping under a treated mosquito net at night. I will elaborate on the implications of the "head massaging" practice in Chapter 4 and how some health practitioners, while they caution again it, maintain its practice in the privacy of their own homes.

Nurses and midwives may give instructions to mothers that are not clear or understandable. This means that some advice about how to take care of their health and/or their newborn's health is not understandable via a logic pathway. In this case, biomedicine does not always make sense within the epistemological framework of local knowledge. Health practitioners may assume this difficulty to some extent, thinking that women will not be able to grasp the reasoning behind why certain practices are encouraged and others shunned. This reason may explain why there is no connecting link between a warning or advice and the outcomes that they intend to give. Health practitioners perceive that it is easier to limit the

explanations for advice and have women exercise faith in the prescription of the health practitioner.

Regardless of whether a valid explanation is given pertaining to a caution or treatment, a mother is expected to actively comply with a doctor's reasoning and resources, but passively accept the reasoning without question. Biomedically, this is what frames a "good" mother. The following case study from my 2011 fieldwork illustrates this point:

> On July 1st, a national holiday that commemorates the date when Ghana became a Republic (in 1960), a mother came to the HMSH for her postnatal checkup. The Maternity Ward, and the hospital in fact, had otherwise been quiet. The senior midwife on duty charged me with weighing the baby. While taking off his clothes, I noticed a yellow string-like substance protruding from where the umbilical cord used to be. There was also a dark circle around this area. I signaled one of the senior midwives to take a look. Upon seeing it the midwife asked the mother what she used to clean the umbilical cord. "Did you use the spirit?" The midwife was referring to the mentholated spirit given to her upon discharge from the hospital the previous week. The mother responded with a yes, but the midwife refused to believe her. "Speak the truth. What did you use?" The woman laughed shyly. "What did you use?"
> "An herb"
> "An herb? What herb?" the midwife asked. The woman again laughed shyly. "So where is the spirit?" .
> "It is there." [Meaning that she still had it in her possession, perhaps at home].
> "It is there? It's there, sitting. Good, you have now given your child a wound. He's got an infection." After weighing the child I was then asked to clean the infected area with mentholated spirit. The black area around the belly button began to peel like a scab.

From this interaction, the midwife ascribed her child's "wound" to something that the mother did and did not do. Before women are discharged from the Maternity Ward, a nurse or midwife shows them how to clean their infant's cord with mentholated spirit. While they are in the ward, the health practitioner does this for them. They are encouraged to purchase a bottle of the mentholated spirit from the Maternity Ward before leaving for home, or stop by their local pharmacy if the money is not readily available. The mother from the case study *did not* use the mentholated spirit given to her upon discharge to use to. She *did* apply an herbal treatment on the umbilical cord to make it fall off.

The mother's responsibility to her child in the biomedical model parallels the local. In the local model she may be indirectly involved in bringing *asram* upon her child by not "protecting herself" while pregnant, or not "protecting the child" after birth, thereby giving leeway for anybody with a "bad spirit" to harm the child. In the biomedical model, however, she may be directly involved in her child's illness by not using prescribed biomedical treatment, whether as a prevention or as a cure, opting for herbal treatment instead. A couple of days later, the mother from the case study returned because her baby's umbilical infection had worsened. Again, she insisted that she used the mentholated spirit and again the health practitioners, this time a different group of nurses and midwives, did not believe her. They referred her to the doctor. However indirect or direct her actions may be, the mother is still responsible for the health outcomes of her child. The role that the mother plays in the local and biomedical models parallels each other.

Parallel Frameworks

In this chapter I have shown how both local and biomedical understanding of illness emphasize preventative and curative measures that dictate the mother's responsibilities to her newborn. These measures are dictated by those who have had experiences in or have knowledge of childbirth i.e. mother, TBA, doctor, nurse, etc. In Osiem, dressing in a socially approved way, or not eating in public does not pose any clear obstacles for biomedical practice , nor does regular antenatal care visits and the taking of routine drugs pose a problem for the local concept of illness. I refer back to the example of Nurse Ruth in the very beginning of the chapter, which shows how Ghanaian women can be caught between the different responsibilities required of

them by the local and biomedical frameworks. Certain aspects of the frameworks can overlap if both mother and child maintain their health, but these same aspects may be contradictory when illness or disease is involved. In the case of a child who has *asram,* the question of "What should we now do that the child is ill?" is answered differently within the two frameworks. These answers, whether to use herbal treatment or to go to the hospital, determine the capacity in which the mother can act in response to her child's illness.

In her study of the significance that social class plays in women's choice and control within American pregnancy and childbirth, Lazarus (1994:134) found that many women felt responsible for the events of childbirth, and that this burden influenced the decisions they made prenatally and perinatally. A study of French and American Neonatal Intensive Care Units (NICUs) revealed that a doctor's recommendation for treatment of a premature child could relieve parental guilt in making a decision regarding the life of their child (Groopman 2011:9). An *asram* diagnosis presents a life or death situation, for, it is a shared belief among local community members and health practitioners in Osiem that the illness could be fatal if not treated properly. It might be necessary for mothers (and others in society) to perceive illness as being of spiritual origin in order to feel as though they can address the issue and help their child. Similarly, when placed in a position where she has limited knowledge and participation, a mother may be relieved of the burden in having to make a life or death decision regarding her newborn. This decision-making task falls instead on the shoulders of the health practitioners. In this chapter, I have presented the competing natures of the local and biomedical frameworks, but the "either/or" approach is insufficient to understanding illness in Osiem. I argue in Chapter 4 that while women exercise varying degrees of agency between the two frameworks of illness,

different contexts of practice affect the authority of biomedicine, whether in the hospital or in the home; in the public, or in the private sphere.

