

# Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and Encounters with (Medical) Anthropology

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**Abstract:** Since the 1920s, there has been a foreground of fluctuating perspectives on indigenous African medicine and therapeutics in the medical anthropology of Africa. These circular perspectives in medical anthropology have stubbornly focused on the ubiquity of “witchcraft,” the natural or supernatural basis of African therapeutics, integration between biomedicine and indigenous systems of healing, but have failed to excavate African perspectives on or the relevance of these issues in the background of African societies. This essay argues the failure to locate African perspectives on therapeutic matters that may or may not be important concerns in African societies is the quest for “ethnographic cases” that lend themselves to issues *in* the field of medical anthropology rather than African knowledge and perspectives *of* the field (i.e., Africa). The Bono, an Akan society of central Ghana, provides but one of many significant case studies in the encounter between African therapeutics and medical anthropology in the twentieth century, and an African perspective on the substance of those foregoing issues in the (medical) anthropology of Africa.

*The healer must first have a healer’s nature... [he or she] who would be a healer must set great value on seeing truly, hearing truly, understanding truly, and acting truly... You see why healing can’t be a popular vocation? The healer would rather see and hear and understand than have power over men. Most people would rather have power over men than see and hear.*

—Ayi Kwei Armah, *The Healers*, pp. 80-81

## Introduction

In twentieth century southern and eastern Africa, “traditional” medicine was the dominant healing system and often regarded as the more appropriate mode of treatment by specialists and recipients.<sup>1</sup> Stretching from Ethiopia, Tanzania, South Africa, and Zambia to Cameroon, Nigeria, and Ghana, indigenous African healing systems remained highly utilized by large segments of the (rural) populations surveyed.<sup>2</sup> These perspectives on and use of indigenous medicine were shared by parallel populations in geographically distinct places such as New Zealand, Hawaii, and the United States among persons of African ancestry.<sup>3</sup> Overall,

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indigenous healers in Ghana and elsewhere rarely translated their knowledge of medicine into social practices that emphasized the omnipresent dichotomies of “spiritual” and “natural” disease causation nor did their praxis revolve around the debates on witchcraft and the existence or denial of African “medical systems” found in medical anthropology. Akan healers in central Ghana, and I would suspect elsewhere, were unaware of and perhaps would care little about the substance of those debates. Since the 1920s, there has been a foreground of fluctuating perspectives on indigenous African medicine and therapeutics in the medical anthropology of Africa. These circular perspectives in medical anthropology have stubbornly focused on the ubiquity of “witchcraft,” the natural or supernatural basis of African therapeutics, integration between biomedicine and indigenous systems of healing, but have failed to excavate African perspectives on or the relevance of these issues in the background of African societies.<sup>4</sup>

This essay argues the failure to locate African perspectives on therapeutic matters that may or may not be important concerns in African societies is the academic quest for “ethnographic cases” that lend themselves to issues *in* the field of medical anthropology rather than African knowledge and perspectives *of* the field (i.e., Africa). This contention is critical for it argues for a strategic distinction between two sites of knowledge production—field of medical anthropology and the “field” of Africa where fieldwork is conducted—on the larger canvas of global health issues using the local case of the Bono (Akan) therapeutic system of Ghana. Contextually, global health issues in Africa were conditioned by the failed structural adjustment and Highly Indebted Poor Countries initiatives of the 1980s and 1990s, collapsing health structures, the emergence and spread of HIV/AIDS, the global confrontation between pharmaceutical companies and African governments, and the lawsuits brought by pharmaceutical multinationals against these governments for seeking less-expensive drug alternatives. The guidelines issued by the World Health Organization (purported to ensure the sustainability and safety of the sixty billion dollars herbal medicine industry) were more than humanitarian as issues of herbal medicine—poisonings, heart problems, addition of steroids to plant medicines, poor plant quality and collection practices—continue to plague the United States, China, and Europe. The U.S. pharmaceutical industry spent \$4.1 billion on drug research and development in the 1990s and consumers purchased in excess of eight billion dollars. Since 74 percent of the chemical compounds of the 119 known plant-derived drugs have the same or related use as the plants they derive, this pharmaceutical industry exploits medicinal “claims from alien cultures” in the “discovery” of new drugs.<sup>5</sup> As industries in the United States and Canada, the European Union, and Japan become more knowledge-intensive, and “as what constitutes national wealth shifts from the natural resource endowments toward the acquisition, manipulation, and application of knowledge,” the ownership and marshaling of indigenous knowledge in and by African societies have perhaps never been so crucial.<sup>6</sup> In the consideration of the foregoing, and as the “Western” world extracts African medicinal knowledge to be brokered between academic and business interests and African ministries of health perpetuate colonial ideas of “traditional” medicine, the contention of this essay could not be more timely.

In this essay, I use the Bono, an Akan society of central Ghana, because they provide but one of many significant case studies in the encounter between African therapeutics and medical anthropology in the twentieth century, and an African perspective on the substance of those

foregoing issues in the (medical) anthropology of Africa. The Bono have occupied an ecological zone between the dense forest and the savannah and, more importantly, have maintained an ancient and complex “ethnomedical” and nutritional system since at least the 1000 CE. After centuries of refinement, the therapeutic basis from which indigenous Bono healers contemporarily operated were dynamic and often did not function in the manner prescribed by or constructed in the minds of anthropologists, and indigenous healers appeared to draw upon a composite spiritual-temporal perspective in their day-to-day healing work uncluttered by the foregoing preoccupations in (medical) anthropology.<sup>7</sup> The potentialities of the indigenous therapeutic system offer an invaluable therapeutic option in addressing issues of health and healing in Ghana. Moreover, the Bono case implies that knowledge produced on such systems are less the realities on the ground than they are the representations of “authorities” who fail to fully grasp an unmediated picture of healing (in village or urban life) with and without the presence of the anthropologist, medical doctor, or NGO worker over time. In the last few decades, the ways in which indigenous (medicinal) knowledge has been “discovered” by these brokers of knowledge is cynically remarkable, and the appropriation and reduction of that knowledge for vested academic and pharmaceutical interests calls into question the vital issues of representations, authority, causation and therapy dichotomies, and the ubiquity of witchcraft.

### **The (Medical) Anthropologist and the Akan**

In medical anthropology, it has become somewhat popular nowadays to have cultural “conversations” about medicine and healing in ethnographic representations of those therapeutic “non-systems” studied.<sup>8</sup> In these ethnographic representations, the ultimate goal is some sort of negotiation “between the insider and outsider perspectives.”<sup>9</sup> Yet, as this goal or the mode of illness conversations seeks the foreground of healing discourses, vital issues that threaten this very same quest are simultaneously pushed to the background. Two of these key issues will suffice. First, relations of inequality and power are glossed over and presented as a given, that is, white university doctors or professors linked to “established” educational or medical institutions are supported by grant-giving agencies to conduct research in African or largely African populated societies in which enslavement and colonialism are a part of the living fabric and memory. Whatever research related discussions or conversations occur, they most likely are “artificial dialogues” configured by the power relations historically situated, in the broad and multilayered scope of historical encounters, between the African and the European. The intent here is not to reduce the matter of research to white power and African subjugation, but rather to remind us that race (variously defined) is itself ubiquitous in ethnographic encounters in Africa and its Diaspora and cannot be simply ignored in any serious consideration of those encounters.