CHAPTER 4: Head Massages and the Question of Authoritative Knowledge

My cousin, Afia, and I decide one day to pay Grandmother Maggie a visit. When we arrive, we find her and Cousin Hannah, with her new baby boy, sitting on the bed in the bedroom. Grandmother tells us how she marveled the day of Hannah's delivery, for, within ten minutes of arrival to the hospital she gave birth. Grandmother Maggie tells us about the soup, abɛdro*, that she made for Hannah before rushing her to the hospital. The soup's purpose was to progress the labor so that "the baby could come out quickly". She takes me to the front yard to show me the ingredients she used to make the soup, only to find that the herbs had been destroyed by the gardeners (Fig. 3). "When they came to spray they must have spoilt them," she said. Returning to the house, she mentions that Hannah had initially refused the soup."Yes, I wouldn't drink it," Hannah agrees, "but it was so good when I did. You wouldn't even think that it was medicine!" "Yes, it was very delicious," Grandmother says, "That is what made the baby come so quickly." For the duration of our stay, Grandmother teaches me and Afia about the various dos and don'ts of pregnancy and childcare. One of these involves infant head massaging. "The nurses tell us to wait six months before we do it. Ah! What purpose will it have at that time? You'll kill the child. Even the nurses who are telling us not to do it, we did the same thing to them. And they tell us to clean the cord with that medicine [mentholated spirit]. Me, I use the hot water and put Shea butter on it."*

This chapter is an analysis of biomedical knowledge as authoritative knowledge. I argue that individuals may challenge or accept the legitimacy of this authority depending on the context in which they are placed, whether within the public space of the hospital or in the privacy of their homes or communities. While Chapter 3 explored the mother's role with respect to *asram* in the context of the village, and the mother's role with respect to newborn illnesses in the context of a hospital, Chapter 4 offers an example of knowledge and practice that is different from *asram*. It presents the difficulty involved in bringing the biomedical and local knowledge systems under one rationale, but reveals that the two models can work on the same body.

The Hawa Memorial Saviour Hospital and Authoritative Knowledge

In Chapter 1 explained how some knowledge may carry more weight than others in a domain where many knowledge systems exist. The nature of biomedicine and the means

through which it establishes itself as an authoritative source of knowledge reveals that in Osiem, biomedicine has become a *public* medical reality through the space of the hospital, but not one that is entirely free from other influences. In *Gydi,* the Saviour Church, a denomination of Christianity also known as *Gydi,* challenges biomedicine via the religious doctrine it imposes on hospital practice. I begin an analysis of how faith and belief play important roles in the acceptance or challenge of the legitimacy of biomedicine by first exploring the history of the HMSH.

Narratives from the Hospital Chancellor (also an elder of the Saviour Church), the Hospital Administrator, and the Church Pastor reveal that the HMSH was built in response to the needs of, first and foremost, the community of the Saviour Church of Ghana, known as *Gydi,* " Saviour". It was not necessarily a response to the nation's drive to reduce maternal and infant mortality rates, although that was inevitably a result. As I mentioned in Chapter 3, women hold a subordinate position to men in *Gydi,* but the leaders of the church, all male, agree that the hospital was built with their female parishioners in mind. The issue of blood transfusions and contraception pushed leaders of the church to establish a facility that would consistently respect church practices when it came to pregnancy and childbirth. Blood transfusions and family planning through the use of contraceptives are often integral aspects of Western medical practice. The very reasons behind why the hospital was built therefore questions just how much of Western medical practice can be adopted, integrated, and taught within a community while other aspects are ignored or discouraged. It also brings into question just who has the power to dictate such rules. As previously mentioned in Chapter 1, Osiem is the national headquarters of the Saviour Church of Ghana. Geographically, the HMSH is located between three very important structures in *Gydi*. To the right of the hospital is the church, a very large and well structured

building, attached to which are housing quarters for some of the church elders. To the rear left of the hospital is the current pastor's compound, with a mansion built large enough to house his five wives, their children, and some of their children's children. There are also smaller boys' quarters in the mansion's compound to house others, such as those who tend to the mansion and the compound around it. To the front of the hospital is the former pastor's compound, which is home to his many wives that survived him, his children, and his grandchildren. The former pastor was the uncle to this current pastor. The hospital as the center of the three structures (church, current pastor's house, and former pastor's house) reveals not only its importance to the religious community, but also the strong religious influence on hospital practice. To further emphasize this point, the hospital administrator informed me that while the health practitioners of the hospital can educate women, most of the health education of *their* women (members of Saviour) is carried out by the church leaders:

> The church leadership always emphasizes the need to use the hospital to prevent problems, like how when you go to the hospital you don't accept blood You're not going to just sit there and become anemic. So they will educate them that they have to take good care of themselves, to go for the ANC. There, the health professionals can tell you about your condition, and if you're anemic, the steps to take to help you.

As a member of *Gydi*, one is raised with the knowledge of religious taboos. Health education, through the church, acts as a safeguard against any advice or pressure that a health practitioner may give, particularly to a pregnant woman who may be more prone to break the taboos in emergency cases. Within the *Gydi* community, the Pastor and church elders are placed above the leadership of the health practitioners: this permeates into the space of the hospital itself. Women's adherence to the advice of their religious leaders does not depend so much on whether that advice is right or wrong, but rather on the status of the person who gives it. Even if they question the advice, the fact that it comes from a church leader overshadows their doubt. Church leaders urge their female parishioners to use hospital resources such as ANC, routine drugs, and

hospital deliveries, not only as a way to ensure safe pregnancies and deliveries, but also as a way to maintain religious taboos observed in their denomination. Ensuring a safe pregnancy and delivery thus means taking the necessary measures to prevent the need of a blood transfusion and to ensure that a mother stays healthy so that she can continue to conceive. The hospital therefore occupies both a geographical and religiously significant space in *Gydi*, which is especially important when one considers how devout the members of *Gydi* are to their religion and to their religious leaders.

While the HMSH is a private facility, it is inclusive to all patients and practitioners. As the Hospital Chancellor, Hospital Administrator, and the Church Pastor described to me in our interviews, the hospital's services have been welcomed and are used by residents of Osiem, and even people from beyond the small town. The taboos imposed by the church, however, are applicable only to their members. Health practitioners who are members of *Gydi* are to uphold their religious practices, and those who are not members of the church are discouraged from educating female *Gydi* patients on the use of contraceptives or intervening in situations that require blood transfusion, unless the patient requests these services. Any member found in violation of these rules could be threatened with excommunication from the church. *Gydi* parishioners, as do other parishioners of different faiths and denominations, have the liberty to make a choice concerning this issue. The stakes presented, however, is such that the wrong choices, according to church doctrine, may lead to excommunication. In Chapter 2 I described how biomedicine constructs its own moral framework based on the responsibilities of the health practitioner and of the patient. Here, I propose that the biomedical moral framework is intertwined with the religious moral framework of *Gydi*, for both health practitioners and patients who are members of the church. While they may accept biomedical knowledge, the religious

moral framework affects the extent to which health practitioners are able to practice in the capacity provided by biomedicine. The legitimacy of biomedical practice, when in line with religious beliefs, is accepted by those of *Gydi*, but challenged when it proves contrary to their religious doctrine. The authority of the hospital is rendered incomplete in the latter case, and may partially account for why, even when they seem contradictory to their medical training, *Gydi* health practitioners can hold firm onto the demands of their religious beliefs. This may also serve as one of the reason why, in a community where biomedical and religious practice coexist many health practitioners and community members acknowledged that the hospital was not entirely free of spiritual influences.