Robert Pool mentions, as one of several constraining factors, a fragment of this issue of power relations; however, this fragment is presented as a featherweight contender in the super heavyweight fight of his conversations about illness. Perhaps, his preoccupation with “witchcraft” obstructed this issue during his mediated dialogues. Secondly, Paul Brodwin talks much about the goal of ethnographic research as one of representation between “insider” and

“outsider” perspectives, yet he does not say much about money in terms of limited options in the availability of biomedicine for most of the rural population that he studied in Haiti. He also does not say much about his payment for witness treatments and consultations, which calls into question what actually occurred during his fieldwork and the dubious picture of village life he presents. In other words, Brodwin wrote as if he was absent from village life when his presence alone affected whatever normalcy existed prior to his periodic arrivals. This is not to suggest that anthropologists have the power to shift the meaning of an entire medicinal system by their mere presence, but that the representation of those systems by such researchers is not the reality they purport but a snapshot conditioned by their foreign presence and the fulfillment of academic interests. Brodwin’s aim, therefore, appears to have not been one of clarifying the reality of healing in rural Haiti but rather a convenient ethnographic exercise linked to issues in medical anthropology.

The emergence and life of a “Western” anthropological project was more than simply “framed by the [supposed] superiority of European and American science and industrial development and by the colonialist context of research.”<sup>10</sup> This project was and is an embodied vehicle of the views and values of those who desire or claim global hegemony in politico-economic and military terms. Therefore, as Sally-Anne Jackson argues, nineteenth century imperialism and biomedicine, which was re-imagined as tropical medicine, were inseparable and the intimate relationship between disease and empire, in terms of ailing African bodies constructed as vectors of infection, allowed for African exploitation and colonial imposition.<sup>11</sup> The diseased African body, cast as “other” or alien through the introduction of co-colonizing diseases such as tuberculosis, necessitated the denigration and suppression of “efficient indigenous healing systems in operation” and expedited the expendability of those from that “afflicted continent.”<sup>12</sup> The very nature of the “Western” anthropological project strongly suggests that “Western” (social) science has a direct relationship with European interests and imperialism, and the global presence of the former is an expression of European expansion. As such, the proposition “that indigenous/folk/local groups should determine... their own historical destiny—with the anthropologist as facilitator or broker”—has been heralded and unquestioned.<sup>13</sup> Even among those who question this belief, they have also “fail[ed] to escape the Western hegemonic mentality that they criticize.”<sup>14</sup>

In the medical anthropology of Africa, the ideas of W. H. R. Rivers and C. G. Seligman, both medical researchers who became anthropologists, have immense implications since the orientation of Rivers’ (1924) work became a widely used model (and some still employ it now) in “ethnomedical” research. For Rivers, death and illness were defined as afflictions and misfortune and the study of health and disease was reduced to his conceptions of witchcraft, sorcery, and magic—conceptions which, no doubt, were rooted in the long history of witchcraft and related phenomena in the European experience and imagination. The primary concern was with the disease—wherein the person was viewed as a diseased organism—and its magical, superstitious sources in terms of an unyielding obsession with magical theories of disease causation as the basis for indigenous therapeutic systems. This same orientation figured prominently in the works of V. M. Turner and E. E. Evans-Pritchard, Evans-Pritchard’s studies, precisely his work on the Azande published in 1937, became the framework which others have used to fit their data linked to “witchcraft” in Africa. Evans-Pritchard studied under C. G.

Seligman, who wrote the foreword to his text on the Azande, and in that same text Evans-Pritchard wrote, in spite of contradictory statements throughout, “witchcraft is ubiquitous” for “the Azande attribute sickness, whatever its nature, to witchcraft or sorcery” and secondary causes are “associated with witchcraft and magic.”<sup>15</sup> His study on the Azande might be oversimplified here, but that study’s concern or obsession with witchcraft parallels those anthropologists before and after him who have had a similar overriding focus.

Evans-Pritchard noted that the “royal class” detested their European colonizers and “were useless as informants,” suggesting that those who were useful informants were receptive or yielding to European conquest which surely made a difference in the value and volume of information obtained during his cumulative twenty month stay among the Azande. The recent works of British anthropologist Robert Pool, who spent time in the Wimbum town of Tabenken (Cameroon), resurrected Evans-Pritchard and propagated the model set forth by W. H. R. Rivers, and his devotees, when he concluded, “in the final instance everything boils down to witchcraft” in Wimbum and apparently in African etiology.<sup>16</sup> According to Pool, witches are the ultimate cause of all (significant) illness, misfortune and death, and given his acceptance of the long-standing dichotomy between “natural” and “supernatural” etiologies, he argues that Wimbum etiology is personalistic (“supernatural”) and the “Wimbum do not have a medical system” at all.<sup>17</sup>

Based in the Bono town of Bonkwae (Takyiman) during his study of the Primary Health Training for Indigenous Healers (PRHETIH) project, Peter Ventevogel also concluded that Akan medicine was not a “real system” because of its highly externalizing and diffuse character.<sup>18</sup> The issues of the existence (or denial) of indigenous African “medical systems,” theories of natural and supernatural or personalistic disease causation and therapy, and the ubiquity of witchcraft, which undergird the foregoing, saturates the discourse on African therapeutics and culture. In fact, these issues have become the discourse in (medical) anthropology.

For the Akan, Robert Sutherland Rattray’s collected works on the Asante, an Akan society, are considered “a monument of colonial ethnography and manifestly a major source,” and are utilized as one of several baseline sources for Asante and general Akan studies.<sup>19</sup> In 1921, the then Gold Coast Government chose Rattray as the first head of the Department of Anthropology. In the capacity of British colonial anthropologist, he traveled to areas formerly under Asante control and documented aspects of socio-political organization and indigenous “religious” life.<sup>20</sup> Rattray’s work focused on the Asante and, in the several chapters dedicated to festivals and Bono “religious life” in Takyiman, he, like his anthropological predecessors, went in search of the “gods” and even requested that one be made for him to take home to Britain.<sup>21</sup> Rattray did not attempt to explore the indigenous medicinal system nor its conceptual underpinnings. Instead, he contended that religion was inseparable from other facets of life and regarded the Takyiman area as a place “hitherto untouched by the anthropologist and hardly opened up to the European, [and which] should be the ideal ground upon which to study Akan customs and beliefs”<sup>22</sup>

In the 1930s, Margaret J. Fields, a British colonial anthropologist intrigued by the new “witchcraft” shrine movement in Ghana, spent time at the Bono town of Mframaso (20 miles north of Takyiman) at a “witch-catching” shrine. She generalized from this experience and concluded, “According to African dogma sickness and health are ultimately of supernatural

origin" and "organic illness is almost always attributed to witchcraft, bad medicine or sin, seldom to worry and stress."<sup>23</sup> In the latter part of the 1960s, Dennis Warren came to Takyiman as a Peace Corps science teacher at the Takyiman Secondary School. Warren later conducted his doctoral study on Bono "disease, medicine and religion" and concluded the "religious system" had nothing to do with the majority of Bono disease lexemes or Bono diseases, which were conceptual, and that the vast majority of Bono diseases were defined in terms of natural causation.<sup>24</sup> Warren's argument here and elsewhere for "natural" rather than "supernatural" disease causation marked a shift from previous anthropologists, but only formed part of the fluctuating or circular contentions in anthropological understandings of African disease causation and therapy. Warren found that the most serious and common diseases were linked to the stomach, head, and malaria, and the highest-ranking causes were associated with (impure) blood, dirt and a dirty body, and insects (e.g., germs and mosquitoes). The anatomical location of most diseases were in the skin or internal; disease prevention strategies included eating good food, a clean living environment, drinking good water, and bathing twice a day, while the most frequently named medicines and ingredients consisted of ginger, varied peppers, water, and lime.<sup>25</sup> The baseline data for Warren's study derived from nearly 1500 "disease names organized into a 12-level taxonomic system expressed by one venerated Bono priest-healer [Nana Kofi Donkor]."<sup>26</sup> The data gathered from Nana Kofi Donkor was compared with data from other informants within the same community; this approach used more than one informant as a reliability check on initial and primary informants, "the most important being Nana Kofi Donkor of [Takyiman]."<sup>27</sup> In addition to the construction of his disease classificatory scheme, Warren argued that spiritual causations of disease do occur but naturally caused diseases did not have structural or functional relationships with Bono "religion" (what he termed *Onyamesom*), hence, his dichotomy between "spiritually and naturally caused diseases."<sup>28</sup>

Peter Ventevogel, who conducted his studies on the effects of the PRHETIH program, argued, "the literature on Akan medicine lacks real consensus on the indigenous nomenclature of nutritional diseases... [and] indigenous disease names cannot be substituted unproblematically by Western disease terms."<sup>29</sup> The PRHETIH program was established in 1979 as a project to "train" indigenous healers in some of the fundamental techniques employed in the biomedical system. The project collapsed in 1983 and was later revived in 1991. Evans-Anfom commented that the outcome of an evaluation of the PRHETIH program "should help in determining how trainable the traditional healers are."<sup>30</sup> Interestingly, Evans-Anfom neither considered nor questioned how "trainable" were biomedical practitioners, who appear to be hegemonic and the most hostile toward attempts aimed at "cooperation" (whatever that means). In sharply criticizing Warren, Ventevogel concluded:

It became clear to me that the indigenous knowledge is not readily available in the minds of the informants, ready to be 'discovered' by the anthropologist... The Techiman-Bono ethnomedical classification system can be seen as an attempt to formalize a system that is not formalized in its nature... Akan traditional medical knowledge is not a solid body of knowledge. It differs from town to town, from healer to healer, from day to day. Akan medical knowledge is partially idiosyncratic and is embedded in an externalizing medical system.<sup>31</sup>

Ventevogel's study compares well with those of Robert Pool, and both noted the few key informants used by Warren and argued that the anthropological understanding of indigenous knowledge was produced and reproduced in an interplay between informants, interpreter, and researcher. However, their conclusions were at odds with those of Helga Fink, who studied in a Bono area but whose work drew heavily on Warren's dissertation and classificatory scheme, and Van Dalen, whose study in a Bono town revealed that disease was always the effect of certain natural and spiritual happenings rather than spiritual or natural (causative) factors. In challenging G. P. Murdock's dichotomy of natural and supernatural theories of illness causation and Pool's assertion that "everything boils down to witchcraft" in African ethnomedicine, Edward Green, a colleague of Warren, attempted to advance his indigenous contagion theory with the claim that major (contagious) diseases in African societies are naturalistic or impersonal.<sup>32</sup> Green, Warren, Van Dalen, Fink, Ventevogel, Pool, and others, no doubt, follow a long tradition of anthropological dichotomists who have argued for either side of the natural-supernatural coin, or claim the coin itself is worthless in their verdict on African medicinal systems, systems long regarded as synonyms for "witchcraft."

### On "Witchcraft" and the Akan Case

Many African nations "still retain Witchcraft Acts promulgated during the colonial era," and in Botswana, for instance, its "witchcraft proclamation" aimed at "diviners" rather than herbalists was passed in 1927 and remains in legal force.<sup>33</sup> On this historical phenomenon, the discourse on "witchcraft" in the African context is often silent as a pragmatic and ideological consideration in ethnographic "conversations" about illness and therapy. The resuscitation of Evans-Pritchard recently by Robert Pool, among several others, argues that there is no such thing as African medical systems since everything in those non-systems are ultimately embedded in and explained by "witchcraft."<sup>34</sup> In Bongmba's attempt at an interpretation of the phenomenon of "witchcraft" among the Wimbun—in one of whose towns Pool conducted his study—he notes the conceptual and contextual translation difficulties surrounding the Limbum terms of *bfui*, *brii*, and *tfu* employed to differentiate the varied phenomena consolidated under the term "witchcraft."<sup>35</sup> The fact that the Wimbun and perhaps other Africans have come to use non-Limbun vocabulary from other parts of Cameroon as well as English terms, such as witchcraft and sorcery, in their "attempt to make sense of what it means to be human" in a capitalist and homogenizing global order suggest the "borrowed" use of "witchcraft" is no more than semantical or misappropriated nonsense.<sup>36</sup>

Though Bongmba criticizes what he considers to be Evans-Pritchard's imposition of Azande thought in terms of epistemological superiority, it was writers such as Eva Gillies who concluded that the Azande or other Africans do not attribute diseases to witchcraft or sorcery for these "actors" make distinctions between different kinds of illness and between levels of etiology and pathogenesis.<sup>37</sup> Even those who argue that "beliefs and practices related to medical care should be subsumed under the domains of religion, magic or witchcraft," while contemplating Evans-Pritchard's contribution to polemic debates on rationality, have merely created ideational structures conducive to their own thinking and offering such creations as the reality.<sup>38</sup> In Murdock's global survey of the ethnographic literature using criteria derived from

medical science and anthropology, he found that witchcraft was “practically universal in the Circum-Mediterranean region but surprisingly rare elsewhere in the world.”<sup>39</sup> According to Murdock, this region includes “Caucasoids,” “the Afroasiatic, Indo-European and Maro-Sudanic,” and is distinct from the “region of Sub-Saharan Africa” offering “essential confirmation to a single region” based on overwhelmingly high witchcraft ratings.<sup>40</sup> “Witchcraft,” Murdock wrote, “is important among about a third of Africa’s peoples but is absent in about half of them.”<sup>41</sup> These findings offered by Murdock—however flawed by his creation or use of the above “ethnic clusters” and his reliance on studies which largely sought the exotic and supernatural—sketches a picture that does not support the “ubiquity of witchcraft” or that everything in African etiology boils down to “witchcraft” propositions.<sup>42</sup>