Spiritual Influence Within and Beyond the Hospital

On the first Saturday after I arrive in Ghana, my friend Eunice, the hospital secretary and a member of Gydi, invites me to accompany her at her baby's dedication ceremony. At this dedication, everyone is elaborately dressed in white, with a few displays of golds, blues, and greens in attire. Baby dedications are a common practice in Ghana, and as a Ghanaian, I have attended many. This was perhaps one of the most elaborate that I had yet seen. The service begins with praise and adoration through dance. The music is upbeat and for ten minutes Eunice dances around the church, followed by a long train of her well-wishers and supporters (Fig. 4). On this particular day, there are two baby dedications, so a second woman begins her dance after Eunice is finished, this time to a different song. Following the praise time, the Pastor preaches his sermon, after which he performs the actual blessing of the child. Besides the pews for the elders, which are to the front left of the church, the congregation is divided into four sections: married men, married women, unmarried girls, and unmarried boys. At the time of the blessing, Eunice's husband comes to take their daughter, who is less than two-months old, up to the pulpit. In Gydi, women are not allowed to come to the pulpit in church, so Eunice and I remain in the pew while the pastor blesses her child in the arms of her husband. When the Pastor is finished, Eunice's husband returns the baby to her, after which he returns to his seat in the married men's section of the church. This section was to the left of the married women's section.

In my interview with Mame Serwaa, the Pastor's third wife, I asked her about the significance of the blessing:

> The pastor prays for the child. He prays so that the child will be a good child and will lead a good lifestyle. The child has come to stay to lead a life. There are also some nurses who have bad spirits and they can give that bad spirit to the child, so when you pray for the child then that spirit will leave.

To lead a good life (meaning to have good behavior), in Mame Serwaa's opinion, a child must have a good spirit. The child has come to stay because at two-months of age, the likelihood of infant death is relatively low (to that of a newborn). A good life was the result of good behavior, which, as a baby, could be threatened by the bad spirit of another. Mame Serwaa gave birth to her eighth child in 2010, when I was interning at the Maternity Ward of the HMSH, and was pregnant with her ninth child during my 2011 fieldwork. With the acknowledgement that even within the hospital, health practitioners could affect the future of her children, Mame Serwaa still gave birth to all of her children at established health facilities. Delivery of her first seven children was done at Tafo Hospital since the HMSH had not yet been built. When I asked her why she opted for hospital care in the next town over rather than delivery by the many TBAs present in *Gydi*, before the HMSH was built, she responded by saying that *"They [health practitioners] treat you better. Sometimes you come to the hospital and they have ways to make the labor progress quicker, or even if there's much bleeding there are injections that they can give you that can stop the bleeding"*. Better treatment was synonymous with the ability to effectively respond to complications such as prolonged labor or postpartum hemorrhage. Mame Serwaa did acknowledge, however, that TBAs had their own knowledge and that some women preferred them:

> There are those who prefer to do that kind of work and some women also prefer them. Some call them and they can determine the time you give birth. If the time hasn't come then they can give you medicine to bring on the childbirth. Afterwards, you can give them a gift to thank them.

Her narrative reveals that while she has never used a TBA, the difference between choosing to give birth at a health facility or by a TBA was based more on faith in one method over the other

than on the spiritual threat that either posed. The fact that such a threat is possible, even within the confines of the hospital, means that medical practice is not entirely free of social factors and that these social factors could be influenced by extra-human agents. I asked another nurse, also a member of *Gydi*, about the significance of the father alone taking the child up to the pulpit:

> In the Bible it says that the husband is like Christ. He is the head of the family, so it is the spirit of the husband that can protect the child. This is why the husband alone takes up the child.

It was this same nurse who told me that when a woman becomes pregnant, she does not go about telling everybody: *"This is a journey and you need prayers, and in this world there are people who are wicked, so you need more prayers for God to protect you"*. In Chapter 3 I explained the necessity of maintaining privacy in pregnancy, and how, locally, pregnant women have the responsibility to take care of themselves so that they can protect the child in their wombs from any human or extra-human agents. The protection that the father offers through his spirit after the child is born, and the power that the prayer of the Pastor has in undoing the effects of a negative spirit again offer insight into the power of faith and religion in an infant's life and the profound social implications that this will have for the child as (s)he grows. The HMSH, as an institution of the Saviour Church, provides the grounds in which there can be interplay between social factors and medical practice, both of which are linked by the strong religious beliefs of *Gydi*.

While not all HMSH health practitioners observe the religious taboos of the church, they are still constrained in the extent to which they can advise church members in regards to blood transfusions and contraceptives. Saviour Church serves as an example of how a religious institution can affect hospital practice, and in effect challenge the legitimacy of biomedical authoritative knowledge in one respect, while simultaneously accepting its legitimacy concerning other practices. There are, however, ways in which individuals can also challenge the

legitimacy of hospital practice and the advice of health practitioners, many of which has to do with the influence of kin.

Infant Head Massaging

The example of infant head massaging reveals a different type of knowledge distribution from that of biomedicine. Whereas biomedical knowledge is hierarchically distributed, local knowledge is horizontally distributed based on kinship relationships. There is still, however, an important type of authority that is enshrined in kinship relations: respect for elders. Similar to the pivotal role that *Gydi* church elders play in health education, a woman's adherence to the advice of her grandmother does not depend so much on whether that advice is right or wrong, but rather on the person who gives it. Trust and experience, specifically in childbirth and care, are all qualifications that establish a grandmother's authority in her kin, as the following interaction illustrates:

The Gydi *midwife refuses to interview with me on the basis that the TBA business is no longer in existence because of the establishment of hospital. She says that if a woman ever needed her it would only be to bathe her child. I am perplexed by this statement. Shouldn't a mother be able to bathe her own children? I don't think too much of what she said, believing that the bath she is referring to is the same as the one everyone takes morning and evening in Ghana. Leaving her compound, my younger cousin (who accompanied me) and I decide to stop by our grandmother, Mame Yaa Atta's, house. Though Grandmother is not a member of* Gydi*, she is respected in the community and lives near the gates through which one exits when leaving* Gydi. *Upon arrival we are told that she is bathing someone's child in a house nearby. Her grandson is sent to fetch her. After waiting a while, I tell the house attendants that it was ok and ask if they could give her our greetings. As we turn to leave I hear my grandmother calling me, "Nana!" (Granddaughter). As she gets closer to where my cousin and I stood, she asked whether I had come to continue our discussion on childbirth and midwifery.*
"Oh no, I just came to greet you." I respond
"Then when shall we continue?"
"OK, maybe this week if you want."
"Today I am giving the babies a bath. One is three months old, the other is two months, and the last one is one month old."
"So they called you to bathe them?"

"Yes, and massage the head and body."
It is with this last statement that I begin to understand the meaning of the bath and the influential position that the elderly women hold in the community, particularly in relation to other younger mothers. I ask Grandmother if I could come and watch. "Yes, you should come see how I do it!" She took me by the hand and begins to lead me to the compound from which she came. "See how I do it so that when you return to America you can do it too." As we are making our way to the house I ask Grandmother about the purpose of the head massage. "It makes the baby strong and it helps him to grow fine. It helps him so he doesn't get sick. If there is any illness in him, it gets rid of it. This keeps him from getting sick." The sickness that she is talking about isn't just any common sickness, like a cold or headache, but she perceives that the head massage could prevent any sickness that could be potentially life threatening. We meet the mother, whom I recognize as a member of the Saviour Church, in the courtyard of the compound. She mentions to Grandmother that the water has cooled down and that she should go and bathe a second Gydi *woman's child, who too was waiting. A young girl from this second woman's house calls out saying that their water has also cooled down. My grandmother then takes the child of the first woman saying that she is in a hurry and that they will just "do it like that". The mother calls one of the children in the compound to heat up more water so that she can add it to the cooled one.*

Inside the house Grandmother has the child on her lap. A large basin is put under her feet and she is given a hand cloth. She dips the cloth in the water and murmurs something about the water being too cold. What she means in actuality is that it is not as hot as she requires it to be. We can't stay long that day, but Grandmother tells us to come back early the next morning to the same house. By 7:30AM the following day we are at the doorsteps. Grandmother is already sitting on a chair, holding the naked baby on her legs which are resting outstretched on the large basin underneath them. She begins by checking the temperature of the water. Hot. She dips in the cloth and squeezes the water onto the baby's head while massaging it with the cloth. The infant begins to wail in discomfort. She pauses for a moment and points her finger to one particular spot on the baby's head (at the fontanel), telling the mother in the room "this part is very soft". It seems to give her all the more reason to concentrate much of the pressure applied to the infant's head on that area. I ask how old the child is. Forty days old (Fig. 5). After spending a little less than ten minutes on the head, Grandmother then massages the rest of the body. "This morning we're going the bath the baby," she says, meaning she is going to actually clean the baby as well (with soap and water), not just give it a massage session. The child stops crying as she begins to bathe him. "In the evening we don't bathe the baby; just massage with the cloth. Some people do it [bathe the child with soap and water] morning and evening. I only do it once, in the morning. If it is a newborn baby, then you bathe him in the morning and in the evening. But when the child is older, you do it just in the morning, and you massage in the evening. You massage the body so that it becomes fine and his arms and legs don't become crooked." The mother who is standing across from her, watching the bathing process, demonstrates what Grandmother means by bending her right arm high enough such that her elbow was jutting out at shoulder height. "You see how some children grow up and their arms are like this," she says, "they can't straighten them. Or their legs are bent like this," she curved both arms inwards, demonstrating a child with bowed legs, "It's because their arms and legs were never massaged. We do it so that the child grows up fine."

Grandmother is soon done with the bathing/massaging session and moves on to a second woman's house. Her child is three months old. When my cousin and I enter the house, the baby was already on Grandmother's lap and the mother was bringing over the hot water. I notice a brown paste on the baby's forehead and ask what it is there for. "His head hurts," his mother replies. This means that he is probably suffering a headache from a cold. "When your head hurts, it's like it's splitting," Grandmother says, pointing to the forehead where I can visibly see a faint divide between the bony part of the infant's skull. "So you put the medicine where the split is so that it closes. If you don't put it there it will keep paining him." Grandmother begins the session by first targeting the forehead, where the medicine had been applied, and applying pressure in a way that resembled bringing the two sides of the skull together. The child cries, but this does not deter Grandmother from her ministration. I recall her spending more time on the head of this infant than on the first one. This was most likely because the first child didn't have a headache. When she is done with the head, she again points to the forehead saying, "See. It has become smaller." I almost can't believe my eyes. The partition between the bones had become visibly fainter. She proceeds to massage the rest of the body. When she is done, she quickly gives the baby back to his mother, and leaves to see if a third mother has arrived with her three-week old baby. The woman had not yet arrived, so my cousin and I bid our leave.

Walking back home, my younger cousin and I begin to discuss what we have just witnessed. "You massage the heads so that they grow up fine! If you don't, then when they grow up they'll have very strange heads. You see Joyce, how big her head is." Joyce is the three-year-old who lived in the house compound adjacent to Auntie Ma's house. "Or Yaw! Such a large head, with very small leg." Yaw is the two-year-old who also lived in the same house. "You see how his legs jut out. It is because they didn't massage him! They didn't press any of the heads of the children in that house. Look at Kwame and his head!" Kwame is the eleven-month old in the family, born to the third unwed teenager in the house, after Joyce's and Yaw's mothers. My cousin continues, "All these nurses that are telling us not to massage the heads, we did the same thing to them!" I am surprised by my cousin. She, a girl of only sixteen years, was not yet married nor with children, yet she is so adamant about the necessity and benefits of the practice. When we return home, Auntie Ma asks us about our visit to Grandmother. We let her know what we saw. To this she says, "Now, because of the hospital, they say that we shouldn't massage the heads. But those doctors and nurses, we did the same thing to them. Look at the children in that house. Like Kwame, Dorcas [Kwame's mother] never massaged his head. Or Joyce and Yaw, none of them from that house did it." She, just like my cousin, her daughter, is referring to the house adjacent to ours.