Among the Bono, the discourse on “witchcraft” finds little solace but rather an opportunity for clarification. *Bayie* (“witchcraft”) is a power or energy with intent used positively or negatively, and writers often translate it as “witchcraft” (the act itself). *Abayisem* as well as the Fante *ayen* is also employed, and the former refers to “witchcraft” or (*a*)*bayie* matters, issues, and cases (*nsem*). According to Akator, *bayie* derives from the phrase *ebeye yie* (“it will be good or all right”); if this is the case, then we must reconsider the exclusive “witchcraft” connotation the term *obayifoo* (pl., *abayifoo*; one who does *bayie*) seems destined to have.<sup>43</sup> The phrase, according to Akator, is an optimistic utterance made to give hope and direction for one who needs to consult the *obayifoo*. In the Bono area of Takyiman, *abayi-bonsam* is the male “witch” who does or uses *bayie*, while *obayifoo*, a gender-neutral term that applies to either sex, is used for the female. The (female) *abayifoo* usually outnumber the *abayi-bonsam*, and the abode of the *obayifoo* is in the female line of the family where the most damage occurs among the *obayifoo*’s own blood relatives.<sup>44</sup>

The idea that *abayifoo* are powerless outside of their own clan, possess an organizational structure akin to Akan polities, and desire and feed on blood suggest that *abayi* is a metaphor embedded in, yet antithetical to Akan social order, which is rooted in the *abusua* (mother-centered family or clan) itself synonymous with *mmogyia* or blood.<sup>45</sup> One may never know who is an *obayifoo*, even the *obayifoo* themselves—as one may be born this way or do the work of an *obayifoo* unconsciously. Nana Kwasi Appiah, one of my informants, argued that “witchcraft” was inborn or inherited with a capacity for positive ends, but it is the person’s mind or the factor of intentionality that shapes *bayie* into something negative.<sup>46</sup> Confessions by *abayifoo* are usually made after they have been caught by one of many “*abayifoo*-catching” *obosom* (“spiritual agents” or “emissaries” of an Akan Creator) called *obosombrafoo* (pl., *abosommerafoo*). If an *obayifoo* does not confess, they are spiritually executed by the *obosombrafoo* prior to a warning of some sort to elicit a confession. The confession appears to be cleansing and medicinal, and akin to the Akan protocol involved in greeting someone: though the person may live next door, he or she must state his or her “mission” or intent for visiting in order to cleanse the social space and prepare it for positive interaction. A confession, though perhaps stating the obvious to others in a way similar to a neighbor stating why he or she is visiting, may operate within the same line of reasoning as the Akan greeting protocol.

Nonetheless, there was a shift from the *tete abosom* (ancient Atano *abosom*) to the increased popularity of *abosommerafoo* in the late nineteenth century and first half of the twentieth century.<sup>47</sup> This shift corresponded to (a) the decline of Asanteman (Asante nation) in the late

nineteenth century and British colonial imposition; (b) instability in Akan society largely occasioned by colonial rule; and (c) the upsurge of what became the cocoa industry, which facilitated the rise and popularity of the *abosommerafoo*, the majority of which came from northern Ghana and Burkina Faso. The spread of the *abosommerafoo* paralleled the spread of migrant workers who came from northern Ghana, Burkina Faso, and elsewhere. In 1879, cocoa plants were successfully cultivated in the Akwapem area of Ghana's Eastern Region. The Gold Coast government took control of this industry by 1890. The cocoa industry's emergence led to not only sharp declines in palm and coffee products, but also occasioned one of the most crucial changes of the twentieth century in Akan (and Ghanaian) society. Thousands of farmers became prosperous and created tremendous income gaps between them and the urban professionals, subsistence farmers, and underemployed migrant laborers.<sup>48</sup>

The outward expansion of the cocoa industry from the Akwapem area caused a migration of farmers who sought new lands for cocoa trees and cocoa regions depended on tens of thousands of migrant laborers who came from northern Ghana, Burkina Faso and elsewhere.<sup>49</sup> The increase in the use of *abosommerafoo*, such as the Tigare *obosom* from Yipala in northern Ghana, mirrored the increase in the cocoa cash crop that brought heavy social tensions as many farmers cultivated this crop and challenged the social structure that provided security for its members.<sup>50</sup> Major socio-economic changes usually alter a society's disease patterns, and the expansion of cocoa farming in southern Ghana provided a stimulus for opening roads and clearing forestlands for agriculture, which further facilitated the breeding of the mosquito that is the major vector of falciparum malaria.<sup>51</sup> The logic that industrialism, economic growth, and increased living standards produces better health conditions, as suggested by Patterson, seems problematic and inconsistent.<sup>52</sup> As Patterson himself notes, with urban growth there has been a decline in human life and health, and with higher incomes consumers could choose nutritious foods or white bread, sugar, tea, tinned milk (for infants), and other foodstuffs of dubious value.<sup>53</sup> The phenomena of deforestation and commercial lumbering, which began in the 1880s, allowed sunlight to reach pools of water creating favorable breeding conditions for malaria-carrying mosquitoes. Though the above transformations presented specific challenges to indigenous healers and their practice, the Bono have maintained an allegiance to their ancient Atano *abosom* despite the shifts in Akan society and spiritual practices, and still regard the *obosomfoo* as senior to the *okomfoo*.<sup>54</sup> The *obosomfoo* attends to the *abosom* and provides healing services, and, in this matrilineally inherited but male position, he oversees the "shrine" attendants, including the gender-neutral role of *J*—another category of indigenous healers. The *abosomfoohene* ("head *obosomfoo*") for Takyiman "state" *obosom* Taa Mensa (Tano Mensa; "Taa" is the contraction of "Tano," as in the Tano River) has a position of authority above all individuals inclusive of the Takyimanhene ("male leader of the polity"). This social configuration and the role of its spiritualists in healing individual and community ailments suggests a strong concern with order and balance, including those that use *bayie* (so-called "witchcraft") for nefarious ends, and this concern forms part of larger perspective on indigenous medicinal knowledge and its dimensions and challenges.

### Akan Perspectives on African Medicinal Systems

In reducing African medicinal systems to “witchcraft,” global readers and Africans consume such anthropological or colonial renderings of those systems and, invariably, fail to appreciate the layers of indigenous (medicinal) knowledge possessed by various members of a community and the ideational basis of the systems’ approach and therapy. In the Bono therapeutic system, there exist key spheres in production, transmission and deployment. The three primary and overlapping spheres include those at the level of core and basic knowledge, specialized and in-depth knowledge, and peripheral knowledge. The first sphere corresponds to the core-basic knowledge shared by most, if not all, community members and the basis upon which those members plan and do. Here, “core-basic” refers to what is fundamental and widely known within the indigenous medicinal system, and at an essentially basic level of knowledge and aptitude, though there are those who are an exception to this general observation. For instance, a “majority of the population [still] prepare and use their own herbal mixtures,” and thereby exhibit agency in the process of addressing their health needs.<sup>55</sup> Informal interviews among the youth of Takyiman found that they were very knowledgeable about many medicinal plants and their functions, in addition to revealing the names and utilities of at least six of the most effective and frequently used medicines cited by indigenous healers in the Takyiman district.

The second sphere corresponds to specialized and in-depth knowledge that is associated with the specialists who function ultimately to maintain the coherency and expand the development of the community as it principally relates to holistic health and healing. Those specialists were the indigenous healers who represent the institutions of *abosomfoo*, *akomfoo*, and *nnunsinfoo* (“herbalists”). Almost all of the indigenous healers interviewed agreed—with the exception of one who qualified her response—that there was a clear distinction between *nyansa* (wisdom) and *nimdee* (knowledge). In terms of the procedural relationship between wisdom and knowledge, wisdom was older than knowledge and one could not acquire knowledge without wisdom. However, it appeared that knowledge was considered heavier or more substantial than wisdom for reasons that one was born with the capacity for knowledge but knowledge had to be learned and developed, and thus it grew, accumulated, and became “heavy” as a result of one’s journey through life.

The third and last sphere of peripheral knowledge refers to information about a people’s existence at varied points and events in their lives. This sphere is “static knowledge” that lacks the dynamism or “lived” characteristic of the core-basic and specialized and in-depth spheres, and archives aspects of the first and second spheres similar to how a camera captures the image of a person or event. The picture only *re-presents* a finite moment in the life of that person or event, and clearly is not the person or event; nor can the picture attempt to embody the person or event as a living entity or experience. The picture merely archives that finite moment, which, interestingly, in and of itself, may contain a vast amount of information and insight well beyond the moment that it visually captures. Numerous narratives or kind of information can potentially be preserved within a single photo or another documenting and archiving mechanism. Yet, even photos and archiving mechanisms spoil, corrupt, or even corrode over time, hence, acknowledging their inherent limitations. This peripheral knowledge, although

significant, has been the nature of all (medical) anthropological writings, and the still pictures they have purported in the field and documenting media of anthropology must always be (re)evaluated in juxtaposition to the “core-basic” and “specialized” knowledge in the fields of Africa.<sup>56</sup>

The above spheres of indigenous medicinal knowledge all share an ideational basis that further questions the ubiquity of “witchcraft” proposition and the common anthropological understandings of African therapeutics. The ideational basis of indigenous African medicine suggests a holistic approach to balanced health and other human circumstances and this basis considers the variables of family, way of making sense of the world, vocation, ecology, and cultural environment while placing a high value on the human being.<sup>57</sup> In one of Mandeng’s interviews with an elder healer in Cameroon, that healer explained, “the living and the dead, we all live in the same world.”<sup>58</sup> Instructive and simple are these healer’s words, yet the dichotomization in the theories of African illness causation and treatment well represented in the literature remain quite pervasive.<sup>59</sup> If this dichotomy were an academic journal, it would appear from the literature that many writers have active or perhaps lifetime subscriptions in terms of buying into the supposed “naturalistic” and “personalistic” explanations of disease and the therapeutic strategies deployed.<sup>60</sup> A few have constructed three categories of illness causation, namely, natural, preternatural, and supernatural to explain the parallel physical, “magical,” and “ritual-sacrifice” dimensions of each respective category, while most have remained vigilant on the natural-supernatural antagonism.

Guided by the belief that the anthropologist’s first task is “to find the simplest taxonomy for causality beliefs” and that to “depersonalize causality” reflects an “evolution of culture,” Foster, among others, argued the principal etiologies of “non-Western medical systems” were personalistic and naturalistic in nature.<sup>61</sup> Painted on a neat canvas as irreconcilable opposites, these two primary etiologies have been criticized as “inappropriate and unnatural categorizations” undermining “a more emic approach,” and as “enormous reduction” that fails to examine health and sickness ideas “as they are in the usually exigent context of social action.”<sup>62</sup> Moreover, the naturalistic-personalistic dichotomized model is deficient not only in terms of addressing how practitioners and patients conceptualize illness and therapy, but in terms of also explaining health behavior and perceptions in situations where multiple health systems are utilized by members of a given society. If a society does not distinguish what researchers call “separate levels of reality,” then why do these same writers present that society in terms of “natural” and “supernatural” worlds?<sup>63</sup> The main idea which emerges then from the varied perspectives riddled by the natural-supernatural dichotomy is that complexities of life, whether health related or not, are often crudely forced into one generalization or another without regard for the ways in which real people approach and resolve health and healing circumstances during their life cycle(s).

Pervasive or not, the dichotomization of African societies and the ideational basis of their therapeutic systems are commonly unrealized in the praxis of indigenous Bono or Akan healers.<sup>64</sup> Accordingly, one can say, “Both the organic and the spiritual aspects of the disease are taken into consideration... [and that the human being] is a compound of material and immaterial substances, which makes the maintenance of a balance between the spiritual and material in [humans] a condition for sound health.”<sup>65</sup> However, to correspondingly claim, “[t]he

practice of medicine is closely tied up with the practice of religion in Africa," confuses indigenous concepts of medicine and healing through the use of the alien variable of "religion" with its untangled linguistic and cultural baggage.<sup>66</sup> The Bono ideational approach to healing is based on a composite spiritual-temporal perspective rather than a "religious" grounding, and that perspective is found in other African societies. For instance, the Bantu-Bakôngo notion of *n'kisi* ("medicine") is complemented by the concept of "self-healing power" as "the biogenetic package of power that is received at the moment of conception in the mother's womb."<sup>67</sup> This package is not only the key to one's health, but it is the excellent healer since it is both creative and generative. For the Bantu-Bakôngo, sickness is the abnormal functioning capacity of one's self-healing power caused not by bacteria or virus, but by the loss of the body's balance or energy.<sup>68</sup> The cure is perceived in terms of wholeness and the therapist (*n'niâkisi* or *m'fièdi*) "believes that therapy is essentially grounded in both flesh and spirit," a process of restoring self-healing power.<sup>69</sup> In Nigeria, Offiong concluded, "It seems proper to assume that religious [i.e., spiritual] factors are intrinsic to healing."<sup>70</sup> In the Ivory Coast, Memel-Fotê found that—among the Mande, Gur, Kru, and Akan—the comprehensiveness of indigenous medicine was characterized by "its broad conception of health, sickness and cure, itself linked to the idea of life," and indigenous "medical theory [was] that man's nature is not only physical but also mental and spiritual."<sup>71</sup>