The role of Grandmother Yaa Atta speaks to the influence of elders in the community. As someone who is also a TBA who has delivered many of the people of Osiem (she boasted during our first interview of the many children she delivered), Grandmother Yaa Attaa holds a very prominent position in Osiem as a wise woman. Pigg writes that the customs observed and

practiced by the local community "are practices through which people care for the bodies that are understood in terms other than those of biomedicine" (Pigg 1997:245). In Osiem, head massaging practices are also grounded in a set of beliefs that have very much to do with the local cultural "reality" of the body (Pigg 1997:245).

As indicated in the preceding narrative, head massaging has three perceived effects. First, there is the belief that it helps facilitate the joining of the bony part of the infant's skull. Recall my grandmother's comment to one of the mothers, saying "this part is very soft" while pointing to the fontanel and concentrating much of the pressure in the head massaging session on and around that area. Secondly, head massaging is believed to have preventative and healing properties. Grandmother Yaa Atta claims that any illness hidden in the child will never fully express itself because of the ritual massage. People who do this practice are assured that their child will not have any major illnesses in the future and that even if (s)he did, the body would be strong enough to combat that illness. The perceived effect of head and body massaging practices can be likened to the Western medicinal concept of building up one's immunity through preventative measures.

The example of the baby with the headache gives insight to the healing properties that this practice is said to have. The decrease in the separation between the bony parts of the infant's skull was an indication to my grandmother that the massaging session alleviated the baby's headache, especially when she had beforehand likened a headache to the splitting of the head. What was seemingly a minor and immediate physical change in the shape of the infant's skull after the massage was evidence enough for her of the healing properties of the practice. The fact that I thought that there was a change reveals just how influential the setting and the authority of my grandmother had in my own perception of what I saw. Thirdly, head massaging

has social implications as far as aesthetics are concerned. The use of the word "fine" by my grandmother, my younger cousin, and the mother who demonstrated how a child's body could become crooked if their bodies aren't massaged, is a connotation of good health, of strength, and of proper growth. The mention of the three toddlers who lived by us and of their mothers who failed to massage their children's heads shows the correlation that my cousin and aunt made in regards to physical appearance and the massage practice. In a sense, their children's physical appearance was the result of something that they, the mothers, did not do. My aunt, however, did not place full blame on the young mothers, for, she pointed to the hospital as the root of the problem and the health practitioners as promoting and participating in a set of rules that dismiss the importance of the massaging practice. It is noteworthy that her complaint was in regards to head massaging, and not to body massages. She never cited any health practitioner who had a complaint about the massaging of infants' bodies. Several other women voiced the same opinion as my aunt. They mentioned their frustration not only with what the health practitioners told them about the practice, again in regards to the head, but also the lack of reasoning as to why they shouldn't do it. In their opinion, the heads of many of the nurses and doctors were massaged when they were infants, and the very fact that they turned out "fine" did not correlate with the strong prohibition that health professionals gave against the practice. Rather, it confirmed their belief in the practice and served as evidence against any harmful consequences, creating a confirmation bias.

Head massaging presents interesting, yet similarly structured, systems of knowledge to those of *asram*. While the former case speaks of women taking preventative measures against any infant illness or improper growth, the latter presents a situation where women have to consider curative measures in treating an illness. These two practices allude to the different

stakes they present, where head massaging presents relatively lower stakes to *asram*, which involves higher stakes because it is potentially fatal. *Both*, however, involve some kind of negotiation between biomedical practice and local practices. Both contexts of practices have their own structures of authority, whether it is kin in the local model, or health practitioners in that of biomedicine. Knowing that I had some affiliation with the hospital (although I tried to tell them that I was not an employee), many of the women would ask me why "we" (they grouped me with the health practitioners) tell them not to massage the heads of the infants. With my little knowledge about this matter from my pre-medical background and from my experience in the hospital, I tried to offer them a possible explanation, while at the same time pondering the reasons behind such a prohibition.

During my 2011 fieldwork I did not go the hospital every day. On one of the days that I was interning in the Maternity Ward there, I asked one of the nurses with me why they cautioned against head massaging:

> They use very, very hot water to massage the heads. Even those who are administering it can't hold on to the cloth for too long because it is hot. Since it is so hot it cooks the brain, particularly since the skull hasn't hardened. You see there is the fontanel.

I then asked her why, if it is so risky, women continued this practice:

> They believe that by doing this that the sutures will join together. Also, they think that when they do that it gives the children nice shape heads.

This young nurse, who had just been employed at the HMSH, mentioned two of the three perceived effects of head massaging. By likening the practice itself to the "cooking" of the brain, and stating its harmful effects as a fact, the nurse immediately disregards any rationality that "they", the local women, have for maintaining the practice. While I doubt that it actually cooks the brain, her opinion was based on her understanding of the head of the infant as

especially tender and the brain as susceptible to injury if the head wasn't handled carefully. In her opinion, head massaging was not careful handling of the infant and could lead to immediate or future health problems for the child. Her opinion was epistemologically different from that of the women who believed that head massaging prevented potentially serious illnesses. The hospital administrator mentioned that as time progressed, members of *Gydi* moved from a "primitive mentality" in regards to health as they began to rely more on biomedicine than on herbal, "traditional" medicine. While epistemological differences may explain why head massaging was seen as dangerous in one context and essential in another, there had to be some driving principle to explain why a woman who uses hospital resources for childbirth continues to partake in a practice that seems so contradictory to biomedical practice. This driving principle I found to be the authority of the elderly women in the community.

The Authority of the Grandmothers

Auntie Stella, a petite woman in her sixties and one of the two senior midwives who worked in the Maternity Ward of the hospital, invited me to her house. Our conversation began with a narrative of her experiences as a midwife and the changes she had seen in regards to childcare over the forty years that she has been practicing. She delivered all of her children in the hospital, mentioning that one of the reasons why she never liked homebirths was because the elderly women would prepare a bucket of very hot water for the woman to sit over after the birth. They perceived that the hot water, in addition to the herbs that were mixed in it, would facilitate a quick healing of the vaginal area. At this point I asked her whether this water was as hot as that used to massage babies' heads.