Noticeably, Ghanaians have been described as "ambiguous" with confused attitudes towards indigenous (medicinal) systems and Western (medical) institutions because of the "fatal impact of irreconcilable social systems and cultures."<sup>72</sup> This ambiguity is a cultural and ideational phenomenon, and its powers compel even academic "authorities" in Ghana to proclaim, "it is for us scientists to throw the light of science on the herbalist's art, and lay a more pragmatic and scientific basis for his practice."<sup>73</sup> This pronouncement is not an anomaly for it is wholly consistent with others that passionately declare, "healing with herbs cannot continue to be just an art" since "African methods were wholly trial and error."<sup>74</sup> Many of these scholars, however, fail to either recognize or accept that there has always been a demystified "scientific" process to indigenous medicine in addition to the vast knowledge of medicines acquired through close observation of nature and animals' application of those medicines, trial tests on animals and sometimes humans, and practical experience accrued over centuries.<sup>75</sup> More importantly, it is the misguided pronouncements of Ghanaian scholars on the issue of indigenous medicine and the gestation and propagation of "witchcraft" driven anthropological understandings of "traditional" medicine that provided a dubious setting for current debates of "integration" or "cooperation" between indigenous and biomedical systems.

### **Integration versus Cooperation**

Some have argued struggles, resistance, adaptation, critique, negotiation, and appropriation have characterized the encounters between indigenous and "Western" medicine, but these processes have all reduced indigenous systems to "things." Correspondingly, individual herbs were objectified through "Western" analytical concepts, bio-chemical analysis, randomized clinical trails, creation of patents for bio-chemical substances, and marketing those substances as drugs and nutritional supplements. In this context, the debate with regard to the

“integration” of indigenous therapeutic systems (specifically their varied categories of healers) into national health delivery systems in Africa remains a discourse captured by seemingly irreconcilable ways of thinking, cultural behavior, and sensibilities.<sup>76</sup> Irrespective of the argument that the distance between “Western medicine” and “non-European folk medicine is a product of post-nineteenth century medical science,” the lives of African people are decisively affected by the contestation that exists between the two.<sup>77</sup> Given that African ministries of health and medical schools still propagate colonial attitudes towards indigenous healers, and missionary and government school curricula nurture those perceptions, it is not surprising then to find ambiguity harbored in the minds of Ghanaians, and the Akan in particular, especially with regards to matters of indigenous healing.<sup>78</sup> Part of this ambiguity is itself rooted in the ways in which colonial rule both heightened so-called “witchcraft” tensions, altered disease environments, and affected the search for and value placed upon viable therapeutic options.

At the turn of Ghana’s political independence in the 1960s, a leading anthropologist among the Bono (Akan) argued, “the introduction of Western institutions has not resulted in conflict between culture or between ‘traditional’ and ‘modern’ segments of culture, but rather in accommodation.”<sup>79</sup> Warren’s perspective, and other anthropological understandings of indigenous medicine, facilitated the first of several integrative health projects and shaped the “integration” of indigenous healers with biomedicine in Africa. In the 1970s, Ghana was one of the first to host health initiatives such as the Damfa project funded by USAID in Greater Accra, the Brong-Ahafo Rural Integrated Development Project (BARIDEP) project funded by the World Health Organization (WHO) and the Swedish International Development Cooperation Agency (SIDA) in the Kintampo district, varied United Nations Children’s Fund (UNICEF) sponsored training projects, and the Primary Health Training for Indigenous Healers (PRHETIH) project which operated between 1979-1983 in the Takyiman district.<sup>80</sup> Several projects of a similar nature were initiated in the Bono inhabited districts of Berekum and Dormaa based upon the PRHETIH experience and the film initially entitled *Bono Medicines* (1983) and later renamed *Healers of Ghana* (1996). Many indigenous healers who participated in the PRHETIH program soon discovered the “one-way” nature of PRHETIH as well as analogous efforts (e.g., the Damfa project). This realization was confirmed by project facilitators who noted how sessions on herbs were the best received while those sessions that “consisted primarily of advice or description” were least welcomed.<sup>81</sup>

The above experiences have engendered multiple arguments and proposals. Some argue that integration is pragmatically impossible but some form of cooperation in areas where both indigenous and “Western” medicine complements each other is feasible. Others propose that integration or collaboration could lead to a reconciliation of the unsettled encounter between indigenous African and “Western” medicines and the cultural frameworks in which they are embedded. In other words, the renewed interest in and debate about the integration of indigenous medicine and “biomedicine” has its origins in and is a synonym for the historic encounters between adherents of both approaches to health and healing. Integration or not, African governments continue to place demands on indigenous medicine to “go modern” by way of scientific rationality, some biomedical doctors recognize healers as potential allies in the fight against AIDS, and pharmaceutical companies and similar agencies exploit indigenous

medicinal knowledge (through intellectual property rights conventions) under the auspices of “collaboration.”<sup>82</sup>

Perhaps the barriers to integration are in fact substantial and the benefits are unproven, as some have argued.<sup>83</sup> Proposals to provide on-the-job training for young health professionals with indigenous healers, for public education to rectify the popularized false perceptions of indigenous medicine, to utilize indigenous healers as part of a global disease reporting systems for emerging diseases, and to create a two-tier medical school system may be missing a vital point.<sup>84</sup> The conjuncture of views and propositions on integration or collaboration suggests what is really at work is a recasting or reduction of indigenous medicine as a mechanical, lifeless, and inhuman adjunct to biomedicine with a “one-size-fits-all” approach that neglects the fact that physiologically, emotionally, spiritually, and ideationally no two human beings are the same. In effect, indigenous medicine will become like biomedicine and since we are dealing with “two different medical paradigms,” as Hedberg and Straugård observed, integrative attempts to compartmentalize the “empirical” and the “spiritual” and, subsequently, disregarding the latter will only engender an inadequate version of “modern medicine.”<sup>85</sup> In this context, Foulkes’ contention that indigenous African medicine is a system that is “irreconcilable with our own” (i.e., “Western” or “bio-medicine”) seems more intelligible though there are those who believe that there is compatibility “in the domain of contagious disease.”<sup>86</sup> Surprisingly, the relatively high levels of collaboration among indigenous healers themselves in places such as Cote d’Ivoire — Ghana’s western neighbor and home of several Akan groups—do not form part of the discourse nor do they figure in proposals for health projects in African societies.<sup>87</sup> Rather than efforts to further collaboration and efficiency among indigenous healers who serve much of the general populace, we are left incarcerated by the idea that “traditional healers are a poorly organized group of people with only a low formal education, and therefore cannot be regarded as equal partners with Western health care workers who are well trained and embedded in powerful institutions.”<sup>88</sup> Lastly, one cannot simply imitate or import, in the African context, the stories of “integration” between “traditional” and “biomedical” specialists in the Asian countries of China, Vietnam, and Singapore.

The way the “cooperation” discourse is framed, indigenous healers and the medicinal system they represent are problematized—that is, there is a problem “training indigenous healers” and integrating them into the biomedical system. In that framing, “cooperation” or “integration” is never stated as a process of creating a new system wherein both participate on agreed upon terms or that biomedical workers “integrate” the indigenous system, particularly if that system represents and is responsive to the overwhelming majority of the population. Rather, the “cooperation” or “integration” debate has been unilateral with the biomedical system being both the source and the destination; this situation has been glaringly demonstrated by the health projects initiated in several Bono districts. It would seem more sensible to “integrate” into a indigenous system that is embedded in the thought and pragmatic structure of society than to do the same with an external (and antagonistic) system, such as the biomedical one, which is imported and removed from the majority of the people, and only accessible to a few financially well-off, urbanized individuals. This debate, however framed, appears to be a distraction from the real issue: the inherent and unbalanced power relations

embedded in society, and the marshaling of human and other resources towards the substance of people's lives. It is not that unequal power relations make therapeutic pluralism impossible, but that very social arrangement, often evident in widening socio-economic disparities, does not marshal the same levels of resources to support indigenous therapeutic options used by large parts of the citizenry.

At the cultural or ideational level, both the indigenous and the biomedical systems are irreconcilable at their very core. The notion of "integration" seems misguided and the idea of "cooperation" (whatever that means) appears more feasible if both systems acknowledge and accept their areas of expertise and limitations, perspectives and cultural foundations from which they operate, and are genuinely concerned about the difficult but necessary task of being human. The fact is medical training in Ghana and other parts of the world traditionally focus on disease diagnosis and management rather than on preventative medicine and health promotion. The lesser focus on preventative medicine and health promotion has historically constituted the very underbelly of biomedicine. It appears, therefore, serious introspection for biomedical systems existing in Africa is an imperative before any pragmatic consideration toward cooperation or collaborative efforts between those systems and indigenous ones. In rural Haiti, the competing ideologies of Catholicism and Protestantism unite and consolidate their assault toward Vodun adherents and specialists as their "demonic inverse," and yet, Haitians continue to seek out and utilize the latter's therapeutic services.<sup>89</sup> In Ghana and other parts of Africa, the collaboration between the truncated nation-state and its political and medical instruments engaged in their own assault through policy, propaganda, and resource misallocation. Yet and still, the cultural views and values of its vast majority, particularly rural dwellers, as well as many "educated," "un-schooled," and Christian or Muslim individuals alike seek out the therapeutic services of indigenous healers. These peoples negotiate socio-political circumstances as best as they can through what they know, and it has become clear to me that their intergenerational knowledge has not brought them this far because it is solely or most importantly hinged on the fear of "gods" and the nocturnal activities of witches.

## Conclusion

Ventevogel concluded, "medical knowledge is not a thing or a fact, it is the outcome of a historic process," and postulated, "constructing an 'ethnomedical' system resembles taking a snap-shot of a certain place at a certain time."<sup>90</sup> Though Ventevogel's notion of a "snap-shot" lends itself to our discussion of peripheral sphere of indigenous knowledge (i.e., capturing what exists in a delimited historical and cultural context), he is really insinuating that the Akan medicinal system is not what it was a hundred years ago nor will it be the same a century from now. The boundaries of what constitutes "Akan medicine" are becoming blurred. However, Minkus's findings on Akan medicine twenty years ago, Maier's findings from the literature related to Asante (Akan) medicine almost two centuries ago, and what eighteenth and nineteenth century writers observed on the Gold Coast (contemporary Ghana) still holds true among many Akan communities.<sup>91</sup> This does not mean Akan medicinal knowledge is static or resistant to refinement, but has been one of continuity in medicinal practices aligned with spiritual-temporal convictions held over the centuries. The boundaries of what constitutes

“Akan medicine,” as opposed to Mossi or Dagomba medicine, are sometimes not easy to discern because of movement, interaction, and incorporation of varied skills and techniques related to health and healing. This development, however, reveals the significance of the Bono cultural and ecological zone as a point of (medicinal) knowledge convergence among varied African societies and implies an internal pan-African knowledge base among West Africa therapeutic systems—a development borne of historic processes in the “field” of West Africa.

Out of historic processes and encounters also came the fluctuating and, at times, divergent perspectives on the “naturalistic” or “supernatural” basis of African therapeutic systems in medical anthropology and a reduction of those systems to an ubiquitous “witchcraft.” I have argued this development came out of a continuous failure to locate African perspectives on the substance of such realities in African societies, and that failing emerged from a quest for “ethnographic cases” and issues of “witchcraft” and “supernatural” etiologies *in* the field of medical anthropology rather than the field *of* African knowledge and perspectives. Our discussion has placed that failing and its importance into proper and broader context. In so doing, this essay also sought to clarify some of significant realities linked to health and healing in Akan societies and since these societies were sites of “integrative” health projects for several decades, those realities contributes a valuable perspective on issues of “witchcraft,” disease causation and therapy, and on the integration or cooperation debate in medical anthropology. An Akan perspective on those issues suggests a strategic distinction between two sites of knowledge production—field of medical anthropology and the “field” of Africa where fieldwork is conducted—on the larger canvas of global health issues. Such a distinction revealed “witchcraft” was more ubiquitous in the anthropological literature than in the “field” of Africa. Anthropological approaches to and understandings of indigenous medicine constructed the “integration” debate and the key factor of incompatibility. The medical anthropology of Africa will remain constricted by its history unless it exorcize its obsessive quest for supernaturally charged medicines, magic, gods, and witchcraft.<sup>92</sup>

## Notes

1. Rukangira 2001, p. 180.
2. Bishaw 1991; Gessler et al. 1995; Puckree et al. 2002; Rukangira 2001, p. 180; Stekelenburg et al. 2005, p. 78; Mandeng 1984, pp. 3-4; Betti 2004, p. 3; Osujih 1993; Offiong 1999, pp. 128-29; Ekpere and Mshana 1997, p. 2.
3. Toafa et al. 2001; Bell et al. 2001; Marbella 1998, p. 184; Payne-Jackson and Lee 1993, p. 3.
4. “biomedicine” and its variants (e.g., biomedical, allopathy, conventional medicine) refer to the use of biological, biochemical, physiological, and other basic “scientific” assumptions to address issues in clinical medicine, particularly as it relates to an almost obsessive focus on the body as a biochemical contraption that is the source and site of disease or sickness
5. See Farnsworth, 1988.
6. Edoho 1997, p. 100.
7. See Konadu 2007.
8. Brodwin 1996; Pool 1994a.