Auntie Stella: Aha, ok, they say, the belief is that the suture that is there [on the head] is a wound, so they do it so that it closes. But you see that it naturally goes away. Have you ever seen a White person who has ever massaged their heads, but he turns out fine. It naturally goes away. (She begins to giggle).
Me: That's right, I've never seen it. The practice isn't there [in the US].
Auntie Stella: You'll put the hot water on the head, on the butt, on the private area. Oh! (which is an exclamation of disbelief)
Me: So you've never done it before?
Auntie Stella: I do! How can I say I don't do it, I do.
Me: You do? That it will shape the child's head or for what reason?
Auntie Stella: We do it. There's the belief that we should do it.
Me: So you did it for all of your children?
Auntie Stella: Yes, I did it.
Me: But then when you go to the hospital, they tell you--
Auntie Stella: Not to do it (She laughs).
Me: Why do they say that? That it will hurt the child or--
Auntie Stella: They say we shouldn't do it.
Me: But then when the women go home--
Auntie Stella: They will do it. People will gossip if she doesn't. You put the hot water to the head, the butt. We do it very much.
Me: So that the head is fine?
Auntie Stella: Yes.
Me: And so what if you don't massage the head?
Auntie Stella: They say that his head will hurt and that he will keep getting sick. So you'll keep massaging the head.

Needless to say, I was very much surprised by Auntie Stella's confession. What is particularly striking in our conversation is how she places herself in the whole matter. She begins by saying "they say". Within the context of my conversation with her, "they" here refers to the grandmothers of the community, the elderly women. Their understanding of what the fontanel is and what should subsequently be done about it is contradictory to what her profession tells her. In the former, it is a "wound", meaning it doesn't belong; it is unnatural. By stating that it "naturally goes away", meaning that it eventually hardens and becomes like the rest of the skull, Auntie Stella acknowledges the sutures as something that is supposed to be there, but only temporarily. It is natural. In this case, what "they", the grandmothers, believe and what "she", Auntie Stella, believes are contradictory to each other. Her giggle at the end, however, alludes to the irony of it all, because she herself did the same thing to her children. By saying "I do it", which is in the present tense, Auntie Stella most likely continues to head massage other women's children.

When I mentioned the hospital, she referred to the health practitioners as "they" and not as "we", which was interesting because she too was a health practitioner, and a highly respected one at that. Auntie Stella gives no explanation behind the prohibition of the practice by the hospital, probably for the reasons that, like her, many of the health practitioners practice it themselves. Her laughter about the matter in this case again points to the irony of it all, because I have seen her warning mothers to "not put hot water to the baby's head" upon their discharge from the hospital. Auntie Stella, therefore, places herself in two different contexts of authority that determines her attitudes and practices based on such authority. On the one hand, there is the local authority exercised by the grandmothers of the community, and the social implications that comes from not heeding such practices ("People will gossip if she doesn't do it"). On the other, there is the authority of the hospital dictating both the responsibilities of health practitioners and of patients. These kinds of structures are very similar to those created by church influence over what health practitioners are allowed to do and not do with *Gydi* members. Whereas the church is able to challenge biomedicine in the public domain occupied by the hospital, head massaging, on the other hand, cannot breach the public domain and remains a practice within the home. Auntie Stella's narrative offers insight on how some women live amidst contradictions of authority – biomedical, and that of the elderly women.

The difference between hospital and elder authorities is not so much a question of the public versus the private domain, but rather a question of context. These contexts in question are those of the hospital and the home. I propose that while biomedicine may be authoritative knowledge, as I established in the beginning of this chapter, community members may either accept or challenge the legitimacy of this authority in the home. In all things relating to pregnancy, childbirth, and child care, this authority resides in the elder women, who have given

birth to many of their own children. The elders in Osiem are not only respected because of their age, but also because of the perceived experiences that allow them to impart knowledge. To further emphasize this point, consider the conversation that I had with a student nurse at the Koforidua Nurses and Midwives Training College when I visited my aunt in Koforidua:

Nurse Ama: I had this friend and her mother was pregnant. One day she went to an elderly woman in the village complaining of abdominal pain. You see, she was in labor, but she didn't know that it was labor. She has given birth to only one other child, so she wasn't aware that these were labor pains. The old woman told her to go and get some herb to grind and use it as an enema. So she did just that. When she gave birth, they found the medicine in the baby's nose.

Me: But as a TBA shouldn't the grandmother have known that it was labor pains?

Nurse Ama: She wasn't a TBA. In Ghana, the old women are seen to have wisdom, and in the village you go to the elderly women for advice, especially since they have given birth before and have delivered before, so they trust them. When they took out the child he was dead; the medicine was coming out of his nose.

The conversation with Ama shows not only why a woman may use local methods of ensuring a smooth pregnancy or delivery, but also the influence of established relationships between the elderly women in the community and the younger women. Indeed, many of the women with whom I spoke referred to the wisdom of their grandmothers who had either given birth to many children themselves and/or had successfully delivered the children of many other women in their families and communities. Generations and generations of knowledge and practice are deeply rooted within the community and the elders in these communities are constant reminders that these practices are effective. In his work on the history of pluralistic medical systems in Ghana, Twumasi writes that "that which is legitimate is that which had been prescribed in the past [by the ancestors]" (1979: 29). As people grow, they come to learn local customs and practices, which are passed down from the elderly. For this reason, my sixteen-year old cousin was able to educate me on why head massaging was important. Cousin Hannah, who I mentioned in the opening vignette, mentioned to me that she knew that Grandmother had delivered many children before her, and so she wanted her to deliver her child. It was rather Grandmother Maggie who

insisted that they go to the hospital for fear of not knowing if the way she knew how to deliver her grandchild would be different from that of the hospital. In other words, Grandmother did not want to be blamed nor have her skills doubted in the event of a birth-related complication.

This chapter has shown that local knowledge plays a key role with respect to whether community members accept or challenge biomedical authority. I compared local knowledge to the knowledge of the hospital, over which the *Gydi* church, an organized religious institution, wields a strong, public influence. The authority of the church reshapes medical practices to avoid practices that, from a Western biomedical standpoint, promote women's health. The authority of the elderly women does not have the capacity to reshape medical practice in a similar way because much of their knowledge is confined to the home. Women are thus constantly negotiating the different kinds of knowledge, thus the implications of the head massing practices are linked to those of the treatment of *asram* or newborn illnesses. A grandmother's success stories relating to birth and childcare practices create a belief confirmation that a mother adopts based on the trust that she has in her grandmother. I again refer to the comparisons that my cousin and aunts made to the children who lived next door to them. The way that her children developed, in comparison to the physical appearances of the neighboring toddlers, confirmed to my aunt the value and practicality of the belief in head massage. The position of elderly women as wise women and the role that they play in childbirth create a type of authority based on perceived experience of the grandmothers. This is different from the relationship a woman may have with her health practitioner, in which authority is established based on certified qualification of the health practitioner by an institution. Between these two relationships, a woman does not have to have a certain qualification to know why certain practices are done in the local community because ancestral knowledge is constantly

being asserted and reinforced by the elders. Her trust in her grandmother is enough to open her to believe that what her grandmother tells her has some truth to it.

CONCLUSION: Incommensurability and a Gradient of Knowledge

In this thesis, I have attempted to show that characterizing the ideas of newborn health and illness in Osiem in "either/or" terms—either biomedical or spiritual—is inadequate. In local understandings of what some women say is "not a hospital sickness", the mother and her kin play an active role in diagnosing and, in some cases, treating *asram*. On the other hand, many health practitioners of the Hawa Memorial Saviour Hospital classify *asram* in terms of a number of newborn illnesses that require medical intervention. Not only is a mother expected to bring her sick child to the hospital in the biomedical model, but asymmetries of power dynamics also correspond to different responsibilities of the health practitioner and the mother, based on Western medical knowledge. These two models of illness are incommensurable in that they cannot be reduced to a common set of rules that "tell us how rational agreements should be reached" (Rorty as cited in Lambek 1993:396). This does not mean, however, that they cannot be used in treating the same baby. While local understanding of illness places *asram* within a social and moral context, biomedical practice is also hardly free from morality, religion, and social organizations. I found that there was a gradient of knowledge among both the community members and the health practitioners, revealing that *asram* and biomedicine could be integrated in certain contexts.

Auntie Ma once told me that a woman should tell her husband if her child has *asram* because he is the one who can provide the money for the medicine. In the event that she has to go the hospital he has to provide the transportation fare. I was confused by this statement because in our previous conversations, she, as well as many of my other aunts in the village, were very adamant about the fact that *asram* was "not a hospital sickness" and requires treatment

beyond that of what a hospital can provide. Auntie Ma went on to explain that sometimes the child's head will hurt and that the hospital sometimes has medicine for that. The mother should, however, also use herbal medicine, *abibidro,* prescribed by her local healer, because it is effective. Several other women acknowledged the success that they had with hospital medicine in addressing their health issues. While this success made them more accepting of the hospital's treatment methods, they still stressed the importance of using *abibidro* simultaneously.

Even if *asram* has spiritual causation, it manifests itself physically. The *abibidro*, therefore, can also address the infant's headaches because it is meant to treat the physical symptoms of *asram.* I refer back to the example of the infant suffering from a headache in Chapter 4 to expand on this point. In this case, the mother not only perceived that the medicinal paste, an *abibidro*, that she put on the forehead of her three-month old child would relieve him of his headache, but that the massaging of his head by my grandmother would also help. By acknowledging that the hospital sometimes has treatment for headaches, while still emphasizing that one should adhere to the regimen of local healers, mothers accept that biomedicine can treat an aspect of *asram,* just not the whole illness. Success can only happen if local treatment methods are used. There is a splitting of the illness where, of the two methods, the *abibidro* is a stronger determinant of recovery than biomedicine.

This pluralistic approach to illness is also adopted by those trained within biomedical practice. John, one of the medical students who had been in Dr. Asiedu's office in the dialogue I quoted in Chapter 2, is a member of the Saviour Church of Ghana, *Gydi*. He told me that even in *Gydi* people believe in *asram*. John mentioned one of the out-patient department nurses who bathed with certain herbs while she was pregnant as a preventative measure against her newborn getting *asram,* and continued to bathe her child with these herbs after he was born. As a medical

student, John has never personally encountered a case of *asram.* Yet, he participated in ideas about the negative spiritual agency of people who cause it, saying *"It is not just an ordinary person who does this. They need a power".* When speaking about *asram*, he never made an "us" vs. "them" distinction by reducing it to tetanus or malnutrition as had other health practitioners. Some health practitioners did, however, mention that the hospital itself was not entirely free from spiritual influences. There is thus a gradient of knowledge, a continuum of beliefs along which people can fall at different points in regards to illness.

Hybrid vs. Spectrum vs. Gradient

There are many other metaphors besides a gradient, such as a hybrid or spectrum, that I could have used to describe concepts and practices regarding newborn illnesses in Osiem. The following are the Oxford English Dictionary definitions of a hybrid and a spectrum:

> Hybrid
>
> 1. *Biology* the offspring of two plants or animals of different species or varieties, such as a mule.
> 2. a thing made by combining two different elements
>
> Spectrum
>
> 1. a band of colors, as seen in a rainbow, produced by separation of the components of light by their different degrees of refraction according to wavelength.
> 2. used to classify something in terms of its position on a scale between two extremes.

Both definitions of a hybrid speak to, more or less, an equal mixture of two things. For the purpose of this paper, this would mean that at some point, local understanding of *asram* and the biomedical concept of newborn illnesses would be commensurable. A hybrid would also mean that the two extremes would not exist within the same domain. I have shown that neither of

these are the case, and that there is much more to the picture than just a dichotomy of two models of knowledge. While a spectrum includes the two extremes of practice, local spiritual knowledge or Western biomedical knowledge, it makes distinct separations between the many other possibilities that result as a negotiation of the two extremes. It is my hope that this paper has shown that many spheres of influence determine how one conceptualizes and responds to illness, and that this varies within different contexts, be they medical, religious, or domestic. The lines are therefore not so distinctly drawn between the differences, and may be fluid and blurred because people change their opinions and practices within the different contexts.