9. Brodwin 1996, p. 194.
10. Good 1994, p. 21.
11. Jackson 2003, pp. 3-5.
12. Ibid., pp. vi, 5.
13. Purcell 1998, p. 260.
14. Pfeifer 1996, p. 47.
15. Evans-Pritchard 1937, pp. 63, 479.
16. Pool 1994b, p. 12.
17. Pool 1994a, pp. 108-112, 254, 264.
18. Ventevogel 1996, p. 136.
19. McCaskie 1983, p. 187.
20. Rattray, 1923, pp. 5-10.
21. Rattray 1923, pp. 172-87; see also Platvoet 2000, pp. 80-96.
22. Rattray 1923, p. 114.
23. Field 1960, pp. 112, 117.
24. Warren 1974, p. 431.
25. Warren 1974, pp. 299, 343, 357.
26. Warren 1974, p. v.
27. Ventevogel 1996, p. 132.
28. Warren 1974, pp. 95, 431.
29. Ventevogel 1996, p. 95.
30. Evans-Anfom 1986, p. 58.
31. Ventevogel 1996, p. 137.
32. Green 1999, pp. 17, 37.
33. Makhubu 1998, p. 40; Hedberg and Straugård 1989, p. 22.
34. Pool 1994a; 1994b.
35. Bongmba 1998, p. 166.
36. Ibid.
37. Feierman 1985, p. 108; Gillies 1976, pp. 358, 391-92.
38. Morley 1979, pp. 2, 8-9; Foster 1976, p. 773.
39. Murdock 1980, p. 21.
40. Ibid., pp. 43, 45-46, 52.
41. Ibid., p. 48.
42. van der Geest 1984, p. 60; Murdock 1980, p. 8.
43. Akator 1988, p. 12.
44. Brempong 1996, p. 44.
45. Rattray 1927, pp. 28-29.
46. Appiah, K. Interview by author. Nyafuman (Takyiman), Ghana, 25 December 2001.
47. Silverman 1987, p. 285.
48. Patterson 1981, p. 103.
49. Ibid., p. 7. The Gold Coast government in 1947 established the Cocoa Marketing Board, which determined the optimal conditions for producers, fixed prices locally and for distribution to the world market, and appointed agents who bought cocoa from farmers

- on behalf of the board. The board was or currently is the only authority to market cocoa outside of Ghana and the Kwahuhene is the head of the board.
50. Ventevogel 1996. Tigare is both a *suman* and an *obosom*, and the latter is a more recent development according to traditions found among the Bono. According to oral historical sources, Tigare was a *suman* used primarily by hunters, as a hunter found it in the forest, and as a *suman* it did not “possess” its custodian. A Tano *obosom* extracted clay from the Tano River, in addition to other ingredients, and placed the composite substance on the Tigare *suman*, transforming it to an *obosom*.
  51. Patterson 1981, pp. 1-4.
  52. Ibid., p. 8.
  53. Ibid., pp. 6, 9.
  54. Konadu 2007, pp. xx, 53-57.
  55. Warren 1974, p. 325.
  56. The spheres of indigenous medicinal knowledge detailed here also exists in other African and African-descended societies, such as those in Cameroon, Ghana, Tanzania, and Haiti, and among healers in the Bolivian Andes and Amazon. See Betti 2004, p. 3; Dokosi 1969, p. 119; Mandeng 1984, pp. 4-6; Swantz 1990, p. 11; Brodwin, 1996, pp. 2-3; Vandebroek et al. 2004, p. 838.
  57. Bishaw 1991, p. 199; Memel-Fotê 1999, p. 328; Mandeng 1984, p. 247; Appiah-Kubi 1981, p. 148.
  58. Mandeng 1984, p. 245.
  59. Green 1999; Murdock 1980; Warren 1974.
  60. Muela et al. 2000; Green 1999; Bierlich 1999; Gyekye 1997, pp. 245-46; Ventevogel 1996; Gbadegesin 1991, pp. 128; Fink 1990; Swantz 1990, pp. 143; Warren and Green 1988, p. 6; Mandeng 1984; Warren 1982, p. 89; Fosu 1981; Morley 1979; Foster 1976.
  61. Foster 1976, pp. 775-776.
  62. Foulks 1978, p. 660; Kleinman 1978, p. 661.
  63. Bierlich 1999.
  64. Ventevogel 1996, pp. 132-133; Van Dalen 1987; Minkus 1980.
  65. Opoku 1978: 149.
  66. Ibid., pp. 148-49.
  67. Fu-Kiau 1991, p. 23.
  68. Ibid., p. 39.
  69. Ibid., p. 49.
  70. Offiong 1999, p. 129.
  71. Memel-Fotê 1999, p. 328.
  72. Assimeng 1999, pp. 246-247.
  73. Addae-Mensah 1992, p. 49.
  74. Addy 2003, p. 31; Addae 1996, p. 13.
  75. Opoku 1978, p. 150.
  76. Offiong 1999; Ventevogel 1996; Good 1987, pp. 17-18; Anyinam 1987; Evans-Anfom 1986, pp. 43-62; Pillsbury 1982; Rappaport and Rappaport 1981; Twumasi 1975.
  77. Meyers 1976, p. xii.

78. Assimeng 1999, p. 246; Nakuma 1994.
79. Warren et al. 1981, p. 18; Warren 1978, p. 77.
80. Warren 1986, p. 26.
81. Warren et al. 1981, p. 14; Appiah-Kubi 1981, p. 148.
82. Liverpool et al. 2004; Yangni-Angate 2004, p. 4; Offiong 1999, p. 128; Gessler et al. 1995, p. 158; Twumasi 1988, pp. 26-27; Warren et al. 1981.
83. Barrett et al. 2004, p. 258.
84. Groce and Reeve 1996, p. 352; Nakuma 1994; Appiah-Kubi 1981, p. 148.
85. Hedberg and Straugård 1989, p. 29.
86. Foulkes 1992, p. 122; Green 1999, p. 17.
87. Memel-Fotê 1999, p. 333.
88. Ventevogel 1996, p. 123.
89. Brodwin 1996, p. 193.
90. Ventevogel 1996, p. 135.
91. Bosman 1967<sup>170</sup>, pp. 224-225; Smith 1967<sup>174</sup>, p. 225; Bowdich 1966<sup>181</sup>, pp. 371, 397.
92. Chesi 1989; Peltzer 1992; Pool 1994a.

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