The Oxford English Dictionary defines a gradient as:

> 1. an inclined part of a road or railway; a slope
> 2. *Physics* an increase or decrease in the magnitude of a property (e.g. temperature, pressure, or concentration) observed in passing from one point or moment to another

The beauty of using this metaphor is found in its definition as a slope, an indication of how one point relates to the next in an observed property. Take, for example, a scatter plot. A scatter plot is used to show the correlation between two sets of data. The horizontal and vertical axes of this plane coordinate system, respectively the *x*- and *y*- axes, are incommensurable. Plots charted on the plane coordinate system, however, have different measures of both *x* and *y* properties. A linear trend line is a straight line that best depicts the relationship between the two sets of data, based on the many plots. The slope of this trend line is the gradient. The advantage of using a gradient as a metaphor is that it can change depending on whether the arrangement of the plots changes. It is not a measure of how commensurable *x* and *y* are, but rather a measure of the degree to which different plots relate to each other between *x* and *y*. In order for there to be a gradient at all, the *x*- and *y*-axes must exist.

The example of *Gydi* church's influence on their parishioners and on hospital practice

seems to suggest that the coordinate system should include more than just the *x*- and *y*- axes, and that a third axis, the *z*-axis, must be incorporated in order to account for religious influences on health care practices. I hesitate to do this because not all patients and health practitioners of the HMSH are members of the *Gydi* church. Religious influence is also a component, to varying degrees, of both biomedical and local understandings of illness. Recall that both local community members and health practitioners mentioned the necessity of prayers in curative and preventative measures pertaining to newborn health. The influence of the *Gydi* church, the position of elder women in Osiem, and the role of the health practitioners at the HMSH are all involved in politics of knowledge, within which is located a discourse of ignorance concerning newborn illnesses. For some local women, health practitioners are able to treat an array of illnesses, but they are not capable of treating *asram*. For some health practitioners, alternative methods used by some local people to treat a sick child or to prevent future ailments deem their proponents ignorant and their practice as ineffective or dangerous. Different contexts of practice, be they the home or the hospital, place one knowledge in a higher authority above the others. It is this discourse of ignorance and these politics of knowledge that contribute to people's rationale in negotiating multiple health care systems. These negotiations affect the shape of the gradient.

Just as the gradient of a scatter plot can be used to conceptualize how individuals relate to one another based on how they negotiate the different health care systems, a linear color gradient gives insight to the decisions that individuals make *within* themselves pertaining to newborn health and illnesses. As Chapter 4 described, the perceived preventive implications of infant head massages and the practices pertaining to the treatment of *asram* reveal that higher stakes are associated with the latter case than with the former. Proponents of Western biomedical

knowledge and local knowledge both agree that *asram* is fatal if not treated immediately and properly. Cognitively, a mother is under extreme anxiety due to the high stakes that an *asram* diagnosis presents, and will most likely listen to the authority figure in which she trusts, or believes to be the most knowledgeable in the treatment of her infant's illness. This authority figure can be found among her close kin, such as a grandmother, among the health practitioners of the hospital, or among her religious leaders, depending on the context in which the mother finds herself. When taking preventative measures, a mother is much more lucid. The stakes presented by head massaging are thus comparatively lower than those of *asram* because preventative measure are usually taken by those who are well.

In a color gradient, different colors mix at different points. While some may appear dominant as one moves along the gradient, all the colors used in the gradient are still present in varying degrees. Different characteristics of a color have different weights, and therefore provide different intensities of that color along the gradient. A mother may be much more flexible in her rationale and practices pertaining to preventative measures than to curative measures of an illness. The higher the stakes, the least likely a mother may be able to negotiate between Western biomedical practices and local practices. Just as there are different intensities that may determine whether one color is dominant above another in a color gradient, the different stakes associated with *asram* and infant head massages may also determine whether one type of authority is dominant over the other in a particular situation. The mathematical linear gradient and the color gradient work more clearly in the example of head massaging, but also reveal that it is applicable to concepts and practices pertaining to *asram* and newborn illnesses.

In Osiem, individuals, both health practitioners and local community members, are aware of local understandings of illness and apply it in their own ways to address newborn illnesses. In

any domain where multiple knowledge systems exist, social structures, belief, and the politics of knowledge, all play a role in the extent to which individuals are able to perceive and act in accordance to an idea, practice, or situation. When there is an established authoritative knowledge, individuals may accept or challenge the legitimacy of such authority depending on the contexts of knowledge, and more importantly, on who imparts that knowledge. The relationships between the elderly women and the younger women in the community, the health practitioners and their patients in the hospital, and the influence that *Gydi* Church Leaders have on the beliefs and practices of their parishioners are examples of how different types of authority are similarly structured within different contexts. Many factors influence how one responds to illness in an "acceptable" manner, and the extent to which one acts in favor of or against a prescribed regimen.

These different contexts allow a continuum of beliefs that create flexibility in rationale as well as social boundaries and hierarchies that determine the role of the mother as a participant in knowledge. While local understandings pertaining to illness are not necessarily top-down, there is still found within them a system of authority by the elders. The authoritative knowledge of the elders within the home is structured similarly to that of medical practitioners within the public domain of the hospital. Mothers who use both biomedical and local methods are able to cross certain social boundaries where they use the physician's prescribed method of treatment while still maintaining a level of control in treating their newborn's illness. Like a scatter plot, these many possibilities between biomedical and local knowledge make up the plots that result in a gradient. This gradient of knowledge is made up of the many moments of discussion, practice, and care in Osiem by mothers, grandmothers, church leaders, TBAs, nurses, doctors, and others involved in newborn health and illness.

APPENDIX OF IMAGES

FIG. 1 (above) Two nurses stand in front of the Second Gate entrance to the Hawa Memorial Saviour Hospital (HMSH), located in the back with the blue roof tiles.

FIG 2. (above) Akua in the Maternity Ward of the HMSH with other nurses during her 2010 fieldwork

FIG 3. (left) Grandmother Maggie points to the spot where the herbs she used to make the abɛdro once stood.

FIG. 4 (above) Women celebrate at Eunice's (in the middle) baby dedication ceremony in *Gydi*.

FIG. 5 (below) Grandmother Yaa Ataa points to how wide-eyed and awake the baby is after he has just received his head and body massages.

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